Avoiding Antitrust Problems

While price-fixing is generally prohibited, the government allows competitors to collaborate if it improves patient care. Learn the three permissible mechanisms for joint collaboration.

This is the third of seven sections in the Guide to Innovative Practice Models. To access other sections or the full guide, visit apapracticecentral.org.

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The nation’s antitrust regulations were originally designed to keep giant oil companies and railroads from becoming monopolies. But the laws also apply to solo practitioners and small practices: Competitors can’t negotiate jointly because that would mean price-fixing.

The government recognizes, however, that sometimes joint negotiation is good for consumers. That ability to jointly negotiate contracts is one of the advantages of certain innovative practice models, such as independent practice associations and management services organizations.

There are two basic approaches for joint negotiation:

**Messenger model.** With this approach, one person agrees to serve as a conduit for price information between a payer and a network of providers. The process begins with asking providers privately what fee they would be willing to accept for a given service. The messenger finds an optimum price point of $100. The messenger then brings that information to the payer, saying, for example, “If you pay $100, I can offer you a network of 200 providers.” If the payer counters with a lower number, the messenger simply consults the list of providers to see how many would be willing to accept that lower rate. The messenger can then either tell the payer, “OK, I can offer you a network of 150 providers at that rate,” or can go back to those 50 providers to see if they’d be willing to accept the lower rate in order to stay in the network.

This model is easy to set up. The downside? It can be difficult for the messenger to avoid the temptation of directly negotiating with the payer, which is strictly forbidden.

**Financial or clinical integration.** Most psychologists aren’t interested in financial integration, which entails sharing financial risks through capitation arrangements or risk pools. Clinical integration is more attractive because it helps practices improve care, lower costs and enhance patient satisfaction while avoiding antitrust problems. To achieve clinical integration, a practice should have most or all of the 11 elements outlined at apapracticecentral.org/update/2015/04-30/antitrust-issues.aspx.

Clinical integration can be hard to set up. An experienced antitrust attorney should review your plans.

The practice must have measurable goals for monitoring utilization and treatment quality, for example. There must also be a process for disciplining or even terminating practitioners who can’t meet those goals.

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* Innovative Practice Models (IPM), formerly referred to as Alternative Practice Models, is now being used to avoid confusion with Alternative Payment Models.
Clinical integration can be hard to set up. An attorney with expertise in antitrust for innovative practice models should review your plans. The upside? That investment will pay off because the elements of clinical integration are beneficial.

Clinical integration is **more attractive [than financial integration]** because it helps practices **improve care, lower costs and enhance patient satisfaction while avoiding antitrust problems.**

Don't ask what the bare minimum is you should do to avoid antitrust trouble. Instead, ask how you can use integration to improve patient care. By doing so, you'll be making your services more marketable to consumers and payers. Plus, you'll have data you can take to a hospital system or payer to show the results you're achieving with your patients.

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