

Navigating Antitrust Compliance in an ACO Context

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ Coordinated guidance from the antitrust enforcement agencies seeks to balance the Affordable Care Act's call for greater provider collaboration to improve care coordination with concerns related to provider consolidation and market power.
- ▶ The agencies propose guidelines by which independent providers who come together in an ACO for purposes of the MSSP also can operate in the commercial market without running afoul of the antitrust laws or being at risk of an agency investigation.
- ▶ These new antitrust guidelines relating to ACOs do not address or change current law or enforcement policy in connection with mergers.

Why Was the Proposed Statement Needed?

- ▶ In general the antitrust laws prohibit competitors from jointly negotiating rates with managed care companies
 - Such joint negotiation is “price fixing” and deemed “per se” illegal under Section 1 of the Sherman Act

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Guidance from Antitrust Agencies

- ▶ Guidance issued by the FTC and DOJ in 1996 included concept of “clinical integration”
- ▶ The guidance indicated that clinical integration might allow joint negotiation of contracts with managed care

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Guidance from Antitrust Agencies

- ▶ The 1996 guidance provided example in which goal of an IPA was to:
 - Assume greater responsibility for managing the cost and quality care
 - Reduce costs while maintaining or improving the quality of care, and thus to attract more managed care patients to their practices

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Guidance from Antitrust Agencies

- ▶ Since 1996, additional guidance from the FTC in Advisory Opinions to groups proposing clinical integration plans
 - Key to any successful clinical integration program is that it yields lower costs, higher quality and more efficient delivery of health care and that any resulting joint negotiation is deemed necessary to the success of the joint venture.

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Clinical Integration – Improving Care

- ▶ Improving quality of care by:
 - Development of clinical protocols applicable for the majority of the physicians' patient population and which reflect current developments in treatment
 - Development of measurable goals to monitor quality of treatment provided
 - Development of measurable goals to monitor utilization
 - Implementation of specific case and disease management programs

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Clinical Integration- Monitor Quality

- ▶ Ensuring improvement in quality of care by:
 - Use of procedures to actively educate, review and assist physicians in meeting the goals of quality and appropriate utilization
 - Removal and/or discipline of physicians who cannot or will not meet the goals established
 - Implementation of credentialing procedures

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Clinical Integration- Investment

- ▶ Significant investment of capital (both human and monetary) by the physicians in the infrastructure necessary for implementation of the program.
 - Development of an integrated computer system to disseminate practice standards and communications and allow physicians caring for the same patients to communicate and share clinical information more easily

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Clinical Integration- Investment

- Significant investment of human and monetary capital
 - Implementation of credentialing procedures;
 - Development and adoption of practice protocols, standards, and performance monitoring

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How Much Is Enough?

- ▶ Remember overall goals
 - Improve quality of care to patients
 - There is no magic number
- ▶ The more features that a clinical integration model includes, the more likely it is that the model will escape scrutiny by the FTC

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What Else For Joint Negotiation?

- ▶ In practical terms
 - Participation of physicians is important
 - The proposed clinical integration permits quality clinical benefits not otherwise possible in the absence of joint pricing
- ▶ Non-exclusivity
 - Every formal Advisory Opinion issued to date has required non-exclusivity
 - Original 1996 guidance required non-exclusivity

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What does the Proposed Statement Add?

- ▶ Provides additional guidance
 - Gives “clues” as to concerns of agencies
 - Provides mitigation strategies

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ In broad terms, the Proposed Statement addresses two issues:
 - Avoidance of Liability for price fixing AND
 - Market Share issues

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ Avoidance of liability for price fixing or other collective action that might be deemed anticompetitive
 - If meet CMS requirements for an ACO gain rule of reason approach
 - Keyed off of clinical integration guidance
 - Applies to all ACOs

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ Market share issues
 - Proposed Statement Provides Safety Zone
 - If two or more independent providers within an ACO have 30% or less of combined market share for shared services; ACO is within safety zone provided
 - Any hospital or ASC in the ACO is non-exclusive – e.g., allowed to contract or affiliate with other ACOs or commercial payors AND
 - Any dominant provider of any service that no other ACO participant is providing (greater than 50% market share) is non-exclusive

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ Rural exception. An ACO may still qualify under the safety zone if the inclusion of rural providers would cause the combined market share to exceed 30% under the following parameters:
 - One physician per specialty from each rural county on a non-exclusive basis
 - Rural hospitals on a non-exclusive basis

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ Market share issues
 - If two or more independent providers within an ACO have greater than 50% of the combined market share for shared services; ACO must seek review from the FTC or DOJ
 - Agencies commit to 90 day review period
 - Proposed Statement provides list of information required for review
 - If two or more independent providers within an ACO have between 30% to 50% of combined market share for shared services;
 - Not within safety zone
 - May seek expedited review
 - Proposed Statement provides 'tips' for avoiding an action by the FTC/DOJ

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ If need approval from FTC/DOJ
 - The CMS MSSP application and supporting documents;
 - Documents or agreements that relate to an ACO participant's ability to compete with the ACO, and documents and agreements that relate to any financial incentives to encourage ACO participants to contract through the ACO;
 - The ACO's business strategies, such as plans to compete in the Medicare and commercial markets and the likely impact on price, cost, or quality of any service provided by the ACO;
 - Documents showing the formation of any ACO or ACO participant that was formed in whole or in part, or otherwise affiliated with the ACO, after March 23, 2010; and

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ If need approval (continued)
 - Information sufficient to show the following:
 - The ACO's PSA share calculations for each common service and the ACO's PSA share calculations for each common service provided to commercial customers where those shares differ significantly from the PSA share calculations based on Medicare data (e.g., PSA share calculations for pediatricians or obstetricians);
 - Restrictions that prevent the ACO from obtaining sensitive pricing or other information related to commercial payors;
 - Points of contact for the five largest commercial plans that will, or are expected to, contract with the ACO; and
 - The identity of any other existing or proposed ACO that will be operating in any PSA in which the ACO provides services.

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Proposed Statement from the DOJ and FTC Regarding Medicare ACOs

- ▶ **Mitigating steps**
 - Don't prevent or discourage commercial payors from steering to particular providers;
 - Don't tie sales of ACO services to a commercial payor's purchase of other services provided by ACO participants and providers;
 - For providers other than the PCPs, don't have exclusive contracts (exclusive to the ACO or to payors);
 - Don't restrict a payor's ability to make information available to members regarding quality, cost, efficiency, and performance measures; and
 - Don't share competitively sensitive pricing or other data among participants (which they could use outside ACO).

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Clinical Integration – What Didn't Work

- ▶ **One Advisory Opinion Rejected Clinical Integration Model**
 - Super PHO (including multiple hospitals and physicians) submitted request
 - Request had four components
 - Medical management
 - Quality management
 - Practice support
 - Physician incentive plan

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What Didn't Work

- ▶ But FTC found
 - No explanation why each hospital couldn't develop program on own
 - Each individual hospital charged with motivation
 - Lacked mechanism for adequate discipline for non-compliance

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What Was Missing?

- ▶ “Hallmark of integration is interdependence”
- ▶ Need for collaborative provision of physician services
- ▶ Need for interaction and contact among participating physicians
- ▶ Failure to include non-employed physicians
- ▶ Failed to provide anything that was truly “new”

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Test of Integration

- ▶ “For a physician network, *having such tools is a necessary, but not sufficient*, predicate for the network to achieve clinical integration among its participants. The test of that integration is what the participants, through the network, actually do—i.e., how they use those tools to create cooperation and interdependence in their provision of medical care, thereby facilitating their efforts to jointly reduce unnecessary costs, improve quality of care and otherwise increase their efficiency in the provision of medical care.”
 - Letter from Marcus Meier of FTC

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Questions?

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