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Antitrust Risks of Accountable Care Organizations

The federal government is becoming increasingly committed to enhancing healthcare quality by linking payment to the quality and efficiency of healthcare. The Patient Protection and Affordable Care Act (PPACA)[1] establishes a new model for physician and hospital integration to achieve measureable, improved outcomes and savings for Medicare populations. Successful Accountable Care Organizations (ACOs)—as they are called in the statute—will share in a portion of the savings that are generated for Medicare.

The antitrust laws place potential limitations on the formation and operation of ACOs that could dissuade providers from extending the benefits of such collaboration to all patients, not just those covered by Medicare. Providers are correct to be concerned about the antitrust implications of ACOs, as the federal agencies charged with antitrust enforcement, the Federal Trade Commission (FTC) and the Department of Justice (DOJ), have been active in enforcement efforts against healthcare providers over the last several years. The formation of physician joint ventures for the purposes of gaining efficiencies and negotiating with payers, however, is not uncharted antitrust territory. Guidance from enforcement agencies and generally applicable antitrust principles provide the guideposts for assessing an ACO's antitrust risk.[2]

A. What is an ACO?

PPACA establishes a Shared Savings Program under which healthcare providers that participate in an ACO will continue to receive payments under the original Medicare fee-for-service program. An ACO, however, will be eligible to receive additional payments if it meets certain quality performance standards and benchmarks for care. These standards and benchmarks will be established by rules issued by the Department of Health and Human Services (HHS). ACOs will bring together primary-care physicians and potentially other

1 The Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119-1025 (2010) (to to be codified at scattered sections of 42 U.S.C.), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1020.

2 *See* FTC & DOJ, Statements of Antitrust Enforcement Policy in Health Care (1996) [hereinafter "Health Care Statements"] *available at:* http://www.ftc.gov/bc/healthcare/industryguide/policy/index.htm.

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Healthcare Reform Chart

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providers of services, including specialists and hospitals, to collaborate and integrate their services to provide a continuum of care for a population of Medicare beneficiaries.[3] ACOs will be designed to improve care through medical management protocols, clinical guidelines, and use of information technology. Proponents of ACOs believe collaborations fostered through ACOs will lower the overall costs of delivering care, resulting in savings to the Medicare program.

The PPACA requires ACOs participating in the Shared Savings Program to:[4]

- Become accountable for the quality, cost, and overall care of at least 5,000 Medicare fee-for-service beneficiaries assigned to it by HHS;
- Sign an agreement with HHS to participate in the Shared Savings Program for at least a three-year period and provide information requested by HHS necessary to support the assignment of beneficiaries to the ACO and determine the amount of shared savings to be distributed to the ACO;
- Have a legal structure for distributing Shared Savings payments among providers in the ACO and a management structure that includes clinical and administrative systems;
- Have a sufficient number of primary-care physicians to serve the number of fee-for-service beneficiaries assigned to it;
- Define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care (e.g., through telehealth, remote patient monitoring, and other technologies).

These requirements will be explained further and expanded upon by forthcoming HHS regulations.

B. Antitrust Risks for ACOs

1. *Joint fee negotiations without clinical integration are per se illegal.*

Antitrust laws benefit consumers by encouraging competition based on quality, service, and price. To that end, courts have regarded agreements among competitors to fix prices or collectively refuse to deal with certain buyers as per se illegal under the antitrust laws because such agreements have "manifestly anticompetitive effects" and "almost always tend to restrict competition and decrease output."[5] Accordingly, agreements among competing providers on reimbursement rates, unless the agreement is ancillary to an agreement to clinically integrate for the benefit of patients and payers, are generally condemned as per se illegal under the antitrust laws. The enforcement agencies have targeted their investigations and enforcement efforts against groups of independent providers who have agreed to negotiate fees jointly with private health insurance companies or have organized group boycotts against private payers unless they meet the reimbursement rate demands of the group.[6]

2. *ACOs formed for the exclusive purpose of obtaining the financial benefits of the Shared Savings Program raise minimal antitrust risk.*

Because Medicare reimbursement rates are a take-it-or-leave-it proposition for physicians and hospitals, there is no meaningful possibility that providers could agree to fix the price of Medicare reimbursements or collectively refuse to deal with HHS. Accordingly, ACOs that do not negotiate with private payers or facilitate the sharing of information related to private reimbursement rates or other competitively sensitive information among competitors, raise minimal antitrust risk.[7]

3. *ACOs that jointly negotiate fees with private payers must demonstrate that such joint negotiations are ancillary to and reasonably necessary to achieve the benefits of clinical integration.*

Having made the significant investments of time, effort, and capital to form an ACO and make it successful in the Shared

3 The PPACA identifies four types of ACO groups that will be eligible for the Shared Savings Program: (i) ACO professionals in group practice arrangements; (ii) networks of individual practices of ACO professionals; (iii) partnerships or joint venture arrangements between hospitals and ACO professionals; and (iv) hospitals employing ACO professionals. The statute also provides that HHS may permit other groups of providers of services and suppliers that it deems appropriate through regulations. PPACA § 3022.

4 PPACA § 3022.

5 *Leegin Creative Leather Prods., Inc.* v. *PSKS, Inc.*, 551 U.S. 877, 886 (2007) (citations omitted). *See also Arizona* v. *Maricopa County Med. Soc.*, 457 U.S. 332 (1982) (holding that agreements among the physician members of two medical care societies to set maximum fee schedules were per se illegal).

6 *See* generally FTC, "Overview of FTC Antitrust Actions In Health Care Services And Products," at 21-53 (June 2010) *available at:* http://www.ftc.gov/bc/0610hcupdate.pdf.

7 *See* John Leibowitz, Chairman, FTC, "A Doctor and a Lawyer Walk into a Bar: Moving Beyond Stereotypes," Remarks as Prepared for Delivery, American Medical Association House of Delegates (June 14, 2010), *available at* http://www.ftc.gov/speeches/leibowitz/100614amaspeech.pdf. ("While the details of the ACO program are not yet available, so long as the government purchases the services and unilaterally sets payment levels and terms, there will not be an antitrust issue.").

Savings Program through reductions in costs and improvement in care, an ACO also may want to take steps to share in the benefits that accrue to private payers as a result of the ACO's investments. Indeed, the PPACA encourages ACOs to offer their clinically integrated services to private payers by permitting HHS to "give preference to ACOs who are participating in similar arrangements with other payers."[8]

As noted above, jointly negotiating pricing or collectively refusing to deal with payers that will not offer reimbursement rates acceptable to the ACO is per se illegal absent clinical integration. Joint negotiations are, however, permitted where joint pricing is ancillary to and necessary to achieve the group's clinical integration goals for delivering services at lower cost in keeping with medical management protocols and guidelines.[9] The clinical integration required by the PPACA is likely to go a long way to meet the requirements of clinical integration the antitrust agencies have described in formal guidelines and published guidance as being sufficient to justify joint negotiations with payers.[10] Nevertheless, the extent to which an ACO that has contracted with HHS for the Shared Savings Program has made a prima facia case that it is sufficiently clinically integrated to justify joint pricing is a critical unanswered question that likely will be the subject of further discussion and guidance from regulators.

4. *Even if the ACO is sufficiently clinically integrated to the benefit of patients and private payers, the ACO may face antitrust risk if it has "market power."*

After the enforcement agency or a court concludes that the ACO has achieved sufficient clinical integration such that joint payment negotiations with private payers are necessary and ancillary to the formation of the ACO, the agencies and courts will weigh the pro-competitive benefits of the clinical integration against the potential for anticompetitive harm. The agencies and courts typically first consider whether the formation of the ACO gives the group "market power," which is the ability to raise physician or hospital reimbursement rates above a competitive level or impede the formation of competitive ACOs and other provider joint ventures.[11] Although the presence of market power is critical to analyzing a venture that is not per se illegal, it is difficult to measure.

The agencies often begin their analysis of market power by determining the group's market share. Determining market share for an ACO, however, is inherently fact-specific. Generally, such analysis requires identifying all providers in the ACO's geographic market that payers and patients would view as interchangeable with the services provided by the ACO's members and determining the "share" of physicians in those specialties and subspecialties that will be part of the ACO.[12]

If the ACO's share of physicians in a given specialty or subspecialty exceeds 30 percent, there is a risk that an antitrust enforcement agency would find that the ACO has market power.[13] This 30 percent market share benchmark, however,

8 PPACA § 10307.

9 Joint pricing negotiations must be *necessary* to achieve the clinical integration and interdependence of the group members (and thus the benefits to patients and payers). Quality controls and cost-containment measures that just as easily could have been implemented without jointly negotiating with payers are not sufficient justifications, nor is simply attempting to recoup (through higher, jointly negotiated rates) the investment the ACO has made in such measures a justification for price fixing.

10 The antitrust agencies have provided the following examples of measures for clinically integrating a multiprovider joint venture:

> (1) establishing mechanisms to monitor and control utilization of health care services that are designed to control costs and assure quality of care; (2) selectively choosing network physicians who are likely to further these efficiency objectives; and (3)…[investing] capital, both monetary and human, in the necessary infrastructure and capability to realize the…efficiencies.

Health Care Statements, Statement 8 at 73 & Statement 9 at 111.

11 *Health Care Statements, Statement 8 at 77. See also NCAA* v. *Board of Regents*, 468 U.S. 85, 109 n.38 (1984) (defining "market power" as "the ability to raise prices above those that would be charged in a competitive market").

12 *Health Care Statements,* Statement 9 at 116 ("[I]n analyzing a [physician hospital organization], the Agencies will consider the network's market share (and the market concentration) in such service components as inpatient hospital services (as measured by such indicia as number of institutions, number of hospital beds, patient census, and revenues), physician services (in individual physician specialty or other appropriate service markets), and any other services provided by competing health care providers, institutional or noninstitutional, participating in the network.").

13 FTC staff has indicated that market shares below 35 percent may not raise concerns about a particular physician network's market power where the network is non-exclusive (i.e., physicians may contract independently with payers) and clinically integrated. *See* FTC, Greater Rochester Independent Practice Association Advisory Opinion, 26 (March 28, 2006) [hereinafter *GRIPA Advisory Opinion*], *available at:* http://www.ftc.gov/bc/adops/gripa.pdf. The Agencies' guidelines also provide "safe harbors" for non-exclusive, physician-only networks whose physician participants constitute 30 percent or less of the physicians in each physician specialty in the relevant geographic market, and where the participants "share substantial financial risk." *Health Care Statements*, Statement 8 at 65. The "safe harbor" threshold is lower—20 percent—for an exclusive network. *Id.* at 64. Sharing "substantial financial risk," however, requires arrangements where a physician network provides services for "capitated" rates or there are significant financial group-wide rewards for meeting cost-containment goals and group-wide financial penalties if goals are not

should not be considered a market share ceiling for forming an ACO. Pro-competitive benefits and the realities of including enough physicians in the network to adequately serve its patient population may justify higher shares. Also, making the ACO non-exclusive by permitting its members to negotiate with private payers independently if they so choose may significantly decrease risk of an enforcement action against an ACO with market shares in excess of 30 percent.[14] It remains to be seen, however, whether an ACO that permits its members to individually negotiate with private payers would be as successful in obtaining the benefits of its clinical integration.

Is additional guidance forthcoming?

The antitrust enforcement agencies have stated that they are working with HHS to develop the regulations for the Shared Savings Program and may provide additional guidance on the formation of ACOs from an antitrust enforcement perspective. In addition, because the current procedure for obtaining an advisory opinion from the FTC or a business review letter from the DOJ can take many months, the agencies have indicated that they are considering procedures for expedited review of ACO formation plans to provide guidance on whether a particular ACO faces a risk of an antitrust enforcement action based on its proposed structure.[15] No such guidance or procedures have been announced to date, however.

The antitrust laws treat collaborations among health care providers that are bona fide efforts to create efficiency and quality-enhancing joint ventures differently from the way they treat price-fixing schemes. Two antitrust questions must be addressed. First, does the proposed collaboration offer the potential for cost savings and quality improvements? Second, are the price or other agreements reasonably necessary to achieve those benefits? If the answer is yes to both questions, then the collaboration is not considered per se illegal, but it is rather evaluated by weighing the likely pro-competitive aspects against any anticompetitive effects from the collaboration. The extent to which independent practitioners must integrate their practice and any anticompetitive effect from any market power gained by the joint venture can be difficult to assess. Accordingly, it is paramount that the formation and implementation of an ACO include attention to the applicable antitrust laws and guidance provided by the enforcement agencies.

met. It is unclear whether ACOs will structure themselves in this way.

14 In two recent advisory opinions, FTC staff emphasized physician networks' plans to be nonexclusive in determining that the proposed networks were unlikely to cause anticompetitive harm. *See GRIPA Advisory Opinion* at 26; FTC, TriState Health Partners, Inc. Advisory Opinion, 31 (Apr. 13, 2009) *available at:* http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf.

15 *See* Statement of Sharis A. Pozen, Chief of Staff, Antitrust Division, Before the Subcommittee on the Courts And Competition Policy, Committee on the Judiciary, United States House of Representatives, Concerning Antitrust Enforcement in the Health Care Industry (Dec. 1, 2010), *available at:* http://www.justice.gov/ola/testimony/111-2/12-01-10-atr-pozen-testimony.pdf; Prepared Statement of the FTC Before the Committee on the Judiciary, Subcommittee on the Courts And Competition Policy, United States House of Representatives (Dec. 1, 2010), *available at:* http://www.ftc.gov/os/testimony/101201antitrusthealthcare.pdf.

We hope you have found this Advisory useful. If you have questions, please contact your Arnold & Porter LLP attorney or:

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