

Clinical Integration Beyond ACOs: The New Frontier

On February 13, 2013, the Federal Trade Commission (FTC) released an advisory opinion approving the proposal for clinical integration of *Norman Physician Hospital Organization* (Norman PHO),¹ a network of 280 physicians comprising 28 medical specialties and the 288-bed Norman Regional Health System located in Oklahoma.² The proposal for the clinically integrated PHO program was made to replace “*messenger model operations*”, whereby providers would supply individually-determined reimbursement rates for services, with a coordinated reimbursement and clinical care plan across all participating providers and specialties.³ The FTC approved the Norman PHO proposal, citing program potential to “*create a high degree of interdependence and cooperation...and to generate significant efficiencies in the provision of physician services*” while “*...appear[ing] unlikely to unreasonably restrain trade.*”⁴

The FTC’s advisory opinion serves as a paramount decision regarding the future of clinical integration as healthcare providers attempt to bridge service gaps and increase integration to stem the rising costs of healthcare while increasing quality of care.⁵ Approval of the Norman PHO proposal denotes “*...the FTC’s first advisory opinion on a proposed clinically integrated network (CIN) since the [Affordable Care Act] was enacted.*”⁶ Several care models utilized in the past several decades, such as physician-hospital organizations (PHO), independent physician associations (IPA), and most recently, accountable care organizations (ACO), have attempted to legally integrate clinical care without impinging on market competition.⁷ For a review of the proposed ACO model of care under the ACA, refer to “*CMS Issues Proposed Rule on Accountable Care Organizations*” in the April 2011 volume of *Health Capital Topics*, as well as the 6-part ACO Series in subsequent issues.⁸ Among the potential benefits stated in the Norman PHO proposal were benefits to:

- (1) Patients – through reduced medical errors; earlier disease detection; more timely communication and scheduling; and elimination of unnecessary and duplicative paperwork and tests;
- (2) Payers – through centralized administrative work; elimination of duplication of services; avoidance of preventable hospitalization; and, lower costs of care; and,

- (3) Providers – through more timely receipt of public health information (PHI) and scheduling of services; more streamlined referrals; and, reduced paperwork, among others.⁹

The FTC approval of Norman PHO’s *proposed* plan for clinical integration, despite incomplete execution, may pave the path for establishing “*...a joint venture evaluated under the antitrust rule of reason which is deemed to be legally compliant...*” particularly for networks already implementing integration plans.¹⁰

However, despite the tentative approval of Norman PHO, the FTC explicitly reserved the right to revoke approval for future implementation if the program, “*...results in substantial anticompetitive effects, if...used for improper purposes, if facts change significantly, or if it otherwise would be in the public interest to do so.*”¹¹ There are several potential pitfalls in the Norman PHO integration plan, not limited to: maintaining a non-exclusive structure; avoiding vertical arrangements that may prevent collaboration between Norman PHO and non-network providers; and, potential “*spillover effects*” of participating physicians improperly leveraging market power associated with network participation to drive non-network contract reimbursement rates.¹² Should Norman PHO fail to appropriately operate and maintain a reliable antitrust-compliant network, it could jeopardize future proposals for clinical integration beyond the ACO model. While the results of full clinical integration have yet to be achieved for Norman PHO, the recent FTC decision provides helpful guidance and encouragement to other provider networks that may choose to forego an ACO model in lieu of alternate integration models, in an effort to adhere to changing clinical and quality outcomes in the era of healthcare reform.

- 1 “Re: Norman PHO Advisory Opinion”, by Markus H. Meier, Federal Trade Commission, February 13, 2013, p. 2.
- 2 *Ibid.* p. 3.
- 3 *Ibid.* p. 4.
- 4 *Ibid.* p. 1-2.
- 5 “Beyond ACOs: FTC Provides Another Path to Coordinated Care”, by Joe Carlson, *Modern Healthcare*, March 9, 2013, <http://www.modernhealthcare.com/article/20130309/MAGAZIN/E/303099969/&template=#> (Accessed March 11, 2013)
- 6 “Clinical Integration on a Promise and a Plan”, by Polsinelli Shughart LLP, *Health Care Law in the News*, March 2013, p. 2.
- 7 Carlson, March 9, 2013.
- 8 “CMS Issues Proposed Rule on Accountable Care Organizations”, by Health Capital Consultants, *Health Capital*

Topics, Vol. 4, Issue 4, April 2011; Accountable Care Organizations Series: “Why Do We Need ACOs?” Health Capital Topics, Vol. 4, Issue 5, May 2011; “What Are ACOs?”, Health Capital Topics, Vol. 4, Issue 6, June 2011; “Who Are ACOs?”, Health Capital Topics, Vol. 4, Issue 7, July 2011; “Where Are ACOs?”, Health Capital Topics, Vol. 4, Issue 8, August 2011; “When Are ACOs?”, Health Capital Topics, Vol. 4, Issue 9, September 2011; “How Are ACOs Compliant?”, Health Capital Topics, Vol. 4, Issue 10, October 2011

9 Meier, FTC, February 13, 2013, p. 11.
10 Polsinelli Shughart LLP, March 2013, p.1-2.
11 Meier, FTC, February 13, 2013, p. 21.
12 Meier, FTC, February 13, 2013, p. 20.



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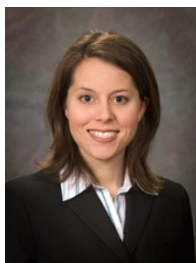
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