



Accountable Care Organizations and Market Power Issues

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INTRODUCTION

Accountable care organizations (ACOs) have received significant attention since passage of the *Patient Protection and Affordable Care Act* (ACA) in the spring of 2010. The ACA directs the Secretary of the U.S. Department of Health and Human Services (DHHS) to create the *Medicare Shared Savings Program*, which encourages groups of providers (e.g., group practices, networks of individual practices, hospitals, partnerships or joint ventures) to come together to form ACOs that will manage and coordinate inpatient and outpatient care for Medicare fee-for-service (FFS) beneficiaries. ACOs that meet certain quality standards will be eligible to receive payments based on shared savings generated by the providers. Additional provisions in the ACA also potentially could apply to ACOs, including bundled payment and other pilot programs.

The ACA provides only the broad outlines of the ACO program. Specific details, including the potential corporate structures and reimbursement methods for ACOs, the quality standards that must be met to qualify for shared savings, and acceptable methods for setting savings benchmarks and calculating savings, are expected to be promulgated through regulation. The Centers for Medicare & Medicaid Services (CMS) has indicated that it will be providing program details and rules through the regulatory process to be released in the fall of 2010.

CMS faces a range of significant challenges in setting the specifications for this program. In addition to the myriad

technical details, it must also grapple with the potential impact on consumers, including the market power and antitrust concerns that can arise when providers aggregate or otherwise come together.

ACOs have the potential to improve quality and reduce costs by providing more coordinated, collaborative care, thus enhancing health outcomes and eliminating preventable events and unnecessary services (e.g., readmissions). But without proper program design, provider aggregation could result in undue market power, leading to higher prices for consumers with little or no quality-enhancing or cost-savings benefits, thereby undermining the intent of this program. As with other industries, health care is not immune from the laws of market power and its impact on competition.

In an effort to assist policymakers, regulators, providers, health plans, and others in considering the rules and regulations that are being formulated for ACOs, America's Health Insurance Plans (AHIP) hosted a forum on ACOs on September 23, 2010, in Washington, DC. Moderated by Joe Miller (AHIP General Counsel and former Department of Justice Antitrust Division attorney), and attended by Congressional staff, representatives of agencies that oversee related issues, and other key stakeholders, this session included a panel of four experts who provided guidance on the implementation of the *Shared Savings Program* and discussed various aspects of market power and antitrust concerns as they relate to ACOs.

Panel members included:

- **Doug Hastings**, Chair of the Board of Directors of Epstein, Becker & Green, P.C., and an expert on legal issues related to ACOs;
- **Cory Capps, PhD**, a partner at Bates White Economic Consulting and a healthcare economist with expertise on antitrust issues;
- **Billy Vigdor**, a partner specializing in antitrust issues with Vinson & Elkins LLP;
- **Mark J. Botti**, co-chair of AkinGump's antitrust group.

This paper summarizes the key lessons and themes discussed by the presenters as well as the participants. The paper does not necessarily reflect the views of AHIP, any presenter, or any audience participant. Rather, it is intended to further thought and dialogue in this area by reflecting and distilling the discussion and, to that end, it is organized into four sections:

- ▶ **Understanding accountable care and ACOs**
- ▶ **Defining and understanding market power**
- ▶ **Antitrust implications of ACOs**
- ▶ **CMS options for avoiding or mitigating market power concerns**

ISSUE #1

UNDERSTANDING ACCOUNTABLE CARE AND ACOs

What Is “Accountable Care,” and What Are ACOs?

The term “accountable care” has become a label for how to address many widely recognized problems with the U.S. healthcare system, including quality issues, care fragmentation, and high costs. To encourage the delivery of high-quality, cost-effective care, broad consensus has developed on the need for providers to work together and become “accountable” for the delivery of coordinated, comprehensive care with a focus on prevention,

screening, and ongoing management of chronic disease rather than focusing on care at the point of service. To help create such accountability, consensus has also developed on the need for payment reform, aligned in both the public and private sector, so that financial incentives encourage the provision of such care (rather than discourage it, as they do today). “Accountable care organizations” or ACOs has become the accepted name used to refer to the provider component of this transformation.

As the payment systems move away from paying for volume rather than value, provider organizations hoping to function as ACOs will have to move further along the continuum of integrated care. Some organizations have already reached this point—that is, they are financially integrated through capitation or other forms of risk sharing or are vertically or otherwise clinically integrated allowing for accountability throughout the organization. What is not clear, however, is how much an organization must clinically integrate and how far it must correct for the perverse incentives created by FFS in order to qualify as an ACO. It also remains unclear whether the shared savings model called for in the ACA will be enough of an incentive to drive true clinical integration and care coordination, as the program still relies heavily on fee-for-service payments.

How Does the ACA Promote Accountable Care and ACOs?

The *Shared Savings Program* combines the creation of ACOs with payment reform. The program, to be launched on January 1, 2012, calls for the formation of ACOs with a sufficient number of physicians to handle the care of 5,000 Medicare beneficiaries. While the details still need to be worked out, the legislation suggests that these organizations will have to meet certain quality standards to qualify for sharing in the savings generated, including having the systems and organizational structures necessary to provide coordinated, patient-centered care and to measure and report on quality and cost outcomes. To participate, ACOs will enter into a contractual

relationship with the Medicare program, essentially becoming accountable for the quality and efficiency of care provided to a defined set of beneficiaries.

In addition to the *Shared Savings Program*, the ACA contains at least 25 other provisions that could potentially relate to ACOs, including several pilot programs designed to test innovative payment models (e.g., bundled payments) that seek to move the Medicare program—and potentially private payers as well—away from FFS reimbursement systems that do not encourage the provision of coordinated, efficient, and effective care.

Some skeptics have suggested that ACOs may be a modern-day version of 1990s-style provider collaborations, such as physician-hospital organizations (PHOs). Others counter that the healthcare landscape has changed in important ways in the last several decades, including much more widespread recognition of the problem and significant progress in developing the science of evidence-based medicine, information technology (IT) to promote coordinated and collaborative care, and measures and measurement systems to assess progress. They argue that, in the new environment, ACOs are being perceived as more than attempts to address the payment system. Rather, they require independent providers to work together to coordinate care, connect with each other through exchange of health information and be accountable for the total care provided to a patient.

How Will ACOs Relate to the Private Sector?

ACO-like organizations already exist in the private sector, which may well move faster than CMS in transforming the healthcare system. In fact, much private sector work has already been done in the area of care coordination on specific chronic disease states that account for the bulk of healthcare expenditures. Consequently, the private sector may offer some lessons as to what works well in the marketplace and what has been less successful. The ACA repeatedly mentions the need to look to private market and other “best” practices that have been shown to work, and it seemingly allows for the creation of ACOs that operate in both sectors.

ACOs created in response to the ACA could potentially be different than ACOs that already exist in the private sector (although the final regulations from CMS will determine the extent to which they will differ). And while ACOs serving Medicare and commercial markets may serve different populations and target different diseases, the basic principles of care coordination and adherence to evidence-based medicine through use of protocols and guidelines will apply in both sectors. Indeed, divergence in how ACOs interact with the private and public sector in certain areas could have unintended and negative consequences. To fulfill their promise, ACOs may need to enter into similar types of payment arrangements with the private and public sectors.

ISSUE #2

DEFINING AND UNDERSTANDING MARKET POWER

“Market power” is the key determinant of whether aggregating providers into an accountable organization such as an ACO may not serve the best interests of consumers.

What Is Market Power?

Market power measures the degree to which an organization has the ability to raise prices or exclude rivals. As with other industries, health care is not immune from the laws of market power and its impact on competition. Several studies have shown that prices go up in markets where large healthcare organizations have amassed substantial market power.

How Is Market Power Measured in Health Care?

Normally, the degree of market power exhibited by a newly aggregated organization can be measured by looking at the “before-and-after” impact on unit prices. In other words, if unit prices rise substantially after the formation of a new entity (via merger, joint venture, or some other means), then that organization has exhibited

market power, thus representing a potential antitrust issue.

The healthcare industry, however, operates a bit differently, and the unit prices of individual healthcare services are not the sole consideration in determining whether market power exists, particularly for an ACO. The underlying premise of an ACO is that by coming together and making investments in care coordination, IT systems, and other infrastructure, the resulting organization can better improve quality and control overall healthcare costs (and hence insurance premiums). These costs are a function of both price and quantity of services (i.e., utilization). Consequently, the price of an individual service, such as a doctor visit, is only part of the equation. Effectively addressing costs also requires that doctors appropriately control “downstream” utilization by ordering only necessary tests and by managing chronic conditions. A typical physician can direct as much as \$30,000 in healthcare spending each day—the impact of what that doctor charges for his or her services is amplified by how that doctor makes decisions that affect this downstream spending. To determine whether an ACO exhibits market power, therefore, one must evaluate the impact on both price and quantity of healthcare services provided.

What Are the Implications of Market Power for Medicare and the Private Sector?

Since CMS sets unit prices for the Medicare program, ACOs will not be able to exert market power by raising prices for Medicare beneficiaries. However, CMS should potentially be concerned that ACOs with market power may not want to participate in the *Shared Savings Program*, preferring instead to raise prices on the private side of the market and not bother with relatively low Medicare reimbursement rates and the potentially burdensome paperwork of qualifying for and obtaining shared savings payments from the program. Moreover, if providers who join ACOs must remain exclusive to the organization (i.e., they cannot contract outside of it), Medicare may find it more difficult to find physicians willing to participate in an ACO.

On the private sector side of the equation, however, payers and regulators must be concerned with the classic

manifestation of market power—that is, the potential for ACOs to raise unit prices in a manner that cannot be justified by increased investments in infrastructure or systems that yield downstream cost savings and quality improvement. The potential for them to do this depends on several factors, including the percentage of providers in the market included in the ACO and the extent to which the ACO prevents—through ownership, explicit requirements of exclusivity, or *de facto* requirements of exclusivity—participating providers from contracting independently (thus limiting the ability of payers to play providers off against one another).

CMS should be concerned about the potential impact that ACO market power can have on both the Medicare program and the private sector. In particular, CMS may be more concerned with the joinder of single-specialty physician groups or the coming together of multiple hospitals than with vertical integration, since horizontal integration tends to create negotiating leverage with payers while offering little opportunity to better coordinate care and achieve organizational accountability and hence reduce downstream costs. By contrast, vertical integration creates relatively less negotiating clout and provides greater potential for downstream quality improvement and cost savings. That said, insurers in multiple markets have complained that some vertically integrated systems also have market power (e.g., through the ability to preclude participating physicians from referring to other hospitals or to prevent physicians from competing with hospitals on certain outpatient services), leading to higher prices and premiums.

ISSUE #3

ANTITRUST IMPLICATIONS OF ACOs

The goals of the antitrust laws and ACOs are congruent—to improve quality and reduce costs for consumers, and accordingly antitrust enforcers and legislators will be resistant to calls from providers to create special rules or exemptions for ACOs. There are however, likely antitrust implications for ACOs, including various approaches that can be used to decide cases and potential “safeguards” that might exist for ACOs.

How Do Courts Decide Antitrust Cases in General?

The antitrust laws use two different modes of analysis in deciding cases. Some agreements between competitors are considered to be “per se” violations of the law—that is, the actions themselves are presumed by courts to lead to market power (thus harming consumers), and no elaborate inquiry into the underlying market dynamics is necessary to declare the agreement illegal. In the healthcare arena, antitrust enforcers have a long history of making “per se” challenges against providers that have engaged in joint negotiating and pricing but made no or little effort to financially integrate and/or coordinate care.

Few ACOs, however, will likely look or feel like a provider group formed to boycott payers or otherwise raise prices with no corresponding improvement in quality. The ACA legislation outlines a variety of requirements calling for ACOs to invest in clinical coordination and integration. As a result, as long as the ACO engages in some base level of clinical integration, the vast majority of antitrust concerns will likely be decided using the second approach, known as the “rule of reason.” This approach focuses on whether the conduct at issue provides a net benefit or harm to consumers.

How Will the Rule of Reason Be Applied to ACOs?

ACOs may simultaneously control a large share of the provider and patient population (particularly in smaller markets) while also generating quality and cost benefits. To assess whether the consumer has experienced net benefit or harm, enforcement agencies and eventually the courts will have to evaluate the actual competitive effects of the ACO. They will also have to consider whether the ACO offers a different, more comprehensive product (i.e., one that does a better job coordinating care and managing diseases) that has yielded or will likely yield quality and cost benefits, and hence may want a higher price. In making this determination, agencies will likely consider the ACOs’ provider and patient market share, coverage, and degree of exclusivity—that is, the degree

to which providers in the ACO can also contract with payers individually outside of the ACO. Certain “red flags” could exist for ACOs, such as having over-inclusive networks or high market shares. In general, the stronger the efficiencies generated and the lower the market share of the ACO, the lower the risk of an antitrust violation.

Will Any “Safe Harbors” or Protections Likely Exist?

While ACOs will likely not be exempt from antitrust considerations, several safeguards may exist that minimize or eliminate the risk of antitrust concerns. Organizations that remain below established safe-harbor thresholds under existing FTC/DOJ guidance (e.g., 20 percent market share or lower) also likely face little or no risk. One potential complication arises from the ACA’s requirement that each ACO include primary care professionals sufficient to care for at least 5,000 Medicare beneficiaries. In smaller communities, ACOs may need to include 30, 40, or even 50 percent of providers within a particular specialty in order to adequately serve this number of beneficiaries. Thus, some are beginning to question whether the prescribed 5,000 patient volume is too high. Going forward, the FTC and DOJ may issue additional “safe harbors” and expedited review processes to foster the creation of ACOs.

What’s the Bottom-Line Risk of Antitrust Concerns, and How Can It Be Minimized?

ACOs may well face antitrust challenges, not only from consumers and consumer groups, but also from providers excluded from the ACO and/or concerned about the increased oversight and discipline exerted by the ACO over the practice of medicine. Even those organizations with some level of clinical integration face the risk of a suit and/or an investigation. Those with a large share of the provider market—particularly within a given specialty or type of facility—will be more likely to face scrutiny.

ACOs can take several steps to minimize the risk that they may have or obtain market power and thus face a lawsuit or investigation. The best safeguard is likely to meet the statutory language in ACA, which requires ACOs to have

the infrastructure necessary to improve quality, support the provision of evidence-based medicine and exchange health information. Another potential safeguard—particularly for ACOs that include a large percentage of providers in the market—is to explicitly allow individual providers to contract with payers outside of the ACO. ACOs also should consider creating a written checklist that documents exactly what the organization has done in the area of clinical integration and how those steps have improved care. This may be particularly important in the early years of an ACO, since the potential benefits of higher quality and lower costs may not materialize for several years, and because current measurement systems may not be capable of adequately capturing the quality and efficiency benefits realized. This documentation may not provide long-term protection against a lawsuit, however. ACOs that still cannot document quantifiable benefits after several years could potentially face a retroactive investigation.

ISSUE #4

CMS OPTIONS FOR ADDRESSING MARKET POWER CONCERNS

CMS should be concerned about potential market power and antitrust issues related to the formation of ACOs. By providing clear guidance on these issues, CMS can help to ensure that provider organizations form ACOs that do not exhibit market power and harm consumers. In the absence of such guidelines, providers may be reluctant to make the requisite investments to form a well-functioning ACO, out of fear that their newly formed organizations will later be challenged under the law. It was noted that, while the current Administration is encouraging providers to come together into ACOs and hence may be reluctant to aggressively enforce existing antitrust statutes, future Administrations may decide to increase the level of scrutiny given to ACOs. Consequently, the agency's rule writers need to provide clear guidance on how these organizations should be structured and act so as to reduce the potential for market power and other antitrust concerns. To that end, CMS should consider guidance in the areas outlined below.

Appropriate ACO Structure

Rules could offer guidelines on the following issues related to the structure of an ACO.

► **Appropriate size of an ACO.** Economists sometimes estimate that organizations with 20 or 30 percent market share in health care provider markets can exercise market power. Consequently, there may be value in CMS establishing a maximum market share threshold beyond which shared savings will require enhanced justification on quality performance metrics. Panelists noted, however, that in smaller communities, the minimum scale necessary to effectively serve 5,000 beneficiaries may be difficult to achieve. They suggested that, in those instances, CMS may wish to combine a more permissive shared savings program beneficiary threshold with requirements for enhanced quality reporting metrics. Other suggestions included having CMS establish a minimum size for an ACO. In utilizing such an approach, however, CMS should consider the degree to which federal and other programs, including private health plan programs, exist to support investment in infrastructure, thus reducing the upfront financial outlay and hence the minimum size necessary to establish an ACO.

► **Ability of less tightly integrated networks and other types of “loose” collaborations to qualify as an ACO.** Some have suggested that these less formal affiliations may be able to produce many if not all of the benefits of clinical integration without creating the potential antitrust problems often seen with full-fledged mergers, ownership of physician practices, and other tightly integrated structures. Such guidance will be especially important in smaller, more concentrated markets where the risks of excessive market power and anti-competitive behavior remain large.

► **Appropriate provider composition for an ACO.**

These rules could encourage an incremental approach to building ACOs rather than bringing in too many providers initially. They will be especially important for determining how many specialists need to be included, as ACOs with a large number of specialists are more likely have market power.

Desired Degree of Exclusivity

Rules could also offer guidance on issues related to the degree of exclusivity, including the ability of ACOs and providers within ACOs to contract with other entities, and of Medicare beneficiaries to seek care outside of an ACO.

► **Degree to which providers can or cannot be “exclusive” to the ACO.** In large markets, these rules might potentially require exclusivity so as to encourage the formation of multiple competing organizations. In smaller markets unable to support multiple organizations, ACOs may need to be prohibited from demanding exclusivity of their providers; otherwise, they could potentially exert pricing power and even drive other providers out of business.

► **Ability of ACOs to contract outside of Medicare.** The rules should make it clear as to whether ACOs under contract with Medicare can also contract outside of the Medicare program. Since the ACA seeks to promote reform throughout the healthcare system, prohibiting such contracting would go against the goals and objectives of the ACA.

► **Degree to which Medicare beneficiaries should be “exclusive” to an ACO.** It was noted that, since the program encourages ACOs to take responsibility for a population of patients and be accountable for outcomes, patients should, to the extent possible, be exclusive to that ACO. For this to occur, however, the beneficiary would have to accept limits on his or her choice of providers, as many do for the Medicare Advantage program today. If CMS is reluctant to mandate exclusivity on beneficiaries, the ACO should create confidence in the consumer to receive care within the ACO, or be accountable for care rendered outside its

organization. Financial incentives may be considered to achieve the same result.

Payment Structures and Incentives

Rules could provide guidance on the following issues related to use of payment structures and incentives, as outlined below:

► **How various payment systems can and should be used.** More sophisticated, tightly integrated ACOs may be ready to take on greater risk-sharing than more loosely structured ACOs. Consequently, allowing for flexibility in payment structures can help to accommodate the different structures likely to emerge. For example, capitated ACOs with tightly aligned providers may be most effective in large markets that can support multiple organizations, while ACOs with looser structures and less risk sharing may be more appropriate in smaller markets that can support only one or two provider networks.

► **How shared savings will be calculated.** The ACA suggests a three-year look-back period with comparisons of actual costs to a benchmark designed to approximate what costs would have been in the absence of the program. But many more details need to be developed as to the exact benchmarks that will be used and how the savings will be shared. Since the program is designed to attract PCPs (who remain in short supply), further discussion and changes related to incentives for these doctors may be necessary.

Measuring and Documenting the Impact of ACOs

Rules could offer guidance on how ACOs can measure and document the impact they have in the marketplace, as outlined below:

► **How to measure ACO benefits.** These rules could acknowledge the potential timing of benefits, taking into consideration that it may take several years for cost savings and quality improvements to materialize, and that the incremental benefits may potentially diminish over time once “easy” benefits have been realized.

These rules should also cover how to determine what would have happened in the absence of the ACO, as this type of “but-for” analysis is critical to determining the incremental impact of the ACO. Because quality can be difficult to measure, rule writers may decide to focus primarily on measurement of cost savings. That said, more progress has been made in health care than in other industries on measuring quality, and hence some guidance on quality measurement could be useful.

► **How to document clinical integration activities.**

Before concrete benefits materialize, ACOs may want to document concrete steps taken in the area of clinical integration, including investments made in IT and other systems designed to promote more coordinated care. Guidance on how to document such activities could be helpful.

CONCLUSION

ACOs have the potential to improve quality and reduce costs for consumers and payers alike, by providing more patient-centered, coordinated, collaborative care. The ACA provides only the broad outlines of the ACO program, and without proper design, provider aggregation could result in market power, undermining the program’s goals of lower costs and higher quality. To avoid bad marketplace outcomes, the ACO rulemaking should structure the program to minimize antitrust concerns.