

Below is a draft synopsis of an April 28 meeting between a cross-section of private purchasers and DoJ anti-trust officials, courtesy of Steve Wojcik at NBGH. It is in the form of responses to the specific questions we provided DoJ going into the meeting. At the end is a DOJ-provided list of links to relevant documents.

As follow up, we are trying to get a better understanding of what would constitute a legitimate joint venture among purchasers established to achieve savings in contracts with providers over and above transactional savings. We will be cataloging past and present examples and assessing their functioning.

**April 28<sup>th</sup> Meeting at DoJ  
Purchasers, Promoting Patient Safety, and Antitrust  
Government attendees: Gail Kursh, Josh Soven, and Luke O'Brien from DoJ and  
Sean Cavanaugh from CMS (for Peter Lee)**

1) Given that consumers are being harmed, sometimes irreparably, by poor quality health care; couldn't an argument be made that the public interest good of steering consumers to better quality care (via purchasing decisions) should at least mitigate some of the anti-trust concerns?

*No. A good motive does not justify anti-competitive behavior and the parties would still be subject to the same anti-trust rules. They candidly sympathized with the unlevel playing field that purchasers face but said that the anti-trust law applies to buyers and sellers alike.*

2) Having a standard "hospital safety report card" to be used by all the National Partnership stakeholders would be very helpful. There are a variety of reporting formats used by a variety of sources—NQF, Leapfrog, CMS, and various companies' proprietary products. The problem is that each of these entities uses somewhat different measures and the proprietary products use black box science to roll up the results, each doing it somewhat differently. The differences undermine the effectiveness of any national strategy. There is precedent in CA for doing this kind of multi-stakeholder common-format reporting: CA P4P, a multi-stakeholder group composed of health plans, capitated medical groups, purchasers, consumers, and some hospitals has been doing it as an initiative of the Integrated HealthCare Association for about 7 years. We understand that Ropes and Gray attorneys engaged with the DOJ on this prior to the launch. As we understand it, the IHA program even includes a standard set of pathways to reward performance, although the \$ amount of the rewards varies by Plan/purchaser

*Buyers coming together and reaching a consensus on quality measures does not pose a problem. Sharing historical information on what works, listing measures, listing payment options, making recommendations, sharing results of studies of payment methods, are all okay. Problems would occur if the coalition of buyers together either stated or implied as a group that if plans, suppliers, or providers did not use the measures, the coalition of buyers would not do business with them. This action would be considered a direct or implicit boycott, and per se illegal.*

3) Purchaser led coalitions (and also the multi-stakeholder coalitions in some communities) often organize meetings with health plans individually but also as a collective group to discuss how to advance value based purchasing efforts at a community/market wide level. The results from the National Business Coalition on Health “eValue8” tool, i.e., material on purchasing experience with health plans available on the NBCH website, are often used to help facilitate these conversations with plans. In these meetings, coalitions, including their employer purchaser members, would like to have a candid group discussion about what health plans are doing to move to performance based payments with providers and, as part of this dialogue, discuss future goals and expectations (for example, that by 2017, like Medicare, 9% of total hospital reimbursement by private sector health plans will be performance based using standardized performance measures). We heard some real push back about these kind of conversations in the March meeting,. We'd be interested in hearing more about the ground rules for meetings between union/employer purchasers and multiple health plans and, specifically, recommendations about how we structure these conversations within the parameters of anti-trust law and keep the goal of moving the needle on performance based payments with providers in measurable ways.

*See response to 2) for what is okay and what is not. If the coalition is operating outside of a joint venture and independent purchasers are coming together, they can talk generally about problems, future goals, desired states, suggestions, and share information as long as it is not price sensitive information or signaling future prices or output. Regarding contract language, you may say here is good contract language but don't recommend that they use it or identify who is using it. If the coalition is a joint venture and is confident that it does not have too much market power to set prices or allocate local markets, then coming together to discuss reimbursements, payments, rates, payment method is okay. Otherwise, it could be okay or not depending on the joint venture's relative market power and its effects on the market and whether the benefit of efficiencies of buying jointly. The rule of reason would apply in these cases.*

*The DoJ cannot give an absolute green light to sharing purchasing data among competitors without knowing the specific data involved. The older the data the better. If it is newer data, aggregate data are better than those indentifying hospitals, plans, or providers. Once we have specific information, the DoJ strongly suggested that we seek a business review. They promised to expedite letters and the goal would be to identify and correct any potential problems so that the end result would be a positive advisory opinion letter.*

4) At the March meeting, mention was made about a “safe harbor” where purchaser form an entity specifically for the purpose of aggregating purchasing power . Did we hear this correctly and , if so, what distinguishes such an entity from purchasers getting together on an ad hoc basis for the same purpose?

*A bona fide joint venture (one that creates market efficiencies by lowering structural costs, not just transactions costs) , if it does not have too much market power, is the only safe harbor in which purchasers can come together to discuss prices, etc. However, they cautioned that even here if it is leveraging too much market power to set prices or control output, it could be a problem.*

5) Some of us were surprised to hear at the March meeting that discussions among employers of measures that would be appropriate for value-based purchasing (VBP) in health care would put those purchasers on thin ice, anti-trust wise. Most of the purchasers in that meeting are working now, informally, to identify all existing measures endorsed by the National Quality Forum that relate to Hospital Acquired Conditions and preventable re-admissions and further identify what would be widely considered as best in class measures. This information would be part of a toolkit that we would make publicly available as a resource for purchasers to use in making their own choices about VBP.

*See response to 2) above.*

6) In a similar vein, we are reviewing what is known about VBP programs currently in use in the private sector, or ones that have been tried in the past. We envision commissioning a health policy analytics firm to interview all the major health plans and conduct a literature search to identify case studies in this regard. That research report would then be used to develop a menu of purchasing methodology for use by individual purchasers in their own decisions. Would that be problematic?

*Not a problem as long as you don't recommend which one or ones to use or identify who is currently using which methods. They didn't see a problem in our reporting out what health plans and/or purchasers see as their more successful VBP efforts in the past, e.g. their idea of best practices, as long as none is recommended going forward and it would not be construed as signaling about future intentions in negotiations with providers.*

7) Would sharing individual purchaser RFP's or actual health plan contract language on VBP methodology (without any pricing information) pose potential problems.

*Unidentified contract language seemed okay to them. They recommended against sharing identified purchasers' contract language or payment terms with other payers.*

Pasted below are links to six of the Division's Business Review letters since 1993 related to data exchange in the health care industry that DoJ provided in conjunction with the meeting.

Pacific Business Group on Health:  
<http://www.justice.gov/atr/public/busreview/258013.htm>

Southwest Oncology Group (Nov. 2, 1995):  
<http://www.justice.gov/atr/public/busreview/0461.htm>

Seeskin, Paas, Blackburn and Company (Jun. 29, 1994):  
<http://www.justice.gov/atr/public/busreview/0787.htm>

Birmingham Cooperative Clinical Benchmarking Demonstration Project (Jun. 20, 1994): <http://www.justice.gov/atr/public/busreview/211862.htm>

Hotel Employees and Restaurant Employees International Union Welfare Fund  
(May 20, 1994): <http://www.justice.gov/atr/public/busreview/0785.htm>

Houston Health Care Coalition (Mar. 23, 1994):  
<http://www.justice.gov/atr/public/busreview/0784.htm>