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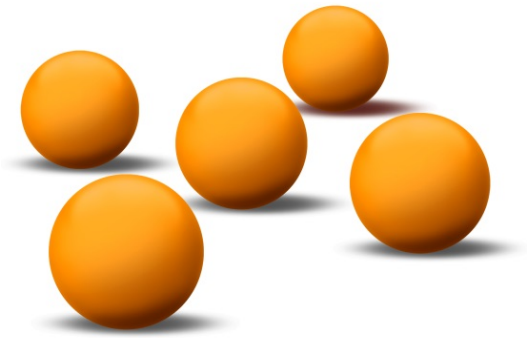

Medicaid Regional Care Organizations – Turning the Clock Back Twenty Years

John T. Mooresmith and April McKenzie Mason

Physicians who were practicing in the 1990s were involved in numerous attempts to organize themselves in order to be able to participate in and even financially survive the onslaught of managed care delivery systems. The new systems were attempting to shift the risk of increasing costs from insurance carriers to the providers themselves. The logic was that if physicians were costing themselves money by ordering more tests, performing more expensive procedures, or hospitalizing patients, they would be incentivized to practice medicine more conservatively.

This idea caught on and Health Maintenance Organizations ("HMOs") began developing different methods of putting physicians at risk. Many sought to simply reduce fees paid for procedures, others tried to directly capitate physicians by paying them a flat fee per month for either their own medical care to the HMO subscribers or by paying the physician more, but making the physician liable for all of the care provided by physicians in other specialties who received the subscriber on referral.

Conflict arose when the physicians signed provider contracts that uniformly stated that the HMO was merely agreeing to pay for the care of its subscribers, but was not practicing medicine or influencing the independent medical judgment of the physician. Given the physician's fiduciary obligation to his or her patient under the physician-patient relationship, malpractice liability for providing insufficient care to a patient was effectively shifted exclusively to the physician.

Recognizing the Catch 22 in which physicians were finding themselves, they began to explore opportunities to organize themselves to negotiate with HMOs for two basic purposes. First, physicians rightly believed that if costs were to be saved and profits increased to HMOs by changes in physician behavior, that physicians should be able to share in those profits if for no other reason than to offset the reduced practice income that was inevitable. Second, physicians wanted to assure that if clinical guidelines were to be imposed to standardize care and reduce cost, that the physicians who bore the malpractice risk for inadequate care were the ones who developed and implemented those clinical guidelines.

Now Regional Care Organizations ("RCOs") mandated by recent changes in the Alabama laws governing Medicaid will be implementing these same managed care changes that developed in the 1990s on a massive scale in which physicians will have no choice but to participate if they wish to continue to treat Medicaid patients. As we pointed out in our previous article, Alabama will be divided into five regions each of which will have at least one RCO. Each RCO will negotiate with Medicaid to deliver all of the covered Medicaid services to Medicaid patients in their region for a flat fee. The individual RCOs just like HMOs will then have to negotiate provider contracts with each provider in their region to provide services to Medicaid patients while keeping total costs within the amount they have negotiated with Medicaid. This will include not only physician providers, but also all other professional and institutional providers as well, all competing for a limited amount of funds.

Many physicians will want to organize themselves again, just as in the 1990s for the same reasons to negotiate with RCOs for the provision of medical services to Medicaid patients. Many of the old acronyms of the 1990s will be dusted off and given new life in this century. The old adage that history repeats itself is certainly appropriate here.

In the 1990s, physicians organized themselves into three primary alternative delivery systems. First were Independent Practice Associations ("IPAs") in which physicians integrated either partially or fully their practices into a separate entity which not only negotiated with the HMOs, but also provided the medical care to the subscribers of the HMO. Second were Preferred Provider Organizations ("PPOs") in which the PPO negotiated with the HMO for fees to be paid for the physician services, but did not provide the services itself. Third were Physician Hospital Organizations ("PHOs") in which a hospital formed a separate entity with members of its medical staff to negotiate and provide both hospital and physician services to HMO subscribers.

The greatest impediments to these new alternative delivery systems were the antitrust laws. Federal antitrust laws include the Sherman Act, the Clayton Act, and the Federal Trade Commission Act.

Section 1 of the Sherman Act, 15 U.S.C. §§ 1-7, provides that "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce . . . is declared to be illegal."[1] While this provision purports to prohibit *every* contract in restraint of trade, the Supreme Court does not interpret the statute literally, instead interpreting the statute to prohibit only *unreasonable* restraints.[2]

Section 7 of the Clayton Act, 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52–53, prohibits mergers if, "in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."[3]

Finally, Section 5 of the Federal Trade Commission Act, 15 U.S.C. §§ 41-51, provides that "[u]nfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful."[4]

Under antitrust laws, physicians are considered horizontal competitors since they compete with each other for patients. This makes physicians prime candidates for the application of the antitrust laws. Some types of antitrust violations are considered so injurious to competition as to warrant sanctions regardless of the intended purpose of the competitors. These are deemed *per se* illegal violations and include price fixing among horizontal competitors.[5] However, *per se* analysis "is reserved for only those agreements that are 'so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality.'"[6] Where *per se* analysis is not applied, the rule of reason is used to determine whether a particular contract or combination is unreasonable.[7] Under

[1] 15 U.S.C. § 1.

[2] *See, e.g.*, *State Oil Co. v. Khan*, 522 U.S. 3, 10 (1997).

[3] *Id.* at § 18.

[4] *Id.* at § 45.

[5] *See, e.g.*, *Texaco Inc. v. Dagher*, 547 U.S. 1, 5 (2006).

[6] *Id.* (quoting *National Soc. of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978)).

[7] *Id.*

the rule of reason, the factfinder "weighs all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition."[8] Relevant factors considered in the analysis include specific information about the relevant business; the restraint's history, nature, and effect; and whether the business at issue has market power.[9] A key purpose of the rule of reason is to "distinguish[] between restraints with anticompetitive effects that are harmful to the consumer and restraints stimulating competition that are in the consumer's best interest."[10]

The antitrust laws are enforced by the Antitrust Division of the Department of Justice ("DOJ"), the Bureau of Competition of the Federal Trade Commission ("FTC") or by private individuals or organizations. They provide for trebled damages and an award of attorneys' fees if a violation is found, and are extremely expensive to defend usually costing even a successful defendant seven figures in attorneys' fees. Needless to say, it is critical for physicians to move carefully and with experienced legal counsel before even considering to organize themselves.

The DOJ and the FTC in the 1990s published Statements of Antitrust Enforcement Policy in Health Care (Aug. 1996),[11] which supported the rule of reason approach to analyzing the antitrust implications of physician alternative delivery systems. Every IPA, PPO or PHO needs to be formed with the idea that it may someday be the subject of an investigation by the FTC or the DOJ. Therefore, it is critical that the intent and purpose of the physician organization be carefully documented so that no allegation of a price fixing conspiracy can be supported in the future.

Recognizing that physicians would need the opportunity to organize themselves to negotiate with the new Medicaid RCOs, MASA worked with Medicaid, the Governor's Office and the Legislature to provide as much antitrust immunity for physicians as possible. While the antitrust laws apply to the concerted actions of horizontal competitors, they do not apply to legitimate actions of the state.[12]

In order to be considered actions of the state, a two pronged analysis is used: (i) the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy" and (ii) the policy must be "actively supervised" by the State itself.[13]

In order to satisfy the first prong of the test, it is not necessary that a legislature "expressly state in a statute or its legislative history that the legislature intends for the delegated action to have

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[8] *Leegin Creative Leather Products, Inc. v. PSKS, Inc.*, 551 U.S. 877, 885 (2007) (quoting *Continental T. V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49 (1977)).

[9] *Id.* at 885-86.

[10] *Id.* at 886.

[11] *Available at* http://www.usdoj.gov/atr/public/guidelines/0000.pdf.

[12] *Parker v. Brown*, 317 U.S. 341, 352 (1943) (holding that the Sherman Act is inapplicable to anticompetitive restraints imposed by the States "as an act of government").

[13] *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (quoting *City of Lafayette v. Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978)).

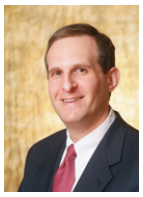
anticompetitive effects."[14] Rather, if it is apparent that the "legislature contemplated the kind of action complained," the first prong will be satisfied.[15]

The Alabama Legislature stated that "collaboration among public payers, private health carriers, third party purchasers, and providers to identify appropriate service delivery systems and reimbursement methods in order to align incentives in support of integrated and coordinated health care delivery is in the best interest of the public. Collaboration pursuant to [Alabama's laws on RCOs] is to provide quality health care at the lowest possible cost to Alabama citizens who are Medicaid eligible. The Legislature, therefore, declares that this health care delivery system affirmatively contemplates the foreseeable displacement of competition, such that any anti-competitive effect may be attributed to the state's policy to displace competition in the delivery of a coordinated system of health care for the public benefit. In furtherance of this goal, the Legislature declares its intent to exempt from state anti-trust laws, and provide immunity from federal anti-trust laws through the state action doctrine to, collaborators, regional care organizations, and contractors that are carrying out the state's policy and regulatory program of health care delivery."[16]

The second prong of the test, active state supervision, is more difficult to establish. MASA staff and attorneys have consulted with Medicaid attorneys to enact regulations which we believe will satisfy this test, but will require careful attention by physicians to both qualify for the immunity and to maintain the immunity in the future. A single misstep in following the requirements of the Medicaid Regulations will result in a loss of the immunity and leave the physician vulnerable to the types of antitrust challenges discussed before in this article. Physicians will need to assure that staff are trained in the requirements, and will need continuing legal monitoring to assure compliance.

The next articles in this series will discuss what physicians need to do to get into compliance with the Medicaid Regulations so that they can receive the antitrust immunity provided by the statute for negotiating with the RCOs as well as maintaining compliance in the future.

FOR MORE INFORMATION, PLEASE CONTACT:



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[14] *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 43 (1985).

[15] *Id.* at 44 (quoting *Lafayette*, 435 U.S. at 415).

[16] *Code of Alabama* § 22-6-163.