# Federal Trade Commission

**Accountable Care Organizations: What Exactly Are We Getting?**

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**Commissioner, Federal Trade Commission**

**before the**

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I.

The Patient Protection and Affordable Care Act (the "Act"), also known as "ObamaCare," was signed into law by the President on March 23, 2010.[1] One of the reforms in the Act is the Medicare Shared Savings Program, which promotes the formation and operation of Accountable Care Organizations (''ACOs'') to serve Medicare fee-for-service beneficiaries. Under this provision, ''groups of providers . . . meeting the criteria specified by the [Department of Health and Human Services] may work together to manage and coordinate care for Medicare .

* The views stated here are my own and do not necessarily reflect the views of the Commission or other Commissioners. I am grateful to my attorney advisor, Darren Tucker, for his invaluable assistance in preparing this paper.

[1] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). This Act was amended a few days later by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

. . beneficiaries through an [ACO].''[2] An ACO can share in a portion of any savings it creates if it also meets certain quality performance standards published by the Centers for Medicare and Medicaid Services (''CMS''). The Act requires that ACOs that wish to participate in the Shared Savings Program enter into an agreement with CMS for at least three years and agree to accept at least 5,000 beneficiaries assigned by CMS.

ACOs may be formed from a variety of entities, including networks of individual practices, partnerships, hospitals, and other health care professionals. Some ACOs are expected to be newly-formed joint ventures among previously independent, competing entities. It is expected that most health care providers that form ACOs for Medicare beneficiaries will also seek to use the ACO structure for their commercially-insured patients.

The final regulations provide for two "tracks" for ACOs: the "one-sided" track and the "two-sided" track.[3] Under the one-sided track, an ACO receives up to 50% of any savings but is not subject to sharing in losses. Under the two-sided track, an ACO receives up to 60% of any savings but must absorb a portion of expenses that exceed a certain benchmark. An ACO participating in the two-sided track can reduce its liability for losses by hitting certain health care quality benchmarks. An ACO can have only one agreement period under the one-sided model; after that, it must agree to shared losses as well as shared savings. CMS has estimated that 1 to 5

The antitrust agencies recognize that the formation of ACOs raises a number of antitrust concerns, in particular that ACOs run the risk of price fixing if they engage in joint price negotiations, and that they may be able to exercise market power, particularly in rural markets.[4] These concerns are heightened when ACOs are negotiating with private payors. After all, Medicare sets its own rates and providers must either take or leave them.

To address these antitrust concerns, last month the FTC and DOJ issued a joint enforcement Policy Statement specific to ACOs.[5] The Policy Statement is intended to describe the standards under which the antitrust agencies will review ACOs that participate in both the Medicare and commercial markets. The final Policy Statement was preceded by a draft Policy Statement that was released for public comment in the Spring.

projected to be over $7 trillion.[9] Thus, the cost savings from ACOs, assuming that these organizations are actually effective in improving quality and containing costs, represent less than one tenth of one percent of expected Medicare expenditures over the next decade. In other words, even under the most optimistic scenario, the savings to Medicare from the ACO program are no more than a rounding error.

Yet even the CBO's modest cost savings projections are likely overstated. CMS has been running what is known as the Physician Group Practice (PGP) Demonstration for the last several years.[10] The PGP Demonstration created incentives for physician groups to coordinate care delivered to Medicare patients, rewarded them for improving the quality and cost of services, and created a framework for collaboration with other providers – in other words, they've done a trial run of the ACO program. The results were nothing to crow about. While all participating physician groups improved the quality of their services based on certain benchmarks, the cost savings were, in CMS's own words, "minimal."[11] Even after five years of the project, a majority of the participating practice groups did not achieve any cost savings.[12] In addition, the practice groups that did hit cost savings targets had, again according to 9

occurred."[13] In other words, CMS acknowledged that the reduction in Medicare expenditures at these practice groups might have occurred even absent the financial incentives of the project. I should also mention that ACOs in the Shared Savings Program will have smaller financial incentives to reduce costs than providers in the PGP Demonstration had.[14]

There is also a substantial risk that any reduction in costs due to the Shared Savings Program will simply be borne by commercial payors. The commercial sector already effectively subsidizes providers accepting Medicare and Medicaid payments for certain services. The ACO program may exacerbate this trend by causing providers to shift more of their costs to commercially insured patients in order to qualify for the Medicare cost-reduction bonuses. This cost shifting may be facilitated by the enhanced market power of some ACOs in the commercial market. One recent study showed that this is precisely what happened in California as independent practice associations flourished there.[15] In short, even if ACO participants demonstrate that they are lowering costs to Medicare, that will say nothing about the net changes in health care costs for the country as a whole.

I thought then, as an antitrust practitioner who frequently represented health care providers, that the 1996 amendments creating a safe harbor for competing providers who were merely clinically integrated were the biggest loophole in the antitrust laws I had seen.[16] For one thing, there was a good deal of joint venture case law to the effect that sufficient financial integration provided efficiencies that would justify shielding from antitrust liability potential competitors who were joint venturers.

For example, in its 1982 *Maricopa* decision, the Supreme Court held that agreements among competing physicians regarding the fees they would charge health insurers for their services constituted *per se* unlawful horizontal price fixing.[17] But the Court distinguished the medical groups from joint ventures in which the participants had pooled their resources and agreed to "share the risks of loss as well as the opportunities for profit," thereby becoming "a single firm competing with other sellers in the market."[18] As an example, the Court suggested that a group of providers that offered "complete medical coverage for a flat fee . . . would be perfectly proper."[19] In addition, there were clear, concrete guidelines in the Health Care Statements as to the forms of financial integration that the agencies will find acceptable.

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[16] Health Care Statements, *supra* note 7, at Statement 8.

[17] *Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 356-57 (1982); *see also Goldfarb v. Va. State Bar*, 421 U.S. 773, 787 (1975); *see also North Texas Specialty Physicians v. FTC*, 528 F.3d 346 (5th Cir. 2008) (upholding a Commission opinion that a group of independent competing physicians violated Section 5 of the FTC Act by orchestrating a price agreement among its physicians, negotiating price terms in payor contracts on behalf of its physicians, and refusing to deal with payors except on collectively agreed-upon terms).

[18] *Maricopa*, 457 U.S. at 356.

[19] *Id*. at 357. The Court also drew a contrast to the blanket license arrangement in *BMI*, which the Court described as "entirely different from the product that any one composer was able to sell by himself." *Id*. at 355 (citing *Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc*., 441 U.S. 1 (1979)).

In contrast, there is no joint venture case la

To its credit, CMS issued regulations providing for both financial carrots and sticks to ACOs. As I previously mentioned, two tracks will be available for the initial agreement period. The first track, which I expect will be more popular, includes shared savings only. The second track includes both shared savings *and* shared losses. An ACO can have only one agreement period with just shared savings; after that, it must agree to shared losses as well as shared savings. In other words, for most ACOs, the financial sticks will not kick in until 2016 or later. And even then, the degree of risk-sharing or withholds required by CMS will be less than that generally required by the FTC or DOJ in giving competing providers a pass to negotiate jointly on the ground that the providers are sufficiently "financially integrated." But the CMS regulations are a step in the right direction.

III.

Next, I'd like to address some of the concerns that were raised about the FTC and DOJ's draft ACO Policy Statement. I think it's fair to say that the final Policy Statement differs in a number of significant ways from the draft Policy Statement and that public comments led to many of the changes.

Perhaps the most fundamental objection to the draft Policy Statement was that the mandatory review by the FTC and DOJ of certain proposed ACOs was an impermissible subdelegation of authority from CMS to the FTC and DOJ. Under the subdelegation doctrine, courts have placed limits on the ability of federal agencies to transfer their statutory authority to outside entities, including other federal agencies.[22] That doctrine was implicated by the draft CMS regulations and the draft Policy Statement because the antitrust agencies would be making

[22] *See generally* Richard D. Raskin, Ben J. Keith & Brenna E. Jenny, *Delegation Dilemma: Can HHS Require Medicare ACOs To Undergo Pre-Clearance by the Antitrust Agencies?*, Health Law Reporter (BNA), June 23, 2011.

the final determination of whether an ACO was eligible to participate in the Shared Savings Program, even though the Affordable Care Act did not expressly authorize CMS to delegate its authority to the FTC or DOJ.

The final CMS regulations and antitrust Policy Statement eliminate mandatory antitrust review at the FTC and DOJ. As a result, the FTC and DOJ will not be able to block an ACO from participating in the Shared Savings Program. That does not mean, however, that participants in the Shared Savings Program have antitrust immunity or that CMS is blind to antitrust considerations. To the contrary, the FTC is committed to challenging anticompetitive ACOs, and CMS will assist us to the extent possible. For example, CMS will be providing the FTC with aggregated ACO claims data and the applications of newly formed ACOs, both of which should help our staff identify ACOs that are exercising market power or not achieving efficiencies. In addition, if an ACO is found to violate the antitrust laws, CMS can kick that ACO out of the Shared Savings Program. The FTC will be vigilantly monitoring complaints about ACOs and will take whatever enforcement action may be appropriate.

Given that some potential applicants to the Shared Savings Program will want antitrust comfort before participating in the Program, the antitrust agencies, upon request, will provide an expedited review for newly formed ACOs. These voluntary reviews will be similar to the usual Advisory Opinions our staff issue, except that we have committed to making an assessment within 90 days after all of the materials have been submitted. ACOs or proposed ACOs that do not seek voluntary review can still rely on the final Policy Statement to understand the agencies' enforcement approach with regard to ACOs participating in the commercial sector and to take steps to reduce their antitrust exposure.

As an aside, I am more than a little curious as to how many requests for voluntary review we will receive.[23] After all, how many merging companies would voluntarily notify the government about their acquisition in the absence of the HSR Act? On the other hand, providers may see the benefits from a voluntary review, given the antitrust agencies' stated interest in this area and the potential for future enforcement action.

Another concern with the draft Policy Statement was that it did not apply to all ACOs. There was language in the draft Policy Statement indicating that it applied only to ACOs formed after March 23, 2010, the date the Affordable Care Act was signed into law. Long-existing providers argued they too should receive the benefit of rule of reason treatment and the safety zone. We agreed.

As a result, the final Policy Statement applies to *all* ACOs that participate in the Shared Savings Program, regardless of when they were formed. Thus, rule of reason treatment and the safety zone apply to all ACOs participating in and meeting the requirements of the Shared Savings Program, not just the ones formed after March 23, 2010. The only exception is that the voluntary review process is limited to "newly formed" ACOs, i.e., those formed after March 23, 2010. The reason for this exception is that FTC and DOJ Advisory Opinions are available only to evaluate *prospective* conduct.

A third common complaint about the draft Policy Statement was that the criteria adopted by the FTC and DOJ were too burdensome and expensive. Specifically, providers complained about the use of PSA data on the ground that the information is too difficult and expensive to gather. PSA refers to a Primary Service Area, which is defined as "the lowest number of postal

[23] Under the mandatory review system initially proposed, the antitrust agencies estimated that 38 to 200 ACOs would have been subject to antitrust review. *See*

zip codes from which the [ACO participant] draws at least 75 percent of its [patients]."[24]

Although a PSA does not necessarily constitute a

interest in the Shared Savings Program had been dashed by formalistic, redundant, and expensive requirements that offered little benefit for patients. This was not, strictly speaking, an FTC or DOJ issue, but it did touch on an important aspect of our enforcement policy. As I previously mentioned, satisfaction of CMS' clinical integration requirements entitles ACOs to rule of reason treatment if they operate in commercial markets in basically the same way as in Medicare markets.

In response to these concerns, the final CMS regulations eliminated a number of requirements, with the goal of giving providers greater flexibility. Nevertheless, the requirements are still intended to mirror the requirements of FTC Advisory Opinions and the Health Care Statements. In addition, the Policy Statement was revised to make clear that rule of reason treatment will not apply if an ACO does not actually implement the required processes or otherwise meet the CMS eligibility criteria, or if the ACO is accepted for, but never participates in the Shared Savings Program.

A final concern with the draft Policy Statement was that the various PSA thresholds were too low and would result in unwarranted scrutiny of unproblematic ACOs. Providers pointed in particular to the 50 percent PSA threshold for triggering mandatory review, which was intended to be a "valuable indication of the potential for competitive harm."[26] Providers argued that shares of this magnitude by a physician joint venture did not necessarily indicate market power and objected to the triggering of mandatory review based on a single practice of a multi-practice ACO having a PSA share in excess of 50 percent.

[26] Draft Policy Statement, *supra* note 6, § IV.B.

real risk that some ACOs will be formed with an eye toward creating or exercising market power. The net result of the Shared Savings Program may therefore be *higher* costs and *lower* quality health care – precisely the opposite of its goal. Sociologist Robert K. Merton, who popularized the concept of the law of unintended consequences,[29] would no doubt get a chuckle out of this state of affairs.

[29] Robert K. Merton, *The Unanticipated Consequences of Purposive Social Action*, 1 American Sociological Review 894 (1936).