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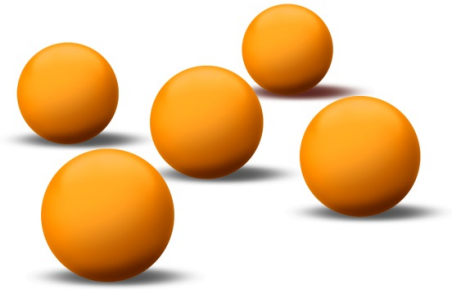

New Medicaid RCOs Raise Antitrust Issues for All Participating Health Care Providers

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Physicians and other health care providers 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 providers at risk. Many sought to simply reduce fees paid for procedures, others tried to directly capitate physicians and other providers by paying them a flat fee per month for either their own medical care to the HMO subscribers. Some experimented by paying physicians more, but making the physicians 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 are implementing these same managed care changes that developed in the 1990s on a massive scale in which physicians and other providers will have no choice but to participate if they wish to continue to treat Medicaid patients. The Alabama Legislature followed a model that has been adopted by many other states in the country, and will be adopted by more. Every state is facing budget shortfalls in funding Medicaid, and the capitated system appears to be the only viable remedy. Alabama has been 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 most professional and institutional providers, all competing for a limited amount of funds.

Many providers 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." 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.

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."

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."

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), 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 providers would need the opportunity to organize themselves to negotiate with the new Medicaid RCOs, the Legislature sought to give providers as much immunity from the antitrust laws as possible. While the antitrust laws apply to the concerted actions of horizontal competitors, they do not apply to legitimate actions of the state. Other states which either have enacted or are considering enacting similar capitated systems are including antitrust immunity provisions in their legislation also.

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 affirmative. The first prong of the test has been satisfied by the Act itself which states "…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."

Physicians and other providers are included in the definition of "collaborators". In order to meet the second prong of the test, and achieve antitrust immunity, collaborators must apply to the Medicaid Agency for a Certificate to Collaborate through an on-line process. This must be done before any meeting of any group of providers to discuss participation in the RCOs. The Medicaid Agency will monitor and supervise the negotiations and collaborations among those who have received a Certificate to Collaborate. The names and addresses of all holders of Certificates to Collaborate are posted on the Medicaid Agency's website. A number of Certificates have already been issued by the Medicaid Agency, both to individual and business entity applicants.

In order to achieve and maintain the antitrust immunity provided by the Act, providers must not only secure Certificates to Collaborate prior to engaging collectively discussing participation in RCOs, but also must carefully follow the Medicaid Regulations to keep the immunity intact

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