



# **Antitrust and ACOs: What the Antitrust Enforcement Agencies Have in Store for ACOs**

Tuesday, April 26, 2011 · 1:00-2:30 pm Eastern

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## Disclaimer

- Susan DeSanti's remarks reflect her own views and not necessarily those of the Commission or any Commissioner.

# Overview

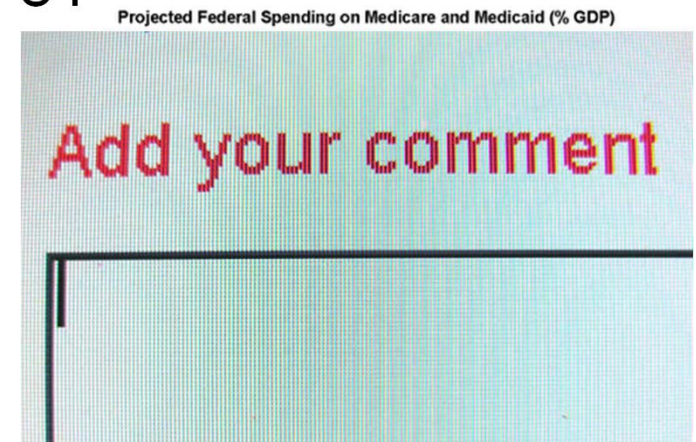
- Background
- Applicability of Policy Statement
- Issues addressed
  - Price fixing: Avoiding the per se rule
  - Rule of Reason: Market power screens
- Specific issues in share calculations
- Examples
- Observations

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## Background

- Why was the Policy Statement issued?
  - Medicare's Shared Savings Program
  - ACOs will operate in SSP and commercial market
  - Providers want additional guidance
  - Payor concern: consolidation, increased market power
- Next step: comments through May 31



## Background

- Prior FTC and DOJ collaboration in areas of importance to health care:
  - Health Care Statements (1996)
  - Improving Health Care: A Dose of Competition (2004)
  - Competitor Collaborations (2000)
  - Merger Guidelines (2010)



## Background

- Joint FTC/CMS workshop on ACOs in 2010



Materials: [www.ftc.gov/opp/workshops/aco/index.shtml#webcast](http://www.ftc.gov/opp/workshops/aco/index.shtml#webcast)

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- **Applicability of Policy Statement**
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## The Policy Statement

- Applies to:
  - ☐ Collaborations among otherwise independent providers formed after March 23, 2010, that seek to participate in the Shared Savings Program
- *Significance of March 23, 2010?*
- *Does the Policy Statement apply to a single integrated organization that forms an ACO?*

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  - Price fixing: Avoiding the per se rule
  - Rule of Reason: Market power screens
- Examples
- Observations and issues

## Price fixing: Avoiding the per se rule

- Issues arise when competitors collaborate
  - Price fixing and market allocation (Sherman § 1)
- Is an ACO integrated?
  - Financial integration
  - Clinical integration
- Test:
  - Is ACO integration likely to produce benefits?
  - Is setting price reasonably necessary for the benefits?

## Price fixing: Avoiding the per se rule

- Previous agency approach to clinical integration
  - FTC staff letters responding to proposals
- Policy Statement approach
  - Greater certainty needed for ACOs
  - Defers to CMS integration criteria
    - See: discussion in Proposed Rule (starts at p. 51)
    - Section 425.5 of Proposed Rule
- Result: Rule of Reason treatment

## Price fixing: Avoiding the per se rule

- *If CMS approves an ACO, will the antitrust agencies permit the ACO jointly to negotiate reimbursement terms with commercial payors?*
- Yes
  - ☐ So long as:
    - ACO uses same governance and leadership model and clinical and administrative processes as used to qualify for SSP
  - ☐ This applies for duration of participation in SSP
- *Are the standards really going to change if the ACO withdraws from SSP?*

## Price fixing: Avoiding the per se rule

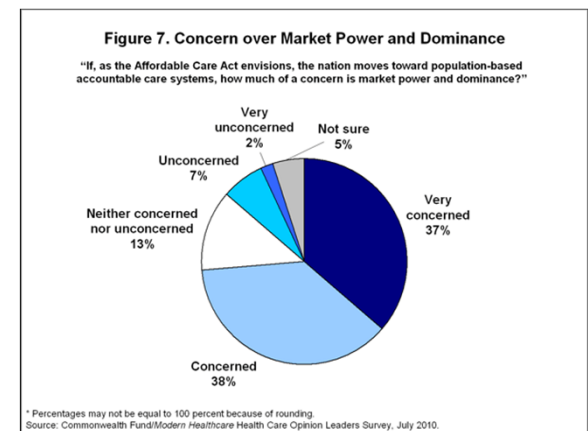
- *What standards will the agencies apply to provider joint ventures that seek to clinically integrate but do not apply for CMS qualification as an ACO?*

# Rule of Reason: Market power screens



## ■ Summary

- Product focus: common services
- Geography focus: PSA
- Share of 30% or less: safety zone
- Share above 50%: clearance needed
- And in between ...



## Rule of Reason: Market power screens

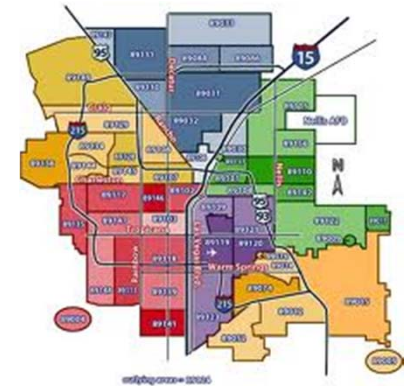


### ■ Common services

- ☐ Physician: primary specialty (MSC)
- ☐ Inpatient facilities: MDCs
- ☐ Outpatient facilities: category as defined by CMS

### ■ PSA

- ☐ Contiguous zip codes making up 75%
- ☐ Borrowed from Stark





## Safety zone

- 30% or less of each common service
  - In each participant's PSA
- What does “safety zone” mean?
  - No agency challenge, absent extraordinary circumstances
  - Does not foreclose private litigants
  - No presumption of illegality outside 30%



## Safety zone

- Hospitals and ASCs
  - ☐ Must be non-exclusive to fall within the safety zone
  - ☐ Regardless of number of hospitals/ASCs in area
- *Can an ACO qualify for participation in the SSP if a hospital participates on an exclusive basis?*
  - ☐ Yes – it just doesn't fall within the safety zone



## Safety zone

- Rural exception: physicians
  - Physicians: ACO in a rural area can include one physician per rural county in a specialty even if that takes the ACO over 30%
  - The physician cannot be exclusive to the ACO
- Rural exception: hospitals
  - ACO can include a “Rural Hospital” and still qualify even if the resulting share exceeds 30%
  - The hospital cannot be exclusive to the ACO



## Safety zone

- Dominant Provider Limitation
  - If a provider with a share > 50% is included, the ACO still qualifies ***if*** the provider is:
    - Non-exclusive
    - The only provider of the service
- *If an ACO includes a single group of OBs who have a 60% share, can the ACO fall within the safety zone?*
  - Yes – but only if it is non-exclusive to the ACO
- *What if that group independently decides not to participate in other ACOs?*

## Safety zone

- How long does protection last?
- For the duration of the ACO's agreement with CMS
  - Unless: provider composition changes significantly
  - Patient growth doesn't matter



## Mandatory review

- If any service line has a share > 50%
- Must obtain clearance letter from an antitrust agency
  - Or CMS will not qualify the ACO
    - See discussion in CMS Proposed Rule at 330-338
    - See Proposed Rule: Section 425.5(d)



## Mandatory review

- What evidence must be submitted to the agencies?
  - ☐ Application to CMS
  - ☐ Documents relating to the ability of the ACO participants to compete with the ACO
  - ☐ Documents discussing business strategies, plans to compete, impact on quality or price
  - ☐ Formation documents
  - ☐ Share calculations, proof of restrictions on exchanging price information among ACO participants, payor contacts, identities of other ACOs in the market.
- *Can the agencies ask for more information?*

## Mandatory review

- *Can an ACO pick and choose between the FTC and DOJ?*

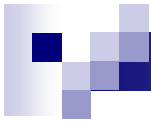


- *Will the agencies ever approve an ACO > 50%?*
  - *What evidence would matter?*
- *Will the agencies take different views?*
- *What about Commissioner Rosch's concern?*



## Mandatory review

- Timing
  - 90 days before the last day on which CMS has stated it will accept ACO applications to participate in the SSP for the relevant year



## Caught in the middle ...

- ACOS between 30% and 50%
- May apply for review
- 90 days; same info



## Caught in the middle ...

ACOs should not:

- Include “anti-steering” clauses in commercial contracts
- Tie their services to payors’ purchase of other services from providers outside the ACO
- Contract with ACO participants on an exclusive basis
  - Exception for primary care physicians
- Restrict a payor’s ability to share cost, quality, efficiency, and performance information with its enrollees
- Share competitively sensitive pricing information regarding ACO participants’ prices outside the ACO

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## Maximum Number of Common Services



- Medicare Specialty Codes (physician)
  - 55 physician specialties
- Major Diagnostic Categories (inpatient)
  - 25 MDCs
- Ambulatory Patient Classifications (outpatient)
  - 31 treatment categories

# MDC as Common Service



- MDC – Major Diagnostic Category
  - Groupings of major diseases or disorders
  - Each MDC typically includes dozens of DRGs
  - Individual services with MDCs are generally not substitutes, usually thought of as “cluster markets” in antitrust analysis
- Using MDC as a “common service”
  - Large enough to group dissimilar services
  - Small enough for subset of services to matter

Example: MDC 5 - Diseases and Disorders of the Circulatory System

- 87 DRGs (50 surgical and 37 medical)
- Some DRGs are low intensity, others tertiary
- Tertiary DRGs can account for large part of patient volume, especially if measured in dollars
- Yet some hospitals in ACO might not offer all DRGs
- Could have overlap at MDC level, possibly with high shares, but no overlap in DRGs that are driving the high shares

## PSA

- *Is it the same as an antitrust relevant market?*
- “[A] court would often be mistaken to conclude that a seller’s ‘trade area,’ or the area from which it currently draws its customers, constitutes a relevant geographic market. In fact, the ‘trade area’ and the ‘relevant market’ are precisely reverse concepts.”

*Bathke v. Casey’s General Stores, Inc.*, 64 F.3d 340, 346 (8th Cir. 1995) (quoting H. Hovenkamp, Federal Antitrust Policy § 3.6d, at 113-14).



## PSA

- “The PSA for each service is defined as the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients] for that service.”

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- “The PSA for each service is defined as the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients] for that service.”
  - ☐ Each common service as defined in Policy Statement
  - ☐ Recall discussion of MDC
  - ☐ Does it matter?

## PSA

- “The PSA for each service is defined as the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients] for that service.”
  - Sort zip codes in descending order of contribution to participant’s total cases
  - Multiple configurations meet criteria if a group of zip codes with same number of discharges are around the 75% level
  - Does it matter?

## PSA

- “The PSA for each service is defined as the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients] for that service.”
  - ☐ Each zip code must touch at least one other
  - ☐ What if zip codes meet at corners only
  - ☐ No requirement of “compactness” (i.e., no holes)
  - ☐ Exclude larger zip code if not touching
  - ☐ Does it matter?

## PSA

- “The PSA for each service is defined as the lowest number of contiguous postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients] for that service.”
  - Add zip codes until the total meets or exceeds 75%
  - Service area size may change dramatically with last zip code, from just under 75% to well over 75%
  - Much omitted in the last 25%
  - Does it matter?

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# Share calculation

Inpatient Services: MDC 06  
Diseases and Disorders  
of the Digestive System



Zip	Hospital Discharges MDC 06	Zip Code Contribution to Hospital Total	Cumulative Zip Code Contribution to Hospital Total	Hospital's Share of Zip Code	Zip Code Total
99999	488	14.8%	14.8%	82.3%	593
99998	357	10.8%	25.6%	77.1%	463
99997	145	4.4%	30.0%	50.3%	288
99996	144	4.4%	34.4%	60.8%	237
99995	112	3.4%	37.7%	60.2%	186
99994	112	3.4%	41.1%	70.9%	158
99993	106	3.2%	44.4%	42.4%	250
99992	98	3.0%	47.3%	23.0%	426
99991	95	2.9%	50.2%	13.6%	696
99990	91	2.8%	53.0%	57.6%	158
99989	80	2.4%	55.4%	57.1%	140
99988	69	2.1%	57.5%	31.7%	218
99987	69	2.1%	59.6%	38.5%	179
99986	68	2.1%	61.6%	20.4%	334
99985	46	1.4%	63.0%	52.3%	88
99984	44	1.3%	64.3%	62.9%	70
99983	43	1.3%	65.6%	16.5%	260
99982	42	1.3%	66.9%	48.8%	86
99981	38	1.2%	68.1%	40.4%	94
99980	38	1.2%	69.2%	11.8%	323
99979	38	1.2%	70.4%	56.7%	67
99978	37	1.1%	71.5%	14.9%	249
99977	37	1.1%	72.6%	56.9%	65
99976	33	1.0%	73.6%	67.3%	49
99975	32	1.0%	74.6%	72.7%	44
99974	32	1.0%	75.6%	55.2%	58
<b>PSA</b>	<b>2,494</b>	<b>75.6%</b>		<b>39.2%</b>	<b>6,359</b>
<b>Total</b>	<b>3,301</b>	<b>100.0%</b>		<b>22.9%</b>	<b>14,437</b>

# Calculations needed



## Mix of large, small providers

	Hospital A	Hospital B	Ancillary K	Ancillary L	Physician X	Physician Y	Total
	A - large, full-service		K - small, limited service		X - large, multi-specialty		
	B - mid-sized, limited service		L - small, limited service		Y - smaller, limited specialty		
MDCs offered (inpatient)	1 - 25	1 - 12					
ASC types (outpatient)	1 - 31	1 - 9	1 - 9	1			
MSC (physicians)					1 - 55	1 - 10	
<b>Number of PSAs and Share Calculations</b>	<b>21</b>	<b>21</b>	<b>9</b>	<b>1</b>	<b>10</b>	<b>10</b>	<b>72</b>



# Calculations needed



## All large providers

	Hospital A	Hospital B	Ancillary K	Ancillary L	Physician X	Physician Y	Total
	A - large, full-service		K - large, multi-specialty		X- large, multi-specialty		
	B - large, full-service		L - large, multi-specialty		Y - large, multi-specialty		
MDCs offered (inpatient)	1 - 25	1 - 25					
ASC types (outpatient)	1 - 31	1 - 31	1 - 31	1 - 31			
MSC (physicians)					1 - 55	1 - 55	
<b>Number of PSAs and Share Calculations</b>	<b>56</b>	<b>56</b>	<b>31</b>	<b>31</b>	<b>55</b>	<b>55</b>	<b>284</b>

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## Observations – agency review

- Change in the role of the antitrust agencies?
- How much information should be supplied with a request for an advisory letter?
- Will agency tell ACO in advance if a negative opinion is forthcoming?
- How much investigation will agencies do to prepare their letters?

## Observations – data limitations

- No Medicare data for obstetrics, pediatrics
- Hospital outpatient department and ambulatory surgery center reimbursed at different rates
- Shares of providers with unusually high Medicare populations not representative of shares of commercial (and possibly opposite)
- Supplemental physician data – physicians located within



## Observations

- Antitrust consequences from exclusion of providers?
- Antitrust guidelines for ACOs



# Questions?

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