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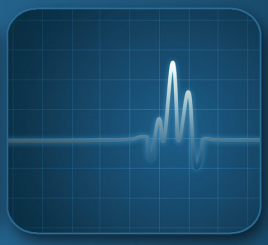


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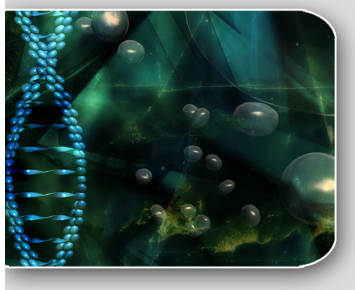



# Clinical Integration on a Promise and a Plan

## Federal Trade Commission Declines to Challenge Norman PHO on Antitrust Grounds

In a Feb. 13, 2013 Federal Trade Commission (FTC) advisory opinion, the agency concluded it would not challenge joint contracting and other activities by a Norman, Oklahoma based physician-hospital organization (PHO). The opinion was novel in several ways.

First, the FTC was willing to accept a high-market share provider network without doing a rigorous market share analysis, based principally on the network's representation that it would be genuinely non-exclusive. The FTC agreed that if the network is non-exclusive, then a third party payor wanting a lower price is free to reject the network's proposed terms and contract with its members directly or through a different network. The agency concluded that true non-exclusivity, coupled with such available alternatives for payors, adequately addressed the market power concerns raised by the network's potentially high market share.

Second, the agency declined to challenge the network on competitive grounds despite the fact that the PHO had done little to actually implement many of its planned clinical integration activities. The FTC was willing to accept the network's representations that it would clinically integrate in the future, and to state that future joint contracting would be acceptable if the network delivered its promised clinical integration. In the face of ongoing health care reform, many hospitals, physicians and other

providers are now collaborating through new network organizations. This favorable advisory opinion may provide comfort to those networks that a comprehensive plan for clinical integration, plus early steps toward implementing that plan, may be sufficient to establish a joint venture evaluated under the antitrust rule of reason which is deemed to be legally compliant under applicable legal requirements.

Third, although the FTC didn't mandate completion of the PHO's planned activities in order to approve the network's plans, the agency also stressed that the failure to implement the promised activities could expose the Norman PHO to future scrutiny. Put simply, the network's failure to actually implement its clinical integration strategies and plans could result in future antitrust challenges.

## Norman PHO

The Norman PHO is comprised of a single hospital system and approximately 280 physicians in independent practice. As such, the venture involved joint contracting only among competing physicians, not among competing hospitals.

The PHO was originally formed in the 1990s and had historically used a "messenger model" contracting strategy for the network's managed care contracts as permitted by the 1996 "Statements of Health Care Enforcement Policy" published jointly by the FTC and Department of Justice (DOJ) (the "1996 Statements"). While the 1996 Statements approved the concept of messenger model network organizations, that type of business arrangement is often difficult to implement, and over the years multiple networks have been challenged by the FTC on the grounds that they improperly colluded to fix prices or otherwise behaved in an anti-competitive manner.

Recently, various networks involving physicians and/or hospitals have sought to effectively implement a strategy of "clinical integration" as delineated in the 1996 Statements through various activities including adoption and use of evidence-based clinical protocols, patient navigation and coordination, and other cooperation involving the network's providers. Antitrust enforcement authorities have approved joint contracting activities including collective negotiation of fees by otherwise independent providers who are sufficiently clinically integrated, where the fee negotiation was deemed reasonably necessary to achieve the efficiencies sought through the clinical integration model.

Norman PHO sought an advisory opinion from the FTC in 2011, after the 2010 enactment of the Affordable Care Act ("ACA"). Subsequently, DOJ/FTC published the agencies' joint "Policy Statement Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (MSSP)" as authorized by Section 3022 of the ACA. Since Norman PHO requested its opinion, over 200 MSSP ACOs have been approved throughout the United States, and similar shared savings initiatives are underway involving commercial payors nationwide. This is the FTC's first advisory opinion on a proposed clinically integrated network (CIN) since the ACA was enacted.

## Key Conclusions

In the advisory opinion, the FTC applied its evolving framework for analysis of clinically integrated networks based upon principles articulated in the 1996

Statements. Among the agency's important conclusions are the following:

- Market Share Analysis. As noted above, the FTC found it unnecessary to analyze the underlying health care services market to resolve potential market share concerns. This approach appears to have been heavily influenced by the fact that the network would be non-exclusive in its operation – meaning that its participants could, and presumably would, join other networks and separately contract with payors in the market, so that commercial payors could effectively choose to ignore the network by contracting directly with individual providers. The agency cautioned that, if the network instead operated in a de facto exclusive manner, other antitrust consequences could well arise.

- Planning vs. Active Engagement. The FTC has historically approved provider networks that "actively engage" in a variety of activities to change care delivery by promoting efficiencies via the participants' investment of capital, time and effort through numerous means. These include provider participation on committees and other forms of "sweat equity," as well as other significant involvement in the clinical integration initiative, such as use of patient care registries, deployment of technology to promote communication, data collection and analysis, development and use of evidence-based protocols, and various arrangements in which the network and its participating providers agree to active monitoring, education and feedback regarding patterns of clinical practice. Norman PHO appears to be very early on in the clinical integration process – suggesting that the network's initiatives were closer to a program of clinical integration that was "planned for" rather than involving "active engagement" as in previous opinions. By the nature of the FTC advisory opinion process, the FTC opines only on proposed future conduct, not current or past conduct. Therefore, the PHO's proposed joint pricing would occur in the future. The FTC did not specify how much clinical integration the PHO will have achieved when joint contracting begins. However, based on the PHO's plans and partial implementation of those plans, the FTC was able to conclude that the PHO's joint contracting will qualify for more flexible rule of reason treatment under applicable antitrust laws, and the agency determined not to challenge the parties' arrangement.

- Spillover Concerns. The opinion also stressed the importance of avoiding "spillover" activities which might improperly influence provider behavior outside the CIN framework. Such spillover concerns could potentially include sharing of price or other competitively sensitive information which impacted conduct outside of the approved network framework. In this context, the PHO agreed among other things to engage in ongoing antitrust oversight and education as well as monitoring of the network and its participants.

- Limited Initial Financial Contributions. In contrast to prior advisory opinions in which the actual financial outlays of network participants were generally significant (typically involving several thousand dollars), in the case of Norman PHO the FTC was willing to accept a network involving low individual physician payments in the form of a $350 initial membership fee and $150 annual membership fee. Nonetheless, the opinion notes that ongoing capital will be required for electronic health records,

computer software and training programs as well as other supporting infrastructure and personnel, and that these ongoing CIN operational needs would be funded through unspecified but presumably significant withholds from physician reimbursement generated through the PHO's payor contracts.

## Implications for Established and Newly Forming Networks

The Norman PHO advisory opinion will be instructive to health care provider communities seeking to develop new organizations to participate in changing health care payment and delivery systems. Non-exclusive CINs must still consider market share, and a review of market share data should be part of every CIN's due diligence and on-going compliance processes. However, the Norman PHO opinion provides some comfort that networks with large market shares may be tolerated if the CIN is truly non-exclusive in its structure and actual operations.

Given the state of many networks that are still in the early stages of development, the opinion may help remove potential barriers to formation by reducing the level of initial financial commitment that may be required from individual providers, and by giving network participants a greater comfort level that managed care contracting may be undertaken without violating antitrust law before clinical integration plans are fully implemented.

Notably, the agency also reiterates the importance and necessity of actually implementing a network's promised activities in order to stay out of harm's way. Overall, however, the FTC in the Norman PHO advisory opinion has provided useful guidance for clinical integration that can be used by provider networks to participate successfully and lawfully in today's changing health care system.

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