# Antitrust and Accountable Care Organizations

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***The Nuts and Bolts of Accountable Care: ACOs and Beyond***

**March 29, 2011**

## Clinical Integration Defined

- "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

## Accountable Care Defined

- Under the Shared Savings Program, an ACO:
  - "promotes accountability for a patient population and coordinates items and services under Parts A and B *[Medicare insurance for hospital, skilled nursing facility and physician services],* and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery"
- 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 in some instances have very high share of providers?
- 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 – or even not -- 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?