



UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Health Care Division

September 17, 2007

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1401 H Street, N.W., Suite 500
Washington, DC 20005-3324

Re: Greater Rochester Independent Practice Association, Inc., Advisory Opinion

Dear Ms. Braun and Mr. Miles:

This letter responds to your request, on behalf of your client, the Greater Rochester Independent Practice Association, Inc. ("GRIPA"), for an advisory opinion concerning a proposal under which GRIPA would negotiate contracts, including price terms, with payers on behalf of its physician members in connection with the sale of a program of "integrated services" by GRIPA.

As is discussed in detail below, based on your representations and the information that you have provided, it appears that GRIPA's proposed program would involve substantial integration among its physician participants that has 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 GRIPA's physicians. Furthermore, it appears that joint contracting with payers on behalf of GRIPA's physician members is subordinate and reasonably related to GRIPA'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. We therefore conclude that the price agreements and collective negotiation of contracts with payers regarding the services of the physician participants in the proposed program should be evaluated under the antitrust rule of reason. Finally, while we have not conducted an investigation or formally defined the product and geographic markets within which GRIPA's proposed program will operate, the information you have provided concerning GRIPA's size, composition, form of operation, and characteristics of the market for sale and purchase of physician services in the greater Rochester, New York, area, where GRIPA will operate its proposed program, suggests it is unlikely that GRIPA, or its physician members acting through GRIPA, would be able to attain or exercise market power, or that the proposed program would be likely to have anticompetitive effects. Accordingly, we have no current intention to recommend that the Commission challenge GRIPA's proposed program if it proceeds to implement the program as described.

I. Description of GRIPA and Its Current Operations

GRIPA is an independent practice association (“IPA”) located in the city of Rochester, Monroe County, New York. GRIPA offers, and contracts with payers for, the professional medical services of certain primary care physicians (“PCPs”) and specialty care physicians who practice medicine primarily in Monroe County and adjacent Wayne County.¹ ViaHealth, a nonprofit health care system consisting of two hospitals, ancillary service providers, and about 130 employed physicians, owns 50 percent of the shares in GRIPA.² Two physician organizations – Rochester General Physicians Organization, Inc. (“RGPO”) and Wayne County Physicians Organization (“WCPO”) – own the remaining 50 percent of GRIPA shares. Under the proposed program, ViaHealth will have six seats on the GRIPA Board of Directors, RGPO four seats, and WCPO two.

GRIPA was incorporated in 1996 as a for-profit New York business corporation, originally to contract for the provision of physician and other health care services on a financial risk-sharing basis with payers offering health maintenance organization (“HMO”) programs.³ GRIPA currently has a staff of 35 full-time equivalent employees, and its daily operations are directed by its CEO and its Chief Medical Officer. GRIPA describes itself as having a “sizeable staff to manage its information technology . . . system,” which includes “a data warehouse used to store claims information and software to analyze the claims data and prepare reports for GRIPA’s physicians and leadership.” GRIPA also currently operates a credentialing and re-credentialing program that meets National Committee for Quality Assurance requirements.

Currently, GRIPA operates a Care Management Services (“CMS”) Department, which has responsibility for GRIPA’s clinical programs, including case management, disease management, and pharmacy management services for patients covered under its risk contracts. Under these programs, GRIPA uses physician referrals and information obtained from review of claims and utilization data to group patients by disease states, and then by risk of high use of services and generation of associated costs. The resulting patient lists are used to identify physician practices with high volumes of risk contract patients who could benefit from CMS Department intervention. The CMS staff then conducts individual patient assessments, and develops and

¹ We understand that GRIPA’s proposed program relates only to the provision of medical services by GRIPA member physicians who agree to participate in the proposed program, and not to the services of GRIPA’s non-physician providers, including its two member hospitals.

² The two hospitals are Rochester General Hospital in Rochester, Monroe County, New York, and Newark-Wayne Community Hospital in Newark, Wayne County, New York.

³ In 1997 the GRIPA shareholders formed ViaHealth PPO, Inc., to contract with payers for non-HMO products, because New York state law prohibits IPAs (e.g., GRIPA) from contracting with entities other than HMOs. ViaHealth PPO currently uses a messenger arrangement to enter into contracts between payers and its individual physician members. Under the proposed program, contracts with payers may be executed with either GRIPA or ViaHealth PPO, depending on whether or not the particular arrangement qualifies as an HMO program.

implements case management programs to educate and monitor those patients, including enrolling them in appropriate disease management programs. GRIPA's disease management programs, which focus on diabetes, asthma, and heart failure,⁴ involve developing, monitoring compliance with, and reinforcing treatment and prescription plans, as well as patient education about the disease and its treatment. GRIPA also monitors claims, laboratory, and pharmaceutical data to determine whether physicians' treatment of disease management patients complies with the program's treatment guidelines.⁵ Where warranted, GRIPA staff make recommendations to physicians regarding these matters, including whether certain patients would benefit from additional personalized attention. GRIPA also monitors and provides performance reports to each primary care physician, obstetrician/gynecologist, cardiologist, and orthopedist regarding the physician's individual and comparative performance in treating patients and adhering to GRIPA performance standards.

II. GRIPA's Proposed Program⁶

A. Genesis and Description

You state that, since its inception, GRIPA has had contracts with payers that involved the sharing of financial risk among its physician participants through percentage of premium arrangements.⁷ However, as local payer interest in risk arrangements has declined significantly in recent years, the number of contracts and covered lives under risk arrangements also have declined for GRIPA. Because of this market development, in 2005 GRIPA began studying possible alternative courses of action, ultimately choosing to develop a program to integrate its

⁴ These diseases have been identified as being responsible for the largest percentage of GRIPA's medical costs for its covered patients. GRIPA has a similar program for geriatric patients that focuses on medical, safety, and quality-of-life issues for that population segment.

⁵ GRIPA's Clinical Consulting Pharmacy Program, which is staffed by three pharmacists, also works with patients and physicians to "reduce medication costs and errors, and optimize patient therapy and outcomes." The program involves reviewing charts of high-risk patients to determine whether they are receiving appropriate medicines in proper dosages, any drugs are contraindicated, the patients are "meeting care goals in a timely fashion," and physicians are avoiding unnecessary drug costs through use of generic drugs, less costly formulary alternatives, and splittable pill dosages, where available.

⁶ Considerable descriptive information about both GRIPA and its proposed program are available at its website(s): <http://www.gripa.org> and <http://gripaconnect.com>.

⁷ We have not examined GRIPA's risk arrangements with payers, or assessed whether they, in fact, involve the sharing of substantial financial risk among GRIPA's physician participants. For a discussion of various forms of financial risk sharing among physicians or other health care providers in a network joint venture, including percentage of premium arrangements, that may evidence such risk sharing, see U.S. Department of Justice and the Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (August 1996), 4 Trade Reg. Rep. (CCH) ¶ 13,153 (hereinafter referred to as *Health Care Statements*) at Statement 8 at § B.1 and Statement 9 at § 9 (available at <http://www.ftc.gov/reports/hlth3s.pdf>).

physicians' services and clinical management activities without employing a risk-sharing arrangement.

You state in your submission that GRIPA will sell to various payers what it calls a "new product"⁸ consisting of "its interdependent members' medical services, on a fee-for-service basis, intertwined with a number of collaborative activities designed to improve clinical outcomes and efficiencies," which you call "clinical-improvement services."⁹ GRIPA's clinical improvement services will be developed and implemented by and among GRIPA's physician members, and between the physician members and GRIPA's staff. GRIPA believes that, as a result, it will be offering a "different, higher quality, and more valuable product" "that none of its members could offer individually."

GRIPA currently has 636 physician members, 506 of whom are independently practicing physicians, and 130 of whom are employed by ViaHealth.¹⁰ GRIPA also contracts with an additional 119 physicians to provide certain medical specialty services and geographic coverage under its risk contracts.¹¹ Overall, GRIPA states that 717 physicians practicing in 41 medical specialty and sub-specialty areas will be eligible to participate in the proposed program.¹² GRIPA anticipates that approximately 90 percent (i.e., approximately 230) of the 257 eligible

⁸ See discussion in § III.C.2, below, for analysis of GRIPA's characterization of its proposed program as a "new product."

⁹ Under fee-for-service billing and payment, each individual physician charges, bills, and is paid, for the specific services and procedures the physician performs in diagnosing and treating each individual patient. The charges and the payments do not vary based on what other physicians in the network do, and are not affected by the services provided to, or overall costs associated with the treatment of, any group of patients for which the network has contracted to provide medical services.

¹⁰ Each GRIPA physician, including those employed by ViaHealth, must be a shareholder in one of the two physician organizations (RGPO or WCPO) that has seats on the GRIPA board. Each GRIPA physician member initially (including the ViaHealth employed physicians) paid \$1650 for a share in one of the physician organizations in order to capitalize GRIPA when it embarked on its risk contracting. No additional direct capital investment of this kind will be required of the physicians in order to participate in, or implement, the proposed program, although other investment will be required. See discussion in § III.B.3, below.

¹¹ Of the 119 contracted physicians, 81 will be eligible to participate in GRIPA's proposed program.

¹² These include adolescent medicine, allergy and immunology, anesthesiology, cardiology, colon and rectal surgery, child psychiatry, critical care medicine, dermatology, endocrinology, family medicine, gastroenterology, general surgery, geriatric medicine, gynecologic oncology, gynecology, hematology/oncology, infectious disease, internal medicine, maternal/fetal medicine, medical genetics, nephrology, neurological surgery, neurology, obstetrics and gynecology, ophthalmology, oral surgery, orthopedics, otolaryngology, pain management, pediatrics, physical medicine and rehabilitation, plastic surgery, psychiatry, pulmonology, radiology, radiation oncology, reproductive endocrinology, rheumatology, thoracic surgery, urology, and vascular surgery.

primary care physicians,¹³ and more than 75 percent (i.e., more than 345) of the 460 eligible specialist and sub-specialist physicians, or a total of slightly more than 575 of the 717 eligible physicians, will participate in the proposed program.

B. Integration Among Participants in GRIPA's Proposed Program

GRIPA identifies a variety of collaborative activities among its physician members that it plans to implement or expand from its risk-sharing program as evidencing the physicians' clinical integration through the proposed program.¹⁴ Specifically, GRIPA will:

(1) develop a collaborative, independent network of PCPs [primary care physicians] and SCPs [specialty care physicians] to provide their medical care in a seamless, coordinated manner; (2) promote the collaboration of its physicians in (a) designing, implementing, and applying evidence-based practice guidelines or protocols and quality benchmarks, [and] (b) monitoring each other's individual and GRIPA's aggregate performance in applying the guidelines and in achieving the network's benchmarks, to improve patient outcomes and to reduce costs and resource utilization; (3) integrate its physicians and providers of other medical services in the community through a web-based electronic clinical-information system in which GRIPA physicians share clinical information related to their common patients, order prescriptions and lab tests electronically, and access patient information from hospitals and ancillary providers throughout the community; and (4) decrease the overall administrative and regulatory burden of its participating physicians by reducing paperwork and the time needed to process treatment information.

One important aspect of the proposed program is that GRIPA physicians agree to refer patients to other GRIPA network physicians, except in unusual circumstances. This both helps to assure that referred patients will continue to receive care under the practice standards and requirements of GRIPA's program, and permits GRIPA to obtain more complete data regarding both the care provided to those patients, and the performance of the treating physicians. This information is

¹³ GRIPA identifies primary care physicians as including those in family practice, general practice, internal medicine, and pediatrics.

¹⁴ The federal antitrust enforcement agencies first discussed "clinical integration" among health care providers in their joint 1996 *Health Care Statements*, *supra* n. 7. The *Health Care Statements* discuss arrangements among competing physicians or other health care providers in a network who, while not sharing substantial risk of financial loss or gain from their collective performance in providing services through the network, nevertheless establish and implement various mechanisms that create a high degree of interdependence and cooperation among the participants in order to control costs and assure quality in the services that the network participants provide. See also *Improving Health Care: A Dose of Competition, A Report by the Federal Trade Commission and the Department of Justice* (July 2004) (hereinafter referred to as *Health Care Report*) (available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>) at Ch. 2 at pp. 36-41.

essential for GRIPA's monitoring and oversight activities, as well as achieving the program's potential efficiencies in providing patient care.¹⁵

Currently, for patients covered under GRIPA's risk contracts, GRIPA's Care Management Services ("CMS") Department operates case management, disease management, and pharmacy management programs. GRIPA will continue to operate these programs for patients under its proposed clinical integration program. Under its CMS Department programs,

GRIPA identifies patients needing CMS assistance through physician referrals and predictive modeling, a process that involves mining claims and utilization data to group patients by disease states and then by cost and high-use risk. After patient lists are generated, they are stratified at the physician level, allowing the CMS department to target physician practices with high volumes of . . . patients who would benefit from CMS assistance. CMS then conducts initial patient assessments, evaluating the patients and determining the needs [for] . . . case management . . . disease management . . . or . . . pharmaceutical management [services].

In addition, GRIPA plans to expand the list of chronic diseases covered by its disease management program – currently addressing diabetes, asthma, and heart failure – to include additional diagnoses, such as coronary artery disease and chronic obstructive pulmonary disease. GRIPA also will use Clinical Services Reports – similar to disease registries – to identify patients who have not received the care recommended by GRIPA's guidelines, and what care needs to be provided. This tool will focus on patients who fall into the categories of high cost, high utilization, chronic disease, co-morbid diagnoses, and under-utilization of needed services, such as preventive care.

A number of GRIPA's physician members will directly participate in the process of developing, assessing, and modifying the practice guidelines and measures that GRIPA will use in evaluating its members' performance. These activities will be performed by GRIPA's Clinical Integration Committee¹⁶ and by Specialty Advisory Groups ("SAGs"), which will be formed for the development of each guideline, and composed of physicians representing each medical specialty affected by the guideline. By this process, GRIPA intends to get many physicians involved in the process of guideline development, as well as involve collaboration between PCPs and specialists

¹⁵ GRIPA reports that under its current PPO contracts through ViaHealth, which do not contractually require patients to stay within the provider network, as do HMO contracts, in 2005, 93 percent of physician referrals nevertheless were within the GRIPA network. Regarding the proposed program, GRIPA states that it "will monitor physicians' compliance with . . . [the in-network referral] policy and failure to comply, without medical justification, will result in corrective action."

¹⁶ The Clinical Integration Committee will be composed of 12 physicians, at least six of whom must be primary care physicians or obstetrician/gynecologists.

regarding each guideline.¹⁷ The SAGs will convene meetings to introduce and explain new guidelines, educate physicians as to their application, and provide a forum for discussion. The SAGs also will solicit specific feedback from affected network physicians at six-month intervals to assess the need for revisions in the guidelines.

Each GRIPA physician member agrees, as a condition of participation in the program, to provide information to GRIPA on all services rendered to patients covered under its programs, to be subject to GRIPA's review of the physician's practice behavior (e.g., following protocols, cooperating with case and disease management procedures, etc.), and to be subject to GRIPA's educational and disciplinary requirements, including possible expulsion from participation in the program. All GRIPA physicians must agree to attend training in the use of GRIPA's technology system, in order to contribute to its data assembly operations. GRIPA will provide each physician with a tablet computer, discounted access to the necessary internet service, and technical support in complying with the program's information requirements.¹⁸ This system will provide each physician with immediate access to patient information. GRIPA will create a central clinical information system – the GRIPA Connect Web Portal – containing all patients' inpatient and outpatient information. This “central data store” will include information for each patient, including: “(1) referral and consultation notes; (2) written drug prescriptions; (3) lab orders and corresponding lab results; (4) diagnostic imaging reports and internet links to the images; (5) hospital inpatient and outpatient information, such as patient registration and visit information, discharge summaries, discharge instructions, consulting physicians' notes, hospital radiology reports, and hospital laboratory results; and (6) information on filled prescriptions.” GRIPA will monitor each physician's use of its information portal, and performance reports will reflect physicians' use or failure to use this tool appropriately.¹⁹

All GRIPA physicians also agree that, unless they already are serving on another GRIPA committee, they will be available for selection to serve a one-year term on GRIPA's Quality Assurance Council. The Quality Assurance Council performs peer review of individual physician performance and adherence to practice requirements, establishes remedial action plans, and recommends potential disciplinary action, where needed.

¹⁷ GRIPA reports that, as of January 2007, the Clinical Integration Committee had approved 14 guidelines, 11 of which had been presented to the GRIPA Board by the Chief Medical Officer, and approved. As of that time, the CIC was reviewing two other guidelines, one SAG was meeting concerning an additional guideline, and GRIPA staff was collecting information regarding two additional guidelines. GRIPA stated that it anticipated that the SAGs would be developing two to four additional guidelines per month throughout the remainder of 2007.

¹⁸ GRIPA estimates that the total cost of providing the tablet computers to its physicians will be about \$750,000. Wireless internet service will cost physicians an estimated \$70 per month. Eight hours of training in the use of the system is estimated to cost \$800 per physician in time cost, or \$573,600 for the entire physician network. Part of the cost of implementing its technology system will be offset by a grant of \$227,835 to GRIPA from New York, as part of the state's health information technology initiative.

¹⁹ GRIPA has stated that it expects its information portal and electronic applications to be in place by the time GRIPA fully implements its proposed program.

C. Efficiencies GRIPA Believes Are Likely to Result From the Proposed Integration Program

GRIPA believes that the integration among its physician members “will generate efficiencies for health-care consumers, payers, and physicians by improving medical-care quality, generating more cost-effective service delivery, and reducing population costs.” Elsewhere, you assert that GRIPA’s program of clinical-improvement services “will result in higher quality medical services delivered more efficiently than GRIPA physicians could render individually,” and note that GRIPA physicians anticipate substantial benefits for their patients and themselves under the proposed program.

To assess its achievement of these performance claims, GRIPA intends to use both what it describes as “process measures” (e.g., percentage of diabetic patients receiving an annual eye exam) and “outcome measures” (e.g., measuring percentage of diabetic patients achieving hemoglobin A1c measures of less than seven percent) to evaluate its performance in improving quality and reducing costs. For measures that it has used regarding its risk contracts, GRIPA will set its initial benchmarks for the proposed program at the same level as for those HMO risk contract patients. Where no national or local benchmark exists, GRIPA will set its initial benchmark at the 80th percentile of current network performance. GRIPA will base its efficiency measures on evidence-based research studies supporting the correlation between various interventions and cost savings and quality improvements.

GRIPA will select cost-savings models and validate their reliability and data assumptions. All available data sources will be considered when creating network-efficiency models. Validation of the cost-saving models’ assumptions will be necessary to predict potential opportunity accurately. Benchmarks for these measures will be based on evidence-based studies from which proven cost-savings have been achieved.²⁰

GRIPA’s Clinical Integration Committee and its Medical Management Committee will monitor and review GRIPA physicians’ aggregate performance under the quality and cost benchmarks. These committees also will receive reports at each meeting “showing cost-savings achieved compared to predicted cost-savings.” If either committee

determines that benchmark-level efficiencies are not being achieved or cost savings are less than projected, additional detailed analyses will be performed to determine network causes for these deficiencies. . . . Depending upon the causes . . . the [committees] will determine the best course of action to solve the problem, which

²⁰ GRIPA states that “[b]ased on the experience of other networks and GRIPA’s own experience with its risk-contracting programs, GRIPA estimates that the [proposed] program will begin generating efficiencies approximately six months after full implementation but that because of data-lag times, measurements may not be available until six- or nine-months later.”

may include general network education, meetings of the relevant SAGs to identify the best approach to changing physician practices and to determine whether patient education or intervention may be necessary, revision of the guidelines, re-evaluation of the benchmarks, creation of new medical-management programs to work with the physicians and their patients, quality assurance action plans for deficient or non-compliant providers, and/or work with payers to identify other possible means of achieving improvement.

D. Assuring Compliance with GRIPA's Program Requirements

GRIPA explains that it will use a two-pronged approach to achieving its goals, including working with its physicians and their staffs "to better understand and apply the GRIPA guidelines to affected patients," and working with patients to educate them and encourage compliance with their physicians' treatment plans. The Clinical Integration Committee and the Medical Management Committee, will be responsible for assuring both individual and overall compliance with program requirements, including, if necessary, discipline and even expulsion from GRIPA of chronically non-compliant physicians.²¹

Accurate information about physician performance is essential to this activity. GRIPA currently provides physicians in a number of practice areas with clinical service reports concerning patients with whom they have not complied with program standards, and has a process for feedback and correction regarding these reports. GRIPA states that this report review and feedback process leads to greater attention to performance and performance report results by its physicians. GRIPA will continue this program, and expand its scope to cover all participating physicians under the proposed program. Quarterly reports will show each physician's compliance rate for each performance measure, compare the physician's performance rate to the prior evaluation period, provide a cumulative compliance rate for all measures regarding the physician, and provide the average score for all physicians to whom each measure applies. Individual and network-wide performance reports will be provided to all physicians, and best-performing physicians for each measure will be publicly identified. Physicians whose performance is deficient relative to the benchmarks and the network average will be identified for intervention by GRIPA's Quality Assurance Council. GRIPA states that, once its web portal system is in place, it will be providing clinical service reports in "real-time," thereby identifying performance measure compliance failures as soon as they occur.

²¹ GRIPA also intends to pursue pay-for-performance or gain-sharing arrangements with payers willing to consider such arrangements. Such programs, if adopted, should provide further incentives for member physicians to improve efficiency and adhere to GRIPA's performance standards.

III. Analysis

A. The Legal Standard

GRIPA's proposed program will involve agreement through GRIPA on the levels of fees to be charged by several hundred competing physicians for their professional medical services provided under contracts between GRIPA and various payers providing health benefits coverage to numerous patients. GRIPA also will be collectively negotiating on behalf of its physician members the terms of dealing, including price terms, by those physicians under contracts between GRIPA and payers. In the absence of adequate justification, under prevailing antitrust law standards, such conduct would be summarily condemned as *per se* illegal price fixing.²² However, further analysis as to competitive effects is required when such conduct occurs in the context of efficiency-enhancing and potentially procompetitive joint ventures among otherwise competing market participants, and the competitive restraints are "ancillary" to achievement of the joint venture's efficiencies.²³

We address GRIPA's proposed program under this standard.²⁴

²² See *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982) ("*Maricopa*").

²³ The *Health Care Statements* specify how, consistent with general antitrust law principles, physician network joint ventures' negotiating and contracting with payers on behalf of their competing physician members will be analyzed by the antitrust enforcement agencies:

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.

Health Care Statements at Statement 8, § B.1. See also *Health Care Statements*, Statement 9 at § A., regarding multi-provider networks; Federal Trade Commission and the U.S. Department of Justice, *Antitrust Guidelines for Collaborations Among Competitors* (April 2000) (hereinafter *Competitor Collaboration Guidelines*) (available at <http://www.ftc.gov/os/2000/04/ftcdojguidelines.pdf>) at § 3.2 ("If . . . participants in an efficiency-enhancing integration of economic activity enter into an agreement that is reasonably related to the integration and reasonably necessary to achieve its procompetitive benefits, the Agencies analyze the agreement under the rule of reason, even if it is of a type that might otherwise be considered *per se* illegal.").

²⁴ See also the analytical framework applied by the Federal Trade Commission in its decision in *Polygram Holding, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003) (available at <http://www.ftc.gov/os/2003/07/polygramopinion.pdf>), and affirmed by the Court of Appeals, *Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005).

B. Integration and Likelihood of Achieving Significant Efficiencies Through GRIPA's Proposed Program

You have stated that GRIPA has been providing its physician members' services under HMO contracts with payers where those physicians shared financial risk through a percentage of premium arrangement.²⁵ Because such arrangements require the program to control costs in order to avoid financial failure, GRIPA has instituted a variety of quality and cost-containment programs to assure that it would be able to provide all necessary covered medical services within the fixed budgets established by those contracts. As the joint FTC and Department of Justice *Statements of Antitrust Enforcement Policy in Health Care* discuss, such financial risk-sharing arrangements generally are analyzed under the antitrust rule of reason, which balances their procompetitive and anticompetitive effects in the market, and generally are lawful in the absence of market power.²⁶

The *Health Care Statements* also address some ways in which physician networks that do not involve the sharing of substantial financial risk may be able to evidence that they involve sufficient integration among the participants to demonstrate that they are likely to produce significant efficiencies:

Such 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. 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.²⁷

²⁵ See n. 7, *supra*, regarding risk-sharing arrangements in health care provider networks.

²⁶ See *Health Care Statements*, *supra* n. 7 at Statement 8 and Statement 9. See also *Maricopa*, 457 U.S. at 356-357 (contrasting the physicians' arrangements, held to be *per se* illegal price fixing with arrangements in which the participants, through their joint venture, also offer another product besides their individual physician services, such as health insurance (e.g., HMO coverage), which the Court seems to suggest would result in the arrangement being analyzed under the rule of reason, as was the case in *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1 (1979) ("*Broadcast Music*").

²⁷ *Health Care Statements* at Statement 8, § B.1. The *Health Care Statements* emphasize, however, that these are only illustrative examples; they "are not . . . the only types of arrangements that can evidence sufficient integration to warrant rule of reason analysis [also assuming, of course, that the agreements eliminating competition among the participants in the arrangement are reasonably necessary to achieve the arrangement's potential efficiencies], and the Agencies will consider other arrangements that also may evidence such integration."

1. Systems and Programs to Improve Quality and Efficiency

Contracts involving the sharing of substantial financial risk among physician network participants generally create a strong financial incentive for the physicians to control costs – and thus reduce their collective and individual downside financial risk, as well as to maximize any potential for upside financial gain that the arrangement may entail.²⁸ Such risk management typically is achieved through implementation of programs aimed at improving and assuring quality and increasing efficiency in the provision of the medical services that the joint venture contracts with payers to provide to enrollees under the payers' programs. In networks involving clinical integration in the absence of risk sharing, the antitrust inquiry and analysis seek to ascertain whether the program's structure and operation have the capability, and the participants have the necessary incentives, to achieve the program's intended efficiency goals in the absence of the incentives and constraints normally provided by financial risk-sharing arrangements.

For several years, GRIPA has been operating, in substantial part, under such risk-sharing contracts and, as described above, has implemented a number of programs in order to control costs, improve quality, and assure its financial success under those contracts. GRIPA states that

GRIPA physicians already have a history of working collaboratively, through GRIPA's risk contracts, to achieve the efficiencies necessary to successfully share financial risk. Although the clinical integration program will not involve financial risk sharing . . . the physicians must work together in a similar manner to achieve the desired efficiencies of their quality improvement and cost containment activities.

Through the Specialty Advisory Groups ("SAGS") and the Clinical Integration Committee ("CIC"), which are integral parts of the clinical integration program, GRIPA physicians are collaborating to create the guidelines and corresponding measures embodying the quality standards to which the physicians will be held. To successfully achieve the organization-level benchmarks that the CIC sets for the guideline measures, the physicians will need to monitor their own guideline compliance and that of their peers. All physicians will be required, if selected by lot, to serve on the Quality Assurance Council . . . which will review and evaluate their peers' guideline compliance and then make and implement the decisions

²⁸ See *Health Care Statements* at Statement 8, § A.4. (" . . . such [substantial financial] risk sharing . . . normally is a clear and reliable indicator that a physician network involves sufficient integration by its physician participants to achieve significant efficiencies. Risk sharing provides incentives for the physicians to cooperate in controlling costs and improving quality by managing the provision of services by network physicians."); Statement 8, ¶ B.1. (Where the participants in a physician network joint venture have agreed to share substantial financial risk . . . their risk-sharing arrangement generally establishes both an overall efficiency goal for the venture and the incentives for the physicians to meet that goal."). Failure to do so potentially could result in reduced payments to network physicians for services that they are obligated to provide, the contractual obligation to provide covered medical services without any payment whatsoever, or the market failure of the joint venture.

regarding discipline and sanctions. The group's ability to achieve its efficiency goals depends entirely on the physicians' working together in their treatment of GRIPA patients and their using their committees to ensure that all GRIPA physicians continue to improve the quality of care they provide.

Under GRIPA's proposed program, which will involve contracting with payers on other than a financial risk-sharing basis on behalf of its physician participants, GRIPA states that it will be maintaining, and expanding the programs it previously instituted in order to improve quality, increase efficiency, and control costs under its risk-sharing contracts. GRIPA's experience in implementing such programs under its risk-sharing programs, as well as its member physicians' familiarity with, and acceptance of, such programs and practice constraints, should facilitate GRIPA's effective use of these systems under its proposed program to provide services under non-risk arrangements with payers.

GRIPA's current operations involve participating physicians in 41 medical specialty and sub-specialty areas.²⁹ While GRIPA cannot yet specify the exact number and mix of its currently participating physicians that also will participate in the proposed program, it expects that a substantial percentage of its current physicians will do so. It therefore appears likely that many or most of these 41 medical specialty areas also will be represented on the network panel for GRIPA's proposed program. Having a broad representation of medical specialties, combined with GRIPA's emphasis on in-network referrals whenever possible, helps to assure that patients with a broad range of diagnoses and conditions will be able to be treated within GRIPA's "system," by physicians subject to its practice standards and requirements, monitoring, and oversight. This, in turn, should help assure that patients will obtain the benefits of the proposed program, which would be lost, at least in part, if they were referred to physicians not participating in GRIPA's program.

2. Selective Participation of Network Physicians in the Proposed Program

One aspect of provider network programs that is likely to affect their success in achieving integrative efficiencies is appropriate selection of the participating physicians. These physicians must agree to certain practice and referral constraints, as well as to be subject to a variety of monitoring, oversight, and remedial activities by the network, in order to assure that the anticipated integration and efficiencies of the program can be achieved. There may exist a tension between a network arrangement's desire to include all interested or eligible providers, and its need to restrict participation only to those who are committed to accepting the limitations on the physicians' independent decision making that are necessary if the network is to succeed. Moreover, the larger a network becomes, the more difficult it may be to establish the "high

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See n. 12, supra.

degree of interdependence and cooperation among the physicians to control costs and ensure quality.”³⁰

In GRIPA’s proposed program, the physicians eligible to participate all participate in GRIPA’s current risk-sharing contracts with payers. The physicians already have participated in the monitoring, data collection, network referral, practice modification, disciplinary, and other efficiency-enhancing program aspects that GRIPA has established to manage the provision of services under those risk contracts. These physicians, to a great extent, therefore already have been pre-selected based on their track records of “success” in providing services under GRIPA’s risk contracts.³¹ Moreover, they each have been provided information concerning the requirements of the proposed program and, according to GRIPA, have individually “bought into” the program and its requirements, including agreeing to personally participate in GRIPA’s peer review activities, if called upon to do so. GRIPA’s proposed program also appears to have a serious system aimed at encouraging and assuring compliance by its physicians with the requirements of the program, up to and including expulsion from the network, if necessary. Thus, GRIPA’s approach to selection and continuing oversight of its physician participants should enhance the likelihood of its being able to achieve its integrative efficiency goals.

3. Physician Investment of Monetary and Human Capital in the Proposed Program

The *Health Care Statements* identify “the significant investment of capital, both monetary and human, in the necessary infrastructure and capability to realize the claimed efficiencies” as one possible indicium of integration in physician network joint ventures and multi-provider networks.³² Such “investment” by participants can evidence their stake in, and likely commitment to, the successful operation of the venture, and therefore the achievement of efficiencies as a result of the participants’ joint activity through the enterprise. GRIPA states that it will be using monies that would have been returned to each physician under its risk contracts in order to finance the \$2.7 million cost of the GRIPA Connect Web Portal and applications under that system. GRIPA estimates that this contribution will amount to approximately \$7,000 per physician. Further, each physician office will need to invest in several computers and printers, the latter for printing prescriptions and copies of records, handouts, and referrals. GRIPA

³⁰ *Health Care Statements* at Statement 8, § B.1.

³¹ As noted previously, GRIPA anticipates that participants in its proposed program will be a subset of the physicians that have participated under its risk contracts.

³² *Health Care Statements* at Statement 8, § B.1.; Statement 9 at § A. (referencing Statement 8 at § B.1.).

estimates this hardware expense at about \$6,000-\$7,000 per office.³³ Each physician also will assume the cost of internet connection for the system, which will be about \$70 per month.³⁴

In addition to contributions of monetary capital, GRIPA physicians will be required to invest what appears to be substantial human capital in GRIPA's operations. All physicians and their office staffs will be required to attend four half-day training sessions on use of the web portal system and the clinical integration program. GRIPA estimates the cost of attendance, in lost patient revenue, to be approximately \$3200 per physician. In addition, each physician will need to make what you characterize as a "significant time investment" each month, on an ongoing basis, in order to contribute data, collaborate in patient care, comply with the guidelines GRIPA adopts, and serve on GRIPA committees and SAGs. GRIPA estimates the additional time to be devoted to these functions at two hours per month, which it estimates as the equivalent of \$2400 per year per physician. You also state that "almost all the [GRIPA] physicians voiced strong support for the [proposed] program, and many have volunteered to serve on GRIPA organizational and operational committees to develop and implement the [proposed program's] clinical-improvement services." To this end, all physicians "will be required, if selected by lot, to serve on the Quality Assurance Council . . . which will review and evaluate their peers' guideline compliance and then make and implement the decisions regarding discipline and sanctions."

In our view, and as described above, GRIPA physicians have made, and will be continuing to make, significant investments in GRIPA's infrastructure and operation. This investment is both in the form of financial support and by contribution of participating physicians' time, effort, and expertise in the program's ongoing operation. While not necessarily sufficient in itself, substantial investment by participants in a joint venture supports the view that the participants are likely to be motivated to work toward the venture's success in the market – which, in this case, requires it to succeed in improving the quality, and controlling the costs, of the physicians' services provided pursuant to the venture's proposed program.

4. Measurement and Evaluation of Performance Results

In addition to monitoring and evaluating each individual physician's performance and adherence to GRIPA's protocols and other program requirements, GRIPA will compare its physicians' aggregate performance to local, regional, and national benchmarks. These benchmarks

³³ Some offices already will have invested in this computer hardware and medical records systems, and therefore will have lower implementation costs.

³⁴ Each GRIPA physician must be a shareholder in either RGPO or WCPO, and previously paid \$1,650 for stock in one of the physician organizations in order to participate in GRIPA's earlier programs and contracts. However, we do not consider this earlier investment to be a capital investment in the proposed program.

will be derived from selected indicators from . . . sources such as federal government agencies (e.g., AHRQ, CMS, and CDC), national organizations focused on quality (e.g., NCQA and The Institute [for] Clinical Systems Improvement), national organizations focused on specific disease states (e.g., American Diabetes Association and the American Heart Association), national specialty societies (e.g., American college of Obstetricians and gynecologists, American Academy of family Physicians, and American Academy of Pediatrics) and the New York State Department of Health. If payors provide claims data, GRIPA will also use risk-adjusted cost measures.

GRIPA also has developed a model for forecasting savings attributable to each clinical guideline, based on avoidance of unnecessary costs “through primary care intervention and disease management.” GRIPA’s software program will allow it to assess guideline compliance, and compare utilization and costs of services provided under its program to historic claims data provided by payers for their enrollee populations. As noted earlier, GRIPA also will be able to compare actual aggregate cost savings to predicted cost savings, and address the causes of any failure to achieve the latter.

5. Conclusion Regarding Integration and Potential to Achieve Significant Efficiencies

Overall, it appears that GRIPA’s proposed program is both intended and structured to be likely to produce substantial integration among its participating physicians in their provision of medical services. Based both on its proposed operation, as well as GRIPA’s past experience managing risk contracts, its physicians’ integration through the proposed program appears to have the potential to result in significant efficiencies, both in terms of cost and quality, in the delivery of the medical services to patients covered under payer contracts for the program. Additionally, it appears that the efficiency enhancements to those services could not be provided by GRIPA’s physician members acting individually outside of GRIPA or through other unintegrated network arrangements.

C. Need and Justification for Joint Pricing and Collective Negotiation of Payer Contracts

Having concluded that GRIPA’s proposed program appears to involve substantial integration by its physician participants that is likely to achieve significant efficiencies, we now consider whether the joint pricing and collective negotiation are “ancillary” to – that is, related and subordinate to, and reasonably necessary to further – the integration and achievement of efficiencies.³⁵

³⁵ For reference to some of the case law underpinnings of the ancillary restraints analysis, which was first articulated in *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *modified* 175 U.S. 211 (1899), was incorporated by the Agencies in the *Health Care Statements* and the *Competitor Collaboration*

Before turning to GRIPA's proffered justifications, however, we address a threshold issue. Since issuance of the MedSouth staff advisory opinion letter in 2002,³⁶ various alternative programs and arrangements to facilitate physicians in interdependently improving performance and quality of care have emerged. Some of these are payer-initiated programs, others have been developed by business or employer coalitions or health care policy groups. The existence of such alternatives, which may not require joint contracting or horizontal agreement on fees by competing physicians, raises the question of whether such agreements among competing physicians therefore can ever be "reasonably necessary" to achieving the efficiencies of clinically integrated programs.

It does appear that parties other than networks of physicians may be capable of developing, and willing to adopt, programs that have the potential to improve quality and increase efficiency in the provision of physicians' services. This is salutary, both for the improvements in quality and efficiency that such programs may bring, and because they represent alternative approaches in the marketplace for achieving those benefits. Their existence, however, does not mean that physicians themselves may not lawfully undertake a different approach and attempt to cooperatively achieve improvements in performance by other means. Different types of programs may have different strengths and weaknesses, and the market should determine which programs are most desirable.

Moreover, the competitive restraints that may accompany integrated physician-initiated network programs must be evaluated for their reasonable necessity in the context in which they occur. We therefore look at the ancillarity of joint contracting by physicians in a clinically-integrated physician network within the context of that type of potentially efficiency-enhancing arrangement.³⁷ Accordingly, we now turn to GRIPA's explanations of why it believes that its

Guidelines, and was subsumed within the analysis that the Commission applied in its decisions in *Polygram Holding, Inc.*, *supra* n. 24, and *North Texas Specialty Physicians*, Dkt. No. 9312 (FTC Nov. 29, 2005) (available at <http://www.ftc.gov/os/adipro/d9312/05120opinion.pdf>), (*appeal docketed*, No. 06-60023 (5th Cir. Jan. 10, 2006)), *see* Letter to Clifton E. Johnson, Esquire, and William H. Thompson, Esquire from David R. Pender, Acting Assistant Director, Bureau of Competition, Federal Trade Commission (March 28, 2006) (staff advisory opinion concerning Suburban Health Organization, Inc.) ("SHO staff advisory opinion") (available at <http://www.ftc.gov/os/2006/03/SuburbanHealthOrganizationStaffAdvisoryOpinion03282006.pdf>), at n. 14-17, and accompanying text.

³⁶ See Letter to John J. Miles from Jeffrey W. Brennan, Assistant Director, Bureau of Competition, Federal Trade Commission (February 19, 2002) (staff advisory opinion concerning proposed clinical integration program by MedSouth, Inc.) ("MedSouth advisory opinion letter") (available at <http://www.ftc.gov/bc/adops/medsouth.htm>).

³⁷ See, e.g., *NCAA v. Board of Regents of the Univ. of Okla.*, 468 U.S. 85 (1984) ("NCAA") (assessing reasonableness of organization's restraint prohibiting individual member colleges from arranging for televising of their league football games, in furthering the organization's legitimate purpose in offering league sports of having "balanced" competition among league members). There, the Court analyzed the necessity for the restraint within the context of the operation of the NCAA, and looked only to other comparable arrangements – other sports leagues with similar purposes and operation – in assessing the necessity for the NCAA's restraint.

program's competitive restraints are "ancillary" to the integration and achievement of efficiencies, and therefore warrant a more detailed inquiry into their likely competitive effects under the rule of reason.

1. Inability to Offer Payers a Predetermined Network of Clinically Integrated Physician Practices Without Joint Contracting, and Its Contribution to Achieving the Program's Likely Efficiencies

GRIPA asserts that joint contracting with payers on behalf of its physician participants is necessary and ancillary to the effective operation of its proposed program because achievement of the program's potential efficiencies requires establishment at the outset of a defined group of physicians, all of whom have committed to practice subject to the program's conditions and constraints, and among whom referrals and other key interactions in treating patients under the program will occur. According to GRIPA, this arrangement will further its efficient operation by allowing it to:

- 1) establish a set panel of providers that are easily identifiable to payors, patients, and referring physicians; 2) reinforce GRIPA's in-network referral policy; 3) ensure that all GRIPA physicians are working towards the same financial and quality goals; 4) maximize the opportunities for GRIPA to affect physicians' practice patterns and the quality of care patients receive; 5) maximize the opportunities for collaboration in the care of patients; and 6) reduce GRIPA's administrative burdens.³⁸

GRIPA believes that these benefits only can be fully achieved if its physicians all are contractually bound at the same time, through their acquiescence in the organization's physician participation agreement, and through GRIPA's joint contracts with payers, to provide services under this system.

³⁸ This justification is similar to what the Commission staff accepted in its evaluation of the proposal that was the subject of the MedSouth advisory opinion letter. See n. 36, *supra*. It is important to distinguish this proffered justification for GRIPA's (and MedSouth's) joint negotiations from what may appear to be a similar justification, but one that really is quite different and not cognizable under the antitrust laws. The argument has been made that physicians will not participate in clinically-integrated arrangements unless they are allowed to agree on prices and collectively negotiate contracts and contract terms with payers regarding their provision of services under such programs. This justification essentially is that physicians will not jointly do such "good things" as clinical integration unless they are rewarded with authorization to fix prices in their dealings with payers. We view this justification not as an ancillarity argument, but rather as akin to the type of argument that was flatly rejected by the Supreme Court in *National Society of Professional Engineers v. U.S.*, 435 U.S. 679 (1978) – that assuring higher prices for engineers through an obvious competitive restraint (a total ban on competitive bidding by engineers) was necessary to achieve a result beneficial to public safety (the avoidance of deceptively low bids which, in turn, could lead to substandard and dangerous construction). The Court characterized this unacceptable rationale as "nothing less than a frontal assault on the basic policy of the Sherman Act," *Id.* at 695, and as "based on the assumption that competition itself is unreasonable." *Id.* at 696.

GRIPA concedes that some reduced level of efficiencies, which it is unable to estimate, may be achievable through its proposed program even if not all physicians were contractually bound to participate under all payer contracts. However, it believes that such an approach would seriously undermine the potential integrative activity and efficiencies of its program, and create numerous administrative and operational inefficiencies, as well. Identifying up front a set network of physicians, all of whom will participate in all aspects of the program of integration regarding all patients covered under all GRIPA contracts, on its face appears calculated to assure that those efforts will have maximum application and efficacy. And this can only be achieved if GRIPA jointly negotiates the contracts with payers on behalf of all of its physician members.³⁹

We agree with GRIPA's arguments that implementing a program in which different subsets of physicians are "in" the program for different payer contracts, while perhaps theoretically possible, likely would be difficult to implement in practice. Doing so could adversely affect the provision of care under the program. It also could interfere with GRIPA's ability to effectively gather data, and monitor and evaluate physician performance under the program. These problems, in turn, could seriously undermine the effectiveness, and possibly even jeopardize the existence, of the entire program.

In sum, we believe that joint contracting on agreed-upon terms by its physician members will facilitate GRIPA's establishment of a pre-determined network of physicians, which is necessary for maximally effective operation of the various potentially efficiency-enhancing activities that make up its proposed program. Moreover, the history of GRIPA's operation, and the apparent substantiality of its proposed program and investments in support thereof, together indicate that the program's competitive restraints are subordinate to, and in furtherance of, that program, rather than the converse. This view is reinforced by GRIPA's non-exclusive operation and apparent absence of market power. If physicians' participation in GRIPA in fact is non-exclusive, it would make no sense for GRIPA to establish and operate its proposed program, with all the associated costs and efforts that it entails, just to implement a price agreement and collective negotiation arrangement that would appear to have little likelihood of succeeding in gaining higher prices for its physician participants due to payers' ability to avoid contracting with GRIPA for their services. We therefore conclude that the anticompetitive aspects of GRIPA's

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GRIPA states that it

can't predict how many or what percentage of its physicians would actually participate in GRIPA contracts if there were no requirement that they do so [for all contracts]. It is possible that a small number of physicians would participate in some contracts, resulting in a correspondingly small amount of data reviewed for compliance and monitoring. The smaller the amount of data, the less statistically significant and unbiased the results of the program will be and the less effective the program is likely to be.

GRIPA has not attempted to determine, objectively and empirically, how much data or what degree of participation is necessary for valid statistics or an effective program. Even having that information would be of little help without the ability to predict which physicians would participate in the contracts.

proposed program should not be condemned at the outset as a price-fixing arrangement, but rather should be subject to a fuller analysis of the program's overall likely competitive effects.⁴⁰

2. The "New Product" Argument

GRIPA also asserts that joint pricing of its physician members' services, and negotiation of contracts with payers, is ancillary to the physicians' integration through GRIPA's proposed program because what it will be offering to the market is a "new product" that combines individual physicians' traditional medical services offered on a fee-for-service basis with various collaborative activities designed to improve clinical outcomes and improve efficiency. This characterization of the proposed arrangement appears to be made in support of the belief that offering a "new product" consisting of inputs from each of the individual joint venturers, *ipso facto*, results in evaluation of the joint venture's pricing of its product under a rule-of-reason analysis, rather than having it possibly subject to summary condemnation as a horizontal price agreement, since any such product necessarily must have a price set for it.⁴¹

We are unpersuaded by the "new product" argument. GRIPA's proposed program may well beneficially affect the quality of the services its physician members provide, as well as help to assure the appropriateness of the services each physician provides to particular patients. Nevertheless, the program does not appear to fundamentally change the nature of the services provided by each physician, or offer them in a way that can be called a new or different product, as that concept was understood and applied by the Supreme Court in its antitrust analyses of joint ventures among competitors in *Broadcast Music* and in *Maricopa*.

Broadcast Music – the only case where the Supreme Court has characterized a joint venture for collectively selling the products of its individual members as a "new" or "different" product – involved a "blanket license," whereby purchasers of the license were entitled to unlimited use of any and all copyrighted compositions of the individual participant composers, without the need to arrange or pay for the use of each individual composition.⁴² *Maricopa*, like GRIPA, involved

⁴⁰ Alternative approaches to improving the provision of health care services may have different levels of success, and their existence would appear to offer potential benefits for the market. Insofar as possible, the market should determine which approach or approaches are preferable.

⁴¹ This view presumably is based on the Supreme Court's decision in *Broadcast Music*, where the Court – having characterized the blanket license arrangement as "to some extent a different product" from the "sum of its parts" (441 U.S. at 21-22) observed that "a necessary consequence of an aggregate license is that its price must be established" (*Id.* at 21), and concluded that the joint venture there properly was subject to rule-of-reason treatment, rather than *per se* condemnation as price fixing, despite its apparently involving horizontal agreements on price. *Id.* at 24.

⁴² In *Broadcast Music* the Supreme Court concluded that joint price setting through the arrangement regarding the new product properly was subject to rule-of-reason analysis, rather than summary condemnation as *per se* illegal price fixing among competitors who participated in the joint venture. In that case, the Court characterized the arrangement as one where "the whole is truly greater than the sum of its parts; [and] . . . to some extent, a

a network of independently practicing physicians, which was created to contract with payers of medical services on the physicians' behalf. There, the Supreme Court observed that "[e]ach of the foundations is composed of individual practitioners who compete with on another for patients. . . . The members of the foundations sell medical services. Their combination in the form of the foundation does not permit them to sell any different product."⁴³ Here, where each GRIPA physician member's services will be individually provided, billed, and paid for, we think that the characterization of the arrangement in *Maricopa*, not *Broadcast Music*, is warranted.⁴⁴ Moreover, in *Maricopa*, the Court appeared to contrast the physician network with other joint venture arrangements among physicians that also sell health insurance – possibly a reference to health maintenance organizations (HMOs) that provide both medical services and an insurance guarantee to provide all necessary medical services, for a fixed, prepaid “insurance” premium – i.e., a “capitation” payment.⁴⁵ Such an arrangement appears to be more closely analogous to the blanket license in *Broadcast Music*, which also provided unlimited access to all the participating composers' compositions for a fixed, predetermined fee. In both instances – the blanket license in *Broadcast Music* and the prepaid healthcare/insurance product referred to in *Maricopa* – the

different product.” 441 U.S. at 21-22. The Court explained that “[t]he blanket license has certain unique characteristics . . . and many consumers clearly prefer the characteristics and cost advantages Thus, to the extent the blanket license is a different product . . . [it] is not really a joint sales agency offering the individual goods of many sellers, but is a separate seller offering its blanket license, of which the individual compositions are raw material.” *Id.* at 22. The Court went on to note that “a necessary consequence of an aggregate license is that its price must be established,” *Id.* at 21, but that “[t]he individual composers and authors have neither agreed not to sell individually in any other market nor [to] use the blanket license to mask price fixing in such other markets. . . . With this background . . . and in the face of available alternatives . . . we cannot agree [with the Court of Appeals] that it [the blanket license] should automatically be declared illegal Rather, . . . it should be subjected to a more discriminating examination under the rule of reason.” *Id.* at 23-24.

⁴³ 457 U.S. at 356. Similarly, in *NCAA*, the Supreme Court distinguished the sale of television broadcast rights to sports events by league members from the blanket license in *Broadcast Music*. (“Unlike *Broadcast Music*'s blanket license covering broadcast rights to a large number of individual compositions, here the same rights are still sold on an individual basis, only in a noncompetitive market.”). 468 U.S. at 113-114. GRIPA's proposed program, and any physician network program in which each physician's services are billed and paid for on a purely fee-for-service basis, likewise would appear to be distinguishable from the type of arrangement that the Court characterized as a “new product” in *Broadcast Music*.

⁴⁴ Since *Broadcast Music*, assertions that a joint venture among competitors creates a “new” or different product have not been uncommon. Many early preferred provider organizations (PPOs), for example, made this argument in attempting to justify rule-of-reason treatment of their collective negotiation of prices and contracts with payers. See also, SHO staff advisory opinion, *supra* n. 35 at 7-9, for a discussion of the “new product” characterization. The Commission and the Department of Justice, in the *Health Care Statements* at Statement 8, n. 36 and at Statement 9, n. 46, have made clear, however, that their analysis of physician and multi-provider network joint ventures will not focus on conclusory assertions that a joint venture creates a new product: “The Agencies' analysis will focus on the efficiencies likely to be produced by the venture, and the relationship of any price agreements to the achievement of those efficiencies, rather than on whether the venture creates a product that can be labeled ‘new’ or ‘different’.”

⁴⁵ See *Maricopa*, 457 U.S. at 356.

Court concluded that rule-of-reason treatment of the pricing of the products was, or would be, appropriate.⁴⁶

GRIPA's proposed program does appear to share some of the characteristics of the blanket license for use of copyrighted compositions that was the focus in *Broadcast Music*, including non-exclusivity and the potential for creating significant integrative efficiencies. However, unlike the blanket license arrangement, the medical services provided by physicians under GRIPA's proposed program will continue to be billed and paid for through individual purchase and sale transactions, with the services being provided by individual physicians who will continue to compete with each other to provide their services to those patients under the program.⁴⁷ Largely based on these characteristics, the Supreme Court in *Maricopa* distinguished the physician network arrangements at issue from the blanket license in *Broadcast Music*, and rejected the argument that sales of physician services through joint contracts entered into by the foundations/networks – as opposed to through a financial risk-sharing arrangement, such as an HMO, or a fully-integrated multi-specialty clinic – resulted in the physicians selling something other than their individual medical services.⁴⁸

Second, in *Broadcast Music* the Court concluded that a single price for the blanket license necessarily had to be set, and essentially concluded, albeit without discussion, that the joint venture offering the license was the only appropriate entity to set that price. By contrast, in *Maricopa*, the Court, based on observations about how other similar arrangements in health care operated, concluded that “[e]ven if a fee schedule is . . . desirable, it is not necessary that the doctors do the price fixing . . . [and] nothing in the record even arguably supports the conclusion that this type of insurance program could not function if the fee schedules were set in a different way.”⁴⁹ Thus, the ancillarity of the joint venturers entering into a price agreement was far more

⁴⁶ In *Broadcast Music*, having concluded that the blanket license really was a fundamentally different product from what the individual composers were offering or could offer, the Court concluded that “a necessary consequence of an aggregate license is that its price must be established,” (441 U.S. at 21), and therefore the arrangement needed to be looked at more carefully under the rule of reason to ascertain its overall competitive effect in the market. *Id.* at 24.

⁴⁷ In *Broadcast Music*, if a customer used a particular composition under the blanket license, the composer of that composition received no additional remuneration, and other composers participating in the program lost no business or revenue from that transaction. In essence, the blanket license rendered the composers no longer competitors with regard to the sale of rights to use songs covered by the license. Here, by contrast, each medical service provided by a GRIPA physician, however enhanced by GRIPA's programs, will be separately billed by or for, and paid to, the individual physician providing the service. Conversely, each other GRIPA physician that could have provided the same service will lose the potential financial benefit that would have resulted had the patient not chosen another, competing, GRIPA physician to provide the service.

⁴⁸ See *Maricopa*, 457 U.S. at 355-357.

⁴⁹ 457 U.S. at 352-353. Apparently, the Court believed that prices for such an “insurance program” more properly should be set by the insurer offering the program, rather than by the physicians providing the medical services covered by the insurance program.

apparent and acceptable to the Court regarding the blanket license in *Broadcast Music* than for the sale of the physicians' individual services through the networks in *Maricopa*.

3. Creation of Transaction Cost Efficiencies Through Joint Contracting

GRIPA also points to reduced transaction costs to both the physicians and payers from joint contracting. The Supreme Court has acknowledged that transaction cost efficiencies may be relevant when it later characterized its decision in *Broadcast Music* as “squarely hold[ing] that a joint selling arrangement may be so efficient that it will increase sellers’ aggregate output and thus be procompetitive.”⁵⁰ Nevertheless, in contrast to the situation in *Broadcast Music*, the potential transaction cost efficiencies from contracting with payers on behalf of otherwise independent and competing physicians in a network, while theoretically cognizable, are also likely to be relatively modest in practice.⁵¹

Any joint marketing arrangement, and indeed any cartel, provides transaction costs efficiencies when compared to engaging in individual sales transactions in markets with numerous participants. Nevertheless, antitrust courts rarely conclude that these efficiencies justify horizontal price fixing. The joint contracting by the medical care foundations in *Maricopa*, for example, which was decided subsequent to *Broadcast Music*, was undertaken on behalf of approximately 2150 total individual member physicians of the Maricopa and Pima foundations for medical care.⁵² Yet the Supreme Court did not even mention, much less consider, this contracting efficiency in condemning the foundations’ activities as *per se* illegal price fixing.

In the present instance, GRIPA currently has approximately 717 eligible physician participants, 130 of whom are employed by ViaHealth, and the remainder of whom practice in a total of 339 separate medical practice groups. Moreover, GRIPA anticipates that not all these physicians will participate in its proposed program, further reducing the potential savings from joint contracting. Therefore, the potential transaction cost efficiencies from joint contracting through GRIPA, while real, do not appear to be of the type, magnitude, or significance of the transaction costs efficiencies that were present in *Broadcast Music*. Except in such rare and unusual situations as *Broadcast Music*, transaction costs efficiencies alone are unlikely to be sufficiently significant to

⁵⁰ See *NCAA*, 468 U.S. at 103.

⁵¹ Some payers, apparently not impressed by the potential transactions costs savings, or perhaps just wary about the risks of dealing with providers collectively, insist on individual contracts with physicians who wish to participate in their programs. GRIPA reports that Excellus Health Plans, Inc., the Blue Cross/Blue Shield plan operating in Rochester, and the largest payer in the area, already has individual contracts with a majority of local physicians. GRIPA has not attempted to quantify the transaction costs efficiencies from its program, and notes that “[g]iven the number of variables involved in such a calculation and their subjective nature, GRIPA is not even sure such a calculation is possible.”

⁵² See *Maricopa*, 457 U.S. at 339, 340.

justify rule-of-reason treatment of an otherwise facially anticompetitive horizontal agreement on prices by competitors.

D. Competitive Effects

1. GRIPA's Position in the Market

We have not done an investigation or formal market analysis to define relevant geographic and product markets within which GRIPA and its participants compete. Our consideration of the likelihood that GRIPA would be capable of exercising market power in the sale of its physician members' services under its proposed program is based on the information you provided to us. You state that GRIPA currently has 717 physician members or contracted physicians eligible to participate in the proposed program, of whom it estimates about 575 will participate.⁵³ You advise that these physicians "are not [geographically] concentrated in one area, but rather are dispersed relatively equally throughout the Rochester area." Nevertheless, it is not clear to what extent non-GRIPA physicians would be available to payers in particular specialties and locations within the tri-county Rochester area.⁵⁴

Because it is uncertain which physicians will ultimately participate in GRIPA's proposed program, you have provided information concerning the composition of GRIPA's current participants. That information indicates that GRIPA physicians constitute more than 35 percent of the physicians in Monroe, Wayne, and Ontario counties in 14 of 44 medical specialties or sub-specialties, in a few specialties the percentage is considerably higher than 35 percent, and in some specialties that is the case within individual counties.⁵⁵ In some of the 14 specialty areas, however, the total number of specialists in the tri-county area is relatively small, such that the percentage involved in the proposed program would drop significantly if a single eligible physician or physician group practice chose not to participate.

In addition, even if all eligible physicians decided to participate in the proposed program, implementation of the program should not result in the exercise of market power as long as GRIPA physicians are available and willing to contract at competitive prices with payers who

⁵³ Any additional participating physicians would be limited to shareholders in RGPO or WCPO. RGPO limits new shareholders to "'active' Rochester General Hospital medical staff in medical specialties in which there is an inadequate number of physicians to service the subscribers of the payers with which GRIPA contracts." GRIPA states that it "has no plans to increase the number of its members." Should those plans change, and GRIPA significantly increase its physician membership overall, or in particular specialty or geographic areas, it may be necessary to revisit the issue of GRIPA's market power.

⁵⁴ A similar concern about the network including relatively high percentages of area physicians in certain specialties was raised in the MedSouth advisory opinion letter, although GRIPA's physicians apparently are less geographically concentrated than was the case regarding MedSouth's physicians.

⁵⁵ The percentages of GRIPA physicians in the fields of internal medicine, pediatrics, and family practice all fall below 35 percent.

prefer not to contract with the network. GRIPA asserts that its proposed program will be non-exclusive. You represent that GRIPA:

will not attempt to force payers to contract with it. If GRIPA and a payer . . . cannot reach an agreement . . . or if a payer notifies GRIPA that it does not wish to contract with GRIPA, GRIPA physicians will be completely free to negotiate with the payer on an individual basis and decide unilaterally whether to participate in the payer's network.

You also state that GRIPA will:

advise its members that they are free to contract individually with payers (or contract with payers through other . . . contracting organizations) and that they have no obligation to contract only through GRIPA unless GRIPA has contracted with the payer in question.

Furthermore, GRIPA represents that it has operated non-exclusively under its existing programs and contracts for almost a decade.⁵⁶ You advise that several other, larger, physician networks or organizations are, or have been, available to contract with payers in the Rochester area.⁵⁷ Among these are Strong Health, which employs nearly 1000 physicians, Rochester Community Individual Practice Association, Inc., ("RCIPA") with approximately 3,200 physicians and allied health professionals, the Rochester Individual Practice Association, Inc., ("RIPA") with approximately 2,700 physicians, and Preferred Health Network, ("PHN") with about 1,700 physicians.⁵⁸ GRIPA reports that "[a]lmost every GRIPA physician" is a member of RCIPA and RIPA contracts through them as well as through GRIPA.

⁵⁶ For discussion of the Agencies' approach to determining the exclusivity or non-exclusivity of physicians' participation in a network joint venture, see *Health Care Statements* at Statement 8, § A.3. See also *Id.* at Statement 9, § B.2.b.

⁵⁷ According to GRIPA, under New York State law, IPAs may only contract with HMOS. In order to contract for non-HMO programs, area IPAs have created parallel organizations. Therefore, GRIPA established ViaHealth, and the Rochester Individual Practice Association, Inc. created Crossbridge Physicians, P.C., to enter into PPO and other non-HMO contracts.

⁵⁸ We note that the availability of alternative physician networks to GRIPA for Rochester-area payers may be more limited than these numbers suggest. GRIPA reports that the market is changing significantly, and that RIPA soon will, or already has, stopped contracting on behalf of physicians. Moreover, PHN contracts exclusively with Preferred Care, the area's second largest payer, and may not contract with any other Rochester area payer. RCIPA likewise has an exclusive contract with Aetna. While RCIPA can and does contract with certain third-party benefits administrators, it may not contract with any other Rochester area health plans RCIPA also contracts with POMCO, and several third-party benefits administrators. GRIPA also reports that a new physician organization, Community Private Practice Physicians Organization ("C3PO") is in the formation stages, and proposes to operate as a "messenger model" for contracting with payers by private practice physicians. GRIPA anticipates that its physicians will join C3PO.

In addition, as noted previously, two large payers – Excellus and Preferred Care – account for 70 and 25 percent, respectively, of the privately insured lives in the Rochester area. GRIPA reports that Excellus already has individual contracts with a majority of Rochester area physicians, and states that “[n]early all GRIPA physicians [have] signed individual contracts with Excellus for 2007. Preferred Care has an exclusive contract with PHN and its 1,700 physicians, in addition to contracting with GRIPA.⁵⁹

Accordingly, it appears that, if GRIPA in fact operates as it has proposed, Rochester-area payers unwilling for whatever reason to negotiate and contract jointly with physicians through GRIPA nevertheless should be able to deal individually or through other networks in order to obtain the services of GRIPA’s member physicians.⁶⁰ Under these conditions, it appears unlikely that GRIPA’s proposed program would permit it or its physician members to exercise market power or have anticompetitive effects in the market for physician services in the Rochester area.⁶¹

2. Higher Fees for Services of GRIPA Physicians Under GRIPA’s Proposed Program

GRIPA candidly states that it seeks and expects to be able to contract at higher fee levels for the services of its physicians. Explicit admission that the joint venture seeks higher prices can be a “red flag,” raising concern that such higher prices are the result of the ability of the joint venture’s participants to exercise market power. Here, however, GRIPA’s higher fee levels are anticipated as part of a program that seeks, and through the participants’ integration appears to have significant potential to achieve, greater overall efficiency and improved quality in the provision of medical care to covered persons. The goal is for the program to result in both higher quality and lower total costs of medical care for payers and their customers (e.g., employers providing coverage to their employees and their dependents). Some of this efficiency gain is expected to result from adjusting the mix of services provided to patients, with increased use of,

⁵⁹ GRIPA reports that PHN was established by Preferred Care, is managed by Preferred Care’s medical director, and has its operational costs funded by Preferred Care. GRIPA contracts with Preferred Care on a non-exclusive basis.

⁶⁰ In considering the blanket license arrangement in *Broadcast Music*, the Supreme Court noted that “[t]he District Court found that there was no legal, practical, or conspiratorial impediment to . . . [customers] obtaining individual licenses [to use individual compositions]; . . . [customers], in short, had a real choice.” 441 U.S. at 24. Assuming that GRIPA, in fact, operates in a truly non-exclusive fashion, payers likewise should have similar options for the purchase of the services of individual GRIPA physicians. Should GRIPA’s actual operation evidence otherwise, and demonstrate that GRIPA is having anticompetitive effects, the staff may rescind this advisory opinion, and may recommend that the Commission institute appropriate law enforcement activity to remedy such anticompetitive conduct.

⁶¹ Should it become apparent that GRIPA and its physician members in fact are not operating on a non-exclusive basis, or that Rochester-area payers are unable to obtain access to physician services needed for their programs outside of GRIPA, our initial view of GRIPA’s market power and likely competitive effects would require reassessment.

and costs for, primary care screening and preventive services, in order to reduce the need for, and use of, more expensive interventions. Costs of medical care services are the product of the unit prices of the individual services times the utilization of those services. Higher unit prices may be of little concern to a customer if they occur within integrated programs that result in lower total costs (e.g., through elimination of unnecessary and inappropriate utilization of services) and higher quality (e.g., better medical outcomes).⁶² Based on its experience under its risk contracts, and consistent with studies it has reviewed in this regard, GRIPA anticipates that total costs of providing care should decrease.⁶³

Under these circumstances, quality-adjusted prices to GRIPA's customers for the services of its physicians may not be higher and, even if they are, customers may be willing to pay those higher unit prices in order to both raise the level of quality and to reduce total costs expended in providing medical services under the program.⁶⁴ If payers unwilling to purchase GRIPA's proposed program, with its attendant higher unit costs (in terms of physician fees), have adequate access to area physicians, both from non-GRIPA physicians, and through the ability to contract directly with GRIPA physicians for their professional services outside the GRIPA program, then any higher fee levels that GRIPA's physician members may be able to obtain for their services

⁶² See L.P. Casalino, *The Federal Trade Commission, Clinical Integration, and the Organization of Physician Practice*, 31 J. Health Pol., Pol'y and L. 569, 578 (June 2006). Assuming that GRIPA operates in a truly non-exclusive fashion, as it states in its proposal, unless the price/cost tradeoff is found to be beneficial to a payer, the payer simply can ignore GRIPA's proffered terms of dealing, and contract with GRIPA's individual physician members, thus avoiding the program's higher unit prices.

⁶³ In this regard, the integration of GRIPA's member physicians through its proposed program appears to distinguish this network from the physician network arrangements condemned in *Maricopa*. The arrangement in that case had no effect whatsoever on the nature, quality, amount, or type of medical services to be provided by physicians in the foundations. According to the Supreme court, the only procompetitive benefit claimed by the foundations in that case was that "their fee schedules . . . make it possible to provide consumers of health care with a uniquely desirable form of insurance coverage that could not otherwise exist . . . [with] a choice of doctors, complete insurance coverage, and lower premiums." 457 U.S. at 351. Under the circumstances, the Court disagreed with the assertion that this benefit only could be achieved by allowing the physicians to jointly set the maximum prices, observing that the insurers could set the prices under such an insurance program, without the need for competing physicians to engage in horizontal price fixing. ("Even if a fee schedule is therefore desirable, it is not necessary that the doctors do the price fixing." *Id.* at 352). The Court concluded that "[t]he [physician] members of the foundation sell medical services. Their combination in the form of the foundation does not permit them to sell any different product. Their combination has merely permitted them to sell their services to certain customers at fixed prices and arguably to affect the prevailing market price of medical care." *Id.* at 356. Here, by contrast, the proposed clinical integration program is intended, and appears to have the potential, to beneficially affect the quality and use of medical services, and the effectiveness of care provided by each GRIPA member physician, as well as the overall quality and cost of the total set of medical services provided by the network to the population covered by contracting payers.

⁶⁴ Both cost and quality efficiencies that may be achieved by physician or multi-provider network joint ventures are specifically recognized in the *Health Care Statements* at Statement 8 at § B.2, and Statement 9 at § B.3, each of which states that "[i]n assessing efficiency claims, the Agencies focus on net efficiencies that result in lower prices or higher quality to consumers."

provided through the program likely will be due to purchasers in the market valuing those services as superior to existing alternatives, rather than as a result of the exercise of market power by physicians through GRIPA.⁶⁵

3. “Spillover” Price Effects

Another area of potential antitrust concern with a physician network relates to possible “spillover” effects on pricing by member physicians of their medical services sold outside the network.⁶⁶ A collusive arrangement by GRIPA physicians as to the fees they will charge outside of GRIPA would raise antitrust concerns, and the competitive analysis of a network considers whether the arrangement is likely to facilitate collusion outside the network, whether tacit or overt.⁶⁷ While GRIPA’s description of its proposed plan of operation does not address its fee-setting methodology in detail, we would have serious concerns if the program’s operation facilitated any such agreement among its physicians acting outside GRIPA’s program.

GRIPA physicians also might seek to charge the higher prices they receive through GRIPA contracts, even when providing services outside of GRIPA and without the quality and efficiency enhancements provided by the program.⁶⁸ However, absent market power, the presence of non-GRIPA physicians and alternative networks, and large, sophisticated payers, in the area makes it likely that the market would effectively constrain individual GRIPA physicians’ ability to obtain supra-competitive prices for their professional services.⁶⁹ Payers would remain free to accept or

⁶⁵ GRIPA notes that “Rochester-area payers and providers, over the last seven years, have begun to require and emphasize quality- and efficiency-based initiatives. The integration of GRIPA’s physicians’ services and the clinical-improvement services, as proposed here, fit directly into payers plans and should be well-received by payers.” So long as that favorable reception is the result of payers exercising free choice, without coercion, in a market not artificially constraining the available choices of providers, it would appear to support GRIPA’s assertions of the potentially procompetitive character of its proposed program.

⁶⁶ The Supreme Court, in *Broadcast Music*, alluded to this type of “spillover” concern through possible anticompetitive agreements by the participants in the blanket license arrangement regarding the sale of their individual compositions outside the joint venture, but found no evidence of the existence of any such agreements. *See* 441 U.S. at 23-24.

⁶⁷ *See Health Care Statements* at Statement 8, § B.2.

⁶⁸ GRIPA has stated that it believes that even now, some of the specialist physicians participating in GRIPA actually could obtain higher fees through direct, individual contracts with payers than they will receive under GRIPA programs.

⁶⁹ As noted previously, GRIPA states that Excellus Health Plans, Inc. (the local Blue Cross/Blue Shield plan) covers approximately 70 percent of the privately insured lives in the Rochester area, and already has individual contracts with a majority of area physicians, including most GRIPA physicians. Preferred Care has about 25 percent of the privately insured lives in the area. It therefore appears unlikely that most physicians would have the ability to individually demand and obtain prices from payers that were at the same levels as those provided for under GRIPA’s programs, where payers presumably were obtaining enhanced value from GRIPA’s operation for that payment level.

reject those terms in a competitive market, and any ability of particular individual GRIPA physicians to obtain higher fees outside of GRIPA should be the result of supply and demand factors unrelated to GRIPA's operation.⁷⁰

IV. Conclusion

As discussed above, and based on the information you have provided to us, it appears that GRIPA's proposed program will involve substantial integration by its physician participants that has the potential to result in the achievement of significant efficiencies that may benefit consumers. It also appears that GRIPA's joint negotiation of contracts, including price terms, with payers on behalf of its physician members who will be providing medical services to the payers' enrollees under those contracts is subordinate to, reasonably related to, and may be reasonably necessary for, or to further, GRIPA's ability to achieve the potential efficiencies that appear likely to result from its member physicians' integration through the proposed program. Because of the procompetitive potential of GRIPA's proposed program, the ancillarity of its joint contracting to furthering achievement of the program's potential efficiencies, and the indications that GRIPA is unlikely to be able to exercise market power, we would not summarily condemn its operation *ab initio*.⁷¹ We therefore would not recommend that the Commission challenge GRIPA's proposed program unless it became apparent that GRIPA in fact was able to exercise market power or otherwise have an anticompetitive effect in a relevant market.

This letter sets out the views of the staff of the Bureau of Competition, as authorized by the Commission's Rules of Practice. Under Commission Rule § 1.3(c), 16 C.F.R. § 1.3(c), the Commission is not bound by this staff opinion, and reserves the right to rescind it at a later time. In addition, this office retains the right to reconsider the questions involved and, with notice to the requesting party, to rescind or revoke the opinion if implementation of the proposed program

⁷⁰ For example, a GRIPA physician operating at capacity might seek to charge a higher price to a new non-GRIPA patient if the opportunity cost of seeing that patient was that the physician was unable to see a GRIPA patient, for whom services were being paid at a higher level. However, this would not represent a supra-competitive price increase, but one that merely reflects the physician's cost.

⁷¹ In *Broadcast Music* the Supreme Court observed that *per se* condemnation of apparently anticompetitive conduct first requires an inquiry focusing on "whether the practice facially appears to be one that would always or almost always tend to restrict competition and decrease output . . . or instead one designed to 'increase economic efficiency and render markets more, rather than less, competitive'." 441 U.S. at 19-20 (quoting *United States v. United States Gypsum Co.*, 438 U.S. 422, 441 n. 16 (1978)).

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results in substantial anticompetitive effects, if the program is used for improper purposes, if facts change significantly, or if it otherwise would be in the public interest to do so.

Sincerely,


Markus H. Meier
Assistant Director