ACHIEVING HOSPITAL-PHYSICIAN ALIGNMENT THROUGH CLINICAL INTEGRATION

PART III – STANDARDS OF INTEGRATION

This is the third in a series of articles on achieving hospital-physician alignment through clinical integration.

In general, federal law considers independent providers banding together for the purpose of creating market power in contract negotiations to be an "anticompetitive" and hence illegal activity. There are circumstances, however, where the law and regulatory agencies believe joint behavior on the part of independent providers, including joint contracting, may serve the interests of competition. These circumstances can involve economic risk sharing, clinical integration or some combination of the two.

Usually, the Federal Trade Commission (FTC) and other regulatory agencies rely on a "rule of reason" to determine whether the level of economic and / or clinical integration is sufficient to make joint contracting a permissible activity. Market circumstances and the facts surrounding the integration inform the agencies evaluation of the arrangement. In general,

- Providers must be sufficiently integrated so as to not be considered competitors conspiring to restrain trade.
- The contracting power of the integrated entity must not be so great as to determine price.
- The integration activities and joint contracting arrangements must produce efficiencies that benefit consumers.
- Integration must result in pro-competitive benefits that enhance the participant's motivation and ability to compete and offset any anticompetitive incentives in the arrangement.

Economic Integration

Standards for economic integration have been relatively well defined, particularly in the context of physician networks and risk contracting.

- Withholds must be network-wide, and the arrangements must involve collective risk, where all participants are at risk for the performance of the whole. The use of collective performance incentives does not also preclude the use of individual incentives.
- Withholds must represent "significant" risk sharing sufficient to influence provider behavior. They must be large enough to motivate providers. For physician contracts, "significant" generally means withholds in the range of 15-20% of fees.
- If performance goals are not met, withheld funds cannot directly or indirectly benefit the network or its members.

Clinical Integration

Regulatory guidance regarding clinical integration is less well defined. There have been few cases testing standards for clinical integration, and few formal advisory opinions describing acceptable and unacceptable practices. Careful reading of available resources[1] does provide some guidance, however:

[1] FTC Antitrust Enforcement Policy in Health Care, August 1996; FTC Advisory Letter dated February 19, 2002 ("MedSouth")

- Clinical integration must involve a active and ongoing program to modify the practice patterns of participating providers, create interdependence and cooperation among providers and control costs and ensuring efficiency, and assure the quality of care.
- The program must be evidenced by significant investment of monetary and human capital in infrastructure. The mere adoption of a common clinical information system would be insufficient. The systems must be employed in the dissemination and implementation of common clinical standards.
- The program must reflect rigorous and effective implementation, with results that would be difficult for individual providers acting independently to achieve.
- Joint contracting must be considered "necessary for and ancillary to" achieving the efficiencies and quality performance goals of the arrangement.

The combination of clinical integration with economic incentives such that participating providers all have "skin in the game" relative to clinical performance improvement strengthens the case in support of joint contracting activity.

Next: Part IV – Clinical Integration Case Study – Southeast Health System

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