Edith Ramirez
Julie Brill

In the Matter of	)	
Minnesota Rural Health Cooperative, a corporation.	)	**DOCKET NO.**

COMPLAINT

Pursuant to the provisions of the Federal Trade Commission Act, as amended, 15 U.S.C. § 41, *et seq.*, and by virtue of the authority vested in it by said Act, the Federal Trade Commission ("Commission"), having reason to believe that Respondent Minnesota Rural Health Cooperative ("MRHC") violated Section 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, and it appearing to the Commission that a proceeding by it in respect thereof would be in the public interest, hereby issues this Complaint, stating its charges in that respect as follows:

I. NATURE OF THE CASE

1. This matter concerns agreements among competing hospitals, physicians, and pharmacies in rural Minnesota to fix prices and collectively negotiate contracts, including price terms, with health insurers and other third-party payers in Minnesota. The hospitals, physicians, and pharmacies orchestrated these agreements through the MRHC. The MRHC, originally composed of hospitals and physicians, has fixed prices of hospital and physician services since 1996. After the Congress enacted the Medicare prescription drug program in 2003, the MRHC recruited pharmacies as members and began to negotiate prices collectively on their behalf. The MRHC has not undertaken any efficiency-enhancing integration that could justify the challenged conduct. By collectively negotiating prices without any legitimate justification, the MRHC has engaged in unfair methods of competition.

II. RESPONDENTS AND JURISDICTION

A. Respondent

2. The Minnesota Rural Health Cooperative is a for-profit corporation that is organized, exists, and does business as a health provider cooperative under and by virtue of the laws of the State of Minnesota with its principal address at 190 E. 4th Street N., P.O. Box 155, Cottonwood, MN 56229-9902.

3. The MRHC has approximately 22 hospital members and 114 physician members, who practice in approximately 47 clinics. During the relevant time period, the hospital members included most of the hospitals, with two-thirds of hospital beds, in the area of southwestern Minnesota in which the MRHC operates.

4. Between early 2005 and late 2007, the MRHC had approximately 70 pharmacist members. These pharmacists operated in rural Minnesota, outside of the Minneapolis-St. Paul area. The MRHC terminated these pharmacist memberships in November 2007.

B. Jurisdiction

5. The MRHC is a corporation within the meaning of Section 4 of the Federal Trade Commission Act.

6. At all times relevant to the Complaint, the MRHC has been engaged in the business of contracting with payers, on behalf of its members, for the provision of physician, hospital, and pharmacy services to persons for a fee. Except to the extent that competition has been restrained as alleged herein, MRHC's physician, hospital, and pharmacy members have been in competition with one another for the provision of physician, hospital, or pharmacy services.

7. The general business practices of the MRHC, including the acts and practices alleged herein, affect the interstate movement of [illegible]

demands. Moreover, in furtherance of this conduct, members of the MRHC have refrained from negotiating individually with payers.

A. Agreement among MRHC Members to Negotiate Collectively

16. Pursuant to the MRHC bylaws, MRHC members elect physicians and hospital representatives to serve on the MRHC's Board of Directors and manage the MRHC's operations. The Board oversees all contract negotiations and approves all contracts between the MRHC and third-party payers.

17. MRHC members, in joining MRHC, agree to participate in the MRHC's contracts with payers. In accordance with their MRHC membership and provider participation agreements, MRHC members grant MRHC the authority to contract on their behalf and they agree to accept payment for their services accor

payers attempted to negotiate separately with particular members, the members rebuffed these efforts.

22. Through its collective negotiations and coercive tactics, the MRHC succeeded in extracting increased payments to MRHC members in at least three forms: higher reimbursement rates than comparable providers, more favorable payment methods, and increased reimbursements for new MRHC members.

23. First, the MRHC obtained higher prices from payers. Indeed, the MRHC told its members at the 2005 annual membership meeting that improvements in its contract with Preferred One would be "worth $100,000s annually for MRHC members." Five payers — HealthPartners, Medica, MultiPlan, Preferred One, and America's PPO — have paid MRHC members more than comparable rural hospitals and/or physicians elsewhere in Minnesota.

24. Second, the MRHC's agreements with two payers — Medica and Preferred One — require them to pay MRHC hospital and physician members based on a percentage of billed charges, rather than a fixed fee for each service. Payers generally prefer a fixed fee schedule because it prevents providers from increasing their billed charges at will. By obtaining reimbursement rates based on a percent of billed charges, MRHC providers can unilaterally increase their reimbursement, by increasing their billed charges up to the maximum specified in the contract.

25. Third, the MRHC has forced payers to reimburse new MRHC members at the higher MRHC rates, even though the members had existing contracts with the payer that paid lower rates. For example, MultiPlan had to increase one hospital's reimbursement rate from 78 percent of billed charges to a significantly higher percent of billed charges merely because it joined the MRHC. Moreover, Medica told the MRHC that "because of the Co-op relationship all of the clinics and hospitals, except Rice, are being paid higher reimbursement then they were prior to our Medica agreement with the Co-op."

C. Price Agreements on Pharmacy Services

26. After pharmacists approached it, the MRHC recruited pharmacies by offering to increase Medicare prescription drug program (Part D) reimbursement levels, urged pharmacies not to deal individually with PBMs, and negotiated collectively and contracted with at least six PBMs.

27. To participate in the new Medicare Part D program, each PBM or other payer had to find enough pharmacies to meet the "Tricare access standard." This standard required that each network include a sufficient number of pharmacies to ensure that 70 percent of rural beneficiaries lived no more than 15 miles from at least one participating pharmacy.

28. By "stand[ing] together and speak[ing] with ONE voice" to the PBMs," the MRHC believed it could leverage the federal access requirements for Part D networks to obtain higher reimbursement rates. The MRHC repeatedly stressed the benefits of standing together and

negotiating as a block in letters to members and prospective members. A June 27, 2005, letter explained that:

> With our membership in MRHC comes the opportunity to stand together and speak with ONE voice to the PBMs. . . . We have to stand together in this effort or once again the PBMs will intimidate us and pick us off one by one with contracts we don't want.

The letter included the precise reimbursement levels that the MRHC would seek from PBMs, which were above the levels that PBMs were offering.

29. To maximize the pharmacies' negotiating leverage, the MRHC urged its pharmacy members not to deal individually with PBMs:

> Do NOT sign and return your Medicare Part D PBM contracts. MRHC will review and negotiate these for you during the next few weeks. The contracting deadline is not until later this summer and our best leverage is to take our time to negotiate as a block. The bigger block the better [sic].

The MRHC repeated this message to prospective members:

> We are asking all MRHC members NOT to sign and return their Medicare Part D PBM contracts. MRHC will review and negotiate these for them during the next couple of weeks. Our best leverage is to take our time to negotiate as a block, and the bigger block the better. . . . [sic]
> Don't sign contracts but notify the PBMs who will act as your agent – the MRHC!

30. To "speed up" the PBMs' acceptance of the MRHC as the pharmacies' bargaining agent, the MRHC provided each pharmacy member with labels that referred the PBM to MRHC to attach to offers that PBMs sent them. Many member pharmacies followed the MRHC's instructions to return the offers to the PBMs with such labels attached.

31. The MRHC negotiated with at least eight PBMs over Part D reimbursement levels and reached agreements on behalf of the MRHC establishing prices and other competitively significant terms with six of them. The MRHC transferred management of these agreements to a pharmacy services administration organization in early 2008.

V. LACK OF JUSTIFICATION FOR THE CONDUCT

ies' neg

The withholding arrangements in the remaining three contracts withhold at most ten percent of physician charges and return money to the MRHC members regardless of whether they achieve cost-containment goals.

34. Nor have the MRHC and its physician members undertaken any clinical programs or activities that create any significant integration among its members' clinical practices. The MRHC provides its physician members with certain practice management programs (including two quality improvement projec

39. As alleged above, the MRHC and its members eng

WHEREFORE, THE PREMISES CONSIDERED, the Federal Trade Commission on this _____ day of _____, 2010, issues its Complaint against the Minnesota Rural Health Cooperative.

By the Commission.

Donald S. Clark
Secretary

SEAL