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

Bureau of Competition
Health Care Division

June 18, 2007

John J. Miles, Esquire
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1401 H Street, N.W., Suite 500
Washington, D.C. 20005-3324

Re: Follow-Up to 2002 MedSouth, Inc. Staff Advisory Opinion

Dear Mr. Miles:

By letter dated February 9, 2002, from then Bureau of Competition Assistant Director Jeffrey W. Brennan to you as counsel for MedSouth, Inc., Commission staff issued an advisory opinion regarding MedSouth's proposed establishment and operation of a "clinically integrated" physician network joint venture. MedSouth's proposed joint venture included contracting with payers on behalf of all of MedSouth's physician members on terms agreed upon by the physicians, including the prices to be charged and paid for the physician services provided pursuant to the contracts.

The staff advisory opinion letter concluded that the proposed program "appears to involve partial integration among MedSouth physicians that has the potential to increase the quality and reduce the cost of medical care that the physicians provide to patients." The letter also stated that the staff had "concluded that the joint contracting appears to be sufficiently related to, and reasonably necessary for, the achievement of the potential benefits to be regarded as ancillary to the operation of the venture." Consequently, the staff concluded that the proposed venture, including its price agreements, appropriately was subject to rule-of-reason antitrust analysis of its likely procompetitive and anticompetitive effects, rather than to *per se* condemnation as a horizontal price-fixing arrangement among competing physicians.

Because staff could not predict with any degree of certainty how MedSouth would operate in practice, its actual number and categories of participating physicians, and its competitive effects in the area within which it planned to operate, the opinion emphasized that its analysis of MedSouth's proposed conduct under the rule of reason necessarily was limited. In fact, staff expressed some concern that the potential MedSouth physician members together might be capable of exercising market power, at least in some medical specialties and in some parts of the Denver metropolitan area. Nevertheless, because of the proposed program's potential for creating procompetitive efficiencies through the integration of its physician participants, and the absence of a sufficient basis for concluding prospectively that MedSouth was likely to have anticompetitive effects or exercise market power, the staff advised that it would not recommend at that time that the Commission challenge the proposed program. The advisory opinion letter noted, however, that staff would "monitor MedSouth's activities, and . . . recommend that the

Commission take appropriate action if the proposed conduct appears to result in actual anticompetitive effects."

Follow-Up Inquiry

After MedSouth had the opportunity to implement its proposed programs, and to do business for a substantial period of time, staff sent a letter, dated July 5, 2006, to you, as MedSouth's counsel, seeking updated information concerning various aspects of MedSouth's operation. Some of the follow-up inquiry addressed aspects of MedSouth's structure and operation that had been identified as possible areas of concern in the 2002 advisory opinion letter. The request focused on three main areas: (1) integrative activities by the MedSouth physicians through MedSouth's operations and programs; (2) the extent to which potential efficiencies had resulted from, and were continuing to be attained, as a result of that integration; and (3) aspects of MedSouth's makeup and operation that were relevant to ascertaining its ability to exercise market power or otherwise adversely affect competition in the market. MedSouth's reply, which included a narrative response from its Clinical Director to the questions raised by the staff, as well as supportive and illustrative documentation, was provided to staff in September, 2006, with additional follow-up information provided in May, 2007.

Having considered the information submitted by MedSouth in response to our request, we have found no reason to rescind or modify the opinion issued by staff in 2002 regarding MedSouth's program. We summarize certain of the submitted information below, as well as our analysis of its relevance regarding issues addressed in the 2002 staff advisory opinion.[1]

Integration

Clinical integration in a physician network involves creating a degree of interaction and interdependence among the physician participants in their provision of medical services, in order to jointly achieve cost efficiencies and quality improvements in providing those services, both individually and as a group.[2] Achieving such integration among otherwise independently practicing physicians is not simple, easy, or costless. The network's goal of achieving collective

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[1] This letter should be read in conjunction with the February 19, 2002 staff advisory opinion issued to MedSouth (available at http://www.ftc.gov/bc/adops/medsouth.htm). In addition, as with the initial advisory opinion, this letter is based on the information MedSouth provided to us; we have not conducted an independent investigation, or otherwise verified MedSouth's representations to us. In response to MedSouth's request in submitting additional information, we have attempted to avoid disclosure in this letter of any confidential or commercially sensitive information that was provided in response to our inquiry.

[2] This type of integration is "partial" in that the physicians in such an arrangement do not totally integrate their individual medical practices, as would be the case if they merged their practices, which would completely eliminate them as competitors of each other.

improvement in efficiency may conflict with the economic incentives of individual physician participants practicing in a fee-for-service environment, as well as many physicians' desire for independence and autonomy in their practices.

Successfully achieving clinical integration in a physician network requires the establishment and operation of active and ongoing processes and mechanisms to facilitate, encourage, and assure the necessary cooperative interaction. It may necessitate selectively restricting participation in the network, both initially and as the program continues, including even expelling persistently uncooperative members. It may require significant investment in the venture by the physician participants, either monetary or in terms of human capital (i.e., investing time and effort by committing to active participation in the mechanisms and processes by which the network hopes to achieve its efficiencies), in order to assure that all participants are committed to working together to achieve the venture's goals. It also requires having the capability to collect and evaluate information relating to practice performance, in order to determine whether the integration is effective and achieving the network's goals, and to identify where changes need to be made to improve individual and collective performance. Finally, there must be an appreciation by employers, patients, and payers of the potential benefits of such programs, and the willingness to contract for what the programs offer.

Typically, clinically integrated programs will involve some or all of the following aspects or characteristics: development or adoption of appropriate performance standards and goals, referral guidelines or requirements, or other performance criteria and measures for the participants, both individually and as a group; establishment of mechanisms, including information systems that permit collection and analysis of relevant data to monitor and evaluate both individual and group performance relative to the established standards, goals, and measures; and provision for appropriate educational, behavior modification, and remedial action, where warranted, to improve both individual and overall group performance.[3] Many of these same approaches and tools also are available to payers and others doing business in the health care area. For a physician network, having such tools is a necessary, but not sufficient, predicate for the network to achieve clinical integration among its participants. The test of that integration is what the participants, through the network, actually do – i.e., how they use those tools to create cooperation and interdependence in their provision of medical care, thereby facilitating their efforts to jointly reduce unnecessary costs, improve quality of care, and otherwise increase their efficiency in the provision of medical care.

The staff advisory opinion issued to MedSouth in 2002 concluded that its proposed operation, which included a number of the aforementioned characteristics, appeared to be structured so as to

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[3] This list is intended to be illustrative, rather than comprehensive. There also may be other tools and approaches that can be used by a physician network to facilitate cooperation and interdependence among its physician members in order to enhance their overall efficiency and improve quality.

create such integration, so that the proposed program appeared to have the potential to achieve significant efficiencies in the provision of medical care by MedSouth's physician participants through the proposed program. It is our understanding that MedSouth's basic program for integrating the provision of medical care by its physician members has continued to follow the approach it initially proposed. MedSouth reports that its somewhat smaller physician panel (discussed below) continues to be committed to working together to achieve the efficiencies in medical practice that it originally set out to achieve.

MedSouth provided an update on its activities for setting the practice standards and goals that it adopts for use by its physician members and uses in evaluating the physicians' individual and collective performance. MedSouth reports that it currently has clinical guidelines or screening protocols in place regarding 60 major diseases. Each individual physician is required to review and sign off on those guidelines that are relevant to the physician's medical practice, both initially and whenever a guideline is modified. MedSouth's Clinical Integration Committee periodically reviews and updates these guidelines as necessary.[4]

Each year, after a review of its previous year's performance, and with payer participation, MedSouth selects 10 practice guidelines as the focus of its efficiency activities for the upcoming year. MedSouth sets its performance goal at the national HEDIS goal level or, if none exists, at the community performance goal set by a payer. "Stretch goals" are set above the previous year's achievement, or at 15 percent above the current performance for new goals not previously measured. Physicians receive an individual "report card" that compares their performance to other physicians in the group, and to the "target" and "stretch" goals set for the group. MedSouth also has a major payer contract that includes "pay-for-performance" ("P4P") provisions whereby, as an added incentive for good performance, financial bonuses can be obtained by the physicians for the network as a whole reaching or exceeding the target and stretch goals for a defined set of performance measures.

In order to facilitate MedSouth physicians' inter-connectivity as a means of helping to integrate and improve performance, MedSouth reports that it has upgraded its electronic data system with a new software system. Physicians now receive and share data in HIPAA-compliant form. The new software system is easier for physicians to enter and use, making communication with other physicians in MedSouth easier. The software system has additional information sources available to physicians (including lab and radiology imaging reports), and has allowed MedSouth to begin direct patient-to-physician e-mail exchanges. MedSouth also reports that it is in discussions with several hospitals to share information back and forth between doctors and the hospitals. Heretofore, MedSouth's reporting to physicians regarding performance has been by

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[4] For example, MedSouth reports that the hyperlipidemia guideline has been updated twice to comply with changing national guidelines. MedSouth's Clinical Integration Committee currently includes one family practitioner, two internists, one gynecologist, one gastroenterologist, one ENT, one radiologist, and MedSouth's Medical Director.

paper reports; however, MedSouth states that it is transitioning to online reporting. Additionally, MedSouth reports that, since 2004, the percentage of MedSouth physicians having electronic medical record systems has grown from less than five percent to more than 30 percent, which MedSouth states is well above the national average.[5]

Achievement of Efficiencies

MedSouth reports observing improvement in both individual physician performance and performance of the network as a whole in meeting or exceeding its benchmarks. While measuring compliance rates may be somewhat misleading from year to year, as benchmarks are raised, MedSouth reports that data show that its care over three measured years is about 15 percent above the community average benchmarks, and has "incrementally improved annually." In fact, MedSouth states that there are several measurement areas where it can no longer raise the benchmark goal, because of the current high level of achievement. For example, it had a 97 percent compliance rate on cervical cancer screening in 2005, and had a colon cancer screening compliance rate of 88 percent, when the target was 79 percent and the stretch goal was 83 percent. The physicians' performance has been rewarded under MedSouth's P4P program with small fee increases over the last three years. Under the P4P program, MedSouth and the payer offering the program together choose the P4P guidelines for that year, based on their potential beneficial clinical impact.

Competitive Effects/Market Power

1. "Spillover" Anticompetitive Price Effects

In analyzing the competitive effects of a physician network under the rule of reason,[6] two key areas of concern about possible anticompetitive effects are the potential misuse of sensitive price information collected by the network for its ancillary joint contracting with payers to facilitate unjustified and unlawful price agreements by the network participants when doing business outside the joint venture, and the exercise of market power by the joint venture itself, due to its size and methods of doing business. With regard to the first concern – possible "spillover" anticompetitive price effects – MedSouth reports that competitively sensitive information, such as fee information from individual members, is collected by an outside contractor who only uses

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[5] Regardless of whether they have an electronic medical record system in place, all MedSouth physicians have always been required to maintain at least one computer with a high-speed internet connection in the office that is dedicated to clinical information, which is not used for office management or billing purposes.

[6] *See* U.S. Department of Justice and Federal Trade Commission, *Statements of Antitrust Enforcement Policy in Health Care* (1996) (hereinafter *Health Care Statements*) (available at http://www.ftc.gov/reports/hlth3s.pdf) at Statement 8 at ¶ B.2 ("Applying the Rule of Reason").

the information in developing MedSouth's contracting fee structure at the latter stages of entering into a contracting relationship with a payer seeking such an agreement. According to MedSouth, the individual fee information is not shared with either MedSouth's members or its Board, presumably to reduce the opportunity for misuse of this competitively sensitive information by the MedSouth physicians regarding fees they charge in offering their services outside of MedSouth.

2. Market Power

The 2002 advisory opinion raised concerns about MedSouth possibly having or being able to exercise market power in the physician services market in the south Denver area due to the number and geographic location of its member physicians' medical practices. In its recent submission, MedSouth provided us with updated information regarding this issue.

a. Participating Physicians

MedSouth reports that, overall, it has substantially fewer participating physicians than at its inception, and that this is true for both primary care and specialty physician categories. Within individual specialties, most have fewer physicians than initially, although a small number of specialties have increased numbers of participating physicians since MedSouth's inception. MedSouth states that, as of the time of issuance of the 2002 staff advisory opinion, it had 415 member physicians, 100 of whom were primary care physicians (those in family practice, internal medicine, or pediatrics), and 315 of whom were specialists, practicing in 29 different specialty areas.[7] MedSouth reports that it currently has 280 total physician members – a 32.5 percent decrease from 2002 – and that this number has held steady at between 280 and 300 for the last two years. These numbers include a total of 75 primary care physicians (down from 101), with reductions in the number of participating family practitioners and internists, but a numerically small increase in pediatricians. MedSouth states that it initially anticipated a reduction in the number of participating primary care physicians, since many were nearing retirement or did not want to invest in the technology connections in their offices that were necessary to implement MedSouth's programs.

Regarding the 29 medical specialty areas identified by MedSouth, in which a total of 205 physicians (down from 315) currently participate in MedSouth, 25 specialties reportedly have fewer physicians than at MedSouth's inception, and one had no change. Several specialties had substantial decreases in the number of participating physicians in those specialties. MedSouth currently has no physicians in its network that specialize in pulmonary medicine, cardiovascular

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[7] The initial MedSouth advisory opinion notes similar, but not identical, participation numbers: 432 physicians, 101 of whom were primary care physicians, and 331 of whom were specialists in 39 specialties and subspecialties.

surgery, or neurosurgery, and lost a large group of general surgeons, a large hospital-based neurology group, and a large cardiology group. Two specialty areas – oncology and urology – have had a numerically small increase in the number of participating physicians.

In its initial proposal, MedSouth stated that, with limited exceptions relating to filling gaps in needed coverage, it did not intend to add physicians to its network. It would, however, permit physicians who joined existing MedSouth member practices to become participating physicians, and this is the explanation for the small increases in the number of pediatricians, urologists, and oncologists noted above. One specialty area – hospitalists – has had a very significant increase, both absolutely, and in percentage terms. MedSouth attributes this increase to a shift in the "culture" of local medical practice, with many physicians finding it unprofitable to spend the time treating patients in the hospital, and turning such treatment over to hospitalist specialists, with local area hospitals hiring many more physicians for this purpose.

b. Non-Exclusivity

The availability of physicians in the market to form competing networks or to contract directly with health plans is a potential issue regarding analysis of the competitive effects of a physician network under the rule of reason, and the exclusive or non-exclusive nature of physicians' participation in a network is relevant to this assessment.[8] MedSouth states that it has continued to operate on a non-exclusive basis, which was a characteristic of its initial proposal. MedSouth has reiterated that physician participation in its program is non-exclusive, although it does not survey its physician members as to their involvement with health plans outside of MedSouth. It states that "[w]e have never sought to have any member drop or pressure a health plan based on their membership to accept a contract [with MedSouth]." While MedSouth provided no specific information in this regard, MedSouth asserts that, in actual practice, its physicians participate in MedSouth on a non-exclusive basis. Given MedSouth's reportedly very small market presence and number of enrollees, it is likely that MedSouth physicians do also contract with payers or networks in the Denver area to provide their medical services under arrangements other than through MedSouth's contracts.[9]

Analysis

It appears that MedSouth has continued to implement and even expand its activities to integrate, coordinate, and improve aspects of the medical practices of its member physicians that it initially

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[8] *See Health Care Statements* at Statement 8 at ¶ B.2.

[9] Regarding its small size and limited enrollment, MedSouth reports that many payors are not interested in contracting with MedSouth for its programs that are aimed at improving quality of care. MedSouth believes that its difficulty in marketing such programs has been exacerbated by consolidation among payers, and the removal of many contracting and policy decisions to company officials in distant locations, where they have little or no connection to the local population.

proposed to undertake. MedSouth also appears to be in the process of upgrading its capabilities for member physicians to more easily interact and share information, as well as to facilitate communication between physicians and patients, which may offer benefits to both physicians and patients.

MedSouth reports that its physician membership has largely stabilized in the last two years, albeit at a somewhat reduced size from what initially was anticipated. The reduced number of physicians participating in the program since MedSouth's inception may well be indicative that a program of clinical integration requires very serious commitment and effort by physicians to engage in the activities that are necessary to achieve the beneficial objectives of such a program, as well as physicians' weighing of the economic costs and benefits of participating in such a program. This may be instructive for other provider networks, particularly ones involving large numbers of physicians, regarding the practical realities and potential difficulties inherent in coordinating and clinically integrating the care provided to numerous enrollees through a network comprising many independent physician practices.

MedSouth states that its efforts at integration appear to be having some success in achieving efficiencies in the delivery of medical care by its member physicians. It reports improvements in both individual and group performance regarding certain practice measures. Moreover, MedSouth reports that its results under its P4P program for the last few years show its physicians collectively meeting or exceeding performance targets established in conjunction with the payer involved, and receiving corresponding performance-based rewards.

The loss of some physician specialists, or the total absence of certain categories of specialists in MedSouth's physician network, potentially could adversely affect its ability to monitor and coordinate patients' care, and thereby to achieve the program's efficiency and quality improvement goals. Patients that seek and obtain care from, or require referral to, physicians not participating in MedSouth's programs, may undergo treatments, have outcomes, and incur costs that differ from what would have occurred had those services been provided by MedSouth participating physicians and subject to MedSouth's protocols and oversight programs. That is the premise on which MedSouth was established. But MedSouth states that the current gaps in available in-network specialty services, and the reduction in numbers of available in-network providers in some specialty areas, are not a problem for the effectiveness of its programs. Most of MedSouth's practice guidelines, and the focus of its monitoring and assessment of physician performance, relate to chronic conditions and diseases. These activities are more oriented to the practices of primary care physicians and "lower-tier specialty" physicians, rather than the one-time events (e.g., open-heart surgery) that are performed by many of the types of specialist physicians not in MedSouth's network. While MedSouth would like to see those specialties represented in its network, it does not believe that their absence has had an adverse effect on the network's performance.

The overall decrease in the number of physicians participating in MedSouth in both primary care and specialty care – a decrease that MedSouth initially anticipated – generally suggests that

concerns raised in the 2002 advisory opinion about MedSouth's possibly being able to exercise market power in the physician services market in parts of the Denver area may be somewhat diminished at this time. Nevertheless, some concern remains regarding the medical specialty areas where MedSouth's physician participation has increased since its inception. Moreover, MedSouth believes that the area's total physician population may have declined somewhat as, in MedSouth's view, physicians in general are leaving the Denver area due to reimbursement and other issues involving managed-care payers.

Overall, nothing that MedSouth reported suggests that it has significantly increased its market power for physician services, or exercised market power, since the staff advisory opinion was issued in 2002. As previously discussed, overall MedSouth has fewer physicians in its program than initially was contemplated. More importantly, it appears that MedSouth's physicians' participation is non-exclusive, and payers wishing to deal with individual MedSouth physicians outside of MedSouth's programs therefore appear able to do so. Insofar as MedSouth physicians are available to, and in fact do, provide their services through arrangements with payers outside of MedSouth's programs, concern about possible exercise of market power is reduced. Finally, while we have not conducted an independent investigation of the market or MedSouth's operations, we are unaware of any information that would suggest that MedSouth is having any anticompetitive effect in the market for physician services in the Denver area.

Under the circumstances, we see no reason at this time to rescind or modify the conclusions that the staff reached in its February 19, 2002 advisory opinion letter concerning MedSouth's proposed operations at that time. As with all advisory opinions issued by the Commission staff, however, we reiterate that 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), 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