
New FTC Advisory Opinion Approves Clinical Integration Program

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In today’s era of health care reform, hospitals, physicians, and other health care providers are collaborating through new network organizations. One important legal compliance strategy is for such combinations of affiliated providers to become “clinically integrated” in the view of federal antitrust enforcement agencies.

In a significant advisory opinion issued Feb. 13,1 the Federal Trade Commission determined not to challenge a physician-hospital organization (PHO) in Norman, Okla., on antitrust grounds even though the network had yet done little to implement many of its proposed clinical integration activities.

The advisory opinion likely will encourage increased collaborative activities by otherwise independent health care providers seeking to implement similar clinical integration programs, although the agency’s approval carries with it various legal and operational requirements. The FTC stressed that the network’s failure to implement promised activities aimed at improving quality in a lawful manner could expose the PHO to future antitrust challenge. It therefore remains essential that newly developing networks effectively design and implement their clinical integration strategies consistent with evolving legal norms in the field to minimize the risk of future antitrust challenges.

The Norman Physician Hospital Organization (PHO) consists of Norman Regional Health System and approximately 280 physicians in independent practice. The network has existed since the mid-1990s and previously had operated as a “messenger model” PHO in which each individual provider individually delivers services and sets its own reimbursement rates. Subsequently, the PHO sought to become “clinically integrated” so that its providers could collectively offer a network of coordinated services. As with other clinically integrated networks, the PHO proposed to engage in a variety of efficiency-enhancing activities, including care coordination, development and use of evidence-based clinical protocols, data analysis and review, and related improvements central to an emerging value-based payment system emphasizing quality and accountability.

Under traditional antitrust laws, joint contracting activities by otherwise competing health care providers that are not financially or clinically integrated can violate federal and state antitrust laws. However, the FTC and the Department of Justice have determined that where otherwise independent providers are sufficiently integrated, and where joint contracting is reasonably needed to achieve desired improvements in quality and other efficiencies through clinical or financial integration, then the collective negotiation of fees by otherwise separate providers can be acceptable when analyzed under the so-called antitrust rule of reason.2

For physicians and hospitals, the potential availability of clinical integration can be important to achieve important legal compliance by permitting the providers

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1 The letter from Markus H. Meier, assistant director, Health Care Division, Bureau of Competition to Michael E. Joseph is available at http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf.

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to combine together for third party payer contracting and other purposes, without having to fully merge their respective medical practices or facilities into a single corporate entity.

The Norman PHO sought an FTC advisory opinion on its proposed clinical integration program in the spring of 2011, and the opinion was issued Feb. 13, nearly two years later, suggesting considerable give and take between the requestor and the agency regarding the proposed activities. Notably, when the opinion was sought, governmental and private payer initiatives such as shared savings programs, accountable care organizations (ACO), and the like were in their infancy. Today, concurrent with accelerating implementation of the Affordable Care Act (ACA), nearly one-tenth of the U.S. population is believed to be receiving care through a commercial or public sector ACO.

In its first advisory opinion on the topic following enactment of the ACA, the FTC applied its evolving analysis regarding clinically integrated networks, focusing specifically on collective physician services since the PHO involved only one single hospital system. The agency previously has approved provider networks that actively engage in a variety of activities seeking to change care delivery and promote related efficiencies. Those activities include investment of time and money by the providers themselves, deployment of health information technologies, development of data registries and other adoption of care management tools, adherence to evidence-based clinical protocols, implementation of care transition and patient navigator systems, and use of organizational structures which involve active monitoring, education, and feedback regarding physician clinical practice patterns, among other things.

In this context, the Norman PHO is somewhat unique in that it represents an enterprise that was, at this stage, merely promising to become a clinically integrated network in its subsequent operations. In previous advisory opinions, the FTC has addressed situations generally arising after an organization is at or near fully operational status and has begun to engage in actual clinical integration, or, at least, has defined its proposed activity with greater specificity. In the Norman PHO advisory opinion, the FTC implicitly suggests that a well-developed business plan may be adequate to obtain a kind of conditional approval which fend off enforcement authorities—although the agency also stressed its expectation that promised activities truly will be implemented and reserved the right to reopen an inquiry if actual circumstances instead reflect a threat to competition.

Other key themes from the opinion include

- The FTC’s willingness to accept relatively low financial outlays by individual physicians (a $350 initial membership fee and $150 annual membership fee), even though prior opinions have involved substantially greater capital outlays by individual physicians. However, the opinion also notes that the presumably substantial ongoing capital requirements for PHO infrastructure, including electronic health records, computer software and training programs, administrative and clinical personnel, etc., would be funded on an ongoing basis in large part through withhold from physician reimbursement otherwise payable through the PHO’s managed care contracts. The actual amount of these projected financial contributions by the participating physicians was not stated.
- While it was noted that most of the physicians practicing “in and around” Norman initially would be network participants, the opinion did not actually analyze the underlying health care services market to evaluate potential market power concerns. This approach likely was influenced by the agency’s reliance on the promise that the network would be genuinely nonexclusive in its operation. That is, there is an explicit understanding that the PHO’s physicians could and actually would join other networks, contract with payers outside the PHO framework, and that commercial payers also could ignore the network to contract directly with individual providers if desired. The agency emphasized that if the arrangement instead operated as a "de facto exclusive network," it would raise serious concerns potentially necessitating a reevaluation of the PHO’s market power and possible enforcement action.
- Consistent with prior opinions the agency accepted the argument that the PHO’s joint contracting with third party payers was necessary to construct a consistent panel of committed physicians dedicated to implementing the clinical integration program, thereby satisfying the antitrust requirement that such otherwise prohibited collective activity be ancillary to a legitimate joint venture under the rule of reason.
- Finally, the opinion also stressed the importance of avoiding “spillover” activities involving collusion on prices or other anti-competitive activities outside the PHO framework. The network agreed that it would engage in ongoing antitrust education, prevent improper disclosure of competitively sensitive information among competing providers, and take other, as yet unspecified, steps to avoid the prohibited spillover efforts.

Conclusion

The Norman PHO advisory opinion is instructive as health care providers participate in the contemporary accountable care environment. The FTC’s recent pronouncement supplies useful guidance as providers continue to develop collaborative arrangements seeking to avoid antitrust risk while moving forward in the post-ACA health care marketplace.

As mentioned above, the advisory opinion also may imply that a well-organized business plan relating to provider network clinical integration can go far to meet the expectations of antitrust authorities, and suggests possible regulatory flexibility when presented with a real commitment by providers to becoming clinically integrated.

Nonetheless, while a proper business plan may possibly permit an organization to obtain preliminary approval from antitrust authorities and avoid a threshold challenge to the network’s activities, a business plan without further action and detailed implementation as promised remains likely to be insufficient. On balance,
however, the FTC in the Norman PHO advisory opinion has articulated a helpful framework for use by hospitals and physicians as they seek to form networks to provide care in a successful, legally compliant manner amid today’s rapidly changing delivery and payment systems.