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FTC Health Care Division Issues Advisory Opinion Letter Approving PHO

Introduction

On February 13, 2013, the staff of the Health Care Division of the Federal Trade Commission (FTC) issued an advisory opinion letter to a physician-hospital organization (PHO) headquartered in Norman, Oklahoma. In the letter, the staff states its lack of intention to recommend an antitrust challenge to the proposed structure and operation of the PHO and sets out its analysis of why the PHO's business plan did violate the federal antitrust laws.[1]

Many aspect of the Norman PHO are typical of clinical integration programs previously addressed by the Commission and in operation or under development in many communities. Centered in Norman, Oklahoma and anchored by the leading regional hospital, the Norman Regional Hospital, and its system facilities, the PHO includes approximately 280 primary care and specialist physicians nearly all of whom have staff privileges at Norman Regional Hospital and its affiliates. The PHO has operated since 1994 using a messenger model to facilitate contracting with third-party payers. Physicians and the hospital system share governance of the PHO. Provider membership fees, hospital contributions, reimbursement withholds and direct employer access fees fund its operations. The physician participation is concentrated in the geography centered on the hospital, but as the network becomes more distant from the hospital, physician concentration falls off sharply and its boundaries intersect with the larger, Oklahoma City metropolitan area and its larger population of physicians.

Enforcement Policy Considerations

The Norman PHO letter provides an important signal that the FTC is receptive to the positive efficiency contribution clinically-integrated provider networks can provide. While the letter does set out limits, the staff's analysis is significant because of its tone and approach. For example, in connection with the implementation of the Affordable Care Act, the FTC sent numerous cautionary signals about the potential harm to private markets that might result from Accountable Care Organizations, despite the federal program oversight and policy support for those organizations. Here, in contrast to earlier signals, the FTC staff is clearly supportive of a clinical integration program unconnected to any federal program. In essence, the FTC staff returns to and reiterates an approach it last articulated in 2009 during its next most recent Advisory Opinion letter. Indeed, the staff makes no reference to the Commission's formal and informal statements on Accountable Care Organizations.

The letter signals a significant degree of receptivity on the part of the Commission to development of clinically integrated provider networks. Its tenor and focus are generally supportive of the development of these networks. The letter re-affirms prior guidance from the Commission staff, in particular addressing issues related to PHOs with market power and the role of nonexclusive contracting. At the same time, the letter provides a few cautionary signals to provider networks that help identify areas where the Commission might object to a network's structure or operation.

[1] While technically not binding on the Commission itself, FTC staff letters are closely vetted by the Commission and regularly cited by the Commission as influential in its thinking.

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Clinical Integration

The letter does not describe a clinical integration program notably different from prior clinical integration programs that the Commission staff has approved. It does note, importantly, that "certain important details of [the] program are yet to be finalized." Despite that incompleteness, the letter implies (although it does not specifically say so) that the Norman PHO can begin joint negotiations with third-party payers without concern that the FTC staff will condemn that as premature and thus "price fixing." To the contrary, the staff cites attributes of the clinical integration that indicate its likelihood of generating significant efficiencies. In particular, the highlights the following attributes:

- A Quality Assurance Committee with responsibility for "group performance benchmarking, monitoring individual and group compliance with the networks standards, and administering corrective action as necessary." The quality measures are not only clinical but include economic measures, such "measures to identify high-cost providers [and] inappropriate use of resources," as well as "failures to comply with clinical practice guidelines."
- Significant Physician Commitment, Investment and Involvement. In addition to recognizing the obvious importance of physician commitment and motivation to achievement of the PHO's goals, the Commission staff highlighted the "meaningful" commitment each physician must make. The letter recites certain modest financial commitments (US$350 membership fee and US$150 annual dues) and the necessity of acquiring and maintaining computer equipment and software. The heart of the staff's analysis, however, is the time and effort required of the physicians and the potential for withholds from third-party payer reimbursement (although the level and significance of the withholds is not discussed). Critical to the analysis is the observation that a comprehensive review process of physician performance and the potential to "exclude any physician" who is unable or unwilling to meet program requirements.

Citing these and other factors, the staff reaches the conclusion as it has in other matters that the joint negotiation by the PHO on behalf of its physicians is not per se illegal.[2]

The staff reiterates the ancillarity analysis of prior letters. In particular, the staff recognizes the contribution to likely achievement of the clinical integration efficiencies that will flow from "maintain[ing] a consistent physician panel of like-minded physicians who have a shared commitment to participating in all aspects of the clinical integration program." Accordingly, the Norman PHO will require physician providers to participate in any contract that the PHO executes.[3]

Competitive Effects

Staff approved the Norman PHO despite recognizing that the "Norman PHO appears to have the potential to exercise market power in the sale of its participating hospitals' and physicians' services." With regard to hospital services, the letter does not explain but necessarily must mean that Norman Regional Hospital Center has preexisting unilateral market power. With regard to physicians, the staff conceives the geographic scope of competition more narrowly than claimed by Norman PHO to assert that payers are unlikely to have practical alternatives. Indeed, the staff cites the PHO's "expectation of negotiating higher reimbursement rates for its participating physicians" but appears to treat this only as potentially indicating an exercise of market power, while describing it as justified due to the increased utilization of physician resources to achieve the clinical integration goals.

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[2] Like prior letters, the Commission provides no analysis of the horizontal competitors within the network whose joint negotiation might give rise to a price fixing concern.

[3] Staff points out that it does not accept that argument that merely incentivizing physicians to participate does not justify joint pricing.

The FTC staff approves the joint contracting because of third-party payers' ability to bypass the PHO. Contractually, the providers remain free to contract independently of the PHO, either directly or through other provider-controlled networks, so long as the PHO has not already contracted with the payer. Payers too remain free to refuse to contract with the PHO. Moreover, Norman PHO will have antitrust compliance protocols to protect against encouraging refusals to deal on the part of the physicians and to communicate the payers their ability to bypass the PHO. Finally, the PHO does not plan to use contractual terms to steer patients to or from particular providers or disincentive payers from contracting with providers not in the Norman PHO network.

Limitations

The FTC staff letter identifies important issues for provider-controlled networks looking to implement a clinical integration program and leaves other issues unaddressed.

First, the staff cautions providers that the operation in fact of their network can subject them to challenge even if they set up the PHO correctly at the outset. For example, the letter cautions that if the PHO were to operate as a "de facto exclusive network, it would raise serious concerns and could be necessary to revisit the issue of Norman PHO's market power." The staff emphasizes the responsibility of the PHO to implement appropriate compliance programs. It also posits that participating physicians should be willing to contract for a lower reimbursement rate outside of the PHO because of the expectation that the PHO will charge higher reimbursement to cover the increased utilization of physician resources through the PHO.

Second, the staff limits its analysis to networks not including otherwise competing hospitals. Apparently, during the lengthy review of the proposed Norman PHO,[4] a small community hospital of 39 beds located near Norman was dropped from the network. Thus, the letter does not address whether the clinical integration analysis, "not price fixing" conclusion, bypass ameliorating market power, or other aspects of the analysis would apply where a network brings together otherwise competing hospitals.[5]

Third, the staff notes the possibility that formation of a clinically integrated PHO might have an impact on competition for "PHO services." The letter does not define these services but observes that because Norman PHO is a preexisting PHO merely replacing its messenger model with a clinically integrated approach, "no horizontal concerns arise with respect to the provision of PHO services." In another circumstance, such as where preexisting independent physician associations or PHOs are combining to offer a clinically integrated network, this staff observation signals that parties should consider the implication of their transaction on a possible market for "PHO services."

Fourth, the letter leaves unaddressed how the staff will weigh potential anticompetitive effects of clinical integration against its substantial efficiency gains if both result. Staff focuses on the absence of likely anticompetitive effects and the inherent promises of efficiencies. It says nothing about what happens if both result.

[4] The review took at least 21 months. Staff cites six separate written submissions from Norman PHO, the earliest dated May 26, 2011, and a number of oral communications and interviews.

[5] Implicit in the staff's analysis is that the competition between Norman Regional Hospital and the small community hospital might be deemed significant, although technically that issue is not addressed.

SQUIRE SANDERS

Contact

Mark J. Botti
+1 202 626 6292
mark.botti@squiresanders.com

Scott A. Edelstein
+1 202 626 6602
+1 415 954 0205
scott.edelstein@squiresanders.com

David W. Grauer
+1 614 365 2786
david.grauer@squiresanders.com

Lisa G. Han
+1 614 365 2773
lisa.han@squiresanders.com

John M. Kirsner
+1 614 365 2722
john.kirsner@squiresanders.com

Peter A. Pavarini
+1 614 365 2712
peter.pavarini@squiresanders.com