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Issue Brief

State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives

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ABSTRACT: Currently, 20 states have had one or more active multipayer medical home initiatives. As more states convene multiple payers and work to align payment policies, concerns regarding antitrust liability will need to be addressed. This issue brief provides a summary of state strategies to navigate antitrust concerns in multipayer medical home initiatives. Information for this brief was obtained from a survey sent to 14 states combined with a scan of state websites. Nine states have policies in place either through legislation or executive order to provide some legal protection for their efforts to displace competition among payers. Out of concern that legislation was not sufficient, policymakers in one state also conducted oversight activities to reduce the risk of antitrust liability. Six of the 14 states surveyed have engaged in multipayer initiatives without formal antitrust protection.

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OVERVIEW

To decrease health care costs, improve health outcomes, and increase patient and provider satisfaction, a majority of states have launched medical home initiatives within their Medicaid and Children's Health Insurance Programs since 2006.¹ In the medical home model, care teams—led by a primary care clinician—provide patients with accessible, comprehensive, coordinated, and continuous patient-centered services. To date, 20 states have implemented one or more medical home initiatives in which they have partnered with other public payers as well as private payers and purchasers.² Medicare has joined Medicaid as a payer in 15 of these multipayer initiatives thus far.³ With the announcement of federal funding for multipayer payment and delivery system reforms through the State Innovation Model Initiative, additional states are expected to adopt multipayer medical home models.⁴

Engaging multiple payers in medical home initiatives has many advantages. It presents a consistent and coordinated message to primary care practices as to the goals for practice transformation. Convening multiple payers also

distributes the costs associated with creating a medical home and results in greater alignment around payment, reporting, and infrastructure investments.

However, as states develop multipayer medical home initiatives, they will have to ensure their programs comply with antitrust laws put in place to safeguard consumers from anticompetitive behavior. This brief summarizes the ways in which states participating in multipayer medical home initiatives have addressed antitrust risk. We do not intend to provide legal guidance, but rather offer information to state policymakers seeking to convene public and private payers in order to achieve alignment around multipayer payment reform.

ANTITRUST LEGISLATION

States that promote collaboration among payers to reach agreement on common or aligned payments for their medical home initiatives risk antitrust liability for their participating payers. The cooperation and collaboration to set prices and payments among a group of otherwise competitive payers would be seen as illegal restraint of trade under the Sherman Act.

Immunity from federal antitrust laws when convening multiple payers may be available to states as well as private payers under the state action doctrine, first articulated in *Parker v. Brown* in 1943.⁵ The doctrine, based on the premise of states' sovereign immunity, provides exemption for anticompetitive actions resulting from state governmental policy.⁶ Each state attorney general can advise on avoidance of antitrust violations and the potential for immunity based on existing state policy.

The doctrine of *Parker v. Brown* may extend immunity to both state actors and private entities if the policy in place meets two criteria:

- The state has clearly articulated a policy to displace competition. This requires that the policy both justifies the anticompetitive behavior and sufficiently expresses that such behavior is both expected and endorsed.

- The state has committed to active supervision of activities by health care payers; simple authorization or regulation of proceedings is not sufficient. The state must be able to review potential anticompetitive acts such as setting prices and rates among payers.

State Actions Addressing Antitrust Risk

States have adopted policies affording various degrees of protection, for themselves and for other public and private payers, from the risk of violating antitrust law in multipayer medical homes initiatives. Eight of 19 states with multipayer initiatives have legislation or executive orders in place. Montana is designing its multipayer initiative and recently passed legislation to address antitrust concerns (Exhibit 1). Rhode Island began convening payers by using the regulatory arm of the Office of the Health Insurance Commissioner, an office with a legislative charge to improve the health system's quality, accessibility, and affordability, but then later turned to legislation to affirm the state's intent to displace competitive behavior.⁷

Two states, Idaho and Pennsylvania, sought to provide some antitrust protection through executive order.⁸

Massachusetts policymakers initially took steps to oversee medical home activity, passing legislation in 2008 that authorized the state to develop new Medicaid payment systems to support patient-centered care.⁹ For the multipayer initiative, the legislation's authorizing statutory language was felt to be too narrowly focused, directing only the office of Medicaid to reform its own payment system through the demonstration. An executive office of the health and human services council was convened to advise on what payment reforms should be permitted. As a result, a memorandum from the then-secretary of health and human services was circulated identifying oversight activities the state would undertake to minimize antitrust risk for commercial payers in payment reform initiatives.¹⁰

Exhibit 1. Multipayer Medical Home Initiatives with State Action Policies Addressing Antitrust*

	Means of Authority	Supervising Authority
Idaho	Executive Order 2010-10: Establishing an Idaho Medical Home Collaborative to Implement a Patient-Centered Medical Home Model of Care (Collaborative)	Department of Insurance
Maryland	Maryland Health-General Statute, sections 19-1A-01-19-1A-05	Health Care Commission, Department of Health and Mental Hygiene ^a
Massachusetts	An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care, chapter 305, section 30, and Memorandum ^b	Executive Office of Health and Human Services
Montana	Senate Bill 84 ^c	Office of Commissioner of Security and Insurance
New York	New York Public Health Law Title 2, section 2959: Adirondack medical home multipayer demonstration program	Department of Health
Pennsylvania	Executive Order 2007-05: Chronic Care Management, Reimbursement and Cost Reduction Commission	Governor's Office of Health Care Reform initially; Department of Health currently ^d
Rhode Island	The Rhode Island Health Care Reform Act of 2004, chapter 42, sections 14.5-14.6 The Rhode Island All-Payer Patient Centered Medical Home Act of 2010, chapter 42, section 14.6-2	Office of the Health Insurance Commissioner
Vermont	Act 48 (H.202) An act relating to a universal and unified health system	Green Mountain Care Board
Washington	Senate Bill 5891	Health Care Authority

* Six of the states surveyed did not have state action policy in place (Colorado, Maine, Michigan, Minnesota, North Carolina, and West Virginia). Five states with multipayer medical home initiatives were not surveyed (Arkansas, New Jersey, Ohio, Oklahoma, and Oregon). These five states' initiatives are solely through the Comprehensive Primary Care Initiative with all meetings conducted in a manner reflecting state action policy for antitrust is not in place. See <http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf>.

^a Maryland Health Care Commission is an independent organization in the Department of Health and Mental Hygiene.

^b Legislation passed was deemed too narrowly focused and a memorandum by the Secretary of Health and Human Services was distributed to identify oversight activities and minimize antitrust risk for participating commercial payers (C. Harrison, email message to author, May 9, 2013).

^c Following the survey, in April 2013, Montana Senate Bill 84 was signed into law, creating a framework for the development of a voluntary, statewide, multipayer patient-centered medical home program.

^d The initial supervision was provided through the Governor's Office of Health Care Reform in Pennsylvania. With the change in gubernatorial administration in 2011, oversight of the Chronic Care Initiative was transitioned to the Department of Health.

Source: Authors' analysis.

Meeting the “Clear Articulation” Test

For state policies to withstand the test of clear articulation under the state action doctrine, they must include justification for displacing competition, since, as noted above, authorization alone does not meet the requirements. States could, for example, acknowledge the failings of the competitive market in certain areas as the reason for regulation.

Various states have adopted legislation justifying public-private payer collaboration in medical home initiatives. For example:

- The preamble to the Maryland legislation references the increase in health care costs, inadequate coordination of care, and the expectation that the Maryland Patient-Centered Medical

Home Program will both promote quality and slow the rise in health costs.

- Washington State's legislation indicates it is in the public's best interest to have “collaboration among public payers, private health carriers, third-party purchasers and providers to identify appropriate reimbursement methods to align incentives in support of primary care medical homes.”¹¹

To meet the test of clear articulation, the policy also should clarify that displacement of competition is necessary to achieve other goals and that anticompetitive behavior is both foreseen and endorsed. For example, Vermont specifies intent to “comply with federal and state antitrust provision by replacing competition

between payers and others with state-supervised cooperation and regulation.”¹² New York’s legislation also specifically notes the expectation that the arrangements may be anticompetitive:

It is the intent of the state to supplant competition with such arrangements and regulation only to the extent necessary to accomplish the purposes of this article, and to provide state action immunity under the state and federal antitrust laws to payors of health care services and health care services providers with respect to the planning, implementation and operation of the multipayer patient centered medical home program.¹³

Test of Active Supervision

For a state policy to meet the second criterion under the state action doctrine—the test of active supervision—states must actively supervise and review the medical home initiative. Authorization alone is not sufficient, because it might give the appearance of private payers acting on their own to decrease competition. States have chosen a variety of agencies to supervise their multipayer initiatives (Exhibit 1).

States must show they exercise judgment in oversight capacity and be actively involved in reviewing and rejecting actions that could be seen as violating the policy. States use various approaches in reviewing and approving the conduct of their multipayer medical home initiatives. In Rhode Island, the Health Insurance Commission cochairs the Steering Committee. Responsibility for oversight for Maryland’s initiative is provided by the Maryland Quality and Cost Council, cochaired by the lieutenant governor and health secretary.

Active supervision also requires states to be involved in establishing rates or prices. For instance, the Idaho Medical Home Collaborative makes recommendations to the Department of Insurance and governor on guidelines for appropriate common payment formulas to qualified patient-centered medical home providers.

Strategies Taken by States Without Antitrust Policies

Although providing safe-harbor protection from antitrust violations through legislative, executive, or regulatory policies has many advantages, not all states with multipayer medical home initiatives are operating with such policies. Six of 14 states surveyed do not have specific policies to navigate antitrust concerns in their multipayer medical home initiatives.¹⁴ Instead, medical home participants in these states sought to avoid group discussions about specific payment amounts and used neutral conveners to try to mitigate the risk of antitrust violations.

Negotiating Payments

In states that have not taken specific policy actions to address antitrust risk, medical home payments were negotiated in different ways, from general discussions among planning teams on payment structure to acceptance of the amounts set by individual payers. Below are some examples:

- *North Carolina Medicare Advanced Primary Care Practice Demonstration Project:* Individual payers set their own payment amounts for medical home services and informed the demonstration project of those amounts as their criteria for participation.
- *Minnesota’s Health Care Home Project:* Payments are negotiated directly between provider organizations/clinics and the health plans. The only rates publicly posted are those for Medicaid.
- *West Virginia Medical Home Shared Savings Pilot:* The pilot did not include any reimbursement changes: each payer maintained their own fee-for-service payment structure.
- *Colorado Multipayer Patient-Centered Medical Home Project:* A document outlining antitrust guidelines was created and reviewed at each meeting ([Appendix A](#)). General talks on the payment structure (a combination of fee-for-service, per member per month, and

pay-for-performance) occurred, but stakeholders did not discuss specific amounts plans would pay the practices.

Other Decision-Making

States without antitrust policies used a variety of approaches to make nonfinancial decisions in their multipayer initiatives. For example:

- In Colorado, the Multipayer Patient-Centered Medical Home Project initiative was supported by HealthTeamWorks, a multistakeholder, non-profit collaborative.¹⁵

Colorado's HealthTeamWorks worked one-on-one with health plans to simplify or clarify contract language or other issues in the Colorado Multipayer Patient-Centered Medical Home Project. The payment contracts and payments themselves were made between the practices and plans. Several of the participating health plan attorneys also developed an "antitrust" document with guidelines read at all meetings of plans, practices, and other stakeholders to ensure antitrust regulations were being followed.¹⁵

- In North Carolina, Community Care of North Carolina has a memorandum-of-agreement with the Department of Health and Human Services and is the organization responsible for the multipayer medical homes implementation project.¹⁶
- West Virginia established the West Virginia Health Improvement Institute as a forum for multiple stakeholders to come together and address improvement opportunities in the state.¹⁷ Nonfinancial decisions and planning for the initiative were done through a work group that included payers, professional associations, the state's quality improvement organizations, and representatives from consumer groups.

- Michigan uses a steering committee to make recommendations on nonfinancial decisions to the Michigan Department of Community Health.

SUMMARY

Convening multipayer initiatives may raise concerns over antitrust risk for states, private health care payers, and other participants. Payers may be protected from antitrust liability through a legal concept known as the state action doctrine in cases where states have clearly articulated the need for displacement of competition among health care payers and actively supervised non-state actors in implementing that policy. This brief provides examples of how states with multipayer medical home initiatives in place are using legislative, executive, or regulatory policies to provide some protection from antitrust laws.

Multipayer medical home initiatives also are occurring in states where there has not yet been a clear articulation of state policy through legislation or executive order. States without such policies in place are still able to advance their multipayer initiatives by avoiding discussion of payment amounts among the different stakeholders. Colorado, for example, has addressed the lack of antitrust protection in one of its multipayer pilots by using a nonstate office as a neutral convener and by working individually with each payer under guidance from legal counsel.¹⁸ Specifically avoiding group discussions about payment amounts and ensuring those participating are aware of antitrust risk can provide an avenue, apart from state-level policies, to advance multipayer initiatives.

APPENDIX A. COLORADO HEALTHTEAMWORKS GUIDELINES

PCMH Pilot Project Antitrust Guidelines for Meetings

HealthTeamWorks

January 14, 2008

- Set an agenda for each meeting and focus your conversations on the agenda topics. Do not let the conversation wander into subjects that have antitrust sensitivity.
- The agenda may include discussions and joint decisions on the elements of the PCMH pilot, including what services physician practices will be asked to perform as “medical homes.”
- Participants may not discuss how to set reimbursement for PCMH services or how much will be paid for PCMH services. However, program elements related to reimbursement that are essential to execution of the pilot program may be discussed and agreed upon.
- Competitively sensitive and confidential information (e.g., provider fee schedules, payers’ market shares, premiums, or marketing plans being developed) may not be discussed.
- Providers who participate in the meetings may not discuss how much they want to be reimbursed for their services.

NOTES

- ¹ M. Takach, “About Half of the States Are Implementing Patient-Centered Medical Homes for Their Medicaid Populations,” *Health Affairs*, Nov. 2012 31(11):2432-40.
- ² West Virginia initiative is no longer active; National Academy for State Health Policy, Medical Home and Patient-Centered Care Map, <http://www.nashp.org/med-home-map>.
- ³ Centers for Medicare and Medicaid Services, Medicare Demonstration Projects and Evaluation Reports—Multi-Payer Advanced Primary Care Initiative, <http://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Medicare-Demonstrations-Items/CMS1230016.html>; and Centers for Medicare and Medicaid Services, Comprehensive Primary Care Initiative, <http://innovation.cms.gov/initiatives/comprehensive-primary-care-initiative/>.
- ⁴ Centers for Medicare and Medicaid Services, State Innovation Models Initiative: General Information, <http://innovation.cms.gov/initiatives/state-innovations/>.
- ⁵ *Parker v. Brown*, 317 U.S. 341 (1943).
- ⁶ American Bar Association, *Antitrust Law Developments*, 7th ed. (Chicago: American Bar Association, 2012).
- ⁷ Office of the Health Insurance Commissioner of the State of Rhode Island, Mission, http://www.ohic.ri.gov/AboutUs_Mission.php. In a May 2008 memorandum, the health insurance commissioner described the state’s policy rationale. Patient-Centered Primary Care Collaborative, “Anti-Trust Memorandum,” available at <http://moo.pcpcc.net/content/anti-trust-3>.
- ⁸ In Pennsylvania, the former Governor’s Office of Health Care Reform (GOHCR) established a commission and convened the state’s multipayer Chronic Care Initiative in 2007. At that time, the governor’s health policy advisor and others felt that the executive order creating the commission and the convening role of the GOHCR provided payers with sufficient protection from antitrust issues. Since the change in administration in 2011, a second phase of the Chronic Care Initiative has been launched and the oversight for the initiative has been moved to the Department of Health. A. Torregrossa, “Partnering with the Private Sector in State Medical Home Initiatives,” Presentation at the National Academy for State Health Policy 2009 Annual Conference, Oct. 5–7, 2009.
- ⁹ AcademyHealth, *Navigating Antitrust Concerns in Multi-Payer Initiatives* (Washington, D.C.: AcademyHealth, 2010).
- ¹⁰ Catherine Harrison, e-mail message to author, May 9, 2013.
- ¹¹ Washington State Senate Bill 5891, Primary Care Medical Home Reimbursement Pilot Projects, <http://apps.leg.wa.gov/documents/billdocs/2009-10/Pdf/Bills/Senate%20Bills/5891-S.pdf>.
- ¹² Vermont Act 48, An Act Relating to a Universal and Unified Health System, <http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf>.
- ¹³ New York Public Health Law Title 2, Section 2959, Adirondack Medical Home Multipayer Demonstration Program, http://www.law-server.com/law/state/new-york/ny-laws/ny_public_health_law_2959-a.
- ¹⁴ Colorado, Maine, Michigan, Minnesota, North Carolina, and West Virginia.
- ¹⁵ HealthTeamWorks, <http://www.healthteamworks.org/>.
- ¹⁶ Community Care of North Carolina, <https://www.communitycarenc.org/>.
- ¹⁷ West Virginia Health Improvement Institute, <http://www.wvhealthimprovement.org/>.
- ¹⁸ M. G. Harbrecht and L. M. Latts, “Colorado’s Patient-Centered Medical Home Pilot Met Numerous Obstacles, Yet Saw Results Such as Reduced Hospital Admissions,” *Health Affairs*, Sept. 2012 31(9):2010–17.

ABOUT THIS STUDY

Information for this brief was obtained primarily through a survey designed in consultation with Emily Myers of the National Association of Attorneys Generals. Project leads of medical home initiatives in 14 of the 20 states with multipayer medical home initiatives received the survey by email.^a All 14 states responded. After the survey was fielded, an additional state (Montana) passed new legislation aimed at mitigating risk of antitrust violations in a multipayer initiative it has been planning for several years. This initiative was added to the results.

We did not reach out to the other five states with multipayer medical home initiatives because their medical home efforts in place were developed under the federal Comprehensive Primary Care Initiative.^b Under this program, all meetings convening payers and practices are conducted in a manner in which there is no antitrust protection.^c

We followed up with states and used other sources to verify information as needed.

^a Colorado, Idaho, Maine, Maryland, Massachusetts, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

^b Arkansas, New Jersey, Ohio, Oklahoma, and Oregon. In the Comprehensive Primary Care Initiative, the Centers for Medicare and Medicaid Services (CMS) invited Medicaid and commercial payers to join Medicare in a multipayer medical home initiative; CMS provided guidance and offered flexibility to payers in developing their own payment models. See <http://innovation.cms.gov/Files/x/Comprehensive-Primary-Care-Initiative-Solicitation.pdf>.

^c Edith Stowe, personal communication with author, June 6, 2013.

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