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ANTITRUST CONSIDERATIONS IN FORMING OR JOINING AN INDEPENDENT PRACTICE ASSOCIATION

Under New York State's (NYS) Medicaid Redesign initiative,[1] many nonprofit health and behavioral health providers serving Medicaid beneficiaries must consider contracting with managed care organizations (MCOs). Because contracting with MCOs on their own can be time-consuming and complex, many such providers are considering forming or joining independent practice associations (IPAs). This legal alert provides general information about the antitrust considerations involved in IPAs. While this alert presents only an overview of basic principles, it should help nonprofit organizations to recognize areas of antitrust concern and identify when further advice from legal counsel is necessary.

The principal antitrust issue is that competing sellers of a service cannot jointly negotiate price and other terms with buyers, except under certain specific conditions. This includes providers negotiating with MCOs through an IPA. There are three generally recognized situations in which an IPA can jointly negotiate with MCOs on behalf of its member providers:

(1) The IPA is **financially integrated**—i.e., the providers share significant economic risk by, for example, offering services at a capitated rate or otherwise providing significant financial incentives to achieve cost containment.

(2) The IPA is **clinically integrated**—i.e., the IPA seeks to improve the quality of care its members provide though strategies such as using care management teams to coordinate patient care or using technology or other means to monitor and manage patients with chronic illnesses.

(3) The IPA does not actually jointly negotiate on behalf of its members at all, but instead simply serves as a conduit for information between MCOs and member providers, thereby facilitating individual contracting. This last situation is known as a **Messenger Model** (MM) network.

The collaborations described above can lead to varying levels of antitrust risk. When forming a network, providers should consider what the purpose of the network will be, what benefits will be conferred to third-party payors and patients, and how much integration the members need or want. The answers will determine the permissible structure and function of the IPA network.

[1] *See* https://www.health.ny.gov/health_care/medicaid/redesign/.

Financially-Integrated & Clinically-Integrated Networks

If the providers in an IPA are sufficiently integrated through their participation in a program of clinical integration or financial risk sharing, then certain joint activities may be permissible under the antitrust laws where they are reasonably necessary to achieve the legitimate purposes of the IPA. This is because integration among IPA members provides incentives to help the IPA network reduce cost and improve quality of services.

A financially-integrated IPA network is demonstrated by financial risk-sharing. For example, the network members share in the profits or losses; form a partnership or joint venture; or jointly invest capital in equipment or systems designed to improve patient care/decrease costs.

Clinical integration generally requires a focus on improved patient care as the benefit of the collaboration. For example, a clinically-integrated network may implement a program to improve cooperation among providers in order to increase patient care quality; integrate patient records, tests, or billing to eliminate duplicative testing or procedures and to reduce errors; or develop joint research and clinical trials.

Even members in integrated IPA networks should continue to compete with each other in areas not covered by the collaboration. For example, if the integration covers only clinical integration for physical therapy treatments, members in the IPA may not also agree on prices for general health care clinic services. Any information not required for the collaboration should not be shared among IPA members. For both financially and clinically integrated networks, it can take a significant amount of time and effort to become integrated. Members in an IPA need a significant amount of integration before having assurance that they are not violating the antitrust laws. Therefore, many providers opt to develop a Messenger Model network either instead of achieving integration, or as a precursor before financial and/or clinical integration can be achieved. Even in a Messenger Model, however, IPA members must take care to avoid to violating the antitrust laws.

Messenger Model Network

Non-integrated provider networks are allowed to contract using the Messenger Model. The simplest messenger model allows a third-party to "messenger" member information to third-party payors and obligates the third-party to "messenger" all proposed contracts and fee schedules to member providers to allow them to *individually and independently* determine whether to accept or reject the proposed contract, and individually notify the messenger of this decision. The messenger (without sharing any information among members) then provides the responses to the third-party payor, which then contracts with those members that are interested in doing so. This type of model can become very time consuming to build if, for example, many members counter the proposal with various changes.

To reduce the problems of the simple model described above, each provider can communicate to the messenger the terms that would be acceptable to *that provider*, thus enabling the messenger to know, when receiving an offer from a third-party payor, which provider will accept the offer. In that way, the messenger will be in a position to communicate to the payor, without tedious back-and-forth, whether the terms the payor is offering will result in a network

of the size and scope the payor is seeking. The messenger could do this, for example, by maintaining a database that will enable it to respond to payor inquiries. It is especially important in this model that the messenger not communicate to one provider the information it has received from another provider, and that it does not use the information to force, **or even negotiate**, terms with the third-party payors.

Regardless of the type of Messenger Model used, there are some ground rules for the actions and behavior of the messenger. The point is for the messenger to remain neutral and not facilitate the exchange of competitively-sensitive information between member organizations, particularly around pricing terms. The messenger should not even offer an opinion about any particular offer – good or bad. Guidance from the messenger on non-economic, non-pricing contract terms is acceptable; however, organizations should proceed with caution, as the antitrust agencies will take a broad view of what constitutes a price or economic term in the contract. For example, a most-favored-nation clause (a requirement to give the third-party payor better pricing than its competitors) or a time of payment clause would be considered an economic term.

Additionally, the messenger cannot unilaterally decide to refuse an offer from a third-party payor it deems unacceptable. It must pass along all offers to the individual member organization. The messenger cannot prevent providers from dealing individually with payors or encourage members not to deal with particular payors. Finally, under no circumstance should the messenger use the information it collects separately from provider organizations to create a fee schedule, even if providers are allowed to opt in or out of the schedule. A fee schedule would likely be deemed price-fixing under the antitrust laws, whether the messenger is creating the schedule or the members themselves are.

Importantly, while providers can communicate pricing information to the messenger, providers cannot share this information with other members in the IPA network. Members also cannot agree among themselves to reject a particular offer. For example, a member cannot contact other providers and agree to or urge them to reject an offer from a payor, or to participate in a boycott of a particular payor or proposal.

Again, third-party messengers <u>should not</u>:

- Adopt a fee schedule;
- Suggest a price level to third-party payors;
- Act to increase fees from third-party payors;
- Negotiate with third-party payors any term or condition on which that payor deals;
- Refuse to messenger any third-party payor proposals to members in the Messenger Model IPA;

- Advise or encourage its members to terminate individual payor contracts; or
- Encourage members to refuse to negotiate individually with any third-party payor.

Because providers in any variation of non-integrated Messenger Models remain competitors for purposes of the antitrust laws, they may not jointly negotiate price, allocate services to eliminate duplication, or enter into any other agreements that would otherwise be illegal for a group of competitors. (Of course, groups of providers that are part of a separate financially-integrated practice, such as a partnership, can negotiate as a group with respect to that practice, even if the group practice participates as a group in a Messenger Model IPA.) This includes using the messenger to facilitate any such agreements. For this reason, the messenger **cannot be a member or an employee** of a participating provider in the network. It is critical that all potential members in the network and the messenger be trained on appropriate conduct and applicable antitrust regulations.

SAMPLE CONSIDERATIONS AND SITUATIONS

Example 1: A small community-based organization (CBO) that offers a small line of Medicaid-billable behavioral health services is approached by a mid-sized multi-services provider with a wider variety of services, including a Medicaid-billable behavioral health clinic that provides different services than the small CBO. If the two organizations provide services that do not overlap, they may discuss rates with each other and work toward providing a "one-stop shop" for the community without using a formal IPA structure. However, if they provide the same or similar services, they may not discuss rates unless the providers become financially or clinically integrated as described above. They may alternatively use a Messenger Model network, but are not permitted to discuss price terms, etc.

Example 2: An existing IPA that comprises several behavioral health nonprofit providers would like to add a small nonprofit food panty that provides no health services, in order to benefit its existing clients with access to food. In this situation, there are no readily identifiable antitrust risks, and the food pantry organization would not be considered a competitor to the organizations in the existing IPA that provide behavioral health services.

Example 3: A mid-sized, nonprofit multi-service behavioral health organization works only in Brooklyn and would like to join with organizations that also provide similar behavioral health services in adjacent neighborhoods. In this scenario, it is key to the analysis to determine whether the organizations are truly "competitors" or whether their service areas are sufficiently distinct that they do not compete. Further legal advice is highly recommended in this scenario to determine whether and under what circumstances the organizations can discuss rates and other financial terms.

CONCLUSION

Unwary nonprofit organizations can get in trouble for violating the antitrust laws, but with careful consideration, it is possible to enter into collaborations with other health services organizations to form or join an IPA. Any collaboration should generate pro-competitive benefits such as lower prices or higher quality care to consumers. If independent, competing

providers join an IPA, they should remember not to jointly negotiate prices for their services *unless* those joint price negotiations are pursuant to a program of substantial financial or clinical integration.

FOR MORE INFORMATION

The United States Department of Justice Antitrust Division and the Federal Trade Commission (collectively the Antitrust Agencies) have issued the Statements of Antitrust Enforcement Policy in Health Care (referred to as the Health Care Statements) that articulate and set forth the Antitrust Agencies' antitrust enforcement policies in the health care industry.[2] The FTC maintains a "Competition in the Health Care Marketplace" webpage with links to guidance, cases, opinions, and more.[3]

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This alert is meant to provide general information only, not legal advice. Please contact Mary Burner at Lawyers Alliance for New York at (212) 219-1800 x 240 or visit our website www.lawyersalliance.org for further information.

[2] https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/statements_of_antitrust_enforcement_policy_in_health_care_august_1996.pdf

[3] *See* https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care.