



August 2015

## Antitrust Issues Facing Physicians in Medicaid and Professional Licensing

By John T. Mooresmith

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. 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 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."<sup>1</sup> 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.<sup>2</sup>

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."<sup>3</sup>

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."<sup>4</sup>

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.<sup>5</sup> 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

---

<sup>1</sup> 15 U.S.C. § 1.

<sup>2</sup> See, e.g., *State Oil Co. v. Khan*, 522 U.S. 3, 10 (1997).

<sup>3</sup> *Id.* at § 18.

<sup>4</sup> *Id.* at § 45.

<sup>5</sup> See, e.g., *Texaco Inc. v. Dagher*, 547 U.S. 1, 5 (2006).

establish their illegality.”<sup>6</sup> Where *per se* analysis is not applied, the rule of reason is used to determine whether a particular contract or combination is unreasonable.<sup>7</sup> Under 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.”<sup>8</sup> 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.<sup>9</sup> 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.”<sup>10</sup>

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),<sup>11</sup> 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, the Medical Association of the State of Alabama 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.<sup>12</sup> 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 affirmatively expressed as state policy” and (ii) the policy must be “actively supervised” by the State itself.<sup>13</sup> With respect to true state agencies, only the first prong applied. However, the U.S. Supreme Court this year in the case of *North Carolina State Board of Dental Examiners v. FTC*, 574 U.S. \_\_\_\_ (2015) changed that principle, and has subjected most state licensing

---

<sup>6</sup> *Id.* (quoting *National Soc. of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978)).

<sup>7</sup> *Id.*

<sup>8</sup> *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)).

<sup>9</sup> *Id.* at 885-86.

<sup>10</sup> *Id.* at 886.

<sup>11</sup> Available at <http://www.usdoj.gov/atr/public/guidelines/0000.pdf>.

<sup>12</sup> *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”).

<sup>13</sup> *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)).

agencies to antitrust actions. In this case, the Supreme Court held that a state licensing board comprised of a majority of active market participants is not immune to antitrust actions unless their actions are actively supervised. In most states, licensing of professions and occupations is delegated by the state to individuals licensed to practice the profession or to perform the occupation. Now, the potential anticompetitive actions of those boards must be actively supervised by the state itself. Since licensing rules are by definition anticompetitive, all rules must be reviewed by the state. Active supervision requires that the state retain the power to approve, modify or disapprove all licensing rules by such boards.

Already, the medical licensing boards in Texas and Mississippi have been sued in antitrust. Other actions are expected to follow. State boards across the country are trying to determine how they must modify either their structure or procedures to comply with the changes in the law. I have been retained as antitrust counsel for the Alabama State Board of Medical Examiners to assist them and the Governor in responding to the new changes. On June 29, 2015, Governor Bentley issued an Executive Order establishing the Alabama Office for Regulatory Oversight of Boards and Commissions. The Office reviewed the first proposed Rule of the Alabama State Board of Medical Examiners relating to physician supervision of mid-level practitioners on July 2, 2015, and approved the rule. This is a temporary measure, and legislation is being prepared that will provide for a more permanent solution.

Now we will review the two prong test that applies to not only physician organizations negotiating with RCOs, but also to state licensing boards. 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 anticompetitive effects.”<sup>14</sup> Rather, if it is apparent that the “legislature contemplated the kind of action complained,” the first prong will be satisfied.<sup>15</sup>

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."<sup>16</sup>

The second prong of the test, active state supervision, is more difficult to establish. On behalf of the Medical Association of the State of Alabama, we 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

---

<sup>14</sup> *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 43 (1985).

<sup>15</sup> *Id.* at 44 (quoting *Lafayette*, 435 U.S. at 415).

<sup>16</sup> *Code of Alabama* § 22-6-163.

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 new law, Act 2013-261, *Ala. Code Sections 22-6-150, et seq.*, will effectively change the Alabama Medicaid system from a fee-for-service to a managed care program.

In order to establish the new Medicaid structure and create RCOs, collaboration among payers, providers, consumers, and governmental entities regarding the delivery of health care and the payment for health care is a necessity. Therefore, the Act statutorily recognizes that any such collaboration is in the best interest of the public and will displace competition in order to achieve "a coordinated system of health care for the public benefit."

In order to avoid antitrust implications normally associated with such collaboration, the Act specifically exempts from state antitrust laws and provides immunity from federal antitrust laws, through the "state action doctrine",<sup>17</sup> those "collaborators" who cooperate, negotiate, or contract to bring Medicaid services to Alabama beneficiaries under the terms of the Act. A "collaborator" is defined by the Act as a "private health carrier, third party purchaser, provider, health care center, health care facility, state and local governmental entity, or other public payers, corporations, individuals, and consumers who are expecting to collectively cooperate, negotiate, or contract with another collaborator or regional care organization in the health care system."

In order to achieve antitrust exemption and immunity, collaborators must apply to the Agency for a Certificate to Collaborate through an on-line process.<sup>18</sup> During the application process, the applicant must provide background information regarding the applicant and the persons who may collaborate on the applicant's behalf, describe the intent of the collaboration (*e.g.*, whether the collaborator intends to establish a RCO, enroll as a provider with a RCO, or engage in other activities), identify the relevant RCO region, describe entities and/or persons the applicant intends on collaborating or negotiating with and the effects of the negotiations and collaborations (*e.g.*, improve quality health care services to Medicaid beneficiaries, contain cost in providing health care services, enhance technology, or maintain competition in the health care services market), and certify that the collaboration is in good faith and necessary in order to carry out the provisions of the Act. The Agency may request additional information as it deems appropriate.

If the application for a Certificate to Collaborate is denied, the decision is deemed to be the final decision of the Agency and the applicant can appeal the denial directly to the circuit court. Alternatively, the applicant may submit an amended application for review by the Agency.

If the application is approved, a Certificate to Collaborate will be issued, which will allow for collective negotiation, bargaining, and cooperation concerning payment and health care delivery. However, a Certificate to Collaborate will only be issued if the applicant has sufficiently shown that the collaboration is necessary in order to facilitate the arrangement and establishment of RCOs or health care payment

---

<sup>17</sup> Generally speaking, the state action doctrine provides immunity from the federal antitrust laws to actions of a state even if the conduct unreasonably restrains trade. When a state delegates responsibilities to others, the allegedly anticompetitive actions are also immune from federal antitrust attack if taken pursuant to a clearly articulated and expressed state policy and if the activity is supervised by the state.

<sup>18</sup> The electronic application is available at <https://rcportal.medicaid.alabama.gov>.

reforms. The Certificate to Collaborate is effective immediately upon issuance and will expire on October 1, 2016. The Certificate will only extend to those persons listed on the application as having the authority to collaborate on behalf of the applicant.

A Certificate may be revoked if the holder violates any of the certifications made in the application. Further, the holder of the Certificate must inform the Agency of any substantial or material corrections or updates to the information submitted with the application. Such corrections or updates will be considered an amended application and, following review, an Amended Certificate to Collaborate may be issued.

In order to promote state action immunity under state and federal antitrust laws, the Agency will monitor and supervise the negotiations and collaborations among those who have received a Certificate to Collaborate. In accordance with such supervision, among other things, collaborators will be required to submit periodic reports to the Agency containing the following information: description of the collaboration activities during the reporting period, description of entities and persons with whom the collaborator negotiated or bargained with during the reporting period, description of concerns or problems encountered during the collaborative process, description of future collaboration activities, and certification that the collaboration and bargaining was done in good faith and is necessary to carry out the provisions of the Act. Additional information for those collaborators who intend to establish or develop a RCO may also be required. Failing to make a periodic report to the Agency is grounds for revocation of a Certificate to Collaborate.

The names and addresses of all holders of a Certificate to Collaborate are posted on the Agency's website.<sup>19</sup> A number of Certificates have already been issued by the Agency, both to individual and business entity applicants.

From a legal standpoint, in order to avoid antitrust concerns, obtaining a Certificate to Collaborate before discussing, negotiating, and bargaining in a manner that can be perceived as anti-competitive is extremely important. However, Certificates are not automatically granted to all who apply, as certain requirements and qualifications must be satisfied. Therefore, health care providers should start the application process before entering into any discussions, negotiations, or bargaining arrangements and should seek appropriate guidance regarding the application process and the requirements for the issuance of a Certificate to Collaborate.

For more information, please contact:

[John T. Mooresmith](mailto:jmooresmith@burr.com) in Montgomery at [jmooresmith@burr.com](mailto:jmooresmith@burr.com) or (334) 387-2072.

---

<sup>19</sup> A list of current holders of a Certificate of Collaboration is available at [http://www.medicaid.alabama.gov/CONTENT/2.0\\_newsroom/2.7.3\\_Regional\\_Care\\_Organizations.aspx](http://www.medicaid.alabama.gov/CONTENT/2.0_newsroom/2.7.3_Regional_Care_Organizations.aspx).