In-Depth Antitrust Analysis: Will Your Proposed Integration Incur Antitrust Scrutiny?

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Overview

- Health reform seeks to stimulate greater focus on improved health outcomes and efficiency, in part through support of Accountable Care Organizations
- Critics of current antitrust agency guidance claim that it could chill desired ACO development
- Others are concerned that providers may in some instances latch onto ACOs to restrain competition and drive price increases
- Our focus will be on ground game of ACOs and clinically integrated networks – what are the truly tough issues and how are they evaluated under the antitrust laws

Accountable Care Organizations

- Section 3022 of PPACA requires the Secretary of HHS to develop a Medicare Shared Savings Program by 1/1/12
- Groups of providers "may work together to manage and coordinate care for Medicare fee-for-service beneficiaries"
  - ACOs that meet quality standards defined by the Secretary are eligible to receive "payments for shared savings," in addition to regular FFS payments
  - May also employ a "partial capitation" model or other model approved by HHS
- ACOs must have a minimum of 5,000 Medicare beneficiaries
- Note difference from Medicare Advantage – beneficiary does not "join"

Healthcare Innovation Zones

- Section 3021(b)(2)(B)(xviii) of PPACA also encourages creation of "Healthcare Innovation Zones"
  - Enabling "comprehensive [Medicare] payments to [HIZs], consisting of groups of providers that include a teaching hospital, physicians, and other clinical entities, that . . . deliver a full spectrum of integrated and comprehensive health care services to applicable individuals while also incorporating innovative methods for the clinical training of future health care professionals."

Antitrust Context

- Price fixing unlawful, but price setting incidental to bona fide joint venture, not per se unlawful
- Depends on overall competitive impact
- Longstanding antitrust issues with provider networks that negotiate price
  - Is there real integration that provides efficiencies - clinical, financial or otherwise
  - Is joint price setting needed to make the initiative work
  - Will the venture blockade competition or cause competitive harms that outweigh benefits -- too much market power? Exclusivity that creates bottleneck?
- ACOs can involve both clinical and, via performance savings distributions, financial integration

ACOs and Clinical Integration

- "Clinical integration" first described in 1996 FTC/DOJ statements on antitrust enforcement in health care --
  - "an active and ongoing program to evaluate and modify practice patterns by the network's physician participants and to create a high degree of interdependence and cooperation among the physicians to control costs and ensure quality."
- Subsequent FTC advisory letters to MedSouth IPA, Suburban Health Organization, Greater Rochester IPA, and Tri-State PHO provided additional guidance
- Statutory criteria for ACOs line up closely with features noted in FTC advisory letters

ACO Requirements Compared to IPAs/PHOs Reviewed by FTC for Clinical Integration

ACO Requirements	MedSouth	GRIPA	Tri-State	SHO*
Accountable for quality, cost, and overall care	✓	✓	✓	✓
Formal legal structure organization to receive and distribute payments	✓	✓	✓	✓
Includes sufficient number of PCPs for number of patients	✓	✓	✓	✓
Leadership and management structure that includes clinical and administrative systems	✓	✓	✓	✓
Reports on quality, utilization, and clinical processes and outcomes	✓	✓	✓	✓
Defines processes to promote evidence-based medicine, reports on quality and cost measures, and coordinates care, such as through use of telehealth, remote patient monitoring, and other technologies	✓	✓	✓	✓
Meets patient-centeredness criteria specified by HHS	?	?	?	?

**** Denied FTC approval***

Additional Factors Considered by FTC

Factors	MedSouth	GRIPA	Tri-State	SHO*
Use of health information technology	✓	✓	✓	✓
Physician investment of capital	✓	✓	✓	X
Non-exclusive contracting by physician members	✓	✓	✓	X
Joint contracting ancillary to expected efficiencies	✓	✓	✓	X
Appropriate enforcement mechanisms to ensure member compliance	✓	✓	✓	X

**** Denied FTC approval***

ACOs and Market Power

- ACOs expected to be of sufficient scale to achieve statutory objectives
- HHS may have less reason to be concerned with market power in FFS Medicare than private payers
  - ACOs will not be negotiating rates of payment under FFS Medicare, but in commercial setting could seek to negotiate rates
- ACO could also in some cases impinge on prospects for Medicare Advantage programs

ACOs and Market Power *(cont'd)*

- ***See* MedPAC Report to Congress, "Improving Incentives in the Medicare Program"** (June 2009):
  - "One danger is that physician groups consolidate into larger entities and use this negotiating power to increase prices charged to private insurers."
- **Berenson, Ginsburg, & Kemper in *Health Affairs*** (April 2010):
  - "If [ACOs] lead to more integrated provider groups that are able to exert market power in negotiations – both by encouraging providers to join organizations and by expanding the proportion of patients for whom provider groups can negotiate rates – private insurers could wind up paying more, even if care is delivered more efficiently."

ACOs and Market Power *(cont'd)*

- **Cf. Guerin-Calvert & Israilevich, "A Critique of Recent Publications Claiming Provider Market Power," (October 2010)**
  - "Conclusions [in recent reports] that provider organization size and provider consolidation are the primary drivers of price are . . . however, not empirically supported or well founded."
  - "Rather than making broad assumptions about the effects of mergers and consolidation or the formation of new organizations such as [ACOs], evaluation should be based on sound economic principles and an examination of very specific facts and circumstances

Tension lines explored in FTC-HHS ACO workshop

- "[C]onsiderable information has been provided in recent years by the FTC. What is missing, however, is user friendly, officially backed guidance that clearly explains to caregivers what issues they must resolve to embark on a clinical integration program without violating the antitrust laws. – AHA
- "The current clinical integration standards published in the Statements and FTC advisory opinions to date will deter the formation of ACOs." -- AMA
- "The agencies must remain vigilant in their enforcement of existing law to ensure that . . . consolidation does not reduce market competition, resulting in higher prices or other consumer harm." -- AHIP
- More clarity needed? Better advisory process needed? Change in substantive policy?

Does current antitrust agency enforcement guidance chill ACO development?

- Should there be more latitude for exclusivity?
  - What is meant by exclusivity?
  - Participation in only one ACO?
  - No managed care contrating outside ACO?
  - No independent contracting if payer has elected to contract with ACO?
- Should there be acknowledgement that ACO could have high share of providers in more circumstances than FTC has yet noted?
- Should there be acknowledgement that in some markets there may be room for only one ACO – a natural monopoly
- Should mergers be permitted to facilitate ACOs or are there less anticompetitive alternatives?
- Should there be a process for ACO approved by Medicare to get fast track antitrust approval, for operations in commercial market as well as Medicare

Should satisfying CMS requirements mean ACO will be OK under antitrust law to operate in commercial market?

- CMS contract with ACO will be strong indicator of procompetitive integration, to avoid "per se" condemnation, where same tools are used in private sector programs by ACO
  - Most past FTC and DOJ enforcement has involved pricing collaboration by providers that lacked meaningful integration
- Greater potential for exercise of market power to force rate increase in commercial sector than Medicare?
  - Medicare FFS rates are fixed by government; commercial rates can be negotiated
  - Will ACO be blockade against providers' participation in Medicare Advantage?
  - When is provider exclusivity a problem? Is the 20% safety zone threshold too low?

Case study

- Hospital system ABC seeks to form an ACO along with 150 of its employed physicians and an additional 250 independent physicians.
  - ABC is one of two major systems in a mid-sized metropolitan area, accounts for about 40% of the hospital admissions in the market.
  - Physicians in the proposed ACO constitute approximately 40% of the total physicians in the market, although the percentages vary from specialty to specialty. In some subspecialties, the percentage is as high as 85%.
- ACO has submitted an application to HHS to be recognized for Medicare purposes, that shows attention to all the HHS requirements, but HHS has not yet acted on it.
- ACO proposes to negotiate network managed care contracts that would include ABC's hospitals and each of the ACO physicians.
  - All participants in the network have agreed that they will not separately negotiate with any payer that has a contract with the network or is in the process of negotiating with it.
  - One of the network's contracting goals is to seek shared savings from private payers tied to performance objectives.
- What level of antitrust risk does the network face in doing private payer business?
- Would the risk level change if the network receives ACO approval from HHS?
- Is this an "exclusive" network under the FTC-DOJ policy statements?
- Should ABC and the physicians seek FTC advice in advance of going into business?