FEDERAL TRADE COMMISSION

I N D E X

P R O C E E D I N G S

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MS. DESANTI: Good morning. This is the first time in my experience of running workshops that we've been ready to go two minutes early, so I'm definitely going to take advantage of that. Bob Galvin, who is sitting at the end there, was on the

us, and I also want to welcome our newcomers.

I want to emphasize at the beginning that we know that we can only have a relatively limited discussion today, so we want to encourage all of you who have thoughts about the policy statement that you would like us to take into account, to please provide written comments. There are instructions for how to do that in the Federal Registry notice at the FTC website on Accountable Care Organizations, and those comments are due on May 31.

Now, here's how we're going to proceed. First I'm going to read the required security briefing. This always happens. It's not related to Osama Bin Laden. Anyone that goes outside the building without an FTC badge will be required to go through the magnetometer or x-ray machine prior to re-entry into the conference center.

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for everyone in the conference center. In the event that it is safer to remain inside, you will be told where to go inside the building. If you spot suspicious activity, please alert security.

Now, we're going to begin with a brief overview of the Medicare Shared Savings Program and the context in which all of this arises, and we're going to be led through that by Lynn Shapiro Snyder from Epstein Becker who will take my place.

MS. SHAPIRO SNYDER: Thank you, Susan. Hello, everyone. I'm Lynn Shapiro Snyder with the law firm Epstein, Becker and Green. I'm a Medicare Medicaid managed care lawyer, been there 32 years, and the title is very brief overview of the Medicare Shared Savings Program and how this particular workshop fits into the broader scheme.

So this is a page I wanted to spend a moment on. I think people talk about the baby boomers, but they don't really know what it looks like, so the last five years, we've added approximately 500,000 new 65 year olds to the Medicare program, and this particular year it is going to be 1.3 million. So it's a three times increase in one year, and then it goes up at a 45 degree angle for about 20 years.

I try to be bipartisan inside the Beltway, so I

have both of our former President Bush and former President Clinton because as you know, we had World War II, and then when they came back, we had babies, and they both turn 65 this summer, and we have to become prepared, and part of what the Medicare Shared Savings Program is a piece of a bigger puzzle to try and figure out how to make the most out of every entitlement dollar.

This is a page that is a summary of the Medicare programs, and historically before the Accountable Care Act, we only had two real Medicare programs. On the left was original Medicare, which is ala carte, fee for service, freedom of choice, and the government's role is as a public plan, and therefore what you worry about from an enforcement and an accountability standpoint is primarily over utilization.

On the other hand, we had Part C of Medicare Medicaid advantage where the government was outsourcing all the Part A and B benefits, and when you outsource on a bundled payment, the government's role is much more consumer protection, because there's an outsourcing, and the concern is underutilization.

Then the only other thing we had before Accountable Care Act were demonstration projects and what we call one offs. The accountable care statute and

the Medicare Shared Savings Program in particular creates what's supposed to be a permanent program option for providers to access the Medicare program and to offer new types of products and new payment schemes, and that's why I call it the hybrid, and one of those hybrids is the Medicare Shared Savings Program.

This is just a very quick summary. As I go around the country, I've been keeping a listing of all the different ways we can control costs. I hear all the speakers, and shifts in health status, I'm sure you've heard if you lose five pounds, each of us, we could really save a lot of money in the healthcare system, changing the way0 512.1600 TD-0.6600 Tw()Tj0.0000 0.0000 TD/F16000 TD(s,)Tj

costs, but it's only for the Medicare beneficiaries who remain in the traditional fee for service program, and then the whole issue of how they get assigned to the ACO.

There are non Medicare accountable care relationships already in place. There are private payers who have already launched relationships with providers in their community, and they sometimes do it with their commercial risk business, and sometimes they do it with their self funded business, but those are not necessarily according to the types of rules that are now in the proposed rule.

Not to make matters any more complicated, but sometimes I hear people talk about accountable care, and what they are really talking about are some of the other Medicaid payment reforms where there's bundling of payments based on episode of care, patient centered health and on the recent Federal Register notice that was issued on value based purchasing.

To be eligible, we all know it's at least physicians. The question is who other than physicians will be participants, and there is some controversy and questions about the role of hospitals and other types of institutional providers playing a significant role, and then the Secretary did extend her discretion to include

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volunteer for the accountable care under Medicare.

Thank you.

(Applause.)

MS. DESANTI: Thank you, Lynn. I am now going to begin our discussion with each of the panelists giving us a two-minute summary of what they view as the most important issues to be discussing today.

I'm going to introduce each panelist and have

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We really agree that competitive marketplaces are important to get to the next kind of -- to really to have effective health reform, so we agree that that is the right model, and I think it's going to be challenging.

I think the whole move to a way for fee for service, which this represents, is the broader concept that we're dealing with here because I think when you try and be accountable and when you move to some sort of prepayment

resuscitation, so we're happy to see a lot of this movement. This group is not formed to talk about ACOs as much as it is to try and give an employer private sector coordinated voice because all of the action or most of the action is happening on the Medicare side.

So speaking on behalf of the employers in general but kind of representing the CPR's thoughts, let me get into specific comments about directives. I think they're really solid work. I think they're thoughtful. I think people work very hard to try and listen to the concerns that many of us had.

I have two big issues with them, and I think it

doesn't do it, but it's a key issue to us. We're seeing it in markets today.

The second issue is this talks about new entities, entities formed after March or independent organizations. You're getting exactly what you were asked to do.

I just want to get on the record that while I think that's important, I think that an equal or far greater risk is organizations that aren't independent organizations coming together, organizations that are a single entity that in many ways are kind of ho

So if I want employees under me to seek cardiologists in a community that happen to be part of a big ACO, can I do that without going to the rest of the ACO? Can I contract with them individually? Are they going to be encompassed by a larger organization that is obviously going to be a different contracting situation?

The second one I mentioned already, which is I think the idea of taking this as an opportunity to look at organizations that are independent groups forming towards this but that are already entities, particularly hospital and physicians are important.

Finally I would like to strongly ask, and we would be willing to help on this, that we could establish a realtime tracker to find out what is happening to prices. I believe some costs shifting is happening. I believe pricing power exists. We have very little ability I think in the current time in the private sector to find out what's actually happening to prices.

There's some methodological issues. There are some other issues involved, but I think it's going to be very important because this is just the beginning of a whole waive of a new kind of payment.

MS. DESANTI: Thank you, Bob. Next we're going to hear from Trudi Trysla, who is associate general

counsel with Fairview Health Services.

MS. TRYSLA: Thank you, Susan, and I also want to reiterate the previous comments. Thank you for the opportunity to have this discussion. It's a valuable opportunity to talk about the potential for changing the way healthcare is delivered today.

I'm speaking from the perspective of a provider that's trying to do this work. Fairview Health Services is a healthcare system located in Minnesota. We have eight hospitals, many of them community hospitals, an academic health center and a physician practice group.

Several years ago we started on turning to change our model of care delivery. We worked with our employee providers and also with the payers in our area to change the financial model as well, so that the exchange wasn't based on the usual conversation around price, but on the actual value that's delivered to patients.

What we've seen in our early results is that it has made a difference. It's made a difference in terms of cost. It's made a difference in terms of quality. It's made a difference in terms of the care providers engaged in the work, and most importantly, it's made a difference to the patients that are being served.

From our perspective and from many across the

country who want to do this transformation, and needless to say it's a significant transformation, to try to carry this model deeper into the community across organizations that are independent but want to actually change that care model.

So we're hoping and hopeful that the final regulatory structure actually supports that and allows again that deeper ability to reach more patients in any community and make a change in the way care is delivered.

Specifically I know we're going to get into it more in the Q&A, but there are significant challenges for providers with the change, with the required review process, particularly within the timeframe that's committed here, within the very short timeframe to try to transform, to react to and observe the CMS requirements and to consider all the work that's necessary for the antitrust review.

The data limitations to doing that review are very significant, and in terms of the exclusivity piece, I think there should be -- the old model doesn't necessarily reflect the model that accountable care represents, and so the issues relative to not being exclusive that has the opportunities, particularly for specialists engaged in multiple providers, I think the

historical view should be different in looking at the view of a healthcare organization, and we welcome further discussion about that.

MS. DESANTI: Thank you very much, Trudi. Next we'll hear from Bob Leibenluft. Bob is someone who was head of our healthcare division at the FTC in the 1990s, and he is now a partner at Hogan Lovells.

MR. LEIBENLUFT: Thanks, Susan. Let me preface my remarks, I represent both providers and plans, but my remarks are totally based on my own views and do not represent necessarily any of the clients.

I want to commend the agencies for three things upfront, and then I'll do a few more things at the end and that I want to focus on some things.

In terms of things that I would like to commend the agencies are on are the following: I think the body rule of reason treatment to ACOs, which is in the Medicare Shared Savins Program is a good idea.

I appreciate the clarification that in the context of ACOs that are sufficiently integrated to participate in the Medicare Shared Savings Program, that joint negotiations with health plans are ancillary, are necessary for their operation. I think that's a useful advance.

Third I think sharing an expedited 90 day review

for those ACOs that want that greater certainty is also an excellent thing. So those are three good things.

Let me go to something that concerns me more, and that's the 90 day mandatory review, and I think it's important to separate out two issues here. One is providing certainty to ACOs that want it as to whether there will be issues with the antitrust review, and I think that can be done with the voluntary review. Those ACOs that want that can get it, and I think that's good.

What concerns me though is requiring all ACOs basically that have a certain trigger threshold, the need to have that 90 day review, and I think that that is going to be problematic for several reasons. One is setting forth any threshold like that upfront is very difficult. It's like a one size fits all kind of approach, and it's not market based. There's a proxy for market shares, but no matter how you do it it's going to be problematic, and I think it's going to probably end up getting a lot of ACOs subject to review which could be burdensome.

What concerns me even more is the commitment to come to an00 0.0000 TD(ad)Tj19.80 0.0000 TD(sev)Tj19.8000 0.0000 TD(era)Tj1

the provider -- from the payer perspective from the Massachusetts market. In our market, our plan has been changing the way you pay for care that the providers are following.

It is very similar in structure to ACOs. The alternative quality contract was developed in 2007 and launched in 2009. Its modeled combined financial incentives are low budget, modest inflation rates over a five year contract period, and robust performance point incentives based on a broad set of quality targets.

The model now governs payment over 40 percent of our HMO population or 500,000 markets. Our experience with this model to date is providing evidence of improvements in both healthcare quality and spending that's achievable through models that establishes provider accountability for quality and outcomes and overall resource use.

There are many factors in our market leading to provider consolidation. Some of this activity may be encouraged in part by our agency delivery model. However, in our opinion, consolidation of smaller practices with limited infrastructure has served to advance coordinated care delivery that would otherwise be left to the managed care service environment.

The absence of our delivery model we believe

would be contracting and interacting would be the essentially the same. Organized health teams, large integrated systems, smaller community hospitals and provider organizations their interactions would be governed by a managed care for service agreement.

We would like to see support for modification statements, to learn broader provider interest in ACO participation while safeguarding against guarantee inclusion and anti steering contract provisions independent of an ACO's PSA share size.

MS. DESANTI: Thank you very much. Next we have Mindy Hatton. Mindy is --

MS. HATTON: General counsel.

MS. DESANTI: -- general counsel and vice president of the American Hospital Association and we are very glad to have her with us today.

MS. HATTON: Thanks, Susan, and thank you very much for the invitation to be here today. I hope that throughout this workshop that we can keep the bigger picture in mind, and by that I mean the Medicare ACO program was designed to be the center piece of the administration's effort to change how healthcare is delivered and paid for in the U.S. I think it's a very ambitious, very worthy goal.

As Lynn mentioned at the outset, the ACO is a

voluntary program. No one has to be an ACO. The hope I think was that there would be broad and enthusiastic participation that would really chart a new direction for how healthcare is delivered in this country, and as you know, the ASH has been raising concerns about the legal and regulatory barriers for making this kind of change for many years.

As a matter of fact, by my count this is the third FTC on this issue. I think the very first workshop where we articulated our concerns about the panoply of legal and regulatory issues was one on clinical integration that you held about five years ago.

When we evaluate the FTC statement, we're evaluating against the benchmark of whether it eliminates or even has a positive impact on the barrier that we know antitrust law can be to an ACO like clinically integrated organization.

We agree with Bob Leibenluft, that there are some very positive aspects to the statement, but overall we think it fails to accomplish its objective, which is to either eliminate or significantly lower the antitrust barriers to participation in an ACO or even a clinically integrated group, rather than relax the antitrust law, which the AHA has never advocated or supported. We're really concerned that it may confound it.

In my allotted two minutes, let me just make

Becker and Green, and we represent entities in all aspects of the healthcare, so my comments are not as representing any client. They're really my own thoughts.

I too have concerns with the constraints of the timeframe. I think everything is getting even more compressed because the CMS final regulations won't b

to the CMS regulations over the weekend, and I noticed in the CMS regulations, as I read them, non PCPs must not be required to be exclusive to be ACO, so I guess I'm looking for a little clarity on how the FTC and DOJ are distinguishing their exclusivity provisions. I guess it's a difference between a choice and a requirement and maybe seeking some clarity in that as well.

Thank you.

MS. DESANTI: Thank you very much, Patricia. Next we are going to hear from Dr. Larry Casalino. He is the Livingston Farrand Associate Professor of Public Health and Chief of the Division of Outcomes and Effectiveness Research at Weil Cornell Medical College.

DR. CASALINO: Thanks. It's a pleasure to be here.

MS. DESANTI: Let me interrupt you. I made a mistake earlier. Each of the panelists, can you please move the mike closer to you so that you can actually be heard. I'm sorry, Professor.

DR. CASALINO: Like Bob, I think the agencies overall have done a very good job dealing with some very difficult problems, and the specific compliments he gave are ones that I would agree with, and I would also add that I'm very happy to see that the CMS proposed regs

are very congruent with the way that the FTC has been looking at clinical integration. I think that's a good thing, and it wasn't inevitable.

So in just the very brief time that I have, I will focus briefly on two areas. First I want to talk a little bit about the likely effects of antitrust policy on hospital employment, physicians and hospital market power, and second, just a brief comment on clarifying the exclusivity.

I think both the -- if indeed there are ACOs that form, and I think there still a question about how many of those there are going to be, at least in the shared statements program, but both the ACO program and the antirust policy I think are likely to lead to increased hospital employment for physicians and increased market power for the hospitals that employ physicians.

I think this will be unfortunate because not only for raising prices but it will reduce patient choice, so there will be -- if large numbers of physicians move from small practices or medium sized practices to hospital employment, there will be few of those practices left, and patients will not have a chance but to pursue care in that kind of a setting.

This has been happening anyway over the last

decade with increasing speed, and now even more increasing with the talk about ACOs, but both primary care physician physicians and specialists have increasingly been employed by hospitals.

Now, hospitals that keep adding physicians, two here, four there, six here, can have a very large market share and may not really be scrutinized under the merger guidelines by the antitrust agencies, and such a hospital can have or hospital system can have quite a lot of market power both because of the large market share they can be in the physician market, but also because, although I'm talking about this as well, I think most people in the industry think that a hospital and physicians do have more market power than either one alone when they can go jointly to these payers.

I think an API, sort of a network, typically smaller and medium size practices, is really disadvantaged in that. First of all, it needs to get antitrust review, and the hospital that employs physicians that doesn't, but secondly, there are people here I'm sure that know more about this than me, but it appears to me that it may not be that hard. The hospital may be able to employ physicians and gain a market share in certain parts of the physician market that's really quite large that would n0000 0.0000 0.0000 cm1.000aw

an ACO from contracting with payers outside the ACO, so I don't have a problem with that.

There's another question that I don't think is completely clear in the guidelines, and that is does not exclusivity through a hospital mean that it's gotten -- it's kind of written into ACO bylaws that this hospital must be exclusive with this ACO, and that's I think fairly obviously going to be prohibited, but what if the hospital just doesn't want to participate in ACOs?

It's going to take a lot of effort for hospitals to participate in ACOs, and it may not want to -- legitimately it may not want to work with more than one ACO. Also, if the hospital is helping form the ACO, really why should it help its competitors and join a competing ACO? So I think that part of the exclusivity policy needs to be clarified.

I will just mention this, and I agree with Steve, and I'll say this in one sentence. I think that the finest things that ACOs are not supposed to do if they have a certain market share -- I agree, they shouldn't be able to do things like try to prohibit payers from publishing quality and cost information no matter what their market share is.

MS. DESANTI: Thank you very much. To my immediate right is Josh Soven who is chief of the

Litigation One section in the Department of Justice Antitrust Division, and therefore like me, is precluded from giving a two minute summary.

So moving on to my immediate left is Professor Tim Greaney, who is director, Center For Health Law Studies and Chester A. Myers Professor of Law at the Saint Louis University School of Law.

MR. GREANEY: Thank you much, and first, thanks to the agencies for making it financially viable for me to put out a new supplement to my case book every six months, and let me first congratulate the agencies. My Roger Ebert review here is two thumbs up. I think they've done a really good job. It's a well crafted rule. It does the difficult job of balancing administrability, and at the same time dealing with what I will speak about in a minute is really this severe problem of health reform, which is provider market power.

I think it's well crafted in the sense that it places the burden on those who should be bearing the burden, those with market dominance, and it makes them come forward, and answering a bit of what Bob Leibenluft said, I think that timetable does a good thing. It does put the burden on those with market power to come forward in a timely way with proof that there's not a

problem there.

At the same time it takes off the table issues for small ACOs, gives some comfort, and probably most importantly, it powers private attorneys to do the job they should be doing, which is counseling and telling clients what is and is not risky, and that's where all the work has to be done, by private counseling.

Let me just mention at the beginning that just the big picture here is I've been trying to convince people that the Affordable Care Act really depends on competition up and down the line, and so much of it depends on that and the risks to provider market power are really the Achilles heal of the entire reform movement.

When you think about not only what ACOs and deliver system reform is trying to do but how exchanges will work, et cetera, competition really, really is the driving force there.

Let me just mention I think there are three kinds of market power here to deal with, and they have to be dealt with separately. One is extant, existing market power that's been around forever, hospitals that got there by superior skill, industry foresight or dumb luck, and are dominant and have been there for awhile.

The second is market power created by mergers in

worrisome to me is not in the FTC DOJ policy statement but what's elsewhere. I think there are real concerns about the CMS regulatory regime, whether that creates its own barriers to entry for smaller ACOs, those who may not be financially viable to go forward.

I think they're colleague at OIG, I'm not sure they gave enough help on the stark and fraud and abuse issues there, and finally I have a couple points, that I won't repeat what Larry just mentioned, but I think there are issues about hospital employment and foreclosure coming out of that.

So I think the three tiered regime that I mentioned earlier, three tiered problem has to be dealt with different problems, with approaches. As to extant market power, I think you really have to worry about coming up with effective enforcement, be it tying law or bundling law or perhaps a regulatory approach that helps with the unbundling.

I'm very heartened by the fact that the policy statements say require the participant to come forward with information about recent mergers, and I think there are some of those that can be looked at under merger law with the possibility of unwinding, especially physician acquisitions, those aren't entirely impossible to unwind, and finally dealing effectively through

effective review on the ACO entry level.

MS. DESANTI: Thank you very much. Next we're going to hear from Toby Singer who is partner with Jones Day.

MS. SINGER: Thank you, Susan, and I do want to echo the remarks of others in thanking the FTC and the DOJ for giving us an opportunity to talk about this. I know in private practice already we represent providers. We represent payers. We represent employers, and so of course these are my personal views from what I've observed in the marketplace and also based on being a former FTC enforcer myself more years ago than I would like to think.

So I will start again as many people have by saying there are a lot of good things in these proposed regs, probably the one that we received the most favorably is by the provider community is the clear establishment of entitlement to rule of recent treatment, which means that there can be a focus simply on market power, which is a very good place I think for the agencies to focus.

Nevertheless, I think there are a lot of things in the way that the mechanism has been set up that are very troublesome from both the policy standpoint and a practical standpoint. I'm very troubled, again as a

former law enforcer, by the regulatory approach that the mandatory review process takes.

It is not a law enforcement approach. It's a regulatory approach, something the antitrust agencies have steered away from in all the years of it, and to it places the burden entirely on the ACOs, the proposed ACOs without any indication whatsoever that there is a potential for unlawful conduct or even the exercise of market power.

In so doing it allows the agencies and sometimes just the agency staff to block a proposal based on, as Bob Leibenluft described a very quick review, without a comprehensive investigation and without really determining that in fact this is likely to have a negative effect on competition.

Beyond the policy problem, the process itself that was set up by these proposed regulations is overly burdensome and overly expensive, and I think that just simply calculating the PSA and measuring the shares in the primary service areas is going to be far more difficult and far more complicated than the agencies are assuming, and by agencies I include CMS in that as well.

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proposed ACO to figure out what the common services are, figure out what the 75 percent PSA is for those common services and then go to CMS and attempt to obtain data

of market power because there are plenty of ways to identify ACOs that might be in a position of having market power without burdening the entire universe of ACOs, although a footnote, that may be a smaller universe than anybody thinks going forward, giving the ACOs management.

Let me conclude by saying I have limited my remarks because we have a short period of time to a critique of a mandatory review. I don't disagree that the agency has the responsibility to look at the potential exercise market power, but there are many ways to accomplish that in a much more streamlined process with a voluntary process where we can have a simplification of the kinds of information that must be submitted without putting unnecessary burden on the people who are really trying to do a good thing.

Thank you.

MS. DESANTI: Thank you very much, Toby. Next we're going to hear from Dr. Lee Sacks who is executive vice president and chief medical officer -- oh, I'm sorry.

MR. MILLER: I thought Toby was obscuring me.

MS. DESANTI: Joe, we definitely want to hear from you. Joe Miller is general counsel for America's Health Insurance Plan.

MR. MILLER: Thanks. I would like to add to the chorus of complements for the agencies, but add mine also to CMS, who delegated the antitrust function to the experts instead of doing it themselves which they could have done but didn't, so that tells me that they're taking the-1.2600 Tw(5)Tj23.0400.00 cm0.00 0.00 0.00 rgBT66.9600 586.6800 TD

agencies are thinking how those are going to be treated. There are existing groups with significant amount of market power. I don't know if the intent is to not apply the same level of antitrust grouping that would apply to groups that are just forming and if there's a basis for treating them differently.

As to the guidance itself, I think the agencies had three choice. One, they could have offered no guidance, and they could have told providers that they exist under the same antitrust laws as the rest of the world, who doesn't get prescreened review from the agencies every time they want to form a joint venture, so they could have treated this the same as the rest of the economy functions, and I think that would have been a defensible choice. I get there was some pressure to add some clarity, so they went down this route, but they didn't have to.

The second option is to do what they did, which is to set a screen, and the screen I think is just intended to or I think will function as identifying those ACOs that require greater scrutiny. I don't think it's intended to be an actual antitrust analysis.

The screens that they set using PSA shares looks like even half of an Elzinga and Hogarty test which is even by the FTC discredited, and it is done just for the

and limitations.

So I think the agencies chose the right approach of setting a screen. Whether they set the screen at the right level, my advice, which I actually wrote down and published in a blog in health affairs for those who want to go into more depth, is to set the screen at the beginning at a relatively low level to have more review rather than less review.

I think if you look at what they're actually going to do, it's relatively light by antitrust standards, and I heard Toby complain about the burden of a 90 review, which I guess is -- right, maybe leading up to the 90 review, but compare that to what? To an actual antitrust review, a real merger analysis takes quite a bit longer than 90 days, costs quite a bit more money.

The document production, at least as I read the pool, is relatively light again by antirust standards. Antitrust work is not simple or easy. It's hard. It's difficult, and if you're going to get it right, then you have to delve into quite a lot of depth.

If you're just looking to do what I think the HSR Act does in the first initial waiting period, which is simply identify those transactions that require greater scrutiny, then I think this is likely to work.

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stifled by the rule.

One thing that I'm a little worried about is that the Medicare rule is not convenient to antitrust aspect, but generally will have the effect of chilling advancement in innovation, and that would be very undesirable.

MS. DESANTI: Thank you very much. Now we will hear from Dr. Lee Sacks who is the Executive Vice President and Chief Medical Officer of Advocate Physician Partners and Advocate Healthcare.

DR. SACKS: Thank you, Susan, and it's a pleasure to be invited to be here and share our perspective as our clinically integrated network operates in the marketplace, and I agree with Joe's last comment.

There's been a lot of innovation predicated on what everybody thought was going to be the opportunity in Medicare, and if that doesn't turn out to be something that delivery systems are interested in doing, it probably will stifle a lot of the innovations.

I've got five areas I want to comment on, and a number of them have been mentioned. One, the issue that the existing rules will tend to hasten the gravitation of physicians to employment in large medical groups or in integrated systems from a slightly different

had improved on every single measure, some might say we're gaming it and we're setting the bar too low with that.

So if we're going to continue to see the innovations, the efficiencies, the improvements in quality that these types of changes can lead to, and we're involved in a contract with the largest payer in our market for over a billion dollars in revenue that started in January, so it's still early on, but have lots of glimpses of what those improvements are going to be. The rules can't be discouraging.

I look forward to the other comments and the Q&A.

MS. DESANTI: Thank you very much. Next we're going to hear from Henry Allen, who is antitrust counsel for the American Medical Association.

MR. ALLEN: Thank you, and the AMA thanks the agencies for their efforts here. We of course plan on submitting written comments at the close of the month, and so my comments here are preliminary, and I have two minutes, and so here we go.

First a bit of background. The AMA has urged the FTC and DOJ to clarify within the context of ACOs requirements for financial integration, sufficient to avoid the Per Se Rule against price fixing. We have

also stated that the current clinical integration standards published in the statements and FTC advisory opinions to date are overly burdensome and likely to detur the formation of ACOs.

Unfortunately, the proposed ACOs statement ignores the question of whether provider collaborations that participate in shared saving programs and posing downside risks are free of price fixing characterizations.

We think that such programs do entail sufficient financial integration, making a price fixing characteristic or characterization inappropriate, and we would like FTC DOJ to say so. This is necessary if only because the CMS has proposed clinical integration eligibility criteria that are expressly premised on its mistaken understanding that avoidance of per se price fixing liability requires ACO adoption of a leadership and management structure detailed in the FTC's MedSouth Grippa and Tri-State opinions or letters.

Surely CMS is needlessly preoccupied with following the FTC's clinical integration guidance given that a price fixing characterization is inappropriate by virtue of the ACO's financial integration. Under the shared savings program, participants must share the risk that if the ACOs does not meet its cost savings targets,

it must compensate Medicare for those losses.

It is hard to predict the possible exposure the ACO could face, but just as the savings could be large, the losses could also be large. Further, given that the ACO's participants will have to contribute substantial time and money to make the ACO viable, the added risk of loss takes on even more importance.

This is especially true of physicians, many of whom do not have a large amount of capital with which to

in the case law and in the FTC and DOJ's other antitrust guidelines.

Without even research supporting the use of PSA shares of the reliable market screen, physicians should not be expected to shoulder the substantial costs of determining their PSAs. More importantly, these PSAs are likely to be small and I think Mindy eluded to the fact that they're likely to result in misleadingly high market shares for PSA participants. Physicians are risk adverse and will not want to join an ACO that has PSA shares falling outside a safety zone or that supposedly trigger an antitrust investigation.

In sum, we think the usefulness of PSA shares should be studied before they are adopted as a market power screen.

MS. DESANTI: Thank you, Henry. Next we're going to hear from Betsy Gilbertson who is chief of strategy for Unite Here Health. Betsy?

MS. GILBERTSON: Thanks again.

MS. DESANTI: Maybe you can pull it closer.

MS. GILBERTSON: Thanks again for the opportunity to be here. In this robust company, I think I may be the only representative of consumers, and although I'm here with half of that hat, we also operate our own health plan and function as purchasers as well.

So that said, in our world, provider market power is already a very significant problem. Especially in small and medium sized markets, hospitals are the most likely ACOs developers, and often they're already market dominant with the ability to command very high prices.

For example, the rates we pay at eastern market dominant hospitals are double Medicare overall and for specific services more than that, and 50 to 60 percent higher than our rates at competitive markets, at hospitals in competitive markets.

So there's a very significant price consequence to market power that we're already experiencing and, the consequences of experiencing it are that, to be p

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because the clients that I represent, physicians, hospitals, healthcare systems and payers all wanted some guidance, so they are grateful that there's guidance, but yet they have all criticisms, and I would say they all have different criticisms.

So I'm going to try to bring up some of the top points, understanding that these are my interpretations of some of their criticisms. One of the big ones is: What does formed before March 23, 2010 really mean? I have some clients that put together their structure many, many years ago but haven't been actively contracting with payers. Are they formed?

I have some clients that were clinically integrated but not contracting with payers before March 23, 2010. Are they formed in the meaning of this statement? And then there are those who were actively contracting with payers and clinically integrated, and obviously they were incorporated before March 23, 2010. Were they formed as an ACO before the date of this statement takes effect?

So I think that's a big question because it appears that if you were formed before March 23, 2010, then you don't have to go through the mandatory review, and yet they still ask, So do we have to calculate our PSA shares to go into our Medicare application? And we

don't know that either, and you may not know because we haven't seen what the Medicare application is going to look like, but there are a lot of organizations out there that I think a lot of people would expect to participate, and Mindy alluded to this, there are some big ones out there that say they're not going to participate.

I have some that are not quite as well know, but still if you asked CMS, they would probably say, yes, we expect those types of organizations to participate, and right now they are pretty much feeling that

the groups I'm working with, and they say, But this really isn't fair because if I just acquired everybody, nobody's going to say you have to do a mandatory review if you acquire more than 50 percent, so maybe I as the hospital should just acquire everybody and form an ACO and then we're not subject to this review, and I think that should be a concern at the agencies.

Then I think there's also the point that there's nothing in here that says there will be any consideration of non exclusivity, so that if in that common service they have more than a 50 percent PSA share but they're non exclusive, and as was mentioned if you're in some of these more rural areas, probably have more than one hospital or maybe have more than one hospital at which these physicians practice, those physicians aren't going to want to be exclusive.

They wouldn't agree to exclusivity even if the ACO asked them to be exclusive, so going through the mandatory review when it's unlikely you could exercise market power because these physicians aren't going to give you that ability has some significant indications.

Then the third point that clients have brought up with me is the five types of conducts that the ACOs should avoid as recommended by the FTC and DOJ have some pretty strong implications; that is, if you don't have

market power, then putting together a closed panel or asking for some steerage to your closed panel is not necessarily going to have anticompetitive effects. In fact it could have some significant pro-competitive effects.

I would make similar points for a number of the other types of conduct that the FTC and DOJ have said that those groups that are outside the safety zone but below 50 percent should avoid. I think that there needs to either be further explanation or at least the explanation that groups should analyze with their attorney whether or not some of this conduct is viable because I think it's giving the wrong impression to groups that things that they thought they could do are going to be prohibited.

MS. DESANTI: Thank you very much, Christi, and finally I will introduce Saralisa Brau, who is Deputy Assistant Director in the Healthcare Division here at the FTC, and with that we will conclude the opening remarks, and we have certainly gone over the time allotted for them, but I think that they have all been very valuable.

What I would like to do now is just run through the topic outline which I think in fact that the panelists have which I think captures many of the

comments that have been articulated here, and what I would like to do is give people who have additional things to say about particular topics the opportunity just to speak up and respond to some of the points that have been made.

And I'm going to take the moderator's prerogative, and starting with the first topic in the outline, which is: What organizations does this policy statement apply to? I just want to clarify, and I can only speak for my own thinking, but I think that from my perspective, looking at the March 23, 2010 date was a way of looking at what organizations will result from the enactment of the Affordable Care Act, but I take the points that have been made that that's not entirely clear to anybody who is reading this, and certainly, Christine, the examples you raise are good examples for us to think about.

I wanted to ask if there are other people who wanted to add to the discussion on whether the statement should include or address some situations that people have raised or should exclude some other situations, and I should always -- our tradition is if you have something you want to add, please put your table tent up on end. Bob?

intention was that if an ACO has been out there in the marketplace for a certain period of time, therefore you don't need a review, and I th hI t

larger concept about whether you want to do this, so I'm sort of putting this into your framework and just focusing on that.

MS. DESANTI: Thank you, Bob. Trudi?

MS. TRYSLA: Just one or two further comments actually. I agree with the issues around the questions on what constitutes formation. I also encourage the FTC to think about the end dates because at least the notice contemplates that it's during the agreement period, and there may be -- I think the focus should be on the organizations that meet the model of an Accountable Care Organization, and consistent with that is that it should extend to Accountable Care Organization models that may have an alternative pathway through CMS like through the innovation center.

MS. DESANTI: Okay. Yes? Larry?

DR. CASALINO: Just looking at your fourth bullet under what kind of organizations the policy statement should apply, do they have the effect of encouraging certain kinds of organizations rather than another?

I guess I will just go back to what I said earlier but I'll say it in a slightly different way. I think that as things stand now, with the way the agencies' policy has gone towards network versus towards

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Are there more points that people want to talk about in terms of whether these are the correct criteria to show clinical integration? Are some of these criteria unrealistic from a business point of view, and if so, which ones and why?

What other problems do you see with the CMS proposed eligibility criteria that relate to clinical integration that's relevant from an antitrust point of view? Bob Leibenluft.

MR. LEIBENLUFT: Thanks.

so what the FTC and DOJ are essentially saying is, we will trust CMS to determine what is clinically integrated, and we'll accept that.

I think that's fine, but I think you should really be concerned about the clinical integration such, how doctors are working with each

of directors, talking about how to approach the improvement of quality, the reduction of cost, how it will benefit the community, so they definitely have those ideas in mind, and some of them do have community representatives, business members on their board of directors, and they do think that that's important, but I can't say that having community representatives on the board of directors necessarily makes them more clinically integrated either.

Some other points I might make. Every single one of them has a medical director but not a full-time medical director. In fact, some of them have a couple part-time medical directors who have their own private practices

think the important point is that CMS is very prescriptive here, and what they've been prescriptive about has not necessarily been what groups who have succeeded in clinical integration have done, and I don't want people to think that you must follow CMS's guidelines to be clinically integrated.

MS. DESANTI: Thank you. Now we're going to move on --

MS. HATTON: I'm sorry, can I ask a question? Since we have representatives, this is one of the things I think that we were most pleased about because this is really a historical collaboration between agencies on this whole set of rules.

I wonder since we have someone from DOJ and a number of representatives from FTC whether or not you actually can speak to what the thinking was

have sort of

viable period of time.

The second was as Susan said was this we thought would promote and I think everyone thought would promote an efficiency across the board as it was not viable to essentially add two parallel hospital systems or ACOs operating, one in the Medicare program and one in the commercial market, so therein lies the tight link both between the clinical integration requirements and the linkage up with the antitrust requirements.

But as Susan said, and I stated to everyone I work with at least on the antitrust side, none of us run a hospital, and none of us run a physician network, and none of us run a large integrated providers group, so it is critical that those who actually do that on a day-to-day basis be quite precise in their comments because I'm qutu

director or part-time medical director.

We're large enough that we fit within all of these, but I think as you already heard, that smaller organizations aren't -- and I absolutely agree that a medical director is much more effective and are practicing in terms of their credibility.

Another one of the requirements from CMS is that 50 percent of the primary care physicians have meaningful use for electronic health records. There are so many variables to that including would a vendor meet the requirements, and I'm waiting for three vendors now who promised us for months that they will be complaint, and they aren't yet. Multiply that by networks that have independent physicians and the complexity.

And yet we've achieved the results that we have in clinical integration and outcomes and efficiency without electronic records, so I don't think that's the be all end all.

MS. DESANTI: Thank you. We'll have Larry, and then we're going to move on because we have to in the interest of time.

DR. CASALINO: I think we've moved a little bit into the critique of the CMS regs, and I'm not going to do that, but I think it does raise a question that I haven't actually heard addressed anywhere which is that

are potentially at issue here. The first is whether ACO participants are exclusive to that ACO in the sense that they will not participate in other ACOs.

The other and the more troublesome type of exclusivity is having the ACO as those participants' exclusive contract vehicle, so that any time a health plan comes along, they think the health plan would have to go through the ACO. I think that as I said the second is much more troublesome and deserves the kind of treatment that it's getting in terms of the safety zone.

But the first type of exclusivity especially when you're talking about a safety zone so by definition talking about providers that probably have a relatively low market share, simply saying we're going to dedicate our resources to one ACO but if a payer doesn't want to contract with that ACO, they're free to come us to directly, that's perfectly fine and it should be allowed for any kind of provider in the ACO.

MS. DESANTI: Anyone else on the safety zone? Patricia?

MS. WAGNER: I'm actually going to talk about exclusivity as well because I can imagine situations where let's take a three hospital town where one of the hospitals is dominant, and therefore in order to participate in the ACO can't be exclusive to the ACO,

and I guess I'm back to my original point of: What does that really mean?

Does it mean if one of the other hospitals in town forms an ACO, that they have to get the dominant hospital in or that they have to ask the dominant hospital in? I mean, I can see a lot of situations where you might not want the dominant hospital in your ACO, and in some cases you might want an ACO without a hospital or you might be able to drive utilization so that having the hospital and the ACO is really not necessary.

So I think I kind of like the language of the CMS regulation, which is it cannot be required to be exclusive because add dominant provider to that, and then you have, you can't require it, but if someone decides not to participate in other ACOs, then maybe that's okay.

MS. DESANTI: Thank you. Mindy?

MS. HATTON: Actually somebody else had theirs up before me.

Just two comments. Obviously we could talk about these all day, and we'll certainly be sending you comments on them, but you're probably aware that we suggested some guidance for the last couple of years, and in looking at whether or not 30 percent is the right

number, we actually thought that 35 percent would be the right number under -- that it should be a little higher and certainly not the 10 to 20 or 20 percent that Joe suggested so just to put that on the record.

Also I think with respect to the dominant providers, I think the agencies are going to really need to look hard at whether or not those provisions -- again if the benchmark is whether or not -- of these regulations whether or not they accomplished their, objective which is to lower or eliminate a barrier to ACO participation, whether or not the dominant providers are the ones again who are most likely to be able to meet all the panoply of requirements that there are to be in ACO and whether or not some of the limitations that you, the agencies, have included in the statements, whether or not those will discourage again the participants that are again likely to be the most ready

exclusivity, a little different variant from other folks have said. To fit within the safety zone, the hospitals and the EFCs must be non exclusive regardless of PSA share, so you could have a market like a Lee Sacks market where there are a lot of hospitals, and even if one of the smaller hospital systems has less than a 30 percent market share, you're telling them that they can't be exclusive.

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sort of antitrust limitation or relief or waiver authority or anything of the sort, so it's providing guidance as to when you're l

MS. DESANTI: Okay. Henry, a

nonexclusivity? Trudi?

MS. TRYSLA: I'll offer a comment similar to the previous discussion. I think the ACOs, in order to foster the providers that really want to do this, should be able to have nonexclusive particularly --

(Discussion off the record.)

MS. TRYSLA: So I think that's point number 1. It's been repeated by others.

In terms of the review process, I would -- again I stated previously it's going to be a significant challenge particularly within the timeframe provided, and I would encourage the FTC and DOJ to maybe think about if they are going to have a mandatory review, that they focus it on the groups of providers that are going to be exclusive so that cuts down on the burdensome, focusing on the primary care provider group and focuses on the traditional approach to really focus on what they actually may observe in terms of anti-competitive behavior.

I think that's something to consider, particularly in the current timeframe by which providers have to transform themselves to accommodate the structures.

MS. DESANTI: Thank you. Let's move on and discuss the list of conduct that's in the policy

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As long as those providers are not exclusive so that a payer doesn't have to contract with the ACO, you can set up a separate contracting forum, then the requirement that the referrals stay within the ACO and that a payer not steer away from it shouldn't be a competitive effect, in fact should foster the possibility of the ACO to follow the guidelines.

MS. DESANTI: Thank you. Bob? Bob Galvin?

MR. GALVIN: Yes, thank you. I think this is a good start. I like these. I had one issue with number 4, which had to do with information to consumers or to payers, and you limit it by saying it has to be similar to what's going on in the Medicare Share Savings Program.

I think there are two issues with that. One is there is no price information there because they administratively set prices. If you're a consumer trying to make a decision, what it costs you is very important, and you wouldn't get that out of Medicare data.

Secondly to go back and review the regs, my sense is that the level of quality data that the shared savings program is going to demonstrate might be at a much higher kind of aggregate number than many of us who work on my side actually are satisfied with this big

MR. GREANEY: So I nicknamed these the five no nos when I first read them, if anybody remembers the IP no nos, and I think clearly number 5 is probably a no brainer for most antitrust counselors, but with respect to the other four, there's an interesting issue here about just how they're going to be enforced or negotiated vis-a-vis applicants.

One approach might be to see them as a ticket of admission to get your clearance letter, and I don't think the agencies are going to do that, but I think that's a concern because there is some nuance here. Some of them could be relatively benign in certain circumstances, certainly when there's not real dominance, but I think they are all important.

I think they are indicia that there is a problem there when a dominant entity engages in these behaviors, so I am heartened that they're in there, and what I'm hoping the purpose they might serve might be again to sort of stiffen the backbone of antitrust counselors when they talk to their clients and say, This thing is really problematic, the agency thinks

MS. DESANTI: Okay. I think we will conclude with Betsy Gilbertson, who we included with in October as well. Betsy?

MS. GILBERTSON:

PANEL 2:

PARTICIPANTS AND AGENCY STAFF:

CHRISTI BRAUN, Mintz, Levin, Cohen, Ferris, Glovsky & Popeo, P.C.

THOMAS GREANEY, St. Louis University of Law

ROBERT LEIBENLUFT, Hogan Lovells

JOSEPH MILLER, America's

To my right, to my extreme right is Steven Wojcik who is the vice president of public policy for the National Business Group on Health; Craig Peters, an economist from the economic analysis group of the antitrust division of the Department of Justice; Dan Gilman, an attorney advisor from the FTC's Office of Policy and Planning, and we were hoping to have Professor David Dranove from Northwestern University. He was called away at the

that has long been supportive of and interested in and trying to foster more organized system of healthcare delivery in this country, and the ACOs have a lot of hope -- we have a lot of hope riding on the ACOs as a key way to truly reform healthcare and move toward an effective efficient healthcare delivery system that we really need in the 21st century world.

Having said that, we have some concerns that have been addressed by a number of the panelists in the first panel, but I just want to reiterate some of them and maybe add some additional information.

We very much appreciate, first of all, the Federal Trade Commission's and the Department of Justice's being proactive on the antitrust implications for ACOs. We believe that this is the right approach to try to avoid antitrust problems at the outset rather than trying to fix them after the fact when, as the panelists in the first panel some of them mentioned, it's harder to remedy antitrust enforcement of ACOs.

It's particularly impor

power of healthcare providers where it exists.

To the extent that ACOs increase their market power and use it to increase revenues fr

MR. GARMON: I also wanted to read into the record comments from Professor David Dranove who was unable to make it today. He sent us some comments about his suggestions for the PSA approach, so I'll read those in.

(Comments from Professor Dranove.)

It is not obvious how to asm TD(r D)Tj19.8000 0.a( )Tj19.8000 0.000

automated rather easily. It would make sense therefore to pay for a consulting firm to do all this work on the contract at the FTC. The FTC should put this out for competitive beating. I think you can get this done for no more than $20,000 per ACO proposal and perhaps for much less.

(End of comments from Professor Dranove.)

I will leave it to you decide whether ACOs or tax payers should foot the bill for this, and he's

ACOs that would not be problem, that would not have to be reviewed.

Those above the thresholds, many of them, maybe most of them, we don't know, could still be pro-competitive, but those are the ones that might need some review, and so that's why we set the thresholds and maybe the thresholds aren't correct, and that's what we would like some feedback on.

We were also told these would not be for mergers. Merger of healthcare providers and doctors are in many cases are irreversible. The guidelines will be for ACOs joint ventures between independent organizations, and again these will be for organizations only involved in the Medicare Shared Savings Program so they will be accountable, they will be monitored by CMS.

So with that we wanted to build a quick screen that is not a substitute for geographic market definition, product market definition, in a normal anti merger or non merger case, but that reflects the competitive dynamics of the market, that is straightforward calculating and interpret, and they can use that rather than the available data so it's transparent, and providers can calculate their shares.

So with that, what I wanted to put out there are three sets of questions. One, what are the advantages

and disadvantages of this approach, and for those panelists that don't like it, is there something you propose is better given those limitations we're working under?

The second set of questions specific with issues with how PSAs are calculated and the categories: Are there improvements we can make in doing that?

Then is there anything that the FTC and DOJ can provide to make this easier on providers in calculating their ACOs? We would love feedback on that as well.

So with that, let me put out the first question: What are the advantages and disadvantages of calculating shares within the primary service area, and are there any approaches that are better that the panelists would like to talk about? Bob?

MR. LEIBENLUFT: Bob. I guess given that you might have some screening device, I'm not sure I can think of necessarily a better screening device that would work for everybody off the cuff. I guess that's your challenge, but I can see how this doesn't work for a lot of situations so.

One suggestion is that -- the problem is once you trigger it, you have to provide all this information, so a lot of things begin to happen, and so one thought is that the agency should be open to an ACO

applicant coming in and saying, Look, I'm in Schenectady and it doesn't make sense to look at the PSAs, let's look at the geopolitical market, geopolitical area, or here's my situation. I only exceed the threshold in one common service by a little bit.

So there's some sort of -- a lot of flexibility built in so let's say within 10 days or 15 days, you can go back to the applicant and say, you're right, you would have been covered by this but you don't need to go through the whole analysis and provide all the documentation, you're okay.

Right now once you're in, you're in, and you're in for the whole thing, and even though you may say don't worry about it, it's just a quick threshold, and many of you won't have any problem, you do have to provide all that information, and then you may be further down the line as to how you get cleared because you are working with the ones that are close to call.

So I just think having something where someone can come in in a short period of time, and maybe that 90 day clock doesn't start until after there's some decision about whether or not you need to go through the whole thing, but something intermediate where if you otherwise would trip it, you really don't have to deal with it.

MR. GARMON: Something like an early termination.

MR. LEIBENLUFT: Yes, without having to submit the whole range of documentation that you have to submit.

MR. GARMON: Christi?

MS. BRAUN: I guess one of the biggest disadvantages of the PSA share is that it is costly to calculate. I appreciated Dr. Dranove's comment because on behalf of a client, I went to some economists first and said, give me an estimate, what would it cost, and the lowest estimate I got was $15,000, and the particular group that I was shopping around for wasn't a large IPA. It was roughly 250 providers.

So I wouldn't want to know what it would cost Dr. Sacks to do that kind of calculation. It would be nice if the government footed the bill and did the calculations, but knowing that they're not likely to do that, then there are smaller, more rural groups that say, it's going to cost me this much to do it, I have this potential amount that I can make with CMS.

At the end of the day the costs of getting into the CMS program are so high, it's probably not worth it for us to do it, and I don't think that's what CMS intended, but that is a consequence of the PSA share

market share.

UNIDENTIFIED SPEAKER: Christi, was that 50,000 or 15,000?

MS. BRAUN: 15, 15.

MR. GARMON: Thank you. Lee?

MR. SACKS: I would second that, that this just becomes one more hurdle that will keep organizations for being interested in doing it. This may be harrassee, but I'm not in the antitrust profession, but if you look at what you have to do to be successful as an ACO, you have to improve service. You have to save money and create efficiency, and you have to improve quality, and if you don't do the latter, you don't get any of the savings, why do you care if I have 20, 30, 40 or 50 percent market share because even if I have 50 percent market share and I save money for Medicare, provide better outcomes and better services and my patients have free choice on whether they want to stay and get care in our ACO or opt out and even if they're in the ACO they can go to Mayo Clinic or M.D. Anderson any time they want and they're still responsible?

We've theoretically improved the system. Then we'll know at the end of three years if I have to write a check to Medicare, we're not going to continue to participate, but for organizations that are willing to

take that risk, and I assume and certainly based on my experience in negotiating with the commercial payers, they're sophisticated enough to put in similar protections if they're going to enter into a contract with us on the commercial side that would make sure that there's protection to assure that we're performing as we intend to with that.

Could it be simpler? Could it just be number of physicians compared to number of physicians in the market? Anybody could do that calculation pretty easily. It's not perfect in terms of market share. I have real concerns that if we have to get data from our independent physicians, many of them don't have the systems in place to easily extract the data in a form that would go into the calculation that you were talking about.

We still have some physicians who don't have computerized registration and billing systems with that, so if that's a requirement, that probably means they will not be in an ACO. They won't be on the pathway to approved care.

MR. GARMON: Joe?

MR. MILLER: The $15,000 is costly compared to what? You have to ask: What is going to happen if you don't do that? Does it mean you can't calculate PSA

willing to defend the suit.

What I'm not sure whether you meant or not was there shouldn't be a suit. There shouldn't be a cause of action. As a legal matter, the antitrust laws still apply here so all that still should count for something, and I think the question here is whether this screening mechanism should be available to providers as they're looking at the program.

I have think it's certainly defensible to say it shouldn't be a screening mechanism. They should take or bear the full risk. Agencies should be regulatory, less involved, but if they're going to go down this path, I think setting the screening mechanism is right.

$15,000 is cheap compared to what you're going to get if you actually draw the attention of the agencies to take a hard look at one of these.

MR. GARMON: Patricia?

MS. WAGNER: I actually like the concept of having or starting maybe starting with a head count, and part of the -- I'm aware of a couple markets where the fee for service Medicare is not actually representative of the market share of the physicians in that market, and I'm not talking about OB-GYN or pediatrics. I'm talking about general internists.

It seems to me if you did an initial screen

based on head count, then there may be a second trigger, right, if you had 51 percent of all internists in the market, then maybe it would make sense to do the PSA calculation to see whether that really translates into some significant market share, and that way maybe is eases the burden and also gives them a safety net to make sure you're not letting things go through inadvertently.

MR. GARMON: Did you have anything else you wanted to say, Joe?

MR. MILLER: I left that up by accident, but yes, I'm glad you asked. There are three tests in the beginning that reflect competitive dynamics, straightforward to calculate or interpret, and readily available data.

The second two are right. The first one I think is wrong. I don't think you can ask a concentration metric to reflect the competitive dynamics of a market. Even real market shares, which these are not, don't tell you that. For instance, compare the '92 merger guidelines to the 2010 guidelines.

There's an emphasis on actual effects as opposed to market definition and shares, and I think that's for a good reason, that it reflects the learning of antitrust practitioners over a couple decades and better

MR. GARMON: Bob?

MR. LEIBENLUFT: Yeah. I guess I'm not worried about too

If the agency doesn't challenge it, then it's like it has no teeth, and so I think there's a tendency here to maybe accelerate things more quickly than anyone is quite ready to go just because we want to have certainty in

market power probably draws from the whole Metro area and would be below the threshold because the number of Zip Codes in their PSAs would be large as opposed to some of the more community hospitals which draw from five or six Zip Codes.

But it's the ones who spread across the Metro area that's a must have and has a commanding presence and would certainly make Joe's members -- they're the ones who get anxious about the impact of that one versus the community hospitals that could have a higher market share in the immediate community.

Then it depends on the concentration of hospitals, and the denser of an area, there's hospitals every two miles and they have a small market share. We have a hospital in the outer ring of suburbs where there's no hospital within ten miles of them, and it's not a surprise, their market share is higher.

In our case none of our hospitals are above 30 percent with that, but I'm sure if we break it down by specialties that are relevant to Medicare, some of the physician groups will be outside of that safety zone.

MR. GARMON: Christi?

MS. BRAUN: Answering your first question about is there a good source for a head count, I would argue that CMS's list of participating physicians is probably

MR. SOVEN: Of PSA or MSA or where?

MS. BRAUN: I have a big problem with PSAs because that's not necessarily how the providers I work with define their primary service areas. It's not contiguous ZIP codes. It's often a spotty map. But I do I think metropolitan areas and rural service areas are better indicators than the PSA is.

MR. GARMON: Christi, can I ask a follow-up? What do you think it would do, plus or minus,

then they may have a larger market share for that smaller geographic area than what they actually covered.

MR. GARMON: Bob?

MR. LEIBENLUFT: Two points. One, on the head count, I think there is an issue about geographic market. It's going to vary by specialty, and you may need to provide some guidance, maybe certain miles, and that's why I think it's flexibility. I think if someone comes in and says, This is what we should do, you could do it.

Second, in terms of data, I think it would be really efficient if DOJ and FTC detailed one economist from each agency, seriously work for six months at CMS and get the numerator data.

I think you would have -- everybody would have much more -- it would be much more reliable. The agencies would know how it works a whole lot better. It would be consistent, and I think unless the data is not physically available at CMS, if it's in there somewhere, I always underestimate how much work is involved in these things, but I think it would really make a whole lot -- it would also I think diffuse some of the concern about the burden on the PSA side.

I think it still should not be the end all and be all, but if someone could just say, here's my TIN,

give me my numerator in some sort of portal or something and you have the macros, that would sort of solve a lot of some of the noise around this, at least initially on the initial burden.

MR. GARMON: Following up on that, our assumption is that the providers would know their numerator. What types of providers is this going to be burdensome to, to get their Medicare revenues?

MS. BRAUN: Primary care providers. Your most important participant in the ACO are also your most difficult to get your data from.

MR. GARMON: Why is that?

MS. BRAUN: Because they often practice in much smaller practices. They don't invest as much in their technology because they don't have as high income, and so they try and keep their costs as low as possible.

MR. LEIBENLUFT: Chris, I think realistically let's say you have 500 doctors, and you ask them all for that data. Just think about how long it's going to take to actually get it back, to figure out whether it's reliable. I mean, it's just the level of reliability and accuracy and efficiency is so much lower I think in asking it that way than having it more centrally done even if it takes a couple of economists to do it.

I'm probably underestimating it, but I think

now or should they be split up that was mentioned at one of the even disease, a lot of DRGs? What do the panelists think about that? If we have more finely defined categories, we're going to get a sample size issue where there may only be one patient in that category, and you have 100 percent share automatically, even though it doesn't mean anything.

So what do the panelists think is the right trade-off there if you thought about that, or maybe you haven't thought about it? Are there problems following up with the way we've classified physician specialties in patient categories and major diagnostic categories, the outpatient categories? No views about that?

MS. BRAUN: I do have one thought.

MR. GARMON: Christi?

MS. BRAUN: In looking to get the example, looks at a couple physician practice groups, recognizes that if a practice group has more than one speciality or provides services in more than one specialty, then it essentially decides which one is the plurality of care, and that's the specialty for the practice, that makes the most sense, and my clients may hate me for saying this, but it also in some ways skews the market share then because if you have a multispecialty practice that has five cardiologists and four cardiovascular surgeons

and you decide, Oh, we're just cardiologists, that doesn't necessarily give you an accurate reflection of what their market share is.

So I think in that respect the head count is actually much more accurate because you can go in the practice groups and break it down by specialists and actually know who you have as opposed to saying, okay, this practice is going to be this speciality, and that's what we're going to attribute all revenues to.

MR. GARMON: One of the questions we put out for public comment is what to do about those areas that are not representative, for example, obstetrics and pediatrics? Do the panelists have any ideas for even if a CMS list of head count would get at that issue? Do the panelists have any idea what we might do in those situations?

Our concern of course is that ACOs will form and have market power on the commercial side, and that's one difference between the commercial side and Medicare side, those specialties? Is there any ideas about that?

MR. LEIBENLUFT: I haven't thought too much about it, but again if there's some way that centrally the agencies could do the best job that anyone could possibly do at once to figure out where OBs and GYNs are, whether that's going to licensing board or going to

Healthcare doesn't neatly fit into the same box that retail or transportation does, and that's obviously the challenge that you have, to figure out how to give us guidance and not retard the potential for improvement.

MR. GARMON: So following up on that, should we develop a screen that's based on overall physician services instead of specific specialties? Does any other panelist have an opinion about that, for instance, ecialties? Does any

Medicaid database seems to be an interesting solution, but also a problematic one, even for the specialties; that is, I haven't looked at this, but it seems to be the sort of thing that could be an exceedingly go

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MR. GARMON: Patricia?

MS. WAGNER: Just so I understand though, more time would be more time to see whether you can transfer the ACO to the commercial market, right? Because nobody is going to want to put in an application if in 90 days they don't know in they can participate in Medicare.

MR. LEIBENLUFT: Well, okay. That's a good point. One thought is CMS r

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MS. WOJCIK: I'm not a data expert, so I will leave that out, but what we would like to see is some kind of baseline metric. We know there's cost shifting now at the outset, and then make sure that the cost shifting is not increasing over that three-year period or the period for which an ACO exists.

We actually believe that only ACOs that have constant or declining ratios of private payments or Medicare payments should be eligible for bonuses. I mean, if there's evidence that the cost shift has increased, maybe I said that wrong, but I think you know what I mean -- if the cost shift has increased, we don't see that that -- somehow that has to be factored in whether a bonus is warranted or not if it's due to undue -- I mean, that's one evidence of undue market power, cost shifting increasing I would think.

MR. GARMON: Bob?

MR. LEIBENLUFT: I think you should just acknowledge you're getting into price regulation, and maybe a decision has been made whether I need that or not, but I don't think a lot of this -- this is a step towards that.

I think it's very regulatory, and why should this sector be subject to looking at how their prices are in any different way than the rest of the economy is

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look at the really big picture, and certainly the conversations that I've had with the health plans in our market post March 23, 2010, they've all started to focus on what's going to happen in 2014 with these changes , and if your cost position is above X and X is a lot lower than anything we're comfortable with today, you are not going to be able to participate in the exchange, and you run the risk of losing market share.

From the health plan perspective, if they can't deliver a product that's at that price point, they're going to cede that market to the exchange, in particular the small and individual market as well as the large

mini experiments going on as the market recalibrates, but the employer community is crystal clear, and I think I can speak for providers across most markets in the country.

Volumes are down this year, a combination of still the impact of the recession and changes in benefit plans related to the cost pressure, and that's something that every hospital and physician is very aware of and is going to be very sensitive to when they think about pricing going forward.

MR. GARMON: Thank you. Any other comments about PSA topic or any other topics? I would like to thank all the panel participants from both panels today. It was a very useful discussion, very informative.

Thank you very much.

(Applause.)

(Whereupon, at 1:02 p.m ., the roundtable discussion was concluded.)

CERTIFICATE OF REPORTER

MATTER NUMBER: P111205

CASE TITLE: Another Dose of Competition: Accountable Care Organizations and Antitrust

HEARING DATE: MAY 9, 2011

I HEREBY CERTIFY that the transcript contained herein is a full and accurate transcript of the steno notes transcribed by me on the above cause before the FEDERAL TRADE COMMISSION to the best of my knowledge and belief.

DATED: MAY 16, 2011

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DEBRA L. MAHEUX

CERTIFICATION OF PROOFREADER

I HEREBY CERTIFY that I proofread the transcript for accuracy in spelling, hyphenation, punctuation and format.

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ELIZABETH M. FARRELL