

GUIDE TO ANTITRUST COMPLIANCE FOR PROVIDERS CONSIDERING COLLABORATIVE CONTRACTING:

USING THE MESSENGER MODEL

The following guide provides a general overview on how providers can collaborate in contracting with payers, including Medicare Advantage and Medicaid managed care plans, without running afoul of the federal and state antitrust laws. There are two possible approaches: 1) the messenger model network; and 2) a financially and/or clinically integrated network. This document focuses on the messenger model.

I. INTRODUCTION

Competing health care providers seeking to lawfully collaborate are faced with the question of how much clinical and/or financial integration is enough to avoid serious anti-trust concerns. These issues must be explored fully when undertaking any joint venture between competitors.

Without such integration, messenger model arrangements may be employed to facilitate contracting between providers and payers and avoid price-fixing agreements among competing providers, if implemented appropriately. The key issue in any messenger model arrangement is whether the arrangement creates or facilitates an agreement among competitors on prices or price-related terms.

Determining whether there is such an agreement is a question of fact in each case. Does the messenger facilitate collective decision-making by network providers, rather than independent, unilateral decisions? It is important to examine whether the agent coordinates the providers' responses to a particular proposal, disseminates to network providers the views or intentions of other network providers as to the proposal, expresses an opinion on the terms offered, collectively negotiates for the providers, or decides whether or not to convey an offer based on the agent's judgment about the attractiveness of the prices or price-related terms. If the agent engages in such activities, the arrangement may amount to an illegal price-fixing agreement.

II. DEFINING A MESSENGER MODEL

1. What is a messenger model and how is one implemented?

In its most basic form, the messenger model is a network of providers that attempt successful joint contracting with payers. The appointed messenger obtains information on proposed fees and fee-related terms from a payer. Then, the

messenger sends that information to each of the providers separately, seeking their individual decision to accept or decline the offer.

When implementing a messenger model, each provider in the network must unilaterally decide the reimbursement rates it will accept for its own individual services. Then, the provider contracting network uses a “messenger” -- a third party that is unaffiliated with any of the individual providers’ and hired by the network -- to handle the contract process. The messenger must not communicate with the member providers as a group, and the members must not communicate with one another with respect to proposed rates. No competitively sensitive information¹ may be shared among the providers.

2. Why have a messenger model?

The primary advantage of a messenger model is a single-point communications conduit for providers and payers. By using a messenger, providers also may benefit from the messenger’s standing in the healthcare community and reputation for quality health care. Payers are able to communicate with thousands or more providers through a single, familiar conduit. Providers use a messenger to decrease the administrative burden of working with networks and to increase access to those networks

Remember that the antitrust laws are designed to protect consumers by promoting a competitive marketplace. The theory is that competition results in lower prices for consumers. In the health care context, this means that if health plans/payers negotiate the lowest possible reimbursement rates with providers, this may help keep consumer health insurance premiums (or taxes, in the Medicare/Medicaid context) low. Just as in other industries, health care providers are competitors and cannot agree on the rates they will accept from a payer. This would be price-fixing, which is an automatic violation of the antitrust laws. In fact, as a general rule, providers cannot take joint action *in any way* to improve their reimbursement rates or agree among themselves on other price-related terms.

The messenger model in effect provides a method to address the prohibition on joint action – so long as all key elements are met. The messenger model is designed to afford some of the benefits of joint negotiations without improperly restraining competition through an agreement among competitors regarding price or price-related terms.

¹ The Federal Trade Commission has defined competitively sensitive information as non-public information relating to pricing or pricing strategies, costs, revenues, profits, margins, output, business or strategic plans, marketing, advertising, promotion, or research and development.

III. POTENTIAL LIMITATIONS AND RISKS WITH A MESSENGER MODEL

1. Can AHCA or its affiliates jointly negotiate price or price-related terms if using a messenger model?

No. The messenger model does not allow providers to jointly negotiate price or price-related terms. Even actions that directly affect, but do *not* determine, the final price may constitute illegal price fixing. Moreover, inappropriate information sharing among providers as a result of using a messenger model system may constitute illegal price fixing.

2. Does providing members with opt-in or opt-out options for the payer contracts resolve antitrust issues?

No. When using a messenger model system, the principal risks lie with how the negotiations and communications are conducted. Thus, providing options to opt-in or opt-out do not resolve the fundamental antitrust concern.

3. Can a participating provider or lawyer of a payer/provider be the messenger?

No. While there is nothing prohibiting a lawyer in general from being the messenger, due to the confidential nature of other providers' fees and responses, having a provider or an association's lawyer functioning as the messenger would likely destroy the model's purpose of facilitating unilateral decision making.

4. Who should be the messenger?

Choosing the right person to be the messenger is one of the most critical decisions that the network's organizers will make. There are no hard and fast rules on the precise educational or experience requirements for messengers. A messenger must be highly organized, have strong communication skills, and be patient in answering questions from payers and providers alike. Also, the messenger must have an in-depth understanding of the business and legal limitations of the messenger role. The messenger must be strong and independent, and not subject to manipulation or bullying by providers or payers. An agent or other third-party may act as a messenger so long as it follows proper messenger model procedures and antitrust protocols. It is helpful for messengers to have an understanding of the local healthcare market.

5. Is there specific training for messengers?

No, there is not any specific training manual or certification program for messengers. The messenger should be encouraged to consult legal counsel with questions, and counsel should prepare the messenger to deal with situations such as: what to do when a provider asks how many of his colleagues have accepted the payer's offer; what to do when the payer asks "what will it take" to get the greatest number of payers to sign the payer's contract; and what do when

providers ask how this offer compares to other offers the messenger has delivered to providers.

6. Is there recent precedent to follow in order to ensure that AHCA or an affiliate is avoiding antitrust violations?

No. The few dated cases on the messenger model do not provide guidance on its usage by trade associations. This lack of precedent further complicates the already difficult task of predicting how government agencies would view AHCA (or an affiliate) implementing such a model. Similarly, relevant case law is nonexistent on assisted-living providers and thus creates another variable in this generally uncharted territory.

IV. MESSENGER MODEL TRAPS TO AVOID

1. Is joint negotiation with payers allowed?

No. Joint negotiations with payers would violate antitrust law.

2. Are the network's leaders and members allowed to jointly review and approve payers' contract offers?

No. Contract offers may not be reviewed or approved jointly. The offer is solely between the payer and the provider.

3. Can a common fee schedule or model contract be developed?

No. Fee schedules² or model contracts³ should not be developed by providers.

4. Can the messenger refuse to communicate a payer's offer?

No. The messenger must deliver each payer's offer to the providers.

² A fee schedule is a complete listing of fees used by Medicare to pay doctors or other providers/suppliers. This comprehensive listing of fee maximums is used to reimburse a physician and/or other providers on a fee-for-service basis.

³ A standard form or model contract (sometimes referred to as a contract of adhesion) is a contract between two parties, where the terms and conditions of the contract are set by one of the parties, and the other party has little or no ability to negotiate more favorable terms and is thus placed in a "take it or leave it" position.

5. Do's and Don'ts of Messenger Models

Dos	Don'ts
Convey objective information ⁴ about proposed contract terms	Do not collectively negotiate with payers
Solicit clarifications and engage in discussion of noncompetitive terms ⁵	Do not develop a fee schedule and model contract
Inform each payer that it has the right to refuse to respond to offers that the messenger conveys	Do not collectively terminate individual contracts and then contract only on collectively determined terms
Inform each payer of its right to terminate the messenger process at any time	Do not refuse to transmit or communicate payers' offers or use negotiated prices to set standing offers
Recognize that providers can deal with the payer independently from the messenger	Do not allow network's leaders and members to review and approve payer's contract offers

V. FINANCIAL RISK-SHARING OR CLINICAL INTEGRATION

1. What can competitors do to collectively negotiate prices?

Antitrust law condemns agreements among competitors that fix prices or allocate markets. Collective price setting by competitors is the central antitrust concern raised by collaborative delivery systems formed by health care providers. In an attempt to provide some guidance to the health care community on this question, in the early 1990s, the Department of Justice ("DOJ") and Federal Trade Commission ("FTC") (collectively, the "Agencies") issued joint "Statements of Antitrust Enforcement Policy in Health Care" (the "Statements"). The Statements were further revised in 1996 and are the guidelines by which the Agencies analyze and apply general antitrust principles to health care markets.

⁴ Objective information includes, but is not limited to, basic terms relating to pricing or pricing strategies, costs, revenues, profits, margins, output, business or strategic plans, marketing, advertising, promotion, or research and development. The messenger may not give advice about whether to accept the offer or not, and providers in the network may not communicate with each other about whether to accept a given offer or not. The messenger may not, directly or indirectly, lead or facilitate a boycott of a payer that is designed to influence the terms of the payer's offer.

⁵ Noncompetitive terms include terms that do not relate to pricing or pricing strategies, costs, revenues, profits, margins, output, business or strategic plans, marketing, advertising, promotion, or research and development.

2. In a nutshell, what guidance do the Statements provide?

The Statements describe the antitrust principles that the Agencies apply in evaluating health care provider joint ventures and multi-provider networks, and address some issues commonly raised in connection with the formation and operation of such networks. The Statements define “multi-provider networks” as ventures among providers that jointly market their health care services to health plans and other purchasers. Such ventures may contract to provide services at jointly determined prices and agree to controls aimed at containing costs and assuring quality. Multi-provider networks vary greatly regarding the providers they include, the contractual relationships among those providers, and the efficiencies likely to be realized by the networks.

3. Under what standard do the Agencies review financial or clinical integration agreements among providers?

Where competitors financially or clinical integrate such agreements are analyzed under the rule of reason standard. In accord with general antitrust principles, multi-provider networks will be evaluated under the “rule of reason”, and will not be viewed as automatically illegal, if the providers’ integration through the network is likely to produce significant efficiencies that benefit consumers, and any price agreements (or other agreements that would otherwise be automatically unlawful) by the network providers are reasonably necessary to realize those efficiencies.

4. How do the Agencies conduct a so-called rule of reason analysis?

The Agencies evaluate whether the agreement likely harms competition by increasing the competitors’ ability or incentive to raise prices above, or reduce output quality, service, or innovation below what likely would exist without the agreement. This is a highly fact-intensive evaluation in which the Agencies will define relevant markets, calculate market shares, and evaluate concentration and market structure.

5. Are there general steps involved in a rule of reason analysis?

The steps ordinarily involved in a rule of reason analysis include the following:

Step one: Define the relevant market.

The Agencies evaluate the competitive effects of a network joint venture in each relevant market in which it operates or has substantial impact. In defining the relevant product and geographic markets, the Agencies look to what substitutes, as a practical matter, are reasonably available to consumers for the services in

question.⁶ The Agencies will first identify the relevant services that the network joint venture provides. For each relevant service market, the relevant geographic market will include all providers who are considered good substitutes for the participants in the joint venture.

Step two: Evaluate the competitive effects of the joint venture.

Next, the Agencies examine the structure and activities of the network joint venture and the nature of competition in the relevant market to determine whether the formation or operation of the venture is likely to have an anticompetitive effect. Two key areas of competitive concern are whether a joint venture could raise the prices for services charged above competitive levels, or could prevent or impede the formation or operation of other networks or plans.

In assessing whether a particular network arrangement could raise prices or exclude competition, the Agencies will examine whether the network collectively has the ability and incentive to engage in such conduct. The Agencies will consider not only the proportion of the providers in any relevant market who are in the network, but also the incentives faced by providers in the network, and whether different groups of providers in a network may have significantly different incentives that would reduce the likelihood of anticompetitive conduct.

If, in the relevant market, there are many other networks or many providers who would be available to form competing networks or to contract directly with health plans, it is unlikely that the joint venture would raise significant competitive concerns. The Agencies will analyze the availability of suitable providers to form competing networks, including the exclusive or non-exclusive nature of the joint venture.

An additional area of possible anticompetitive concern involves the risk of “spillover” effects from the venture. For example, a joint venture may involve the exchange of competitively sensitive information among competing providers and thereby become a vehicle for the network’s participants to coordinate their activities outside the venture. Ventures that are structured to reduce the likelihood of such spillover are less likely to result in anticompetitive effects.

Step three: Evaluate the impact of procompetitive efficiencies.

This step requires an examination of the joint venture’s likely procompetitive efficiencies, and the balancing of these efficiencies against any likely anticompetitive effects. The greater the venture’s likely anticompetitive effects, the greater must be the venture’s likely efficiencies. In assessing efficiency claims, the Agencies focus on net efficiencies that will be derived from the operation of the

⁶ A more extensive discussion of how the Agencies define relevant markets is contained in the Agencies’ 1992 Horizontal Merger Guidelines, available at <https://www.ftc.gov/sites/default/files/attachments/merger-review/hmg.pdf>.

network and that result in lower prices or higher quality to consumers. The Agencies will not accept claims of efficiencies if the parties reasonably can achieve equivalent or comparable savings through significantly less anticompetitive means. In making this assessment, however, the Agencies will not search for a theoretically least restrictive alternative that is not practical given business realities.

Experience indicates that, in general, more significant efficiencies are likely to result from a provider venture's substantial financial risk sharing or substantial clinical integration. However, the Agencies will consider a broad range of possible cost savings, including improved cost controls, case management and quality assurance, economies of scale, and reduced administrative or transaction costs.

In assessing the likelihood that efficiencies will be realized, the Agencies recognize that competition is one of the strongest motivations for firms to lower prices, reduce costs, and provide higher quality. Thus, the greater the competition facing the network, the more likely it is that the network will actually realize potential efficiencies that would benefit consumers.

Step four: Evaluation of collateral agreements.

This step examines whether the joint venture includes collateral agreements⁷ or conditions that unreasonably restrict competition and are unlikely to contribute significantly to the legitimate purposes of the joint venture. The Agencies examine whether the collateral agreements are reasonably necessary to achieve the efficiencies sought by the joint venture.

6. What is financial risk-sharing? Is it just the creation of a joint venture?

No. The mere fact that a group of providers would pay fair market value consideration to purchase their interests in a joint venture likely will not be sufficient to create the kind of financial integration which the Agencies are looking for in these instances. Significant efficiencies must be achieved through agreement by competing providers to share substantial financial risks for their services. In such cases, the setting of prices would be integral to the venture's use of such an arrangement and, therefore, would warrant evaluation under the rule of reason.

7. What are the Agencies looking for with respect to financial integration?

The following are examples noted by the Agencies of some types of arrangements which may create financial integration through the taking of substantial financial risk:

⁷ A collateral contract is usually a single term contract, made in consideration of the party for whose benefit the contract operates agreeing to enter into the main contract, which sets out additional terms relating to the same subject matter as the main contract.

- Agreement by the venture to provide services to a health plan at a “capitated” rate;
- Agreement by the venture to provide designated services or classes of services to a health plan for a predetermined percentage of premium or revenue from the plan;
- Use by the venture of significant financial incentives for its provider participants, as a group, to achieve specified cost-containment goals. Two methods by which the venture can accomplish this are:
 - Withholding from all provider participants a substantial amount of the compensation due to them, with distribution of that amount to the participants based on group performance in meeting the cost-containment goals of the venture as a whole; or
 - Establishing overall cost or utilization targets for the venture a whole, with the provider participants subject to subsequent substantial financial rewards or penalties based on group performance in meeting the targets; and
- Agreement by the venture to provide a complex or extended course of treatment that requires the substantial coordination of care by different types of providers offering a complementary mix of services for a fixed, predetermined payment, 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.

8. What is clinical integration?

At the outset, it should be noted that in order to negotiate as a network, clinical or financial integration is needed, but not necessarily both. Jointly negotiating fees through clinical integration requires an active and ongoing program to evaluate and modify practice patterns of the provider participants that creates a high degree of interdependence and cooperation between the providers to control costs and ensure quality. To avoid antitrust scrutiny, the parties must demonstrate that joint pricing is reasonably necessary to achieve cost efficiencies and quality improvements generated through clinical interdependence and cooperation. In other words, the parties must be able to track cost savings and establish quality benchmarking.

The Agencies will consider the particular nature of the services provided by the network in assessing whether the network has the potential for producing efficiencies that warrant rule of reason treatment. In all cases, the Agencies’ analysis will focus on substance, not form, in assessing a network’s likelihood of producing significant efficiencies. To the extent that agreements on prices to be

charged for the integrated provision of services promote the venture's achievement of efficiencies, they will be evaluated under the rule of reason.

9. What guidelines are available for establishing successful clinical integration?

The FTC has noted that achieving clinical integration is not simple, easy, or costless. Clinical integration may necessitate selectively restricting participation in the network, both initially and as the venture continues, including even removing uncooperative members. It may also require significant investment in the venture by the provider participants in order to assure that all participants are committed to working together to achieve the quality and cost efficiencies. The FTC has further indicated that clinical integration must involve some or all of the following aspects or characteristics:

- Development or adoption of appropriate performance standards and goals, referral guidelines or requirements, or other performance criteria and measures for the participants, both individually and as a group;
- Establishment of mechanisms, including information systems, that permit collection and analysis of relevant data to monitor and evaluate both individual and group performance relative to the established standards, goals and measures; and
- Appropriate educational, behavior modification, and remedial action, where warranted, to improve both individual and group performance.

10. What questions should be asked when analyzing the legality of the clinical integration?

As the FTC has explained, the antitrust analysis of clinical integration arrangements focuses on three key questions:

- Does the arrangement have the potential to produce substantial cost or quality efficiencies that could not be achieved by the providers acting independently?
- Are joint negotiations reasonably necessary and related (*i.e.*, ancillary) to achieving those efficiencies?
- Will the arrangement have market power and what will be its likely competitive effects?

11. Has clinical integration been extensively used among provider networks?

No. Only a handful of provider networks that rely primarily on clinical integration have been established. Provider groups have blamed this in part on the lack of better guidance from the antitrust agencies, coupled with concerns about regulatory restrictions governing patient referrals, tax, corporate practice of medicine, and other issues. There is also skepticism that clinical integration alone, without substantial financial risk, can bring about significant efficiencies. Moreover, some clinically integrated groups have reported that local health plans have not been interested in contracting with them and thus whatever investment was made in establishing them may result in little return.

VI. CONCLUSION

The table below summarizes key differences in using a messenger model versus a joint venture model in collaboration efforts regarding contracting with payers, including Medicare Advantage and Medicaid managed care plans, without running afoul of the federal and state antitrust laws.

	Messenger Model	Joint Venture (Financial or Clinical Integration)
Providers can jointly negotiate	No	Yes
Providers can share info about rates	No	Yes
Providers can share contract terms or offers	No	Yes
Is a new entity required?	Yes, an agent	Yes
What are the associated fees?	Fact-specific; will depend on the number of providers and complexity of the arrangement	Fact-specific; will depend on the number of providers and complexity of the arrangement
What is the main benefit of this approach?	<p>Single-point communications conduit for providers and payers</p> <p>Providers benefit from messenger standing in the community and reputation for quality health care</p> <p>Payers are able to communicate with thousands of providers through a single, familiar conduit</p> <p>Maintains providers' independence</p>	<p>Creates clinically or financially integrated network (high standard)</p> <p>Network may legally negotiate prices and other contract terms on joint basis</p>

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