Clinically Integrated Networks

The New Way for Healthcare Providers to Play Together in the Sandbox

by Michael F. Schaff and Alyson M. Leone

The implementation of the Affordable Care Act[1] has shifted the attention of the healthcare industry away from fee-for-service payment toward performance-based reimbursement. This reform of the healthcare system focuses on reducing healthcare costs while improving the quality and efficiency of care provided to patients. One way to achieve these goals is the formation of a clinically integrated network (CIN). The term 'clinical integration' was coined by the U.S. Department of Justice (DOJ) Antitrust Division and the Federal Trade Commission (FTC) as a way for competing healthcare providers to jointly negotiate fees for services without violating the antitrust laws.[2]

CINs are Not New

Collaboration among physicians and hospitals has been around in different forms for many years. The goal of each of these relationships is similar to CINs—insurers agree to a negotiated fee for medical services in exchange for physicians agreeing to control costs and provide proficient quality care. Some examples of these alliances include the following:

- Physician hospital organizations (PHO)—a collaboration between hospitals and their medical staffs to provide a broad spectrum of care to beneficiaries.
- Independent practice associations (IPA)—a group of physicians who agree to provide medical services to beneficiaries, typically on a per capita rate.

- Co-management agreements—a contractual agreement between a hospital and a group of physicians to provide management and administrative services, which includes quality- and safety-related targets.
- Messenger model contracting—a relationship between hospitals and physicians whereby they jointly negotiate with the insurers, but each party may elect whether or not to participate in the contract.

Each of these ventures intend to contract with payors on behalf of a defined network of providers and share the financial benefits of providing quality medical services at lower cost.

Benefits of CINs

The overarching benefit of CINs is to allow providers who are otherwise independent and not financially aligned to jointly contract with third-party payors. Negotiating together, rather than individually, often bolsters the providers' clout with insurers. Typically, the third-party contracts provide some incentive payments to reward providers who deliver quality and effective care.

The fundamental component of a CIN is the adoption of clinical protocols, which are a common set of standards used to govern treatment and utilization of services. Requiring all of the providers to follow the protocol metrics is intended to improve the quality of care provided to patients. Further, it provides a way to oversee and monitor a physician's performance against pre-established benchmarks. It is these protocols and metrics, and their evidence-based outcomes, that contribute to a CIN's joint negotiation of fees.

Unlike the previous collaboration models, CINs are meant to be selective in the providers that are included. Since the objectives are efficient and quality medical care, only those physicians who are willing and capable of meeting those goals should be invited to participate in the CIN. Members must be committed to adhering to the clinical protocols, and willing to improve when they do not meet those standards.

Sharing of health information technology among providers is another benefit to CINs. This allows physicians to access test results and hospital admissions/discharges quickly. It permits providers the ability to monitor patients with chronic diseases. Further, common electronic medical record systems will allow the CIN to generate reports to show insurers just how they are saving money and improving the quality of the care provided to patients.

Although CINs are often spearheaded by hospitals due to their ability to provide start-up capital, technology and support, physicians typically have strong governance authority. A CIN cannot be successful without strong physicians who will help achieve the CIN's goals. In particular, physicians should be intimately involved in the development of clinical protocols and procedures to modify physician behavior when necessary.

Legal Considerations in Forming CINs

Forming a CIN is not for the faint of heart. The arrangement must be analyzed under a wide array of laws, including state and federal anti-kickback and self-referral laws (in particular the electronic health records items and services safe harbor/exception), tax laws, privacy laws, anti-fee-splitting laws, corporate practice of medicine prohibitions, and most notably antitrust laws. Because the CIN involves joint negotiation of fees with insurers, the arrangement may raise concerns of anti-competitive behavior.[3]

In 1996, the DOJ and FTC acknowledged that sufficient clinical integration of physicians, despite the lack of sharing substantial financial risk, could lead to efficiencies that are significant enough that joint payor negotiation is not *per se* illegal, but rather subject to a rule of reason analysis.[4] A rule of reason analysis takes into account the characteristics of the arrangement and the environment in which it operates to determine the likely effect on competition. It determines whether the network of providers has a substantial anticompetitive effect and whether that effect is outweighed by any pro-competitive efficiencies. The DOJ and FTC noted that clinical integration "can be evidenced by the network implementing 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 and ensure quality."[5]

Such a program may include:

1. establishing mechanisms to monitor and control utilization of healthcare 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.[6]

In 2002, the FTC issued an advisory opinion regarding an IPA,[7] holding that it would not raise antitrust concerns because the network was non-exclusive and provided for efficiencies such as coordination of care, information sharing, clinical protocols, and performance monitoring. The FTC noted that "the program…appears to involve partial integration among MedSouth physicians that has the potential to increase the quality and reduce the cost of medical care that the physicians provide to patients. In addition, we have concluded that the joint contracting appears to be sufficiently related to, and reasonably necessary for, the achievement of the potential benefits to be regarded as ancil-

lary to the operation of the venture."[8]

In 2007, the FTC advised that an IPA would have the "potential to produce significant efficiencies in the provision of medical services, including both improved quality and more efficient and appropriate provision of those services by [the IPA's] physicians. Furthermore, it appears that joint contracting with payers on behalf of [the IPA's] physician members is subordinate and reasonably related to [the IPA's] plan to integrate the provision of medical care by its members, and is reasonably necessary to implement the proposed program and achieve its efficiency benefits."[9]

Again in 2009, the FTC declined to challenge a clinical integration program established by a PHO.[10] The non-exclusive program intended to coordinate care provided to patients, while improving quality and reducing the costs of care. Physicians were to be subject to performance measures, including adherence to clinical practice guidelines. Physicians were also responsible to be both financially and personally involved in the program, including participation on committees and monitoring peers. Physicians were required to refer to other providers within the network, and the program would monitor and oversee physicians' performance in following best practice standards and in meeting performance goals and benchmarks. Further, the proposed program would use a web-based health information technology system, including electronic health records, to help identify patients and providers where it would be productive to intervene in improving care and patient outcomes.

Most recently, in 2013, the FTC again upheld a PHO.[11] The FTC noted the physicians were substantially involved in the PHO, including being responsible for developing the clinical practice guidelines and physician performance measures, conducting peer review and corrective action processes, and designing and implementing quality improvement initiatives. Each physician would make "meaningful contributions" to the CIN. The PHO had an extensive electronic platform and interface system, which allowed it to measure and evaluate physician performance and compliance with the clinical practice protocols. Providers would be required to participate in all payor contracts of the CIN, but could independently contract in any insurance plans in which the CIN did not participate.

Conclusion

With a new focus in the healthcare industry on the reform of payment methodologies, clinically integrated networks have become a popular way for providers to contract jointly with insurers by increasing population health and improving the experience of patient care, while lowering overall costs of providing care and maintaining their independence. However, CINs must be carefully structured to avoid violation of the

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law, in particular anti-trust laws.

It is important that CINs develop standards and protocols to provide cost-effective and quality care, health information systems to measure and monitor performance, and procedures to modify hospital and physician behavior when necessary. Naturally, cooperation between the CIN participants is needed to achieve these efficiencies. The future of healthcare is unknown, but to be proactive in this environment providers must learn to play together in the sandbox in order to maximize reimbursement potential. ⚖

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ENDNOTES

1. The Affordable Care Act consists of two pieces of legislation—the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2012) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010).
2. Statements 8 & 9 of the Statements of Antitrust Enforcement Policy in Health Care Issued by the U.S. Department of Justice and the Federal Trade Commission dated Aug. 1996.
3. 15 U.S.C. §1 *et seq*.
4. *Id*. at (i).
5. *Id*. at (i).
6. *Id.* at (i).
7. FTC Advisory Opinion (Feb. 19, 2002), available at ftc.gov/bc/adops/medsouth.shtm.
8. *Id.*
9. FTC Advisory Opinion regarding Greater Rochester Independent Practice Association, Inc. (Sept. 17, 2007), available at ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf.
10. FTC Advisory Opinion regarding TriState Health Partners, Inc. (April 14, 2009), press release available at ftc.gov/news-events/press-releases/2009/04/ftc-staff-advises-maryland-physician-hospital-organization-it.
11. FTC Advisory Opinion regarding Norman Physician Hospital Organization (Feb. 13, 2013), press release available at https://www.ftc.gov/news-events/press-releases/2013/02/ftc-staff-advises-oklahoma-physician-hospital-organization-it.

This article was originally published in the April 2016 issue of New Jersey Lawyer Magazine, a publication of the New Jersey State Bar Association, and is reprinted here with permission.