THE
NATIONAL LAW REVIEW

FTC Says New York's Medicaid Redesign Program May Promote Anticompetitive Behavior

Monday, May 4, 2015

In an April 22, 2015 letter to the New York State Department of Health (DOH), the Federal Trade Commission (FTC) cautioned that part of the State's Medicaid reform program may sanction anticompetitive behavior. The FTC's concern stems from the Certificate of Public Advantage (COPA) regulations, which offer federal antitrust immunity for certain collaborations among providers participating in the Delivery System Reform Incentive Payments (DSRIP) program. Specifically, the FTC expressed its "strong concern" that COPAs immunize collaborative activities that otherwise may be impermissible under federal antitrust laws, and may "lead to increased health care costs and decreased access to health care services for New York consumers."

Despite the FTC's warning, DOH is pressing forward with DSRIP. At the heart of the FTC and DOH's divergent viewpoints is the mounting tension between health care reform (at both the state and national levels), which focuses on transformative health care models that seek to curb costs and improve care through coordinated and integrated systems, and antitrust laws, which seek to protect the consumer — i.e., the recipients of health care — from anticompetitive pricing. While the FTC continues to insist that the fundamental goals of healthcare reform and antitrust policy are aligned, recent action by the FTC, like its letter to DOH, arguably suggest otherwise.

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Background

In 2011, Governor Cuomo formed the Medicaid Redesign Team (MRT) to address health care cost and quality issues in the State's Medicaid program. The MRT was tasked with transforming a payment system that was bleeding money by rewarding providers for keeping people healthy through improved quality care, which in turn would rein in spending. The MRT developed a multi-year action plan, and last year announced that it had finalized a waiver amendment with the federal government that will allow the State to reinvest $8 billion in federal savings generated by MRT reforms, $6.42 billion of which will be used for DSRIP.

The primary goal of DSRIP is to reduce avoidable hospital admissions by 25% over 5 years. In order to receive payment from the state, collaborating "safety net providers" are required to achieve results in system transformation, clinical management and population health. Hospitals and non-hospital providers that meet Medicaid patient volume and other criteria can become participants in, and share in the potential performance payments of, a Performing Provider System (PPS) within DSRIP.

DOH allows providers to participate in more than one PPS, and expects there to be collaborative efforts among PPSs in the same region since they are likely to have similar patient populations. In this regard, if a PPS can show that a potential collaboration among PPS providers will benefit the community, the PPS can apply for a COPA in order to shield itself from antitrust scrutiny. According to the COPA regulations, parties that receive a COPA are provided state action immunity under federal antitrust laws and immunity from private claims under state antitrust laws. They also may negotiate, enter into, and conduct business pursuant to a Cooperative Agreement

or a planning process covered by a duly issued COPA. A COPA will be granted if it appears that the benefits of the proposed PPS collaboration will outweigh its anticompetitive effects. DOH will make this determination in consultation with the Office of the Attorney General, and together they will conduct a competitive analysis of the market and the potential competitive and anticompetitive impact of the arrangement.

The FTC Letter

On October 10, 2014, the New York Health Plan Association (NYHPA), joined by other health plans and trade organizations, wrote a letter to the FTC expressing its concern that providers would utilize the blanket of protection offered by a COPA to join forces in order to extract higher reimbursement rates from health plans. Such tactics, the NYHPA argued, would "create disproportionate negotiating leverage for providers and systems over Medicaid plans whose rates are determined by DOH and over commercial insurers who, while negotiating Medicaid rates, will be forced to reveal pricing and cost data to various competing hospitals (and other providers)." The FTC appears to agree.

According to the FTC, the COPA regulations "are based on two fundamentally flawed premises: that efficient, procompetitive collaborations among otherwise independent health care providers are prohibited under the antitrust laws, and that COPA regulations are necessary to encourage such collaborations." The FTC explained that competitive collaborations can in fact be procompetitive, and that the antitrust laws do not obstruct the kind of collaborative arrangements contemplated by health care reform at the federal or state level. Rather, the FTC will only oppose an arrangement when there is a likelihood that it will "substantially lessen competition." The FTC believes that, by encouraging providers to share pricing information and conduct joint price negotiations, the COPA regulations will lead to higher costs to the detriment of consumers, thereby "undercutting the very objectives they aim to achieve."

Discussion

Under the antitrust laws, price-fixing, group boycotts, and other collusive activity among competing providers is strictly prohibited. Thus, joint pricing among providers is only permissible if it occurs in the context of an efficiency-enhancing arrangement such as a clinically or financially integrated entity or similar joint venture where the procompetitive benefits of the arrangement are likely to outweigh the anticompetitive effects. Joint conduct among providers that collectively control a substantial share of the market in a particular service or specialty raises significant concerns among antitrust authorities, who seek to ensure that provider collaborations do not eliminate price competition or otherwise allow providers to gain increased leverage over managed care plans.

While the FTC acknowledged that it had not conducted an independent antitrust analysis into the structure and operation of the three DSRIP PPS networks that applied for COPAs, it noted that all three of the networks at issue "appear to involve substantial portions of competing health care providers in their respective geographic regions, thereby increasing the potential for anticompetitive harm." Moreover, the FTC has routinely expressed its objections to federal and state attempts to create antitrust exemptions for collective provider negotiations, asserting, as it does here, that "no special 'exemption' or 'immunity' from existing antitrust laws is necessary to ensure that such procompetitive collaborations occur."

The antitrust enforcement agencies emphasize that there is no inconsistency between the goals of antitrust enforcement and the goals of health care reform. They believe that health care reform objectives can be achieved within the current framework of antitrust policy. But that seems increasingly not to be the case. The recent decision by the United States Court of Appeals for the Ninth Circuit in Nampa, Inc. v St. Luke's Health System, which, in effect, rejected arguments based on the goals of health care reform as being insufficient to counter perceived anticompetitive behavior, as well as the FTC letter to DOH regarding DSRIP, act to inhibit providers undertaking the cooperative actions that are needed for them to transition from a fee-for-service world to one in which alternative payment methodologies dominate, which is a key goal of health care reform.

Alternative payment methodologies require the ability to coordinate care horizontally and vertically, and yet it is just this behavior that antitrust enforcement seems to be deterring. If there is wariness about cooperative clinical affiliation arrangements, then formal governance consolidation could be a legally safer route for providers. At least the antitrust rules are somewhat clearer there than they are relating to clinical affiliations and clinical integration. Yet the antitrust enforcers also indicate a clear preference for clinical affiliation over formal consolidation. This is a paradox that these agencies will need to address and resolve, based on a clearer understanding of facts on the ground, if the goals of health care reform and antitrust enforcement are truly to be consistent.

Conclusion

In light of the FTC's position on the COPA regulations and its warning that it "will continue to challenge defenses

based on asserted state action immunity where the state fails to provide adequate active supervision," it is critical for hospitals and providers to work with legal counsel to ensure that the collaborations and efficiencies they seek to achieve align with antitrust principles. While antitrust immunity is currently afforded under the COPA regulations, PPS participants should not overlook the FTC's authority to investigate and challenge relationships that may, in fact, be anticompetitive.