Background

Many states are considering initiatives to promote the medical home model as a way to improve health outcomes, give patients better care experiences and, hopefully, ultimately reduce overall costs in the U.S. health system. When medical home projects include the development of a payment model that is consistent across payers, insurance plans that normally compete agree to coordinate the development of payment policies. As this paper illustrates, this necessitates the consideration of antitrust issues and related policies to ensure compliance with antitrust law. Such issues need not, however, prevent a state from implementing a medical home or other payment reform initiative.

The medical home seeks to replace episodic, poorly integrated care that only responds to patient complaints and illnesses, with well-coordinated care and a long-term healing relationship that emphasizes prevention, wellness, and effective management of chronic conditions. Approaches to designing and implementing a medical home initiative vary in scope and details; the core idea is for every patient to have an ongoing relationship with a health care provider who leads a team of care professionals at the practice level with the team being responsible for all of the patient’s health needs. The team arranges care from additional providers as needed and coordinates the patient’s care across the health care system. Other hallmarks of the model include ongoing performance measurement and quality improvement; active patient engagement in care and the provision of feedback; and payment reform to support those efforts.

Medical home pilots are supported in a variety of ways. The payment method recommended by the Patient-Centered Primary Care Collaborative, a diverse national group promoting medical homes, has three parts: 1) a prospective monthly fee for coordinating care; 2) visit-based, fee-for-service payments; and 3) performance incentives to support and reward improved quality, outcomes, and practice efficiency.

Recent medical home initiatives have sought to engage multiple payers in support of a coordinated payment approach, which enables payers to send a sufficiently strong (and consistent) signal to providers. In the absence of a multi-payer effort, the plans must try to coordinate care through call centers and other efforts not embedded in provider practices or they face the challenge of engaging providers when their competitors are sending different or contradictory messages about expectations related to quality, cost and care coordination. In addition, participation of multiple payers eases payers’ concerns that nonparticipating competitors will reap the benefits of change without sharing the costs.

The collaboration required by competitors as part of these initiatives raises antitrust issues — chief among them is that the activities of multi-payer medical home initiatives will be seen as illegal restraint of trade under Section 1 of the Sherman Act. Potential antitrust immunity exists for participants in state-led initiatives under the State Action Immunity Doctrine, but the initiatives must meet two tests: (1) clear articulation by the state of its intent to displace competition; and (2) active and ongoing state supervision of the process and results.

This issue brief examines potential state solutions to antitrust issues in multi-payer initiatives—in particular, steps taken by Pennsylvania and Maryland. It is based on a February 2010 cyber-seminar sponsored by the State Quality Improvement Initiative (SQII), a project of AcademyHealth and The Commonwealth Fund. SQII provides assistance for health care quality improvement efforts to eight competitively selected states. 1 A transcript and presentation materials are available at www.academyhealth.org/state-q-i-institute.

Overview of the State Action Doctrine

Section 1 of the Sherman Act prohibits “combination, contract or conspiracy in restraint of trade or commerce.” Behind it and all other antitrust laws, both federal and state, is the idea that robust competition benefits consumers by producing lower prices, more choices, and greater innovation. Governments sometimes may decide those and other ideals are better served by collaboration among competitors and alternative regulation.

The federal government may enact specific exemptions—for example, it permits the sharing of loss data by insurers—and states may exempt any behavior from their own laws. But as Congress has not explicitly or implicitly expressed limits on state antitrust authority, the Supreme Court—under the State Action Immunity Doctrine—has found that legitimate state decisions to supplant competition should also override federal antitrust law.

As part of the SQII cyber-seminar, antitrust expert Emily Myers outlined the key aspects of the state action doctrine. Myers is antitrust chief counsel for consumer issues at the National Association of Attorneys General, where she assists states with multi-state activities. 2 For specific guidance, she urged states to contact the antitrust chief in their Attorney General’s office.

The Supreme Court first articulated the state action doctrine in 1943, holding that restraints on competition were protected by antitrust immunity only if the restraints were “state action of official action directed by a state.” Over time, the Court ruled on cases in which parties other than the state acted in restraint of trade...
at the direction of the state. In 1980 in California Retailer Liquor Dealers v. Midcal, the Court outlined a two-prong test that provides the basis for state action immunity today:

1) Has the state clearly articulated and affirmatively expressed as state policy its intent to displace competition? Of note here is that a broad grant of statutory authority will not suffice. But, where the state clearly expresses its intent, even prior conduct may be shielded.

2) Has the state itself committed to actively supervise the anti-competitive conduct and its results with ongoing oversight?

State action immunity, in its application, is “somewhat of a sliding scale,” Myers said. Numerous court rulings have clarified both standards. As a rule, the more clearly articulated the state policy and the more active the state oversight, the more likely it is that the anti-competitive behavior will have antitrust immunity. It also matters who articulates the policy and who oversees implementation. The strongest tools for creating immunity are actions by the state legislature or the highest court. Next strongest are actions by a state executive branch agency, such as the health department. If the regulator is a state board with private members, a crucial factor is how much direct oversight it gets from what level of state authority, such as the governor, legislature, or state Supreme Court.

What constitutes clear articulation? States must be specific about the anti-competitive behavior permitted, and clear about the purpose of allowing exemption from antitrust rules. According to Myers, state policies that allow but do not require anti-competitive behavior might meet the test of clear articulation if the state has foreseen the anti-competitive behavior as a possible and permissible result. For example, in Michigan, county clerks did not allow the resale of county title record information that they had provided. The court found that the state intended to give registrars some monopolies—on recording real estate transaction information and on possession of the original documents, for example. However, as the state did not clearly articulate intent to displace competition in the provision of duplicate title documents, the clerks’ action that tried to limit the resale of the documents was not protected under the state action doctrine.

What satisfies the active-supervision test? Meyers indicated that authorizing anti-competitive actions, without reviewing their reasonableness, is insufficient. Merely regulating the procedures (as opposed to actively supervising) is also inadequate. States must review the particular actions of private parties and reject those that do not accord with state policy. Merely authorizing private parties to agree on rates or prices is not sufficient. States must also control the process and exercise sufficient independent judgment, so that details of rates or prices are established as the product of deliberate state intervention. This last criterion, Myers noted, comes from a United States Supreme Court case, FTC v. Ticor, in which more than 40 Attorneys General filed briefs supporting the Federal Trade Commission (FTC).

The Approach in Pennsylvania
Pennsylvania, in its medical home chronic care initiative, paid careful attention to antitrust issues from the start. The effort began in 2007 with the governor’s creation of a commission explicitly charged with developing a medical home-type model to improve chronic care in the state. The executive order detailed specific duties of the commission, which included working with insurers and providers to develop a reimbursement model and to construct common performance and outcome measures.

A steering committee, involving the Governor’s Office of Health Care Reform (GOHCR), participating payers and providers, and a not-for-profit company created to aggregate data (among other services) did the initial work. As the committee wanted multi-payer involvement and a consistent reimbursement level, “it was clear that antitrust problems could arise,” said Richard Snyder, M.D., chief medical officer of Independence Blue Cross, who had a leadership role in the first phase of the initiative.

As part of the SQII seminar, Snyder discussed the initiative’s handling of antitrust issues; his presentation is the basis for this section of the issue brief.

Pennsylvania involved its Attorney General and also secured independent counsel to evaluate whether it could provide antitrust protections for participants. Each commercial payer also secured external counsel to help them safely communicate their positions. The GOHCR’s role as convener and driver of the work was seen as providing some antitrust protection. In addition, lawyers for the state and the payers were present during many of the initial conversations to help participants avoid dangerous territory.

Pennsylvania chose a payment model designed to minimize antitrust risks while achieving its goals of aligning consumer and provider incentives and providing adequate funding. The initiative does not touch the underlying pay-for-performance contracts that exist between payers and providers. Rather, its payment model only established an incremental payment to support the costs of implementing the transformation. The state avoided negotiations over the base payment rate by instead analyzing the real costs of transforming care in all of the available pilot projects around the country. Based on that analysis, the state set an aggregate reimbursement level to be divided among the providers. It documented both the methodology and the funding.
The most important aspect, Snyder said, is how the funding model avoids any impression of impropriety by having the governor’s office determine what each payer (carrier) pays to each medical home practice. Physician practices submit their 1099 revenue from all sources to the governor’s office, which communicates data for each payer, only to that payer, for validation. The governor’s office then generates a quarterly bill for each payer based on their share of a practice’s revenue. A formal agreement spells out each party’s role, specifically defining how the governor’s office coordinates the flow of funds and data.

A shared-savings payment model was envisioned as the ultimate goal for the southeastern Pennsylvania roll-out. Snyder said he is not sure whether that type of payment model will ultimately happen—in part due to the complexity of the issue and the antitrust risks. To help ensure the sustainability of the effort, Independence Blue Cross plans to implement, in January 2011, an incremental per-member-per-month payment for medical homes. Snyder indicated that other payers are considering similar actions.

**The Approach in Maryland**

Maryland’s medical home initiative began more informally than Pennsylvania’s although, like Pennsylvania, it used a commission created by executive order—the state Health Care Quality and Cost Council—for much of the planning. Partly to provide more antitrust protection, the state decided to pursue medical home legislation, which was signed into law in April 2010.

As envisioned by the legislation, the payment structure will maintain the existing fee-for-service rates used by the individual carriers but add consistent per-member-per-month payments and performance bonuses tied to attainment of quality measures and cost savings, said Ben Steffen of the Maryland Health Care Commission, who is staffing the effort. This section of the issue brief is based on Steffen’s comments during the SQII cyber-seminar.

The Health Care Quality and Cost Council initially hoped to rely on the executive order for antitrust protection and avoid legislation. Planners were not sure what statutory changes were needed and worried that the legislative amendment process might weaken the initiative. They also feared that the legislation proposed might not garner enough support to pass, given that 2010 is an election year in Maryland and the initiative was not included on the administration’s legislative agenda.

While those planning the initiative knew of the non-statutory approaches that have been used successfully in other states, there were significant questions about whether those approaches would work for Maryland, Steffen said. The state has something of a tradition of working within statute for health care regulation, having established its all-payer rate-setting system—the only such in the nation—by statute. Similarly, planners felt that the state should formally define its role in the chronic care medical home initiative.

Steffen noted that the council by itself was deemed inadequate to run such a program—in part because its mandate is broad; the council’s initiatives, for example, include programs to promote hand-washing and reduce bloodstream infections. The council has no designated staff other than a director in the health secretary’s office, nor does it have formal authority to require actions or develop regulations.

While an executive order can work if it includes a clear articulation of intent under the state action doctrine, the council concluded that the executive order establishing it would not meet that test, Steffen said. The order expresses no intent to supplant competition and is too vague, making no mention of a medical home. (The executive order Pennsylvania used, in contrast, is specific.)

Many private payers argued that antitrust issues could be addressed at a later date, but the council worried antitrust-related tensions might mount after a pilot was underway and early euphoria could give way to future frustration related to payments, quality standards and participation criteria. Planners also felt a broad rollout across the state—the initiative’s ultimate goal—would require legislation so why not change the statute for the pilot?

Yet, antitrust issues alone might not have pushed the state to legislation, Steffen said. Barriers to a medical home model in the state’s insurance and health articles—such as a prohibition on incentive payments based on cost savings—also encouraged a statutory solution. In addition, the council had a desire to establish standards that would align current or future single-payer medical home projects with the state’s multi-payer effort.

The “clear articulation” and “active supervision” tests established in the Midcal ruling guided development of the legislation, Steffen said. The regulatory language says the state is supplanting competition. It designates the Maryland Health Care Commission as the regulator, and charges the commission with actively supervising participants, defining participation criteria, specifying payments for care coordination, designing the bonus structure, and establishing quality and efficiency standards.

**Summary**

Collaboration of competitors, regardless of the size of initiatives, raises antitrust issues. When and how states choose to address those issues may depend on their goals and particular circumstances. Pennsylvania and Maryland provide two examples of how states have designed initiatives to meet the state action doctrine for
Other State Approaches

Massachusetts
Massachusetts launched its payment reform effort—a follow-up to its health care reform of 2006—with a 2008 law that created a special commission to recommend a new payment system to support efficient and effective patient-centered care. The 10-member commission consisted of heads of key state agencies and representatives of private-sector stakeholders appointed by the governor. Creation by statute, a specific mandate, and state participation laid a foundation for antitrust immunity under the state action doctrine. As directed by the law, Massachusetts’ attorney general then issued specific guidance for the commission and its members, laying out what potential behaviors would be protected and what would not. Price fixing and other per se unlawful collusion were explicitly excluded from protections. Among the actions explicitly protected were obtaining aggregate price and cost data using a procedure described in the guidelines and obtaining non-price-specific payment information such as payment methodologies. The attorney general appointed a representative to attend commission meetings and ensure compliance with the guidance. In July 2009, the commission recommended adopting a global payment model.

Rhode Island
Rhode Island developed a medical home pilot project through the state Office of the Health Insurance Commissioner (OHIC), which was established within the executive branch Department of Business Regulation by 2004 legislation. OHIC based its efforts on the 2004 legislation, which charged the office with “encouraging policies and developments that improve the quality and efficiency of health care services delivery and outcomes.” In 2007, OHIC convened a Chronic Care Sustainability Initiative of about 40 stakeholders, which, with state participation and supervision, reached agreement to use a medical home model and on the design, management, and oversight of a pilot. The pilot included a payment methodology standardized across the payers with a consistent use of tools for measuring results of the pilot. OHIC described the state’s supervision of the effort and its policy rationale for the collaboration in a May 2008 memorandum to the three participating private payers. The memorandum does not state it is meant to provide antitrust protection; it does not, in fact, use the word “antitrust” at all. However, articulation of the state’s intent and description of its active and ongoing oversight directly addresses the two-prong test for the state action doctrine. OHIC noted in the memorandum that the pilot’s provider-contract template was created with state participation and oversight. When the pilot ends, payers and physicians will decide individually whether and under what terms to continue. The two-year pilot was launched in October 2008.

Washington
Washington State took a strong and direct legislative approach to antitrust issues. A 2009 law creates two or more pilot projects specifically to test reimbursement models for primary care medical homes. It directs two state executive branch agencies to design, oversee implementation of, and evaluate the pilot projects, with input from multiple—and sometimes competing—stakeholders. The law declares that such collaboration is in the public interest and that the legislature intends that activities undertaken pursuant to the authorized pilots be exempt from state antitrust laws and immune from federal antitrust laws under the state action doctrine. Like Massachusetts, Washington explicitly states that the antitrust protections do not apply to per se illegal violations such as price fixing. The program is expected to be operational in the fall of 2010.

antitrust immunity; Pennsylvania with an executive order, and Maryland with legislation. An executive order is an effective approach and might be the easier approach in some cases, while legislation provides the most clear and certain antitrust protections. Other states have used other approaches to address antitrust concerns (see box).

About the Cyber-seminar Faculty:
Emily Myers, J.D., has been antitrust counsel with the National Association of Attorneys General (NAAG), with some breaks, since March 1993. Her duties at NAAG include providing legal counsel to the Association and to Attorneys General and staff on matters relating to antitrust and assisting in the development of policy positions in this area; maintaining an information clearinghouse and facilitating activities of NAAG multistate task forces; serving as liaison to federal agencies; and planning the annual antitrust seminar and antitrust trial practice training for state Attorney General offices. She was the author of the state enforcement chapter of the ABA publication Antitrust Law Developments V, as well as several annual updates to the treatise. Before joining NAAG, Ms. Myers was an associate in the Washington office of Squire, Sanders & Dempsey from 1987 to 1993. She received her law degree in 1987 from the University of Pennsylvania, where she was an Arthur C. Littleton legal writing instructor. She received her undergraduate degree in history from Brown University in 1982.

Richard Snyder, M.D., is the chief medical officer for Independence Blue Cross (IBC), a leading health insurer in southeastern Pennsylvania. Dr. Snyder is the chief clinical spokesperson for the company and has overall corporate responsibility for medical management, quality management, and all clinical policies and programs. Dr. Snyder joined IBC in 1997 as the senior medical director of utilization management. Over the last 13 years, he has assumed greater levels of responsibility, first as vice president of quality management and most recently as senior vice president of health services. He is a member of various medical societies, including the American Medical Association, the Pennsylvania Medical Society, the American Academy of Family Physicians, and the Pennsylvania Academy of Family Physicians. Dr. Snyder is a graduate of Franklin and Marshall College and The
Medical College of Pennsylvania, and is a board certified family practice physician.

Ben Steffen, M.A., is director for information services and analysis at the Maryland Health Care Commission (MHCC). He is responsible for developing and managing the Commission’s analyses of physician workforce, performance and payment issues. He has been a proponent of elevating payments to primary care providers and has taken the lead in promoting the patient-centered medical home model in Maryland. Mr. Steffen represents the MHCC at state and national levels on physician payment and workforce issues, health care data collection, information security, and patient privacy issues.

Before joining the Commission, Mr. Steffen was a program manager in the Computer Sciences Corporation's health care policy and systems consulting practice. Earlier in his career, Mr. Steffen worked at the Congressional Budget Office where he assisted Congress in assessing the budgetary impact of legislative proposals for health care and income security programs. Mr. Steffen holds a M.A. from American University, a B.A. from the University of New Mexico, and has completed post-graduate study at the University of Michigan.

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Endnotes

1 See additional information about this project on the AcademyHealth Website: www.academyhealth.org/state-qi-institute, accessed August 19, 2010.

2 All cyber-seminar participants noted that the comments they are providing are their own and do not represent the views of the organizations with which they are employed.


Additional Resources

A listing of the additional resources below, with full links, is available on the SQII website.


Massachusetts


Rhode Island

The Rhode Island Chronic Care Sustainability Initiative: Final Report., accessed on August 17, 2010.

Washington

Health Care Authority Medical Homes Project., accessed on August 17, 2010.

Payment Options and Learning Collaborative Work in Support of Primary Care Medical Homes., accessed on August 17, 2010.