

## CLINICAL INTEGRATION: A PHYSICIAN AND HOSPITAL STRATEGY FOR BETTER QUALITY, ENHANCED COMPETITION, AND COLLECTIVE CONTRACTING

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Since the 1970s, the development of managed care speaks to a common need among consumers, health plans, employers, hospitals, and physicians – to find a *value proposition* in the financing and delivery of health care services. While this value-seeking provides a source of perpetual tension among these stakeholders, it also serves as the engine that drives innovation in our American health care system.

It begins, appropriately enough, with patients – who, as consumers seek an elusive combination: broad provider choice, high quality care, rich benefits, and low cost. Employers seek to meet this consumer desire as means of attracting new employees and retaining their current workforce, while at the same time pursuing benefit designs that address the factors that most significantly impact the costs of health care. For their part, health plans attempt to deliver what their employer customers demand, while at the same time retaining as much of the employer's premium dollar as possible to produce the profits that their shareholders have come to expect. All of these factors serve to motivate providers – the doctors, hospitals, and other health care facilities and practitioners who actually care for patients – to meet their duty to provide good care in a manner that yields both measurable, positive results and fair compensation.

Today, a new model of managed care, *clinical integration*, promises to align these sometimes violently conflicting incentives in a manner that provides greater access to care, better clinical quality, and cost control in the long-term. Clinical integration provides hospitals and physicians with the ability to thrive in the advent of consumerism, pay-for-performance, and quality report cards. It positions health care providers to compete in their local market on the basis of providing high quality health care, and not on the basis of unit cost alone.

And, in addition to improving health care quality and providing an effective business strategy, clinical integration also allows networks of independent physicians and hospitals to enter into innovative, collective arrangements with PPO health plans in a manner that does not violate antitrust laws. This is particularly significant today in light of the active and rigorous enforcement of these laws against doctors and hospitals by the Federal Trade Commission over the last five years.

## 1. Antitrust Law and the General Prohibition Against Collective Negotiation

Many health care providers find it anachronistic at best that U.S. antitrust laws generally prohibit otherwise competing doctors and hospitals from negotiating jointly with health insurers. After all, with the massive health plan consolidation that has occurred over the last decade, payers often wield disproportionate leverage at the bargaining table. This seeming unfairness notwithstanding, however, U.S. antitrust laws have developed over time to treat hospitals, physicians, and other health care providers the same as any other seller of a product or service.

In 1890, Congress passed the Sherman Act to combat corrupt practices that restrained trade (through the creation of trusts) in the steel and railroad industries.<sup>1</sup> The application of the antitrust laws to physicians was not contemplated by Congress in 1890. In fact, for nearly a century, the Sherman Act was interpreted to apply to all industries except those of the “learned professions,” e.g., physicians and lawyers.<sup>2</sup>

Not until 1975, two years after the passage of the federal HMO Act and the creation of the IPA, did the Supreme Court abandon the “learned professions” exception to the Sherman Act.<sup>3</sup> This decision had little immediate impact on physicians, as, prior to 1975, physicians traditionally did very little in a collective fashion outside of the exchange of clinical quality data. After 1975, the first antitrust cases against physicians were brought by other physicians. The formation of the organized medical staff<sup>4</sup> and the onset of its use of peer review and credentialing activities gave rise to the first antitrust allegations -- i.e., that physicians, acting as medical staff members, failed to credential fellow physicians in order to limit competition in restraint of trade.<sup>5</sup>

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<sup>1</sup> See Binder, John J., *The Sherman Antitrust Act and The Railroad Cartels*, Journal of Law and Economics, 1988.

<sup>2</sup> This ‘exception’ was based on the recognition that the States had an exclusive interest in licensing and regulating professional practitioners as a means to protect the public health and safety, and that, further, some “forms of competition usual in the business world may be demoralizing to the ethical standards of a profession.” *United States v. Oregon State Medical Society*, 343 U.S. 326, 336 (1952). See also *Semler v. Oregon State Board of Dental Examiners*, 294 U.S. 608, 611-613 (1935).

<sup>3</sup> *Goldfarb v. Virginia State Bar*, 421 U.S. 773. Note that the Court specifically stated that “[i]n holding that certain anticompetitive conduct by [professionals] is within the reach of the Sherman Act we intend no diminution of the authority of the State to regulate its professions”. *Id.* at 793.

<sup>4</sup> For a brief history of the rise of the organized medical staff, see Starr, Paul, *The Social Transformation of American Medicine – The Rise of a Sovereign Profession and the Making of a Vast Industry*, 156 (1982.) For a summary of physicians’ closing of medical staffs to prevent competition, see *id.* at 162.

<sup>5</sup> See, e.g., *Patrick v. Burget*, 486 U.S. 94 (May 16, 1988). In the Supreme Court’s seminal case on the applicability of the federal antitrust proscriptions with respect to physician credentialing, the Court determined that physicians participating in hospital peer review proceedings were, indeed, subject to the antitrust laws and liable for any resultant damages to the physician whose performance was being reviewed. See *id.* at 105. Of course, while this case was pending before the Court, Congress had passed the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq., which immunizes participants in proper peer review processes from antitrust scrutiny. For other, earlier cases, see also *Quinn v. Kent Gen. Hosp., Inc.*, 617 F.Supp. 1226 (D.C. Del.,1985); *Weiss v. York Hosp.*, 745 F.2d 786 (D.C. Pa., 1984); *Pontius v. Children's Hosp.*, 552 F.Supp. 1352 (D.C. Pa., 1982); *Silver v. Queen's Hospital*, 629 P.2d 1116 (Hawaii, 1981); *Williams v. Kleaveland*, 1983 WL 1844, Filed Jan. 27, 1983.

## 2. Networks of Independent Physicians: Price Fixing Cartels or Legitimate Joint Ventures?

It wasn't until the advent of managed care that the principles of the federal HMO Act of 1973 (which encouraged collective action by physicians) collided with the fundamental prohibitions of the Sherman Act (under which collective action by physicians can be criminal), now applicable to physicians through the Court's rejection of the long-standing "learned professions" exception to the Sherman Act. As this area of antitrust law developed, IPA contracting could have been regarded as acceptable under the Supreme Court's views on the collective pricing of joint venture products.<sup>6</sup> However, by 1982, contracting activities of physician networks were brought into direct focus by *Arizona v. Maricopa County Medical Society*.<sup>7</sup> In *Maricopa*, the Supreme Court held that the Maricopa County Medical Society's creation of a "maximum" fee schedule for its members resulted in "de facto" price fixing because medical society members would likely establish their individual fee schedules at the maximum levels prescribed by the medical society.

Importantly, the Court differentiated the members of the Maricopa County Medical Society from a network of true joint venturers – whose combination serves not merely to establish joint prices, but instead offers a qualitatively different "new product" in the marketplace. In this regard, the Court maintained a distinction that it had made several years earlier in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 22 (1979)<sup>8</sup>, and reiterated several years later in *Northwest Wholesale Stationers v. Pacific Stationary*, 472 U.S. 284 (1985).

In 1988, in the case of *Hassan v. IPA*, 698 F. Supp. 679 (E.D. Mich., 1988), a federal district court first applied this concept of the "legitimate" joint venture to a collective physician negotiation. In *Hassan*, HMO Health Plus of Michigan had traditionally paid Independent Practice Associates ("IPA") on a fee-for-service basis. From these amounts, IPA then paid to its physician members amounts limited by a maximum fee schedule that all IPA members had accepted. As in the *Maricopa* case, the issue in *Hassan* was whether the network's internal maximum fee schedule constituted a "de facto" price floor, i.e., unlawful price-fixing. The court held that, although the fee schedule certainly constituted an agreement on fees among competing physicians, the agreement was related to a legitimate health care joint venture and, therefore, was not *per se* price-fixing in violation of the antitrust laws.<sup>9</sup>

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<sup>6</sup> See *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 22 (1979) ("BMI") (At issue was the propriety of licensing agencies' issuance of blanket licenses to perform copyrighted musical compositions; the Court determined that the blanket license substantially lowered costs – which benefited both sellers and buyers – and therefore the blanket license was a "different product" than the individual use license). Similarly, the services rendered through an IPA, as envisioned by the HMO Act, could have been regarded as "different services" than an individual physician's professional services.

<sup>7</sup> *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982)

<sup>8</sup> *Id.*, 457 U.S. 332, 355-56 (1982).

<sup>9</sup> *Id.*, 698 F. Supp. at 688-90.

The court drew several distinctions between the maximum fee agreement in *Maricopa* and the maximum fee schedule of IPA in *Hassan*. In *Hassan*, the maximum fee agreement only affected “what IPA member physicians can charge Health Plus members” and did “not dictate what those doctors can charge to non Health Plus patients.”<sup>10</sup> More importantly, evidence established “that IPA member physicians share the risks of loss as well as the opportunities for profit by accepting... payment from Health Plus, unlike the physicians in Maricopa.”<sup>11</sup> Moreover, the physician members of the IPA accepted the risk of nonpayment of some of their fees, specifically the part of their fees that the IPA withheld from the physicians in order to protect the organization against loss if expenses exceeded revenues. Finally, it was critical to the court that “Health Plus...underwrites and arranges for a comprehensive range of health services for a fixed premium from the consumer” and provided consumers “with a new product: guaranteed comprehensive physician services”. Relying in part on the Supreme Court’s decision in *BMI*, the court drew a distinction between the activities in *Maricopa* and the activities in *Hassan*, i.e., between horizontal price-fixing among “independent, competing” physicians and the legitimate establishment of prices by a medical services joint venture.

### **3. Clinical Integration: an FTC-Sanctioned, Competitive Justification for Joint Contracting**

Within the last eighteen months, both a federal appellate court<sup>12</sup> and the Supreme Court<sup>13</sup> have reiterated the long-held principle that joint ventures of otherwise competing sellers of a product or service must be able to assert “plausible and legally cognizable competitive justification” for their collective activity, in such a manner that any joint pricing “involves the core activity of the joint venture itself.” For the last ten years, this notion that procompetitive efficiencies can somehow “outweigh” an otherwise illegal restraint on trade has provided the theoretical framework for the Federal Trade Commission (“FTC”) in its enforcement policy regarding negotiations by networks of independent physicians and hospitals – including the potential justification provided by clinical integration.

#### **(a) The Joint Statements**

The FTC and U.S. Department of Justice first coined the term, “clinical integration,” in their 1996 Statements of Antitrust Enforcement Policy in Health Care.<sup>14</sup> In particular, Statement 8 defines clinical integration as the implementation of:

*... an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and create a high degree of interdependence and cooperation among the physicians to control costs*

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<sup>10</sup> *Id.* at 689 n3.

<sup>11</sup> *Id.* at 689.

<sup>12</sup> *PolyGram Holdings, Inc. v. FTC*, \_\_\_ F.3d \_\_\_, 2005 WL 1704632, (D.C. Cir, 2005).

<sup>13</sup> *Texaco, Inc. v. Dagher*. 126 S.Ct. 1276 (2006)

<sup>14</sup> Federal Trade Commission and the U.S. Department of Justice, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 8 available at <http://www.ftc.gov/reports/hlth3s.htm#8>. last visited December 12, 2006.

*and ensure quality. This program may include: (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3) the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies.*<sup>15</sup>

Such integration affords joint negotiations by a network of independent physicians the ability to escape “per se” illegal treatment, and instead to have its contracting conduct evaluated according to the so-called “rule of reason.” Under the rule of reason, joint contracting arrangements by competing sellers that would otherwise constitute section 2 violations of the Sherman Act and section 5 violations of the FTC Act are analyzed under a balancing test that considers the anticompetitive effects of the arrangement against its potential to achieve procompetitive efficiencies. Integral to this balancing test is the concept of ancillarity – i.e., the ability of the joint conduct to greatly facilitate the efficiencies promised by the joint conduct. As explained in Statement 8, at section B.1., with reference to the U.S. Supreme Court’s 1979 decision in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*:

*Antitrust law treats naked agreements among competitors that fix prices or allocate markets as per se illegal. Where competitors economically integrate in a joint venture, however, such agreements, if reasonably necessary to accomplish the procompetitive benefits of the integration, are analyzed under the rule of reason. In accord with general antitrust principles, physician network joint ventures will be analyzed under the rule of reason, and will not be viewed as per se illegal, if the physicians' integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be per se illegal) by the network physicians are reasonably necessary to realize those efficiencies.*<sup>16</sup>

The FTC has continued to refine this definition of clinical integration through both its advisory opinions to physician networks and in its numerous consent decrees with IPAs and PHOs. Significantly, however, this refinement has not altered the fundamental legal reasoning employed by the FTC with respect to its analysis of the sufficiency of clinical integration as a justification for joint contracting.

#### **(b) The Advisory Opinions: *MedSouth* and *SHO***

In the *MedSouth* advisory opinion, the FTC staff evaluated the business plan of the MedSouth IPA, a network of independent physicians in Denver, Colorado that intended to contract with fee-for-service health plans without any sort of financial

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<sup>15</sup> *Id.*

<sup>16</sup> Federal Trade Commission and the U.S. Department of Justice, *Statements of Antitrust Enforcement Policy in Health Care*, Statement 8 available at <http://www.ftc.gov/reports/hlth3s.htm#8>. last visited December 12, 2006, citing 441 U.S. 1, 21-22 (1979).

integration, but rather on the basis of clinical integration alone.<sup>17</sup> In this opinion, the FTC staff described what the FTC seeks when evaluating clinically-integrated physician networks:

*Efficiency-enhancing integration typically involves joint performance of one or more business functions of the participants in a way that potentially benefits consumers by expanding output, reducing price, or enhancing quality, service or innovation, and that could not reasonably be achieved by the participants individually. The integration must likely generate procompetitive benefits that enhance the participants' ability or incentives to compete, and thus offset any anticompetitive tendencies of the arrangement. Joint negotiation of prices is not "reasonably necessary" if the participants could achieve an equivalent or comparable efficiency-enhancing integration through practical means that provide significantly less restriction on competition.*

The *MedSouth* advisory opinion stands for the proposition that a network of independent physicians may be able to contract jointly with fee-for-service health plans under rule of reason treatment where the totality of its clinical integration program evidences a real probability of improvements in clinical quality and efficiency:

*We conclude that MedSouth's overall proposed course of conduct, as described in the information you have supplied, should not be accorded per se treatment. The program in which MedSouth proposes to engage appears to be capable of creating substantial partial integration of the participating physicians' practices, and to have the potential to produce efficiencies in the form of higher quality or reduced costs for patient care services rendered by network physicians. More elaborate analysis under the rule of reason, therefore, is warranted.<sup>18</sup>*

However, once again, the FTC staff placed tremendous weight in the *MedSouth* opinion on the issue of ancillarity:

*The extent to which collective negotiation of prices is ancillary to this integration is a crucial question. Generally speaking, an agreement is ancillary to a competitor collaboration to the extent that it is subordinate to and reasonably necessary to accomplish the goals of the integration, unless the parties could have achieved similar efficiencies by practical, significantly less restrictive means. It may be possible to develop an arrangement, apart from payment for the professional services of the network physicians, under which those physicians could be appropriately compensated for the costs entailed in providing programs of the type MedSouth intends to undertake. In this instance, however, we conclude that the price agreement embodied in joint negotiation of contracts for services to be provided subject to the entire proposed program appears to*

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<sup>17</sup> <http://www.ftc.gov/bc/adops/medsouth.htm>

<sup>18</sup> FTC, *MedSouth Advisory Opinion*, available at <http://www.ftc.gov/bc/adops/medsouth.htm> (last visited December 12, 2006.)

*be reasonably related to the integration among MedSouth members, and reasonably necessary for MedSouth to achieve the procompetitive benefits it seeks.*<sup>19</sup>

In this articulation of ancillarity, the FTC explicitly referenced the formula of the U.S. Court of Appeals for the Seventh Circuit in *General Leaseways, Inc. v. National Truck Leasing Association*.<sup>20</sup> In that case, the court stated that there must be an "organic connection between the restraint and the cooperative needs of the enterprise that would allow us to call the restraint a merely ancillary one."<sup>21</sup>

Ancillarity also figured prominently – indeed, crucially – in the advisory opinion the FTC issued in March of 2006 to Suburban Health Organization (“SHO”), a “super PHO” composed of eight PHOs affiliated with a number of competing hospitals and hospital systems throughout the Indianapolis metropolitan area. This opinion, issued in March 2006, rejected SHO’s proposed clinical integration program for primary care physicians employed by SHO’s affiliated hospitals. In arriving at this conclusion, the FTC identified both a lack of “interdependence” among the primary care physician groups, and the ability of the employing hospitals to influence the practice patterns of these doctors without resorting to the joint negotiation of fees with health plans.<sup>22</sup>

*SHO’s proposed joint contracting on behalf of its member hospitals regarding their employed physicians’ services and fees, and the accompanying prohibition on individual contracting for those services by the hospitals, eliminate price competition among the eight otherwise competing providers of those services. Without this program restraint, payors could contract individually with SHO member hospitals for the services of their respective employed physicians, and competition for payor contracts could lead the hospitals to reduce prices or enhance the quality of those services. Absent a valid and cognizable justification under the antitrust laws, SHO’s pricing conduct would be presumed to injure competition, and would be summarily condemned. More extensive analysis of the arrangement’s procompetitive and anticompetitive effects would be warranted if the competitive restraints were determined to be “ancillary” to – i.e., related and subordinate to, and reasonably necessary to achieve the efficiencies of – some primary, potentially efficiency-enhancing economic integration among the joint venture’s participants.*<sup>23</sup>

By incorporating the “inherently suspect” test articulated by the District of Columbia Circuit in *PolyGram Holdings, Inc. v. FTC*<sup>24</sup>, the FTC expanded its explanation of ancillarity in the SHO opinion beyond that provided by the Seventh Circuit in *General Leaseways*, and also by the D.C. Circuit in *Rothery Storage & Van Co.*

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<sup>19</sup> *Id.*

<sup>20</sup> *General Leaseways, Inc. v. National Truck Leasing Association*, 744 F.2d 588, 595 (7th Cir. 1984)

<sup>21</sup> *Id.*

<sup>22</sup> FTC, *Suburban Health Advisory Opinion*, available at <http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf#search=%22suburban%20health%20organization%22> (last visited December 12, 2006).

<sup>23</sup> *Id.*

<sup>24</sup> *PolyGram Holdings, Inc. v. FTC*, \_\_\_ F.3d \_\_\_\_, 2005 WL 1704632, (D.C. Cir, 2005).

v. *Atlas Van Lines*<sup>25</sup>:

*To be ancillary, and hence exempt from the per se rule, an agreement eliminating competition must be subordinate and collateral to a separate, legitimate transaction. The ancillary restraint is subordinate and collateral in the sense that it serves to make the main transaction more effective in accomplishing its purpose ... [T]he restraint imposed must be related to the efficiency sought to be achieved. If it is so broad that part of the restraint suppresses competition without creating efficiency, the restraint is, to that extent, not ancillary.*<sup>26</sup>

**(c) Enforcement Actions: NTSP and the Consent Decrees**

Significantly, ancillarity and the “inherently suspect” formula of *Polygram* figured prominently in the FTC’s administrative decision in the matter of North Texas Specialty Physicians (“NTSP”).<sup>27</sup> Faced with NTSP’s claim that the “culture of teamwork” that had developed among its member physicians provided the justification it needed to jointly negotiate fee-for-service contracts, the administrative law judge found that NTSP had:

*... failed to articulate a logical nexus between these [anticompetitive] activities ... and the claimed efficiencies. ... As we stated in *Polygram*, a defendant ‘...must articulate the specific link between the challenged restraint and the purported justification to merit more searching inquiry into whether the restraint may advance competitive goals.’<sup>28</sup>*

The FTC has maintained this position relative to the necessary conditions for clinical integration in the many consent decrees it has reached in the last several years with physician networks. Although there is similarity in the language in all of these settlements, one case in point is the consent decree that concluded the FTC’s investigation of the California Pacific Medical Group, better known as Brown & Toland.<sup>29</sup> In this 2004 consent decree, the FTC used the defined term “qualified clinically-integrated joint arrangement” to describe specific conduct that it would not prohibit a physician network from pursuing.

This clinical integration definition, which the FTC has closely adhered to in all of its recent consent decrees with IPAs and PHOs, identifies:

*...an arrangement to provide physician services in which: 1. all physicians who participate in the arrangement participate in active and ongoing*

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<sup>25</sup> *Rothery Storage & Van Co. v. Atlas Van Lines*, 792 F.2d 210, 224 (D.C. Cir. 1986), cert denied, 479 U.S. 1033 (1987)

<sup>26</sup> FTC, *Suburban Health Advisory Opinion*, available at <http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf#search=%22suburban%20health%20organization%22> last visited December 12, 2006.

<sup>27</sup> FTC, *North Texas Specialty Physician Group Final Order*, available at <http://www.ftc.gov/os/adjpro/d9312/051201finalorder.pdf> last visited December 12, 2006.

<sup>28</sup> *Id.*

<sup>29</sup> *Brown & Tolland*.



*programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, these physicians, in order to control costs and ensure the quality of services provided through the arrangement; and 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the joint arrangement.*<sup>30</sup>

With regard to the *Brown & Tolland* consent decree, it bears noting that, in a number of recent discussions regarding other physician network matters, it would appear that the FTC staff considers *Brown & Tolland*, along with *MedSouth*, as providing something approaching a “model” for clinical integration, and *NTSP* as clinical integration’s antithesis.

#### **4. Passing the Clinical Integration “Test”**

Distilled to its essence, the legal framework described above demands that any network of independent physicians who wish to use a clinical integration program as a justification for joint contracting with fee-for-service health plans must be able to positively answer the following three questions:

- (1) whether the program is “*real*,” i.e., composed of legitimate, well-founded initiatives, involving all the physicians in the network;
- (2) whether the program is designed to create *likely efficiencies* in terms of better health care quality or lower cost; and
- (3) whether joint negotiations with fee-for-service health plans is “*reasonably necessary*” to achieve the efficiencies sought by the program.

Surviving this analysis will prove very difficult for physician organizations interested only in collective negotiations as a way of extracting higher prices from health plans. Such physician groups will not likely withstand the inevitable antitrust scrutiny of an already-skeptical FTC and the hostility and even litigation by some health plans. But, for those doctors and hospitals willing to use joint contracting with PPOs as an integral part of an innovative program to accelerate the implementation of advanced clinical technologies, facilitate the adoption of evidence-based medicine, and generally reduce the underuse, overuse, and misuse of clinical resources, clinical integration ceases to simply be a matter of antitrust compliance and becomes instead a powerful business and clinical strategy. Such collaborations should allow doctors and hospitals to proceed in confidence that, with proper advice and implementation, their efforts will not only satisfy FTC enforcers but will also leave them well-positioned to compete in their local market on the basis of providing high quality health care, and not on the basis of unit cost alone.

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<sup>30</sup> Federal Trade Commission, *Brown and Tolland Consent Decree*, available at <http://www.ftc.gov/os/adjpro/d9306/040511dod9306.pdf> (last visited December 12, 2006).

## 5. Advocate Health Partners: Clinical Integration in the Crucible

A good illustration of such a collaborative effort among a network of independent physicians and a hospital system is Advocate Health Partners (AHP), a physician hospital organization (PHO) in the greater Chicago area. Over the last four years, this managed care contracting joint venture between a large, urban health system and over 2000 independent physicians on staff at its eight hospitals, has successfully developed and implemented a robust clinical integration program. On that basis, it has collectively negotiated numerous clinically-integrated, pay-for-performance contracts with fee-for-service health plans. Building upon existing systems and “core measure” compliance activities at the Advocate hospitals, as well as disease management and quality improvement efforts undertaken by AHP for patients under capitated HMO contracts, AHP realigned and reoriented this infrastructure to support a comprehensive program that drives utilization of evidence-based best practices, accelerates the adoption of innovative clinical technologies, and generally improves quality and reduces cost. Today, the AHP Clinical Integration Program includes over 20 clinical quality and efficiency initiatives through which primary care and specialist physicians collaborate to improve their care both in the hospital and the doctor’s office.<sup>31</sup>

Remarkably, AHP developed, implemented, and refined its innovative Clinical Integration Program under what can only be described as “battlefield conditions” – high-stakes, private antitrust litigation with insurance giant, United Healthcare, and an intensive FTC investigation (itself prompted by a lawsuit filed, and later dropped, by another health plan, BlueCross BlueShield of Illinois). Most important of all, these matters concluded in ways that allowed AHP to continue the development of its Clinical Integration Program – and its joint contracting activities on behalf of independent physicians.

### (a) United Healthcare v. Advocate

In the United arbitration – a two-year ordeal that included massive document and testimonial discovery, a seven week contested hearing, and a demand of over \$250,000,000 in damages – a panel of three experienced arbitrators found that AHP's attempt in August, 2003 to jointly contract for its physicians with United in a "clinically integrated" contract to begin January 1, 2004, was *not* a violation of the antitrust laws. The Panel considered extensive testimony about Advocate's development of a clinical integration program and found that the evidence presented at the hearing established that Advocate was prepared as of January, 2004 to provide a "clinically integrated" product for fee-for-service patients. The Panel found that the proposed benefits from such a program, as recognized by six other health care insurers who entered into clinically integrated contracts with Advocate between 2003 and 2005, "sufficiently justified Advocate's conduct in attempting to reach a joint contract with United."<sup>32</sup>

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<sup>31</sup> See Advocate Health Partners, *The 2006 Value Report*. Available at <http://www.advocatehealth.com/corphealth/about/valueReport/> last visited December 12, 2006.

<sup>32</sup> American Arbitration Association, Decision in the Matter of *United Health Networks v. Advocate Health Care Network, Advocate Health and Hospitals Corporation, and Advocate Health Partners*. Available at

### **(b) The AHP Consent Decree**

More recently, in a unanimous vote on December 29, 2006, the FTC concluded its four-year investigation of AHP with a consent decree that specifically allows the AHP Clinical Integration Program to proceed – and permits AHP to continue its collective contracting activities with PPOs and other fee-for-service health plans. This marks the first time the FTC has granted such permission to a physician organization already engaged in joint contracting on the basis of clinical integration.<sup>33</sup>

The significance of the AHP consent decree as a watershed in the development of clinical integration as an established basis for joint contracting becomes particularly evident when it is compared to all prior consent decrees in physician joint contracting cases – even in the instance of Brown & Toland. In every other consent decree between an IPA or PHO and the FTC, the agreed settlement prohibits the IPA or PHO from illegally negotiating physician fees on a collective basis, except through a “qualified” clinically or financially integrated model. Whenever the IPA or PHO wants to pursue such a “qualified” arrangement, it must provide significant advance notice to the FTC and must deliver to the FTC an exhaustive analysis describing why the arrangement meets the clinical integration standards set forth in Statement 8.

In the case of AHP, however, the FTC carves out a third “exception” to the general prohibition against joint contracting. The consent decree not only allows AHP to jointly negotiate through a qualified clinically or financially integrated arrangement, the FTC further permits AHP to continue the joint negotiations it has undertaken with payors since 2003 under what the FTC calls, “The Program.” As defined by the Decision and Order in the AHP consent decree, “The Program” describes:

*...the non-exclusive arrangement that AHP refers to as its Clinical Integration Program, which was implemented by AHP on January 1, 2004, with respect to fee-for-service contracts with payors, and which requires participating physicians to agree to adhere to certain health care information technology, quality, and cost/utilization initiatives, as well as to being monitored and subjected to a system of enforcement mechanisms consisting of financial incentives and sanctions, including termination from the Program; provided further, that the Program includes modifications to those initiatives and those monitoring and enforcement mechanisms that are related to improving quality of care or reducing health care costs.*

In other words, AHP has arguably received permission to proceed in joint contracting under its consent decree that exceeds even the advisory opinion provided by the FTC to MedSouth in 2002. As discussed above, in the *MedSouth* opinion the FTC staff evaluated a business model that had yet to be implemented, and essentially stated that, if MedSouth acted in a manner that closely adhered to that plan, it would *probably*

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[http://hmltd.com/article\\_advocate\\_decision.pdf](http://hmltd.com/article_advocate_decision.pdf). Last visited January 7, 2007.

<sup>33</sup> Federal Trade Commission, *Advocate Health Partners Consent Decree*, available at <http://www.ftc.gov/opa/2006/12/ahp.htm>. Last visited January 7, 2007.

not violate the law if it contracted collectively with fee-for-service health plans. In the AHP consent decree, on the other hand, the FTC directly and explicitly allows AHP to continue joint contracting under its Clinical Integration Program – and makes no attempt to nullify the payor contracts AHP has already negotiated on the basis of the program over the last several years. While providing the FTC with the ability to keep an intensely watchful eye on AHP, this consent decree essentially allows the market to decide whether AHP’s model of clinical integration will deliver the efficiencies it promises in terms of health care quality and efficiency. If AHP’s success in securing contracts with almost every major payor in the Chicago metropolitan area is any indicator, it would seem that the market has already spoken.

## 6. Clinical Integration and the “Pay for Performance” Movement

The FTC’s recent positions vis-à-vis clinical integration could not be timelier, given recent developments in health care reimbursement policy. On August 27, 2006, President George W. Bush signed an executive order calling for federally-sponsored health plans, including Medicare and the benefits plans for numerous federal agencies to adopt “four cornerstones” when purchasing health care services: (1) interoperable health care information technology, (2) reporting of quality of care measures, (3) reporting of health care price information, and (4) incentives for high-quality, cost-effective care. Acting on the recommendations contained in Chapter 4 of MedPac’s March 2005 Report to Congress on Medicare Payment Policy<sup>34</sup>, the President made very explicit his purpose for this “four cornerstone” plan:

*...to ensure that health care programs administered or sponsored by the Federal Government promote quality and efficient delivery of health care through the use of health information technology, transparency regarding health care quality and price, and better incentives for program beneficiaries, enrollees, and providers. It is the further purpose of this order to make relevant information available to these beneficiaries, enrollees, and providers in a readily useable manner and in collaboration with similar initiatives in the private sector and non-Federal public sector. Consistent with the purpose of improving the quality and efficiency of health care, the actions and steps taken by Federal Government agencies should not incur additional costs for the Federal Government.*

The most prominent results of the President’s executive order are Medicare’s widely-reported “pay-for-performance” demonstration projects.<sup>35</sup> However, to those involved in the clinical integration and pay-for-performance movement in the health care industry over the last decade, the “cornerstones” set forth most recently by the Bush Administration have provided a consistent foundation for an innovative model of health care delivery – one premised on the power of economic rewards as an incentive to providing better quality, more efficient health care.

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<sup>34</sup> MEDPAC, March 2005 Report to Congress, available at [www.medpac.gov/publications/congressional\\_reports/Mar05\\_TOC.pdf](http://www.medpac.gov/publications/congressional_reports/Mar05_TOC.pdf) (last visited December 12, 2006).

<sup>35</sup> Available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1343>. Last visited January 3, 2006.

And so, the White House and two major agencies of the federal government, the Department of Health and Human Services and the Federal Trade Commission, have now decisively added their voices to a growing consensus that represents all the stakeholders in the American health care system: coalitions of public sector employers like Bridges to Excellence<sup>36</sup> and The Leapfrog Group<sup>37</sup>, statewide payor-provider collaboratives like California's Integrated Healthcare Association<sup>38</sup>, commercial health plans like Blue Cross Blue Shield of Massachusetts<sup>39</sup>, provider-owned plans like ClearChoice in Portland, Oregon<sup>40</sup>, and clinically integrated networks of independent physicians like San Francisco's Brown & Toland Medical Group<sup>41</sup> and Advocate Health Partners<sup>42</sup> in Chicago.

## 7. Developing Clinically Integrated Provider Networks – the Role of Legal Counsel

Essential to an effective clinical integration program are physician leaders and hospital executives committed to providing better care through the application of evidence based medicine and the latest in clinical technology. Nevertheless, attorneys with specialized knowledge of health care, managed care, and antitrust law can offer invaluable assistance in the evaluation, development, implementation, and operation of clinically-integrated networks of hospitals and physicians. These efforts include:

- **Clinical Integration Readiness Assessment** – the evaluation of existing infrastructure and programs to determine an organization's preparedness to engage in clinical integration activities.
- **Network Contracting Risk Assessment** – the evaluation of past and current contracting activities to determine the antitrust risks, if any, posed by this conduct.
- **Clinical Integration Program Formation and Evaluation** – consultation and advice in the formation of clinical integration and pay-for-performance programs that satisfy prevailing legal and regulatory standards.
- **Proper Messenger Model Formation** – consultation and advice in the implementation of "messenger model" procedures that satisfy FTC guidelines.
- **Executive, Board of Directors, and Member Education** – presentations regarding the legal and business case for clinical integration for health care

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<sup>36</sup> Available at <http://www.bridgestoexcellence.org> last visited December 12, 2006.

<sup>37</sup> Available at <http://www.leapfroggroup.org> last visited December 12, 2006.

<sup>38</sup> Available at <http://www.ihha.org> last visited December 12, 2006.

<sup>39</sup> Available at

[http://www.bluecrossma.com/common/en\\_US/aboutUsIndex.jsp?repId=Repositories.PressReleases.2004PressReleases.pressRelease081004.xml&levelTwoCategory=News+%28with+Archives%29&isLevelThreeSelected=true&targetTemplate=pressReleaseDetail.jsp&iphl=communities:partnering:healthcare:partnered:community:partners:partner:](http://www.bluecrossma.com/common/en_US/aboutUsIndex.jsp?repId=Repositories.PressReleases.2004PressReleases.pressRelease081004.xml&levelTwoCategory=News+%28with+Archives%29&isLevelThreeSelected=true&targetTemplate=pressReleaseDetail.jsp&iphl=communities:partnering:healthcare:partnered:community:partners:partner:) last visited December 12, 2006.

<sup>40</sup> Available at <http://www.clearchoicehp.com/DesktopModules/ProviderPortal/QAPExplained.aspx> last visited December 12, 2006.

<sup>41</sup> Available at [http://www.browndtoland.com/publish/en/visitors/for\\_brokers\\_\\_\\_employers.html](http://www.browndtoland.com/publish/en/visitors/for_brokers___employers.html) last visited December 12, 2006.

<sup>42</sup> Available at <http://www.advocatehealth.com/corphealth/about/valueReport/> last visited December 12, 2006.

executives, physician and hospital network boards, and general physician membership.

- **Contracting and Transactional Support** – legal review and advice regarding contract negotiations and language for clinically-integrated, fee-for-service arrangements.
- **Representation in Litigation** – aggressive legal defense in federal and state court actions, as well as private arbitration, brought by health plans seeking to attack or undermine the network’s clinical integration efforts.
- **Advisory Opinion Practice** – petitioning the FTC and U.S. Department of Justice to obtain regulatory advisory letters in connection with a physician or hospital network’s clinical integration program.
- **Government Investigation Practice** – vigorous representation and advocacy in response to FTC and U.S. Department of Justice inquiries into the contracting conduct of physician and hospital networks.

## **Conclusion**

Fostering collaboration among independent doctors and hospitals in a way that both increases the quality and efficiency of patient care, the concept of clinical integration has expanded its usefulness to hospitals and networks of physicians well beyond that of mere antitrust compliance. It affords doctors and hospitals the ability to thrive in the advent of consumerism, pay-for-performance, and quality report cards. Simultaneously, it presents an opportunity for independent physicians to negotiate forthrightly with PPOs and other fee-for-service health plans. In short, clinical integration has become a powerful business and clinical strategy that finally aligns the value interests of consumers, payors, and providers.