

Complaint

IN THE MATTER OF

TENET HEALTHCARE CORPORATION, ET AL.

CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5 OF THE FEDERAL TRADE COMMISSION ACT

Docket C-4106; File No. 0210119

Complaint, January 29, 2004--Decision, January 29, 2004

This consent order addresses practices used by Respondent Tenet Healthcare Corporation, a for-profit corporation that owns or operates more than 100 hospitals throughout the United States; Respondent Frye Regional Medical Center, a for-profit corporation owned by Tenet Healthcare Corporation that operates a 338-bed hospital in Hickory, North Carolina; and the Piedmont Health Alliance, Inc. (“PHA”), a for-profit physician-hospital organization operating in the western North Carolina area of Catawba, Burke, Caldwell, and Alexander Counties (known as the “Unifour” area), which has as members approximately 450 physicians – or roughly 75 percent of the physicians in the Unifour area – and three of the five Unifour area hospitals, including Frye Regional Medical Center. The order, among other things, prohibits the respondents from entering into or facilitating any agreement between or among any physicians practicing in the Unifour area (1) to negotiate with payors on any physician’s behalf; (2) to deal, not to deal, or threaten not to deal with payors; (3) on what terms to deal with any payor; or (4) not to deal individually with any payor, or to deal with any payor only through an arrangement involving PHA. The order also prohibits the respondents from facilitating exchanges of information between or among physicians concerning whether, or on what terms, to contract with a payor, and from attempting to engage in – or inducing anyone to engage in – any action prohibited by the order. In addition, the order requires the respondents, for five years, to notify the Commission at least 60 days prior to initially contacting, negotiating with, or entering into agreements with payors, concerning any qualified risk-sharing arrangement or qualified clinically-integrated arrangement, as defined in and permitted under the order. The order also prohibits the respondents from challenging or interfering with the termination, required by any Commission order, of any contract between PHA and any payor pursuant to which Frye is reimbursed for hospital, physician, or other healthcare services.

Participants

For the Commission: *David M. Narrow, Christi J. Braun,
Karan R. Singh, Mary Connelly-Draper, Emily Jones, David R.*

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Pender, Jeffrey W. Brennan, Joseph Eckhaus, Roberta S. Baruch, Timothy A. Deyak, Louis Silvia and Mary T. Coleman.

For the Respondents: *Clifford H. Aronson, Skadden, Arps, Slate, Meagher & Flom, L.C.C.*

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41 *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission (“Commission”), having reason to believe that Tenet Healthcare Corporation (“Tenet”) and Frye Regional Medical Center, Inc. (“Frye”), herein collectively referred to as “Respondents,” have violated Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint stating its charges in that respect as follows:

NATURE OF THE CASE

1. This action concerns a horizontal agreement among approximately 450 physician shareholders and non-shareholder subcontracted physicians (collectively, “physician members”) of Piedmont Health Alliance, Inc. (“PHA”), to agree collectively on the prices they demand for physician services from payors, including health insurance plans, health maintenance organizations, preferred provider organizations, employers directly providing self-funded health care benefits to their employees and their employees’ dependents, and other third-party purchasers of health care benefits. The physicians, in conspiracy with Frye and with and through PHA, have eliminated price competition to the detriment of payors and consumers in the “Unifour area” of North Carolina, which comprises Alexander, Burke, Caldwell, and Catawba Counties.

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THE RESPONDENTS AND OTHER PARTIES

2. PHA, a physician-hospital organization (“PHO”), is a for-profit corporation based in Hickory, North Carolina.

3. PHA’s three hospital members are Frye, Caldwell Memorial Hospital (“Caldwell Memorial”), and Grace Hospital (“Grace”). Caldwell Memorial and Grace are organized as nonprofit corporations.

4. Tenet is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of Nevada, with its principal address at 3820 State Street, Santa Barbara, California 93105.

5. Frye is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of North Carolina, with its principal address at 420 North Center Street, Hickory, North Carolina 28601. Tenet controls Frye, an acute care hospital with 338 staffed acute care beds. Frye is the largest hospital in the Unifour area.

6. PHA’s 450 physician members include both primary care and specialist physicians. A substantial majority of these physicians practice in small group practices on a for-profit basis. A small number of PHA physician members are salaried employees of a PHA member hospital.

7. Tenet owns one or more medical group practices that provide physician services to patients in the Unifour area and employ physicians who are members of PHA.

JURISDICTION AND INTERSTATE COMMERCE

8. Tenet, through its subsidiaries, including Frye, has been engaged in the business of providing physician and hospital services in the Unifour area for a fee.

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9. The general business practices of Tenet and Frye, including the acts and practices herein alleged, are in or affecting “commerce,” as defined in Section 4 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 44.

BACKGROUND

10. Payors often contract with physicians, hospitals, and other providers of health care services in a geographic area to create a network of health care providers (“provider network”) that have agreed to provide health care services to enrollees covered under the payors’ programs. Those providers may enter into contracts individually and directly with the payor, or through a provider organization, such as a PHO.

11. To become members of payors’ provider networks, physicians often enter into contracts with payors that establish the terms and conditions, including fees and other competitively significant terms, for providing health care services to enrollees under the payors’ programs. Physicians entering into such contracts often agree to reductions in their usual compensation in order to obtain access to additional patients made available to them by the payors’ contractual relationships with their enrollees. Such reductions in physician fees may permit payors to constrain increases in, or reduce, the premiums they charge to their customers, or to offer broader benefits coverage without increasing premium levels or out-of-pocket expenditures by enrollees.

12. Medicare’s Resource Based Relative Value Scale (“RBRVS”) is a system used by the United States Centers for Medicare and Medicaid Services to determine the amount to pay physicians for the services they render to Medicare patients. The RBRVS approach provides a method to determine fees for specific services. In general, payors in the Unifour area make contract offers to individual physicians or groups at a price level specified as some percentage of the RBRVS fees for a particular year (*e.g.*, “110% of 2003 RBRVS”).

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13. Absent agreements among competing physicians on the prices and other contract terms on which they will provide services to the payor's enrollees, competing physicians or medical group practices decide unilaterally whether to enter a contract to participate in the payor's provider network on the terms and conditions, including price, offered by the payor.

14. Some self-insured employers contract with other payors to gain access to established provider networks. Payors who are not self-insured employers typically sell their programs to various customers, including employers or other entities that purchase or arrange for (and sometimes pay all or part of the cost of) programs providing health care benefits to their employees and their employees' dependents.

15. To be marketable and competitive in the Unifour area, a payor's health plan generally must include in its physician network a large number of primary care and specialist physicians, offering services in a sufficient number of practice fields, who are available to customers at convenient or accessible locations, and at affordable prices. Because the substantial majority of the primary care and specialist physicians who practice in the Unifour area are members of PHA, many payors doing business in the Unifour area cannot offer marketable and competitive health plans without having at least a substantial portion of PHA's physician members in their provider networks.

**FRYE WAS INSTRUMENTAL IN PHA'S FORMATION
AND EXPANSION**

16. In 1993, Frye's Chief Executive Officer ("CEO") formulated a plan to create a PHO that would include Frye and physicians who practiced at Frye. Frye paid a health care consultant to conduct surveys of physicians practicing at Frye to determine their level of interest in forming a PHO, and the services they would expect the PHO to offer. The consultant told Frye that the surveyed physicians "stated a need to form the group to negotiate with group clout and power" and "maintain[] their

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income” in anticipation of the arrival of managed care organizations to the Unifour area.

17. At the request of Frye’s CEO, the chief of Frye’s medical staff recruited eight physicians practicing at Frye to serve on a PHO “steering committee” with Frye’s CEO and Chief Operating Officer (“COO”). This committee met periodically, for more than a year, to make decisions about the purpose, form, and organization of the PHO.

18. Frye’s Board of Directors authorized Frye’s CEO to use Frye funds to develop the PHO. Some of this money was used to pay a health care consultant and others who assisted the steering committee in establishing the PHO.

19. In 1994, PHA was incorporated and its shareholders elected a Board of Directors, made up of physician and hospital representatives from among the PHA membership. Frye’s COO initially directed PHA’s operations. Frye’s CEO conducted a management search, which led to PHA hiring a full-time CEO in 1995. PHA’s CEO was charged with overseeing the day-to-day operations of PHA, subject to approval by the PHA Board.

20. In early 1995, Frye’s CEO and other representatives of PHA participated in discussions with Caldwell Memorial, Grace, and their medical staffs about the possibility of joining PHA to form a “super PHO.” In 1996, PHA amended its Articles of Incorporation, Bylaws, and Policies and Procedures to permit Grace, Caldwell Memorial, and their respective medical staffs to join PHA and share equally in its governance.

21. Frye has invested substantial funds to further PHA’s formation and expansion. PHA’s other hospital members and its physician members likewise have paid substantial money to PHA to further PHA’s formation and expansion.

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**RESPONDENTS HAVE ENGAGED IN PRICE-FIXING
AND OTHER ANTICOMPETITIVE ACTS**

22. According to its records, PHA was “created to be a contracting entity for its members and serves to negotiate managed health care contracts with [payors].” In 1994, PHA informed potential physician members that “[e]ach [payor] contract will be carefully reviewed to determine advantages and disadvantages (including but not limited to reimbursement issues) to Piedmont Health Alliance participants and only those [contracts] which the directors determine to be favorable on balance to our participants as a whole will be signed.”

23. PHA’s physician members signed agreements that bound them to participate in all contracts that PHA entered, to accept PHA-negotiated prices, and to agree that if PHA entered into a contract with a payor with which the physician had an individual contract, then that physician would terminate the individual contract. PHA agreed to attempt to negotiate contracts with payors that included all PHA physician members.

24. In early 1994, the PHA steering committee established a Contracts Committee to negotiate contracts with payors on behalf of PHA and its physician and hospital members. The PHA Bylaws authorized the Contracts Committee to evaluate and negotiate proposed contracts with payors on behalf of PHA and its members. Until 2001, the Contracts Committee met regularly and was actively involved in PHA’s contracting activities. Frye’s COO and Chief Financial Officer (“CFO”) participated in the activities of the Contracts Committee during this period. Over that period, PHA negotiated and entered into more than 50 payor contracts.

25. From 1994 through 1996, Frye’s CFO and COO served as PHA’s principal contract negotiators with payors. Beginning in 1996, PHA’s CEO and her staff assumed the responsibility for negotiating PHA’s payor contracts, and PHA’s Board and

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Contracts Committee advised PHA's CEO regarding the price and other contract terms to demand from payors.

26. PHA's Board must approve PHA contracts with payors before they can take effect. PHA's Board is composed of 14 physician directors and six hospital directors, two representing each hospital (but with only one vote per hospital). Contract approval requires that both a majority of the PHA physician directors and two of the three hospital shareholders approve the contract. Frye's, the other PHA hospitals', and the physician members' representatives on the PHA Board voted on the approval of contracts containing physician fee schedules that PHA collectively negotiated with payors.

27. PHA hired actuaries and other consultants to develop physician fee schedules containing price terms that PHA subsequently demanded from payors as a condition of contracting for the services of PHA's physician members.

28. PHA's most common contracting method has been to enter into a single-signature contract between PHA and a payor that covers the services of all PHA physician members. Payors that failed to reach agreement with PHA on contract terms, including price and price-related terms, were denied access to PHA's physician members for inclusion in their provider networks.

29. PHA's physician members agreed with each other and with PHA that they would not deal individually, or through any other organization, with any payor with which PHA was attempting to negotiate, or had signed, a contract jointly on behalf of PHA's members. Until 2001, the physicians' participation agreements with PHA expressly included this provision. After 2001, this provision was no longer written into the PHA participation agreements, but PHA physicians nonetheless continued to adhere to it. PHA's physician members also refused to deal directly and individually with payors after PHA terminated its contracts with those payors.

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30. By and through PHA, the member physicians and hospitals, including Frye, jointly agreed to require payors, as a condition of dealing with the PHA physicians, to refrain from contracting with non-PHA physicians or physician organizations in the Unifour area.

**PHA’S SO-CALLED “MESSENGER” APPROACH TO
CONTRACTING CONSTITUTES PRICE-FIXING**

31. Competing physicians sometimes use a “messenger” to facilitate their contracting with payors in ways that do not constitute an unlawful agreement on prices and other competitively significant terms. Legitimate messenger arrangements can reduce contracting costs between payors and physicians. A messenger can be an efficient conduit to which a payor submits a contract offer, with the understanding that the messenger will transmit that offer to a group of physicians and inform the payor how many physicians across specialties accept the offer or have a counteroffer. At less cost, payors can thus discern physician willingness to contract at particular prices, and assemble networks, while physicians can market themselves to payors and assess contracting opportunities. A messenger may not negotiate prices or other competitively significant terms, however, and may not facilitate coordination among physicians on their responses to contract offers.

32. In February 2001, the PHA Board voted to change prospectively PHA’s method of contracting with payors for physician services. PHA called its new contracting method the “modified messenger model.” PHA told physician members that this contracting method would not apply to existing PHA payor contracts or to contracts then in the final stages of negotiation – all of which contained price and other terms that the PHA physician members had fixed and jointly demanded through PHA. Since the PHA Board’s decision to institute its so-called “messenger” method for contracting, many existing PHA payor contracts renewed, and a number of new contracts were finalized, without being processed through PHA’s messenger model.

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33. In setting up this new contracting method, PHA told its physician members to report to PHA the minimum price levels they would accept under payor contracts. To aid physicians in making these price decisions, PHA informed them of the prices they had been paid for their most common medical procedures under several pre-existing, PHA-negotiated payor contracts. All such contracts contained prices that the physicians had collusively fixed and demanded through PHA. Many PHA physician members used these fixed prices to determine the prices that they would demand under the new “messenger” method.

34. PHA has processed a total of two payor contracts for its physician members pursuant to its “messenger” method for contracting – one with CIGNA HealthCare of North Carolina, Inc. (“CIGNA”), and the other with United HealthCare of North Carolina, Inc. (“United”). PHA and its members, including Frye, engaged in price-fixing in connection with both contracts. PHA negotiated with CIGNA and United, respectively, on the overall average price levels that each would pay to all PHA physicians in the aggregate. PHA engaged in this conduct without transmitting contract offers to its physician members for their unilateral acceptance or rejection.

35. After fixing the overall average price level that would be paid to all its physician members under each of these two contracts, PHA, through its actuarial consultant, created fee schedules that established different price levels for each medical procedure and for different medical specialties. The actuary calculated these fee schedules such that, in their aggregate, they would total the overall average price level that PHA had negotiated for all PHA physicians to receive under the contract. In effect, the overall average price level was the “pie” that the PHA physicians collectively would share, and the fee schedules were the “pieces of the pie” that individual physicians could earn – depending on their specialty and the procedures they performed. PHA negotiated for United’s and CIGNA’s acceptance of these fee schedules. It did so without transmitting contract offers to its physician members for their unilateral acceptance or rejection.

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36. PHA negotiated with United and CIGNA regarding, or collectively agreed on, various other contract terms as well – including pricing terms such as a demand for periodic, across-the-board percentage increases in physician fee levels to occur at certain times under the contract, and cost containment programs – without transmitting contract offers to PHA physician members for their unilateral acceptance or rejection.

37. After PHA had collectively negotiated with United and CIGNA on behalf of its physician members, more than 90% of PHA's physician members agreed to participate in those contracts.

**FRYE CONSPIRED WITH PHA PHYSICIANS TO FIX
PHYSICIAN PRICES**

38. Beginning in 1994 and continuing through the present, through its representatives on the PHA Board and otherwise, Frye acted to implement and facilitate the fixing of prices that PHA physicians charge payors for services rendered. Frye agreed with PHA and its physician members to fix physician prices by, among other things: (a) approving proposed contracts with payors that included fixed prices for PHA's physician members; (b) rejecting proposed contracts or contract terms, including price, that payors offered to PHA's physician members; (c) authorizing PHA's Contracts Committee and other representatives to negotiate with payors for fixed physician fee schedules and prices; (d) authorizing PHA representatives to make specific counteroffers to payors containing fixed prices for PHA physician members; (e) authorizing development of, and approving, physician fee schedules for use by PHA in negotiations and contracting with payors; (f) terminating contracts for physician services between PHA and payors; (g) approving recommendations of the PHA Contracts Committee concerning payor contracts and terms, including physician payment rates; and (h) refusing to contract with payors for hospital services unless those payors agreed to meet the PHA physicians' price-fixed terms.

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PHA'S PRICE-FIXING IS NOT JUSTIFIED

39. PHA's collective negotiation of fees and other competitively significant contract terms has not been, and is not, reasonably necessary to achieving any efficiency-enhancing integration.

ANTICOMPETITIVE EFFECTS

40. Respondents' actions described in Paragraphs 16 through 38 of this Complaint have had, or have tended to have, the effect of restraining trade unreasonably and hindering competition in the provision of physician services in the Unifour area of North Carolina in the following ways, among others:

- A. price and other forms of competition among PHA's physician members were unreasonably restrained;
- B. prices for physician services in the Unifour area have increased or been maintained at artificially high levels; and
- C. health plans, employers, and individual consumers were deprived of the benefits of competition among physicians.

**VIOLATION OF THE FEDERAL TRADE COMMISSION
ACT**

41. The combination, conspiracy, acts, and practices described above constitute unfair methods of competition in violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45. Such combination, conspiracy, acts and practices, or the effects thereof, are continuing and will continue or recur in the absence of the relief herein requested.

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this twenty-ninth day of January, 2004, issues its Complaint against Tenet Healthcare Corporation and Frye Regional Medical Center, Inc.

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DECISION AND ORDER

The Federal Trade Commission (“Commission”), having initiated an investigation of certain acts and practices of Tenet Healthcare Corporation (“Tenet”) and Frye Regional Medical Center, Inc. (“Frye”), hereinafter sometimes referred to as “Respondents,” and Respondents having been furnished thereafter with a copy of the draft of Complaint that counsel for the Commission proposed to present to the Commission for their consideration and which, if issued, would charge Respondents with violations of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45; and

Respondents, their attorneys, and counsel for the Commission having thereafter executed an Agreement Containing Consent Order to Cease and Desist (“Consent Agreement”), containing an admission by Respondents of all the jurisdictional facts set forth in the aforesaid draft of Complaint, a statement that the signing of said Consent Agreement is for settlement purposes only and does not constitute an admission by Respondents that the law has been violated as alleged in such Complaint, or that the facts as alleged in such Complaint, other than jurisdictional facts, are true, and waivers and other provisions as required by the Commission’s Rules; and

The Commission having thereafter considered the matter and having determined that it had reason to believe that Respondents have violated said Act, and that a Complaint should issue stating its charges in that respect, and having accepted the executed Consent Agreement and placed such Consent Agreement on the public record for a period of thirty (30) days for the receipt and consideration of public comments, now in further conformity with the procedure described in Commission Rule 2.34, 16 C.F.R. § 2.34, the Commission hereby issues its Complaint, makes the following jurisdictional findings and issues the following Order:

1. Respondent Tenet is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of

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the State of Nevada, with its principal address at 3820 State Street, Santa Barbara, California 93105.

2. Respondent Frye is a for-profit corporation, organized, existing, and doing business under and by virtue of the laws of the State of North Carolina, with its principal address at 420 North Center Street, Hickory, North Carolina 28601.
3. The Federal Trade Commission has jurisdiction of the subject matter of this proceeding and of the Respondents, and the proceeding is in the public interest.

ORDER**I.**

IT IS ORDERED that, as used in this Order, the following definitions shall apply:

- A. “Respondent Tenet” means Tenet Healthcare Corporation, its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.
- B. “Respondent Frye” means Frye Regional Medical Center, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees, agents, attorneys, representatives, successors, and assigns of each.
- C. “Piedmont Health Alliance” or “PHA” means the Piedmont Health Alliance, Inc., its officers, directors, employees, agents, attorneys, representatives, successors, and assigns; the subsidiaries, divisions, groups, and affiliates controlled by it, and the respective officers, directors, employees,

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agents, attorneys, representatives, successors, and assigns of each.

- D. “Hospital” means a health care facility licensed by any state as a hospital.
- E. “Medical group practice” means a bona fide, integrated firm in which physicians practice medicine together as partners, shareholders, owners, members, or employees, or in which only one physician practices medicine.
- F. “Participate” in an entity means (1) to be a partner, shareholder, owner, member, or employee of such entity, or (2) to provide services, agree to provide services, or offer to provide services to a payor through such entity. This definition applies to all tenses and forms of the word “participate,” including, but not limited to, “participating,” “participated,” and “participation.”
- G. “Payor” means any person that pays, or arranges for payment, for all or any part of any physician or hospital services for itself or for any other person. “Payor” includes any person that develops, leases, or sells access to networks of physicians or hospitals.
- H. “Person” means both natural persons and artificial persons, including, but not limited to, corporations, unincorporated entities, and governments.
- I. “Physician” means a doctor of allopathic medicine (“M.D.”) or a doctor of osteopathic medicine (“D.O.”).
- J. “Preexisting contract” means a contract that is in effect on the date this Order becomes final.
- K. “Principal address” means either (1) primary business address, if there is a business address, or (2) primary residential address, if there is no business address.

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- L. “Qualified clinically-integrated joint arrangement” means an arrangement to provide physician services, hospital services, or both physician and hospital services in which:
1. all physicians and hospitals that participate in the arrangement participate in active and ongoing programs of the arrangement to evaluate and modify the practice patterns of, and create a high degree of interdependence and cooperation among, the physicians and hospitals that participate in the arrangement, in order to control costs and ensure the quality of services provided through the arrangement; and
 2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the arrangement.
- M. “Qualified risk-sharing joint arrangement” means an arrangement to provide physician services, hospital services, or both physician and hospital services in which:
1. all physicians and hospitals that participate in the arrangement share substantial financial risk through their participation in the arrangement and thereby create incentives for the physicians and hospitals that participate jointly to control costs and improve quality by managing the provision of physician and hospital services, such as risk-sharing involving:
 - a. the provision of physician or hospital services to payors at a capitated rate,
 - b. the provision of physician or hospital services for a predetermined percentage of premium or revenue from payors,

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- c. the use of significant financial incentives (*e.g.*, substantial withholds) for physicians or hospitals that participate to achieve, as a group, specified cost-containment goals, or
 - d. the provision of a complex or extended course of treatment that requires the substantial coordination of care by hospitals or physicians in different specialties offering a complementary mix of services, for a fixed, predetermined price, where the costs of that course of treatment for any individual patient can vary greatly due to the individual patient's condition, the choice, complexity, or length of treatment, or other factors; and
2. any agreement concerning price or other terms or conditions of dealing entered into by or within the arrangement is reasonably necessary to obtain significant efficiencies through the arrangement.
- N. "Tenet physician PHA member" means any physician practicing in a medical group practice owned or controlled in any manner by Respondent Tenet or Respondent Frye, whose services are paid for pursuant to a preexisting contract between Piedmont Health Alliance and any payor, and for as long as such physician continues to receive payment pursuant to such contract.
- O. "Unifour area of North Carolina" means the North Carolina counties of Alexander, Burke, Caldwell, and Catawba.

II.

IT IS FURTHER ORDERED that Respondent Tenet and Respondent Frye, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting commerce, as "commerce" is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, cease and desist from:

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- A. Entering into, adhering to, participating in, maintaining, organizing, implementing, enforcing, or otherwise facilitating any combination, conspiracy, agreement, or understanding between or among any physicians practicing in the Unifour area of North Carolina:
 - 1. to negotiate on behalf of any physician with any payor;
 - 2. to deal, refuse to deal, or threaten to refuse to deal with any payor;
 - 3. regarding any term, condition, or requirement upon which any physician deals, or is willing to deal, with any payor, including, but not limited to, price terms; or
 - 4. not to deal individually with any payor, or not to deal with any payor through any arrangement other than Piedmont Health Alliance;
- B. Exchanging or facilitating in any manner the exchange or transfer of information among physicians practicing in the Unifour area of North Carolina concerning any physician's willingness to deal with a payor, or the terms or conditions, including any price terms, on which the physician is willing to deal with a payor;
- C. Attempting to engage in any action prohibited by Paragraph II.A or II.B above; and
- D. Encouraging, suggesting, advising, pressuring, inducing, or attempting to induce any person to engage in any action that would be prohibited by Paragraphs II.A through II.C above.

PROVIDED HOWEVER, that nothing in Paragraph II of this Order shall prohibit any agreement involving, or conduct by, Respondent Tenet or Respondent Frye that:

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- (i) solely involves physicians employed by Respondent Tenet or Respondent Frye, or any physician to the extent he or she is providing services pursuant to a contract with Respondent Tenet or Respondent Frye; or
- (ii) is reasonably necessary to form, participate in, or take any action in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, so long as the arrangement does not restrict the ability, or facilitate the refusal, of physicians who participate in it to deal with payors on an individual basis or through any other arrangement.

III.

IT IS FURTHER ORDERED that Respondent Tenet shall assure that no Tenet physician PHA member, directly or indirectly, or through any corporate or other device, in connection with the provision of physician services in or affecting commerce, as “commerce” is defined in Section 4 of the Federal Trade Commission Act, 15 U.S.C. § 44, submits claims for payment pursuant to a preexisting contract between Piedmont Health Alliance and any payor, where such claims are for services provided at any time ninety (90) or more days after the date this Order becomes final; *provided, however*, that Respondent Tenet may permit any Tenet physician PHA member to continue to submit claims for payment pursuant to contracts listed in Confidential Appendix A of this Order.

IV.

IT IS FURTHER ORDERED that, for a period of four (4) years after the date this Order becomes final, Respondent Tenet and Respondent Frye, directly or indirectly, or through any corporate or other device, shall cease and desist from entering into any arrangement with any physicians pursuant to which Respondent Tenet or Respondent Frye acts as a messenger, or as an agent, for or on behalf of any physicians practicing in the

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Unifour area of North Carolina, with payors regarding contracts or terms of dealing involving the physicians and payors.

PROVIDED, HOWEVER, that, nothing in Paragraph IV of this Order shall prohibit any agreement involving, or conduct by, Respondent Tenet or Respondent Frye that solely involves physicians employed by Respondent Tenet or Respondent Frye, or any physician to the extent he or she is providing services pursuant to a contract with Respondent Tenet or Respondent Frye.

V.**IT IS FURTHER ORDERED** that:

- A. For five (5) years after the date this Order becomes final, pursuant to each qualified risk-sharing joint arrangement with any physician or each qualified clinically-integrated joint arrangement with any physician in which Respondent Frye is a participant (“Arrangement”), Respondent Tenet or Respondent Frye shall notify the Secretary of the Commission in writing (“Notification”) at least sixty (60) days prior to either Respondent’s contacting a payor, pursuant to an Arrangement to negotiate or enter into any agreement relating to price or other terms or conditions of dealing with any payor, on behalf of any physician or hospital in such Arrangement.

PROVIDED, HOWEVER, that Notification shall not be required for any Arrangement in which all the physician participants:

- (i) are employed only by Respondent Tenet, Respondent Frye, or Respondents Tenet and Frye; or
- (ii) are physicians who have contracted with Respondent Tenet or Respondent Frye, but only to the extent that the physician is providing services pursuant to that contract.

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PROVIDED FURTHER, that Notification shall not be required for subsequent contacts with any payors pursuant to any Arrangement for which Notification has been given pursuant to this Paragraph V.A.

- B. With respect to any Arrangement, Respondent Tenet or Respondent Frye shall include the following information in the Notification:
1. the name, address, telephone number, medical specialty, and medical practice group, if applicable, of each physician participant, and the name of each hospital where he or she has privileges;
 2. the name and telephone number of the person responsible for each hospital participant's relationship with the Arrangement;
 3. a description of the Arrangement and its purpose, function, and geographic area of operation;
 4. a description of the nature and extent of the integration and the efficiencies resulting from the Arrangement;
 5. an explanation of how any agreement on prices (or on contract terms related to price) furthers the integration and achieves the efficiencies of the Arrangement;
 6. a description of any procedures proposed to be implemented to limit possible anticompetitive effects resulting from the Arrangement or its activities; and
 7. all studies, analyses, and reports that were prepared for the purpose of evaluating or analyzing competition for physician or hospital services in any area, including, but not limited to, the market share of physician services in any area or the market share of hospital services in any area.

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- C. If, within sixty (60) days from the Commission's receipt of the Notification, a representative of the Commission makes a written request for additional information to Respondent Tenet or Respondent Frye, Respondent Tenet or Respondent Frye shall not engage in any conduct described in Paragraph V.A. of this Order prior to the expiration of thirty (30) days after substantially complying with such request for additional information, or such shorter waiting period as may be granted in writing from the Bureau of Competition. The expiration of any waiting period described herein without a request for additional information or without the initiation of an enforcement proceeding shall not be construed as a determination by the Commission or its staff that a violation of the law or of this Order may not have occurred. Further, receipt by the Commission from Respondent Tenet or Respondent Frye of any Notification of an Arrangement is not to be construed as a determination by the Commission that any such Arrangement does or does not violate this Order or any law enforced by the Commission.

VI.**IT IS FURTHER ORDERED** that:

- A. Respondent Tenet and Respondent Frye shall not challenge or interfere with any termination, required by a Commission order, of a contract between Piedmont Health Alliance and any payor, pursuant to which contract Respondent Frye receives payment for the provision of hospital, physician, or any other healthcare services.
- B. Within thirty (30) days after the date this Order becomes final, Respondent Tenet shall distribute by e-mail with return receipt requested, or by first-class mail with return receipt requested, a copy of this Order and the Complaint:

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1. to each officer who is at the level of senior vice-president or higher, each member of the board of directors, and each regional director of managed care of Respondent Tenet;
 2. to the chief executive officer, the chief financial officer, and each person having primary responsibility for managed care contracting of each hospital owned or controlled by Respondent Tenet, except for Respondent Frye; and
 3. to each officer, each member of the board of directors, and each person having primary responsibility for managed care contracting of Respondent Frye.
- C. Within thirty (30) days after the date this Order becomes final, Respondent Tenet shall distribute by first-class mail, return receipt requested, a copy of this Order and the Complaint to the chief executive officer of each payor with which Respondent Frye has a record of having been in contact since January 1, 1994, regarding contracting for the provision of hospital services or physician services.
- D. For a period of five (5) years after the date this Order becomes final, Respondent Tenet shall distribute by e-mail with return receipt requested, or by first-class mail with return receipt requested, a copy of this Order and the Complaint:
1. to each officer who becomes a senior vice-president or higher, each member of the board of directors, and each regional director of managed care of Respondent Tenet, and who did not previously receive a copy of this Order and the Complaint, within ninety (90) days of the time that he or she assumes such responsibility;
 2. to each person who becomes the chief executive officer, the chief financial officer, or a person having primary responsibility for managed care contracting of each hospital owned or controlled by Respondent Tenet, except for

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Respondent Frye, and who did not previously receive a copy of this Order and the Complaint; and

3. to each person who becomes an officer, a member of the board of directors, or a person having primary responsibility for managed care contracting of Respondent Frye within ninety (90) days of the time that he or she assumes such responsibility.
- E. For a period of five (5) years after the date this Order becomes final, Respondent Tenet shall:
1. distribute by first-class mail, return receipt requested, a copy of this Order and the Complaint to each payor that contracts with Respondent Frye for the provision of hospital or physician services, and that did not previously receive a copy of this Order and the Complaint, within thirty (30) days of the time that such payor enters into such contract;
 2. annually publish a copy of this Order and the Complaint in an official annual report or newsletter sent to all physicians employed by and hospitals owned by Respondent Tenet within the Unifour area of North Carolina, with such prominence as is given to regularly featured articles; and
 3. cooperate with the Commission in any action related to this proceeding that the Commission may take against Piedmont Health Alliance or any physician who participates in Piedmont Health Alliance, by i) producing, at its own expense, information and documents in its or Respondent Frye's possession, custody, or control; ii) making its or Respondent Frye's representatives available to provide deposition or hearing testimony, as may be requested by any duly authorized representative of the Commission; and iii) making its or Respondent Frye's representatives available, upon reasonable notice, for interviews in person or by telephone with Commission staff. Nothing in this paragraph shall require the production of materials as to which

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Respondent Tenet or Respondent Frye may assert a valid claim of privilege on its own behalf or pursuant to the terms of any written joint defense agreement with any respondent in any Commission proceeding against Piedmont Health Alliance or any physician who participates in Piedmont Health Alliance.

- F. Respondent Tenet shall file a verified written report within sixty (60) days after the date this Order becomes final, annually thereafter for five (5) years on the anniversary of the date this Order becomes final, and at such other times as the Commission may by written notice require. Each such report shall include:
1. a detailed description of the manner and form in which Respondent Tenet and Respondent Frye have complied and are complying with this Order;
 2. the name, address, and telephone number of each payor with which Respondent Frye has had any contact related to contracting since this Order became final;
 3. copies of the e-mail return receipts and signed postal return receipts required by Paragraphs VI.B through VI.E of this Order; and
 4. a detailed description of any actions taken in furtherance of a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement provided for in Paragraph II of this Order.

PROVIDED, HOWEVER, that, if Respondent Frye no longer is owned or controlled by Respondent Tenet, then Respondent Frye (rather than Respondent Tenet) shall have the obligation to comply with those provisions of Paragraphs VI.B through VI.F of this Order to the extent applicable to officers, members of the board of directors, other officials, or official reports or newsletters of Frye.

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VII.

IT IS FURTHER ORDERED that each Respondent shall notify the Commission at least thirty (30) days prior to any proposed change in it, such as dissolution, assignment, sale resulting in the emergence of a successor company or corporation, the creation or dissolution of subsidiaries, or any other change in Respondent Tenet or Respondent Frye that may affect compliance obligations arising out of this Order.

VIII.

IT IS FURTHER ORDERED that each Respondent shall notify the Commission of any change in its principal addresses within twenty (20) days of such change in address.

IX.

IT IS FURTHER ORDERED that, for the purpose of determining or securing compliance with this Order, Respondent Tenet and Respondent Frye shall permit any duly authorized representative of the Commission:

- A. Access, during office hours and in the presence of counsel, to inspect and copy all books, ledgers, accounts, correspondence, memoranda, calendars, and other records and documents in their possession, or under their control, relating to any matter contained in this Order;
- B. Upon five (5) days' notice to Respondent Tenet and Respondent Frye, and in the presence of counsel, and without restraint or interference from them, to interview officers, directors, or employees of Respondent Tenet and Respondent Frye.

Decision and Order

X.

IT IS FURTHER ORDERED that this Order shall terminate on January 29, 2024.

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Confidential Appendix A

[REDACTED FROM PUBLIC RECORD VERSION]

Analysis

**Analysis of Agreement Containing Consent Orders to Aid
Public Comment**

The Federal Trade Commission has accepted, subject to final approval, an agreement containing a proposed consent order with Tenet Healthcare Corporation (“Tenet”) and Frye Regional Medical Center, Inc. (“Frye”). The agreement settles charges that Tenet and Frye (“Respondents”) violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, by directly facilitating the orchestration and implementation of agreements among the physician members of Piedmont Health Alliance, Inc. (“PHA”) to fix prices and other terms on which the physicians would deal with health plans, and to refuse to deal with such purchasers except on collectively-determined terms. The proposed consent order has been placed on the public record for 30 days to receive comments from interested persons. Comments received during this period will become part of the public record. After 30 days, the Commission will review the agreement and the comments received, and will decide whether it should withdraw from the agreement or make the proposed order final.

The purpose of this analysis is to facilitate public comment on the proposed order. The analysis is not intended to constitute an official interpretation of the agreement and proposed order, or to modify its terms in any way. Further, the proposed consent order has been entered into for settlement purposes only and does not constitute an admission by Tenet or Frye that they violated the law or that the facts alleged in the complaint (other than jurisdictional facts) are true.

The Complaint Allegations

Frye is a for-profit corporation that operates a 338-bed hospital in Hickory, North Carolina. Tenet is a for-profit corporation that owns or operates over 100 hospitals throughout the United States, including Frye. Frye was instrumental in the foundation and operation of PHA, a for-profit physician-hospital organization (“PHO”), operating in the western North Carolina area of

Analysis

Catawba, Burke, Caldwell, and Alexander Counties that is known as the “Unifour” area. PHA has as members approximately 450 physicians, or roughly 75% of the physicians in the Unifour area, and three of the five Unifour area hospitals, including Frye. A separate complaint has been issued against PHA and 10 of its physician leaders relating to their activities.

In 1993, Frye’s Chief Executive Officer (“CEO”) developed a plan to create a PHO that would include Frye and the physicians practicing at Frye. He hired a consultant to survey the Frye physicians regarding what they would expect from a PHO. The consultant reported that the Frye practicing physicians “stated a need to form the group to negotiate with group clout and power” and “maintain their income” in anticipation of the arrival of managed care organizations in the Unifour area. Frye’s CEO and Chief Operating Officer (“COO”), along with eight physicians practicing at Frye, formed a steering committee, which was responsible for establishing and organizing the PHO.

PHA was established in 1994 with the aim of facilitating collective bargaining by physicians with health plans in order to obtain more favorable fees and other terms than PHA’s physician members could obtain through dealing individually with health plans. In early 1994, the PHA steering committee established the Contracts Committee to negotiate contracts with payors on behalf of PHA’s physician members. Frye’s Chief Financial Officer (“CFO”) and COO actively participated on the Contracts Committee, and were the PHA physicians’ principal contract negotiators between 1994 and 1996. In 1996, PHA expanded to include Caldwell Memorial Hospital (“Caldwell Memorial”) and Grace Hospital (“Grace”), both nonprofit hospitals, and their respective medical staffs.

PHA is managed and controlled by a Board of Directors made up of 14 physician directors and six hospital directors, two representing each hospital member (but with only one vote per hospital member). Thus, Frye has two representatives on the PHA Board of Directors. Both a majority of PHA physician directors

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and two of the three voting hospital directors must approve each payor contract entered into on behalf of PHA's physician members. The PHA Board representatives voted on the approval of contracts containing physician fee schedules that PHA collectively negotiated with payors. Since 1994, PHA has negotiated and executed over 50 contracts with payors.

The complaint alleges that with the assistance of Frye and Tenet, PHA has successfully coerced a number of health plans to pay artificially high prices to PHA physician members, and thereby raised the cost of medical care in the Unifour area. As a result of the challenged actions of Tenet and Frye, consumers in the Unifour area have been, and are, deprived of the benefits of competition among physicians. By facilitating agreements among PHA member physicians to deal only on collectively-determined terms, and through PHA's and its members' actual or threatened refusals to deal with health plans that would not meet those terms, Tenet and Frye have violated Section 5 of the FTC Act. The collective negotiation of fees and other competitively significant terms by PHA physician members with the assistance of Frye and Tenet has not been, and is not, reasonably necessary to achieving any efficiency-enhancing integration.

The Proposed Consent Order

The proposed consent order is designed to remedy the illegal conduct charged in the complaint and prevent its recurrence, while allowing Tenet and Frye to engage in legitimate conduct that does not impair competition. For example, other than the limitation in Paragraph IV regarding acting as an agent or messenger, the proposed order does not prohibit involvement in vertical arrangements between Frye or Tenet and physicians that do not involve illegal horizontal agreements among physicians. The proposed order is similar to recent orders that the Commission has issued to settle charges relating to unlawful agreements to raise physician prices.

The proposed order's specific provisions are as follows:

Analysis

The order's core prohibitions are contained in Paragraphs II, III, and IV. Paragraph II.A prohibits Tenet and Frye from entering into or facilitating any agreement between or among any physicians practicing in the Unifour area: (1) to negotiate with payors on any physician's behalf; (2) to deal, not to deal, or threaten not to deal with payors; (3) on what terms to deal with any payor; or (4) not to deal individually with any payor, or to deal with any payor only through an arrangement involving PHA.

Other parts of Paragraph II reinforce these general prohibitions. Paragraph II.B prohibits the Respondents from facilitating exchanges of information between or among physicians concerning whether, or on what terms, to contract with a payor. Paragraph II.C bans them from attempting to engage in any action prohibited by Paragraph II.A or II.B. Paragraph II.D prohibits Respondents from inducing anyone to engage in any action prohibited by Paragraphs II.A through II.C.

As in other orders addressing health care providers' collective bargaining with payors, certain kinds of agreements are excluded from the general bar on joint negotiations. First, Tenet and Frye would not be barred from activities solely involving their employed physicians. Second, Tenet and Frye are not precluded from engaging in conduct that is reasonably necessary to form or participate in legitimate joint contracting arrangements among competing hospitals and physicians, whether a "qualified risk-sharing joint arrangement" or a "qualified clinically-integrated joint arrangement." However, such arrangements must not restrict the ability, or facilitate the refusal, of the arrangements' physician members to deal with payors on an individual basis or through any other arrangement. As discussed below in connection with Paragraph V, Tenet and Frye are required to notify the Commission about such an arrangement prior to negotiating on behalf of the arrangement's members or before those members jointly discuss any terms of dealing with a payor.

As defined in the proposed order, a "qualified risk-sharing joint arrangement" must satisfy two conditions. First, all physician and

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hospital participants must share substantial financial risk through the arrangement and thereby create incentives for the physician or hospital participants jointly to control costs and improve quality by managing the provision of services. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

As defined in the proposed order, a “qualified clinically-integrated joint arrangement” also must satisfy two conditions. First, all physician and hospital participants must participate in active and ongoing programs to evaluate and modify their clinical practice patterns, creating a high degree of interdependence and cooperation among physicians and/or hospitals, in order to control costs and ensure the quality of services provided. Second, any agreement concerning reimbursement or other terms or conditions of dealing must be reasonably necessary to obtain significant efficiencies through the joint arrangement.

Paragraph III requires Tenet to assure that no physician practicing in a medical group practice owned or controlled in any manner by Tenet or Frye submits claims for payment pursuant to a preexisting contract between PHA and any payor, where such claims are for services provided at any time 90 or more days after the date the order becomes final. However, the order permits these physicians to continue to submit claims for services pursuant to certain PHA contracts listed in Confidential Appendix A. The purpose of Paragraph III is to prevent Tenet and Frye employed or contracted physicians from continuing to receive the benefit of the unlawfully fixed prices under PHA’s contracts with payors.

Paragraph IV prohibits Tenet and Frye, for four years, from directly or indirectly entering into any arrangements with any physicians practicing in the Unifour area under which Tenet or Frye would act as an agent or messenger for those physicians regarding contracting or terms of dealing with payors. An exception is made for those physicians employed by Tenet or Frye.

Analysis

In the event that Frye or Tenet forms a qualified risk-sharing joint arrangement or a qualified clinically-integrated joint arrangement, Paragraph V requires the Respondents, for five years, to notify the Commission at least 60 days prior to initially contacting, negotiating, or entering into agreements with payors concerning the arrangement. This notice is not required for arrangements in which all the physician participants are employed by Frye or Tenet. Notification is not required for subsequent negotiations or agreements with payors pursuant to any arrangement for which notice was already given under Paragraph V. Paragraph V.B sets out the information necessary to make the notification complete. Paragraph V.C establishes the Commission's right to obtain additional information regarding the arrangement.

Paragraph VI.A prohibits Tenet and Frye from challenging or interfering with the termination, required by any Commission order, of any contract between PHA and any payor, pursuant to which Frye is reimbursed for hospital, physician, or other healthcare services. This provision helps to ensure the effectiveness of any future Commission order against PHA.

Paragraph VI.B requires Tenet to distribute the order and complaint, within 30 days after the order becomes final, to each officer who is at the level of senior vice-president or higher, each member of the board of directors, and each Tenet regional director of managed care; to the CEO, the CFO, and each person having primary responsibility for managed care contracting of each hospital, other than Frye, owned or controlled by Tenet; and to each officer, each member of the board of directors, and each person having primary responsibility for managed care contracting for Frye.

Paragraph VI.C requires Tenet to distribute the complaint and order, within 30 days after the order becomes final, to every payor with which Frye has been in contact since January 1, 1994, regarding the provision of hospital or physician services.

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Paragraph VI.E.3 requires Tenet to cooperate with Commission staff in any litigation, or other action taken by the Commission, against PHA and any of its member physicians.

The remaining provisions of Paragraph VI, and Paragraphs VII through IX, of the proposed order impose obligations on Tenet (or Frye, if it is no longer owned or controlled by Tenet), with respect to distributing the proposed complaint and order to payors that contract with Frye and to other specified persons, and the reporting of certain information to the Commission.

The proposed order will expire in 20 years.

Complaint

IN THE MATTER OF

VITAL BASICS, INC., ET AL.CONSENT ORDER, ETC., IN REGARD TO ALLEGED VIOLATIONS OF
SEC. 5 AND SEC. 12 OF THE FEDERAL TRADE COMMISSION ACT*Docket C-4107; File No. 0123248**Complaint, April 26, 2004--Decision, April 26, 2004*

This consent order addresses practices used by Respondent Vital Basics, Inc., and by Respondents Robert B. Graham and Michael B. Shane, individually and as officers of the corporation, relating to the advertising and promotion of Focus Factor – a dietary supplement containing, among other things, vitamins, minerals, botanicals, and amino acids – and V-Factor Natural Pack, a dietary supplement containing, among other things, yohimbine and L-arginine that was marketed as a men’s sexual performance enhancer. The order, among other things, prohibits the respondents from representing that Focus Factor or any substantially similar product (1) improves the focus, memory, and concentration of healthy adults; (2) alleviates stress, fatigue, irritability and mood swings in healthy adults; (3) makes children and teenagers feel more alert, focused, and mentally sharp; (4) improves students’ ability to concentrate and their academic performance; or (5) improves senior citizens’ memory, mental clarity, and energy; unless the claims are substantiated by competent and reliable scientific evidence. The order also prohibits the respondents from making any future claims about the safety, performance, benefits, or efficacy of any food, drug, or dietary supplement for certain functions or processes – or the treatment, cure, mitigation, or prevention, of any disorder – without possessing competent and reliable scientific evidence that supports such claims. The order requires the respondents to disclose any material connection that exists between an endorser and the respondents or any other person or entity – involved in marketing or selling the product or program that is the subject of the endorsement – and to pay \$1 million to the Commission.

Participants

For the Commission: *Tawana E. Davis, Shira D. Modell, Heather Hippsley, Mary K. Engle and Dennis Murphy.*

For the Respondent: *Jonathan Shapiro, Moon, Moss, McGill & Shapiro, P.A., and William C. MacLeod, Collier Shannon Scott, PLLC.*