



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

Bureau of Competition
Health Care Division

February 13, 2013

Michael E. Joseph, Esq.
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10th Floor, Two Leadership Square
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Oklahoma City, Oklahoma 73102-7103

Re: Norman PHO Advisory Opinion

Dear Mr. Joseph:

This letter responds to your request for a Federal Trade Commission staff advisory opinion on behalf of Norman Physician Hospital Organization ("Norman PHO"). Norman PHO is a multiprovider network joint venture that seeks to create a "clinically integrated" network and to then engage in joint contracting with third-party payers on behalf of its participating physicians and hospitals (together, "participating providers"). On behalf of Norman PHO, you asked whether FTC staff would recommend challenging, under the antitrust laws, Norman PHO's proposed joint contracting activities.

Based on the information provided, it appears that Norman PHO's proposed activities contemplate horizontal pricing agreements only with respect to its provision of physician services. If implemented as described to us, Norman PHO's proposed clinical integration program offers the potential to create a high degree of interdependence and cooperation among its participating physicians and to generate significant efficiencies in the provision of physician services. Further, Norman PHO's proposed joint contracting on behalf of its participating physicians appears to be both subordinate to the network's integrative activities and reasonably necessary to implement the proposed program and achieve its efficiency benefits.

Moreover, Norman PHO represents that it will operate as a non-exclusive network. In the event a health plan, employer, or other third-party payer does not wish to contract with Norman PHO (or vice versa), it will have the ability to negotiate with the network's individual participating providers or other networks in which they may participate without interference from Norman PHO. Neither the network nor its participating providers will seek to influence any other participant's independent contracting intentions or strategies, or otherwise confront any payer with the group's aggregate bargaining power.

Based on these understandings,¹ Norman PHO's proposed activities appear unlikely to unreasonably restrain trade. FTC staff therefore has no present intention to recommend an enforcement action against Norman PHO or its participating providers. As a prospective assessment of efforts you describe as evolving, however, this advisory opinion necessarily is tentative.² The staff's current enforcement view likely would change to the extent that, for whatever reason, Norman PHO's actual operations deviate substantially from its proposal, as described below, or otherwise prove to have anticompetitive effects.

I. Background: Norman PHO and Its Proposed New Activities

Norman PHO was founded in 1994 by the Norman Physicians Association and the Norman Regional Health System as a physician-hospital organization that facilitates "messenger model" contracting between its participating providers and third-party payers.³ Norman Physicians Association is an Oklahoma limited liability company whose members are physicians who hold a medical staff appointment or clinical privileges at Norman Regional Health System's hospitals. Norman Regional Health System is owned by the City of Norman and the Norman Regional Hospital Authority.⁴ Norman Regional Health System includes: Norman Regional Hospital, a satellite hospital location, and a family medicine center in Norman, Oklahoma; Moore Medical Center and a family medicine center in Moore, Oklahoma; and family medicine centers in Newcastle and Blanchard, Oklahoma.⁵ Norman Regional Health System and Norman Physicians Association shared equally in the initial funding of Norman PHO and continue to share equally in the cost of operations and ongoing capital needs.⁶

Norman PHO is managed by a Board of Managers that is comprised of eleven representatives, one of whom is the president of Norman Regional Health System, two of whom are appointed by

¹ Our analysis and conclusions rely on your representations to staff, including those made in the correspondence and documents you provided to us on May 26, 2011; December 27, 2011; August 27, 2012; December 8, 2012; January 20, 2013; and January 22, 2013, as well as those made during our telephone conferences with you and other Norman PHO representatives. We have not conducted an independent investigation or otherwise verified the information that you provided.

² Norman PHO's request for an FTC staff advisory opinion, by definition, pertains to the network's proposed course of conduct, and not to ongoing conduct. *See* 16 C.F.R. § 1.1.

³ Letter from Michael E. Joseph, McAfee & Taft, to Donald S. Clark, FTC (May 26, 2011) ("Request Letter"), at 1–2, 30.

⁴ *Id.* at 2, 6.

⁵ *Id.* at 2.

⁶ *Id.*

Norman Regional Health System, and eight of whom are physicians elected annually by the members of Norman Physicians Association. The chairman of the Board of Managers is always a physician and typically also serves as the chairman of Norman Physicians Association.⁷

Norman PHO generates revenue for its day-to-day operations primarily through provider membership fees and dues; percentage withholdings from reimbursements paid to participating physicians by payers that contract with the network, along with dollar-for-dollar matching contributions by Norman Regional Health System; and monthly access fees from direct employer agreements.⁸ Additionally, Norman PHO has received certain grants and awards that enable it to pursue activities that appear likely to benefit its patients, payers, and the network's participating providers. For example, Norman PHO currently is participating in programs designed to assess whether the use of electronic medical records affects quality and costs.⁹

Today, Norman PHO includes approximately 280 participating physicians representing roughly 38 specialty practice areas, as well as Norman Regional Health System.¹⁰ All of the participating physicians are members of Norman Physicians Association, and nearly all of the participating physicians are members of Norman Regional Health System's medical staff. The network's participating hospitals are the Norman Regional Health System's hospitals. Norman PHO initially indicated that Purcell Municipal Hospital, a 39-bed community hospital located in Purcell, Oklahoma, was a member of the network.¹¹ On August 27, 2012, however, Norman PHO informed FTC staff that Norman PHO had terminated Purcell Municipal Hospital as a participating hospital provider.¹² Consequently, Norman Regional Health System is the only provider of inpatient hospital services and outpatient hospital and ambulatory care services that will participate in the network.

Norman PHO represents that it serves a geographic area that "overlaps almost entirely with the boundaries of the Oklahoma City metropolitan area and the Oklahoma City Combined Statistical Area (CSA)."¹³ The CSA includes the micropolitan area of Shawnee (Pottawatomie County) and seven counties: Canadian, Cleveland, Grady, Lincoln, Logan, McClain, and Oklahoma.¹⁴

⁷ *Id.* at 4.

⁸ *Id.* at 2, 3.

⁹ *Id.* at 29.

¹⁰ *Id.* at 3; Letter from Michael E. Joseph, McAfee & Taft, to David M. Narrow, FTC (Dec. 27, 2011) ("Supplemental Letter"), at 1.

¹¹ Request Letter at 2, 6.

¹² E-mail from Michael E. Joseph, McAfee & Taft, to Christine L. White, FTC (Aug. 27, 2012).

¹³ Request Letter at 3, 7.

¹⁴ *Id.* at 8.

Norman PHO's service area reportedly encompasses four of the seven counties in the CSA: Cleveland, Grady, McClain, and Oklahoma, and also includes Garvin County and all of Pottawatomie County.¹⁵ Norman PHO's participating hospitals are located in Cleveland County.¹⁶ Its participating physicians' offices and clinics, as well as its family medical centers, are located in six cities within Cleveland and McClain counties: Norman, Moore, Blanchard, Newcastle, Purcell and Noble.¹⁷ The vast majority of the network's patients (roughly 84 percent) and physicians (approximately 95 percent) reside or have office locations (respectively) in Oklahoma and Cleveland counties.¹⁸ In the network's reported service area, Norman PHO includes only approximately 10 percent of the physicians and the same percentage of hospitals.¹⁹ In Cleveland and McClain counties, however, Norman PHO's participating hospitals account for more than 50 percent of patient discharges.²⁰ Moreover, the network includes most of the physicians who practice in and around Norman, Oklahoma, as well as the only hospital system in the immediate Norman area.²¹

In recent years, Norman PHO has devoted meaningful resources to learning about the potential benefits of, and business strategies and market demand for, clinically integrated provider network services. Norman PHO and its participating providers have determined to replace their messenger model operations, in which each provider is responsible for individually providing clinical services and setting its own reimbursement rates for those services, with a clinically integrated program in which its providers collectively offer a network of coordinated services. Norman PHO anticipates that its proposed new operations will result in the delivery of improved quality of care in a more efficient manner than the participating providers could otherwise achieve independently.²²

Norman PHO and its participating providers intentionally have "moved slowly and deliberately" with the objective of carefully constructing a clinical integration program that has strong provider support and is also attractive to health plans, employers, and other third-party payers.²³

¹⁵ *Id.* at 8.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.* at 8–9.

¹⁹ *Id.* at 3, 7.

²⁰ *Id.* at 11.

²¹ *Id.* at 2, 9.

²² *Id.* at 34.

²³ *See* Supplemental Letter at 17.

Indeed, Norman PHO acknowledges that certain important details of its program are yet to be finalized. Nonetheless, Norman PHO believes that the driving principles and essential features of its proposed operations have been determined, and that its proposed program will offer payers and their enrollees—that is, Norman PHO patients—improved quality of care, reduced costs of care, and increased patient satisfaction.²⁴ Norman PHO asserts that one of the network’s primary goals is “to set the standard for efficient and high-quality care in the greater Oklahoma City area.”²⁵

Norman PHO does not yet know how many physicians will seek to participate in its clinical integration program, but estimates that most, if not all, of the current participants will do so, at least initially. Further, although Norman PHO does not currently plan to increase its membership, membership will remain available to applicants who meet the network’s membership guidelines and criteria.²⁶

A. Norman PHO’s New Infrastructure

Norman PHO has established a new organizational structure, under the direction of its Board of Managers, for accomplishing the integrative goals of its proposed program.²⁷ The new structure is designed to ensure that participating physicians work collaboratively to establish clinical practice guidelines, to create a high degree of transparency and visibility with respect to their practice patterns, and to provide mechanisms for monitoring and enforcing compliance with Norman PHO’s clinical practice guidelines. Participating physicians will be obligated to participate in, and comply with, the network’s clinical integration program pursuant to the terms of the network’s revised and newly approved participating practitioner agreement (the “Participating Practitioner Agreement”).²⁸

Key components of Norman PHO’s new organizational structure include the newly formed Specialty Advisory Groups, Mentor’s Committee, and Quality Assurance Committee. The Specialty Advisory Groups will be responsible for developing and periodically updating clinical practice guidelines.²⁹ Each Specialty Advisory Group will be comprised of physicians practicing in a specialty practice area represented by a medical department of Norman Regional Health

²⁴ See, e.g., Request Letter at 14–15; Supplemental Letter at 27 (“enhanced quality, improved efficiencies, and reduced cost . . . is what Norman PHO is offering”).

²⁵ Request Letter at 24.

²⁶ *Id.* at 3; Supplemental Letter at 2.

²⁷ Request Letter at 16, 25–27.

²⁸ *Id.* at 17, 20, 23.

²⁹ Supplemental Letter at 15–16.

System, and all physicians “will be required to actively participate in [a Specialty Advisory Group].”³⁰ The Mentor’s Committee will “oversee global quality improvement planning,” including approval of clinical practice guidelines, monitoring of implementation, and enforcement of adherence to the guidelines.³¹ It will include physicians practicing in numerous specialties.³²

The Quality Assurance Committee, which will include participating physicians and a Quality Assurance Director, will be broadly responsible for establishing the measures for individual and group performance benchmarking, monitoring individual and group compliance with the network’s standards, and administering corrective actions as necessary.³³ Although specific performance measures have yet to be developed, the Quality Assurance Committee will develop measures to identify high-cost providers, inappropriate use of resources, and failures to comply with clinical practice guidelines.³⁴ The Quality Assurance Committee will audit medical records and generate regular reports on individual and aggregate physician compliance rates for clinical measures. These reports will include information such as: (1) individual physician compliance rates under applicable measures; (2) comparisons of the physicians’ compliance rates against their previous performance and with that of peer physicians; and (3) cumulative compliance rates for all physicians for whom particular measures are applicable.³⁵ The reports will be shared with both the participating physicians, individually and as a group, and with payers, to promote transparency, compliance, and accountability.³⁶ The Quality Assurance Committee also will make recommendations for improving individual and aggregate compliance performance and assist with risk management. Additionally, physicians on the Quality Assurance Committee will provide or arrange for medical education and information to promote compliance with network clinical practice guidelines.³⁷ The Quality Assurance Committee will implement and oversee corrective actions when noncompliance or risk concerns are identified, including engaging in physician-to-physician mentoring and other counseling and educational activities. The Quality Assurance Committee also may implement financial withholds or penalties, and, in extreme cases of noncompliance, may expel a participating physician from the network.³⁸

³⁰ Request Letter at 26.

³¹ *Id.* at 25–26.

³² *Id.*

³³ *Id.* at 22–24, 26.

³⁴ *Id.* at 23.

³⁵ *Id.* at 23.

³⁶ *Id.* at 23–24.

³⁷ *Id.* at 25, 22–23; Supplemental Letter at 14.

³⁸ Request Letter at 23.

Additionally, Norman PHO has appointed a Medical Director and has hired new employees to support the clinical integration program.³⁹ Specifically, Norman PHO has contracted with a Medical Informatics Officer who specializes in “the management and processing of data, information, and knowledge”; hired a registered nurse to serve as the Director of Quality Assurance; and hired several full-time staff members for electronic records management and training, data extraction, and other activities relating to network’s use of its electronic platform.⁴⁰

B. Clinical Practice Guidelines

Norman PHO and its participating physicians expect to develop their own evidence-based clinical practice guidelines for as many as 50 disease-specific conditions, and to periodically review, reassess, and update these guidelines as appropriate.⁴¹ They seek to establish physician-centered processes and procedures for developing, implementing, monitoring, and enforcing clinical practice guidelines. The physicians’ involvement in and control over these activities—through the Specialty Advisory Groups, Mentor’s Committee, and Quality Assurance Committee—is expected to promote a high degree of confidence in, and adherence to, the network’s clinical practice guidelines, as well as the collective achievement of patient care, quality, and cost goals.⁴²

Norman PHO has already collected and analyzed some physician data for purposes of assessing high-prevalence, high-cost, and high-risk chronic conditions that most affect its current patient population.⁴³ To date, the network has identified nine diseases (including diabetes, anemia, and hypo- and hyperthyroid disease) for which the Specialty Advisory Groups, with oversight from the Mentor’s Committee, have developed and will be implementing clinical practice guidelines.⁴⁴

C. Electronic Platforms and Interface

Norman PHO has invested substantial time, money, and effort in developing an electronic platform and views full use of its electronic platform by participating physicians as a “critical component” of its clinical integration program.⁴⁵ The electronic platform includes an electronic

³⁹ *Id.* at 16, 26–28.

⁴⁰ *Id.*

⁴¹ *Id.* at 22; Supplemental Letter at 14.

⁴² *See* Request Letter at 21, 22, 23, 25–26.

⁴³ *Id.* at 21; Supplemental Letter at 14.

⁴⁴ Supplemental Letter at 9.

⁴⁵ Request Letter at 18–20.

clinical decisions support system, e-prescribing, electronic medical records system, and an electronic health interface system.⁴⁶

Norman PHO anticipates that, among other benefits, the network's electronic tools will help participating physicians to use quality measure parameters in evaluating and treating patients, streamline submission of prescriptions and reduce errors, and facilitate physician-to-physician communication.⁴⁷ Additionally, the network will use the electronic platform both to measure and evaluate physician performance and compliance with the network's own clinical practice guidelines and to "facilitate data collection, outcomes measurement, utilization management, and performance reporting required by Medicare and other Payers."⁴⁸

To ensure that the network can realize the full potential of its electronic platform, the participating physicians will be required to both (1) acquire and maintain the necessary computer equipment, software, rights, or licenses (or acceptable alternatives);⁴⁹ and (2) make available practice data and medical records for the network's use in connection with developing, reviewing, and enforcing clinical practice guidelines.⁵⁰

D. Participating Physician Commitment, Investment, and Involvement

Norman PHO and its participating providers recognize that the success of their proposed program rests on the participating physicians' commitment and motivation—both individually and as a group—to improve quality of care, to reduce costs of care, and to otherwise jointly offer services that payers find to be both attractive and attractively priced.⁵¹ Each physician, therefore, must satisfy the network's eligibility criteria, make certain investments in, and demonstrate a personal commitment to, Norman PHO's clinical integration program.⁵²

At the outset, and in connection with annual reappointments, each physician must satisfy credentialing and medical staff appointment requirements;⁵³ pay a \$350 membership fee and

⁴⁶ *Id.* at 14, 18–19.

⁴⁷ *Id.* at 18–20.

⁴⁸ *Id.* at 18.

⁴⁹ *Id.* at 17–20.

⁵⁰ *Id.* at 19.

⁵¹ *Id.* at 17–18, 20–21.

⁵² *Id.*

⁵³ *Id.* at 4, 5.

\$150 annual dues;⁵⁴ enter into and comply with the Participating Practitioner Agreement; and generally commit to the network's clinical integration program.⁵⁵ As previously noted, each physician also must acquire and maintain certain computer equipment, software, rights or licenses, and training as necessary to use the network's electronic platform (or acceptable alternatives).⁵⁶

Each physician also must make meaningful ongoing contributions, including commitments of time and effort, to the network's development, implementation, and enforcement of clinical practice guidelines. For example, each participating physician must serve as a member of one or more of the Specialty Advisory Groups, the Mentor's Committee, or the Quality Assurance Committee.⁵⁷ Further, each participating physician must adopt, implement, and adhere to the network's clinical practice guidelines when providing clinical services, patient care, and referrals. In the event of noncompliance or other concerns, a physician must participate in peer education, individualized counseling or proctoring, and corrective action plans as directed by the network.⁵⁸ Additionally, as noted above, each physician must make his or her practice data and medical records available for the network's review and analysis.⁵⁹ Each physician also must make ongoing financial contributions, in the form of "withholds" from reimbursements made to them by payers who contract with Norman PHO, to support the network's clinical integration activities.⁶⁰

Norman PHO states that "the ongoing selectivity of only those physicians who are committed to Norman PHO's goals and requirements is essential" to the network's success.⁶¹ To ensure that physician commitment, Norman PHO will implement comprehensive review processes and may exclude any physician who is unable or unwilling to comply with the program's requirements.⁶² Norman PHO anticipates that some natural attrition may occur because physicians who are not fully committed to the program will drop out of the network rather than make the substantial time, effort, and other contributions necessary for continued participation.⁶³ For example, some

⁵⁴ *Id.* at 3.

⁵⁵ *Id.* at 17, 20–21.

⁵⁶ *Id.*

⁵⁷ *Id.* at 25–26.

⁵⁸ *Id.* at 21, 23.

⁵⁹ *Id.* at 17–20.

⁶⁰ *Id.* at 3.

⁶¹ *Id.* at 20.

⁶² *Id.* at 21.

⁶³ *Id.*

physicians may not be willing to make the investments necessary to access the network's electronic platform.⁶⁴ In the event of severe or continued noncompliance, the network may impose financial penalties or terminate a physician's participation in the network.⁶⁵

E. Payer Contracting and Non-Exclusivity

Norman PHO intends to establish a contracting committee that will be charged with evaluating payer contract proposals to determine whether the network's goals can be accomplished within the framework of those proposals.⁶⁶ Norman PHO has yet to actively market its new program to payers, but intends to do so once the program is ready to be implemented. Norman PHO states that its marketing activities will be successful, and the network will secure payer contracts, only to the extent that it is able to demonstrate the value of its program to payers. In other words, Norman PHO's proposed new program will be financially viable only to the extent that customers recognize its value and wish to do business with the network.⁶⁷

Pursuant to the Participating Practitioner Agreement, Norman PHO will require all participating physicians to participate in any contract between Norman PHO and a payer.⁶⁸ According to Norman PHO, this requirement will enable the network to provide "a stable and identifiable roster of physicians and facilitate in-network referrals," and thereby "increas[e] patient volume and harness[] network effects and economies of scale, while providing efficiencies and reducing transaction costs to both physicians and [p]ayers."⁶⁹

Norman PHO specifically represents that, as a partially integrated, non-exclusive network, its participating providers will remain free to contract independent of Norman PHO with any payer that chooses not to contract with the network.⁷⁰ Norman PHO will clearly inform payers and participating providers that the network is non-exclusive.⁷¹ The network also will provide antitrust counseling and training to its participating providers and will specifically address the

⁶⁴ *Id.*; Supplemental Letter at 12.

⁶⁵ Request Letter at 21.

⁶⁶ *Id.* at 29.

⁶⁷ Supplemental Letter at 14 ("the market will decide' whether Norman PHO's product is worthwhile").

⁶⁸ Request Letter at 31.

⁶⁹ *Id.*

⁷⁰ *Id.* at 4, 30.

⁷¹ *Id.* at 30.

antitrust concerns associated with concerted refusals to deal.⁷² As such, Norman PHO anticipates that payers who seek to contract with local providers will have the choice of contracting with Norman PHO for clinically integrated services, contracting individually with Norman PHO's participating providers (i.e., outside the network), or pursuing alternate contracting strategies.⁷³

F. Anticipated Savings, Efficiencies, and Other Benefits

Norman PHO states that it cannot currently “quantify . . . the likely overall efficiency benefits of its proposed program, or specify how overall cost or quality efficiency gains will be measured.”⁷⁴ Nonetheless, Norman PHO anticipates that its proposed new program will generate meaningful savings and efficiencies that will benefit its patients, payers, and participating providers. For example, Norman PHO projects the following potential benefits for each:

Patients: improved outcomes; better adherence to preventive screenings and services; reduced medical errors; better infection control rates; shorter hospital stays; lower hospital re-admission rates; earlier disease detection and better disease control procedures; more timely communication of current treatment plans; more timely scheduling of primary and specialty care appointments; and the elimination of unnecessary duplication of tests and repetitive completion of registration paperwork.⁷⁵

Payers: centralized credentialing and contracting; more satisfied beneficiaries; elimination of unnecessary duplication of services; earlier disease detection; avoidance of preventable hospitalizations; reduced medical errors; improved infection control rates; decreased lengths of hospital stay and re-admittance rates; and lower costs of care.⁷⁶

Participating Providers: reduced paperwork; greater ease of scheduling; improved patient diagnosis and treatment plans through timely receipt of diagnostic information and availability of clinical practice guidelines; “seamless referrals” to specialists and admission to ancillary and hospital providers; reduction of staff time required to duplicate medical records; and timely scheduling of patient care services.⁷⁷

⁷² See, e.g., *id.*

⁷³ *Id.* at 4 (noting that participating providers may join other provider networks), 33.

⁷⁴ *Id.* at 24.

⁷⁵ *Id.* at 28–29, 14.

⁷⁶ *Id.* at 28, 14.

⁷⁷ *Id.* at 28.

G. Organizational Protection Against “Spillover Effects”

Norman PHO recognizes that, in a competitive market free of anticompetitive restraints, market forces “[u]ltimately . . . will decide if Norman PHO’s product is valuable.”⁷⁸ Among other activities, Norman PHO acknowledges that the antitrust laws prohibit the network and its participating providers from collectively exercising market power, including by setting prices or otherwise coordinating the terms on which they will (or will not) contract with payers outside of the network.⁷⁹

Norman PHO acknowledges that it is responsible for ensuring the network’s compliance with the antitrust laws. It specifically represents that it will provide appropriate antitrust training to its administrators and participating providers, and will implement mechanisms to limit opportunities for anticompetitive “spillover effects” or other unlawful coordination among its participating providers.⁸⁰ For example, Norman PHO will take steps to ensure that competitively sensitive information (e.g., prices, pricing, or negotiating strategies or intentions) is not improperly shared between or among participants.⁸¹

II. Analysis

FTC staff has analyzed Norman PHO’s proposed activities pursuant to the federal antitrust laws⁸² and case law precedent⁸³ pertaining to multiprovider network joint ventures.⁸⁴ The

⁷⁸ Supplemental Letter at 10.

⁷⁹ Request Letter at 33.

⁸⁰ *See, e.g., id.* at 31, 33.

⁸¹ *Id.*

⁸² Sherman Act Section 1 (15 U.S.C. § 1); Federal Trade Commission Act Section 5 (15 U.S.C. § 45).

⁸³ *See, e.g., Arizona v. Maricopa Cnty. Med. Soc’y*, 457 U.S. 332 (1982); *United States v. Addyston Pipe & Steel Co.*, 85 F. 271 (6th Cir. 1898), *modified & aff’d*, 175 U.S. 211 (1899).

⁸⁴ The federal antitrust enforcement agencies have issued guidance explaining how they apply existing antitrust standards, as interpreted by the courts, to a variety of joint arrangements in the health care context, including provider networks. *See generally* Statements 8 and 9 of U.S. Department of Justice (“DOJ”) & FTC, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996) (“Statement 8” and “Statement 9,” respectively), *available at* <http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm>; *see also* FTC & DOJ, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000) (“Competitor Collaboration Guidelines”) § 3.2, *available at* <http://www.ftc.gov/os/2000/04/>

antitrust laws condemn as per se illegal “naked” agreements among competitors that fix prices or allocate markets. Where competing providers achieve clinical or financial integration in a manner that is likely to produce significant efficiencies that benefit consumers, and any pricing or other agreements among those providers that would otherwise be per se illegal are reasonably necessary to realize the efficiencies, those agreements will be analyzed under the rule of reason.⁸⁵ A rule-of-reason analysis determines whether the formation and operation of the joint venture may have a substantial anticompetitive effect and, if so, whether that potential effect is outweighed by any procompetitive efficiencies resulting from the venture.⁸⁶

As a threshold matter, staff first determined that Norman PHO’s formation and operation potentially could affect relevant markets for the provision of the following services: physician services provided by network participants, inpatient hospital services, outpatient hospital and ambulatory care services, and physician hospital organization (“PHO”) services. Within these markets, Norman PHO’s proposal contemplates horizontal combinations or agreements only in markets for physician services. In particular, the network’s participating physicians, including physicians who compete or potentially compete with one another, will make joint decisions with respect to the pricing of their services and other terms of dealing with payers through Norman PHO. In contrast, Norman PHO’s operations will not involve horizontal agreements among competing providers of inpatient hospital services, or outpatient hospital and ambulatory care services, because Norman Regional Health System is the only provider of such services that will

ftcdojguidelines.pdf; DOJ & FTC, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), available at <http://www.ftc.gov/opa/2004/07/healthcarerpt.shtm>. The FTC also has issued numerous advisory opinion letters to provider groups seeking guidance on clinical integration and other activities. See <http://www.ftc.gov/bc/healthcare/industryguide/advisory.htm>.

⁸⁵ Two types of analysis are used by the courts to determine the lawfulness of an agreement among competitors: per se and rule of reason. See *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 692 (1978). Agreements of a type that always or almost always tend to raise price or to reduce output (e.g., price fixing, market allocation) are presumed to be illegal, without inquiry into their claimed business purposes or justifications, or their competitive effects. *Id.*; see also *Maricopa Cnty. Med. Soc’y*, 457 U.S. at 357 (holding that agreements among independent physicians “fit squarely into the horizontal price-fixing mold”). All other agreements are analyzed under the rule of reason. See *Nat’l Soc’y of Prof’l Eng’rs*, 435 U.S. at 692; see also Statement 8 and Statement 9. However, the line between per se analysis and rule of reason is not always bright and it sometimes is appropriate to perform an “abbreviated” or “quick look” rule-of-reason analysis. See *Cal. Dental Ass’n. v. FTC*, 526 U.S. 756 (1999); see also, e.g., *Polygram Holding, Inc.*, 5 Trade Reg. Rep. (CCH) ¶ 15,453 (FTC 2003), available at <http://www.ftc.gov/os/caselist/d9298.shtm>, *aff’d. sub nom. Polygram Holding, Inc. v. FTC*, 416 F.3d 29 (D.C. Cir. 2005).

⁸⁶ Statement 9 § B.

participate in the network. By definition, Norman PHO will not reduce existing competition among its providers of these services. Further, no horizontal concerns arise with respect to the provision of PHO services, because Norman PHO and its participating providers are simply replacing their current “messenger model” PHO with a clinically integrated PHO.

With respect to Norman PHO’s provision of physician services, staff determined that the network’s proposed joint pricing and contracting activities qualify for rule-of-reason analysis because the network reportedly will require its participating physicians to integrate their clinical services in a manner that appears to create the potential for significant efficiencies that benefit patients and payers *and* because the participating physicians’ pricing agreements are reasonably necessary and subordinate to—that is, ancillary to—their integrative activities. Staff then determined that the venture’s formation and operation do not appear likely to have a substantial anticompetitive effect in the provision of physician services, and any such potential effect is likely to be outweighed by plausible procompetitive efficiencies.⁸⁷ Next, staff determined that Norman PHO’s proposed new operations do not involve “vertical” arrangements that restrict providers in one market from dealing with non-network providers that compete in a different market.⁸⁸ For example, Norman PHO represents that it will not limit the incentive or ability of its participating providers to participate in other network joint ventures or to contract directly with payers that do not wish to do business with Norman PHO (or vice versa).

Finally, staff determined that Norman PHO understands the antitrust risks associated with multiprovider networks, including “spillover effects,” and has represented that it will take affirmative steps to ensure that both the network and its individual participating providers refrain from engaging in such anticompetitive conduct. The following sections describe, in turn, staff’s analysis of each of these issues.

A. Horizontal Analysis of Pricing and Other Agreements Among Competing Physicians

1. Clinical Integration of Participating Physicians

Norman PHO represents that its participating physicians will integrate their clinical services in a manner that appears likely to create the potential for significant efficiencies that benefit patients and payers. The federal antitrust enforcement agencies have explained that clinical integration may be evidenced when a provider network “implement[s] an active and ongoing program to

⁸⁷ Competitor Collaboration Guidelines § 3.3. Norman PHO was not able to provide sufficient information for purposes of defining the relevant product and geographic markets in which Norman PHO and its participating providers compete, and FTC staff did not perform an investigation or formal market analysis.

⁸⁸ See Statement 9 § (B)(2)(b).

evaluate and modify practice patterns by the network's physician participants and create[s] a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."⁸⁹ Although certain aspects of Norman PHO's proposed new program have yet to be finalized, the network and its participating providers have identified key features and mechanisms, and have invested or committed to investing substantial resources, for purposes of creating the infrastructure and capabilities necessary to jointly achieve their claimed efficiencies.

Norman PHO and its participating providers have created various mechanisms intended to monitor and control costs and utilization, while assuring quality of care. These mechanisms include the network's collaborative, physician-centered processes for developing, implementing, and enforcing evidence-based clinical practice guidelines. Much of this work will be accomplished through the network's newly established Specialty Advisory Groups, the Mentor's Committee, and the Quality Assurance Committee, with the assistance and support of Norman PHO employees, including several new employees hired specifically to support clinical integration activities.

Further, Norman PHO's new electronic capabilities reportedly will foster a high degree of transparency and visibility into the participating physicians' actual practice patterns and accomplishments. They will permit the network to efficiently collect and review individual and aggregate data relating to cost, utilization, and quality of care. They also will enable the network to efficiently monitor and review individual and aggregate compliance with network standards, including clinical practice guidelines. For example, the network will use its electronic systems to perform medical record audits and to generate reports on individual and aggregate performance.

Additionally, Norman PHO's newly revised Participating Practitioner Agreement provides another important mechanism for achieving network goals. It commits each physician to participate in the development, implementation, and enforcement of the network's clinical practice guidelines, including those requiring use of the network's electronic platform. It also enables the network to undertake corrective actions, including, in egregious instances of noncompliance, the expulsion of a participating physician.

Norman PHO and its participating physicians also apparently have made, or will make, meaningful contributions, including investments of human capital, time, and money, to the development of the infrastructure, capabilities, and mechanisms necessary to jointly realize their projected efficiencies. As an organization, they have established new structural and operational capabilities (including the Specialty Advisory Groups, the Mentor's Committee, and the Quality Assurance Committee), established a preliminary set of disease clinical practice guidelines, developed the network's electronic platform, and hired key personnel. Each participating physician has invested or will invest non-trivial and continuing time and effort to support key

⁸⁹ Statement 8 § (B)(1).

aspects of the network's clinical operations and infrastructure, including through participation on committees such as a Specialty Advisory Group, adoption of clinical practice guidelines, and participation in network compliance activities. Participating physicians also have already purchased and obtained training for the necessary computer hardware and software, or will be required to do so. Additionally, they have paid, or will pay, membership fees and dues, and will make other ongoing contributions, in the form of "withholds" from reimbursements made by payers who contract with the Norman PHO, to support the network's clinical integration activities. Together, the participating physicians' contributions of human capital, time, and money appears to give them a stake in the success of Norman PHO such that the potential loss or recoupment of their investment is likely to motivate them to work to make the program succeed.

Moreover, Norman PHO ultimately will operate as a "selective" network that includes only providers who are dedicated to the network's collective attainment of its cost, utilization, and quality goals. Although Norman PHO anticipates that all of its current participating physicians initially will join the new program, certain of those physicians ultimately may find that they are unable or unwilling to devote the time, effort, or commitment necessary to achieve the network's goals. For example, some physicians may not be willing or able to participate in a relevant Specialty Advisory Group, to cooperate with Norman PHO's various compliance activities, such as medical records auditing, or, in the event noncompliance or other risks are identified, to participate in corrective actions, such as physician-to-physician mentoring and other counseling and educational activities.⁹⁰ Over time, some participating physicians therefore may leave the network, voluntarily or otherwise, and the network may constrict in size.

2. Ancillarity

Norman PHO's proposed joint contracting appears to be subordinate to the network's effort to improve efficiency and quality through the clinical integration of its participating physicians. Norman PHO represents that establishing and jointly contracting on behalf of a single, pre-determined physician panel consisting of primary care physicians and specialists representing roughly 38 specialty areas of practice will facilitate the network's projected benefits and efficiencies.⁹¹ In particular, Norman PHO states that joint contracting is necessary to establish and maintain a consistent physician panel of like-minded physicians who have a shared commitment to participating in all aspects of the clinical integration program for all patients covered under network contracts.⁹² Absent joint contracting, each physician would be required to independently evaluate contracting opportunities and decide whether or not to participate in them. In Norman PHO's experience, this can result in physician panels that vary significantly

⁹⁰ Request Letter at 20–21.

⁹¹ *Id.* at 3, 29–31.

⁹² *Id.* at 1 ("joint contracting is essential for meaningful clinical integration"), 31–32.

from contract to contract.⁹³ For example, of the twenty-four contracts held by Norman PHO in 2012, the number of physicians who elected, via “messenger model,” to participate in any one of those contracts ranged from 107 to 237.⁹⁴

Further, Norman PHO represents that, once contractually bound to participate in all Norman PHO contracts, the participating physicians will have a greater incentive to contribute their time and effort to the network’s clinically integrative efforts, to collaboratively develop and pursue network goals, and otherwise to promote the program’s success.⁹⁵ Additionally, the use of a single panel of readily identifiable physicians will facilitate marketing to patients, payers, and physicians.⁹⁶ Norman PHO, therefore, anticipates that the use of a single panel will increase the value of its services, enable it to attract more patients, and promote in-network referrals.⁹⁷ This in turn will enable the network to fully deploy its plans for delivering coordinated care and enhance its ability to collect, analyze, and respond to data points and experience gained from treating network patients.⁹⁸ As a result, Norman PHO expects to have an enhanced ability to harness network effects and economies of scale, to influence physicians’ practice patterns, and to increase the quality of care that its patients receive.⁹⁹

Norman PHO’s proffered justification for its proposed joint contracting activities should not be confused with a claim that physicians would not be incentivized to participate in a clinical integration program absent the ability to fix prices and engage in joint negotiations with payers. This claim is not a valid justification and does not establish ancillarity under the antitrust laws.¹⁰⁰

⁹³ *Id.* at 30, 32, 33.

⁹⁴ *Id.* at 30.

⁹⁵ *Id.* at 30–32.

⁹⁶ *Id.* at 31–32; Supplemental Letter at 6, 10.

⁹⁷ Request Letter at 31–32; Supplemental Letter at 6, 9–10.

⁹⁸ Request Letter at 31, 32.

⁹⁹ *Id.*

¹⁰⁰ See *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679, 687–90 (1978) (the purported justification of a ban on competitive bidding by engineers on the basis “of the potential threat that competition poses to public safety and the ethics of its profession [amounted to] nothing less than a frontal assault on the basic policy of the Sherman Act” to promote competition); Letter from Markus H. Meier, Assistant Director, Bureau of Competition, FTC, to Christi J. Braun and John J. Miles (Sept. 17, 2007) (staff advisory opinion analyzing the proposed clinical integration program by Greater Rochester Independent Practice Association, Inc., and rejecting as invalid the implication that “physicians will not jointly do such good things as clinical integration unless they are authorized to fix prices”), at n.38, available at <http://www.ftc.gov/os/closings/staff/070921finalgripamed.pdf>.

3. Competitive Effects

Norman PHO has identified important savings and efficiencies that it believes are likely to accrue to the benefit of its patients, payers, and participating providers.¹⁰¹ Due to the preliminary nature of its proposed activities, however, Norman PHO states that it is not currently able to provide direct evidence of actual efficiencies or competitive effects. Nonetheless, Norman PHO's representations regarding the competitive impact of its proposed activities and the market environment in which it operates suggest that implementation and operation of its clinical integration program is not likely to have a substantial net anticompetitive effect.

Instead, Norman PHO's proposed program appears likely, on balance, to be procompetitive or competitively neutral. Implementation of the program is not expected to affect the number of contracting alternatives available to payers seeking to obtain provider services in Norman PHO's service area. This is because Norman PHO and its participating providers are effectively replacing their current "messenger model" network with a clinically integrated model. When payers do not wish to contract with Norman PHO (or vice versa), the individual participating providers will remain free to contract with those payers, directly or through other networks, without interference from Norman PHO.

Nevertheless, as a combination of a substantial portion of the physicians in the Norman, Oklahoma area with clinical privileges at the only hospital in Norman, Norman PHO appears to have the potential to exercise market power in the sale of its participating hospitals' and physicians' services. Although Norman PHO states that its service area "overlaps" with the Oklahoma City CSA, it does not appear that payers would have practical alternatives to contracting with the Norman PHO or its participating providers for purposes of providing services to patients who live in the immediate Norman area. This creates a potential concern because Norman PHO proposes to jointly contract, including negotiating and setting prices, on behalf of the majority of local physicians and the only local hospital. Moreover, Norman PHO notes that the network has some expectation of negotiating higher reimbursement rates for its participating physicians because the proposed program will require increased utilization of physician resources to offer the potential to achieve greater efficiency, improved care, and, ultimately, lower costs for network patients.¹⁰²

These concerns are mitigated, however, by Norman PHO's representations that potential customers who do not perceive that Norman PHO offers an attractive product, or who for any other reason do not wish to contract with Norman PHO, will have the ability to bypass the

¹⁰¹ See *supra*, Part I.F.

¹⁰² Request Letter at 23; Supplemental Letter at 16.

network and contract directly with the individual providers.¹⁰³ More specifically, Norman PHO states that: (1) under the terms of the Participating Practitioner Agreement, network participants will be allowed to contract on an individual basis (that is, outside the network) or through other networks with payers who, for whatever reason, do not wish to contract with Norman PHO and (2) Norman PHO will not attempt to force payers to contract with it (such as by instructing or encouraging participating providers to refuse to contract individually with payers who do not wish to deal with Norman PHO, thus forcing those payers to contract with the network in order to maintain adequate provider panels). Norman PHO will make it clear to payers and participating providers that the network is non-exclusive, and will counsel participating providers about the antitrust concerns associated with concerted refusals to deal.¹⁰⁴ If, contrary to these representations, Norman 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 and reevaluate whether staff would recommend an antitrust enforcement action.¹⁰⁵

B. Vertical Analysis

Norman PHO's proposal does not appear to include "vertical" arrangements that would enable it to use any market power the network might possess in selling certain services to limit competition in the sales of any other services. For example, Norman PHO does not propose to use any contracting requirements that would require payers to do business with all of the network's participating hospitals or to prevent payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the network, through "anti-steering," "anti-tiering," "guaranteed inclusion," "most-favored-nation," or similar contractual clauses or provisions. Likewise, Norman PHO has not identified any arrangements that would limit the incentives or ability of its participating physicians to participate in other networks or to contract directly with payers that choose not to contract with Norman PHO (or vice versa). To the contrary, Norman PHO has affirmed that its participating providers are free to do so. As Norman PHO and its participating providers finalize and implement the network's strategic plans and operations, Norman PHO must take appropriate measures to ensure that the network does not use any market power it might possess in selling certain services to limit competition in the sales of any other services.

¹⁰³ Request Letter at 30, 33.

¹⁰⁴ See Statement 9 § (B)(2)(b). Antitrust concerns normally do not arise where individual providers independently choose not to contract with a particular customer or type of customers. However, where a large percentage of local providers agree to engage in joint negotiations, a payer's inability to secure individual contracts with local providers could require further investigation.

¹⁰⁵ Statement 9 details the factors that the FTC will consider in assessing whether a network is truly non-exclusive. *Id.*

C. Spillover Effects

Norman PHO's proposed clinical integration program is likely to promote increased communication and interdependence among its participating providers, and could thereby facilitate collusion, whether tacit or overt, in their contracting activities outside the network. Among other concerns, participating providers could improperly coordinate with respect to the terms on which they are willing to contract outside the network, or whether they are willing to contract outside the network at all. For example, it would be unlawful for the network's participating physicians to agree to reject any contract proposal containing reimbursement rates that are lower than the rates established by the network for its clinically integrated program. Absent improper coordination among the participating physicians, payers presumably should be able to negotiate lower reimbursement rates from individual physicians because, as Norman PHO has described its proposed program, services provided through the network will require increased utilization of physician resources and therefore may warrant higher reimbursement rates.

Norman PHO acknowledges that it is responsible for operating an antitrust-compliant network and represents that it will do so. In particular, Norman PHO represents that it will ensure that its legitimate business activities do not lead to improper conduct or "spillover effects."¹⁰⁶ For example, Norman PHO will provide antitrust counseling and training to ensure that its participating providers do not collectively set their terms of dealing with payers that choose not to contract with the network.¹⁰⁷ Additionally, although the network has not provided specific details, it has represented that it will utilize appropriate mechanisms to prevent improper disclosure of competitively sensitive information among competing providers.¹⁰⁸

Ultimately, Norman PHO and its participating providers are responsible for developing and implementing appropriate and effective mechanisms (e.g., confidentiality agreements, internal firewalls, antitrust training of staff and board members) and preventing such "spillover effects," and failure to do so could result in serious antitrust violations.

III. Conclusion

As discussed above, and based on the information you have provided to us, FTC staff has no present intention to recommend that the Commission bring an enforcement action against Norman PHO or its participating providers.

¹⁰⁶ Request Letter at 33.

¹⁰⁷ *See, e.g., id.*

¹⁰⁸ *Id.*

Norman PHO Advisory Opinion
February 13, 2013
Page 21

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 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