RUPRI Rural Health Panel
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Federal Trade Commission,
Office of the Secretary
Room H–113 (Annex W)
600 Pennsylvania Avenue, NW
Washington, DC 20580
(by electronic transmission)

RE: Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program; FTC Matter No: V100017

Dear FTC:

The Rural Policy Research Institute (RUPRI) Rural Health Panel was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The RUPRI Rural Health Panel appreciates the opportunity to comment on the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (ACO-MSSP). The Panel supports high-quality, accessible, and coordinated health care for rural people and places and is pleased to comment on the Joint Proposed Policy Statement for ACOs participating in the Medicare Shared Savings Program (MSSP). The agency's effort to provide guidance for those wishing to participate in ACO-MSSPs is appreciated.

INCLUSION OF A RURAL EXCEPTION

The RUPRI Rural Health Panel supports including a Rural Exception in the anti-trust safety zone, allowing safety zone treatment for certain ACO-MSSPs that include rural-based providers. Rural areas typically struggle to attract health care professionals, hospitals and other providers.[1] High market percentages in rural communities are generally the result of the limited number of providers in rural

[1] COMMITTEE ON THE FUTURE OF RURAL HEALTH CARE, BOARD ON HEALTH CARE SERVICES & INSTITUTE OF MEDICINE, QUALITY THROUGH COLLABORATION: THE FUTURE OF RURAL HEALTH. (2005).

areas rather than anti-competitive behavior.[2] The Rural Exception offers a balanced approach by granting safety zone status to ACOs in which rural physicians and rural hospitals have more than a 30% PSA for any common service.

However, the RUPRI Rural Health Panel has four suggestions for refining the Rural Exception to target it more effectively to rural America.

#1. Definition of "rural" for purposes of the Rural Exception allowing one physician per specialty in a rural county

PROPOSED GUIDANCE: The Joint Proposed Policy Statement's Rural Exception allows an ACO to include "one physician per specialty from **each rural county (as defined by the U.S. Census Bureau)** *on a non-exclusive basis* [italics in original]" and qualify for the safety zone, even if the inclusion of these physicians causes the ACO's share of any common service to exceed 30 percent in any ACO participant's PSA for that service.

COMMENT: The U.S. Census Bureau does not define rural areas by county. The Census Bureau uses census tracts and classifies any town or village of more than 2,500 people as urban with all other areas being rural.[3] The Census adopted this relatively narrow definition of rural in 1906 without any explanation and while it is the second most commonly used definition of rural, it is not widely used by other federal agencies or researchers.[4]

Rural researchers and social scientists tend to rely on the Office of Management and Budget's (OMB) designation of "nonmetropolitan" and "metropolitan" counties, counting all "nonmetropolitan" counties as rural.[5] OMB classifies counties as metropolitan if they are located within a metropolitan area, which in turn is defined as a large population nucleus of over 50,000 people. Suburban counties that have a high degree of economic and social integration with the population nucleus of the

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[2] *See, e.g.*, TriState Health Partners, Inc., Op. Fed. Trade Comm'n (April 13, 2009) (The FTC determined that high market percentages (well over 50% in some markets) were not "over-inclusive" given "TriState's non-urban geographic location and the limited total number of physicians in its primary service area, combined with the fairly modest absolute numbers of member physicians and physician practices in each specialty area." The FTC also held that the PHO's inclusion of the only hospital in their market could not reduce competition, since the hospital had no competition either way); Letter from Markus H. Meier, Assistant Director, Bureau of Competition, Federal Trade Commission to Christi J. Braun, Ober, Kaler, Grimes & Shriver (April 13, 2009), *available at* http://www.ftc.gov/os/closings/staff/090413tristateaoletter.pdf.

[3] *2010 Census Urban and Rural Classification and Urban Area Criteria*, U.S. CENSUS BUREAU, http://www.census.gov/geo/www/ua/2010urbanruralclass.html; Andrew F. Coburn, A. Clinton MacKinney, Timothy McBride, et al., *Choosing Rural Definitions: Implications for Health Policy*, RUPRI ISSUE BRIEF, March 2007, at 4, *available at* http://www.rupri.org/Forms/RuralDefinitionsBrief.pdf.

[4] *See* Katherine Porter, *Going Broke the Hard Way: The Economics of Rural Failure*, 2005 WIS. L. REV. 969, 1016 (2005). *See also* Coburn, supra note 3, at 4.

[5] ANDREW F. COBURN, A. CLINTON MACKINNEY, TIMOTHY MCBRIDE ET AL., ASSURING HEALTH COVERAGE FOR RURAL PEOPLE THROUGH HEALTH REFORM (2009), *available at* http://www.rupri.org/Forms/Health_ReformBrief_Oct09.pdf.

metropolitan area are also classified as metropolitan. A chief advantage of the OMB definition is that counties are simple to understand and their boundaries are stable over time. Moreover, data are updated annually on metropolitan and nonmetropolitan criteria.[6]

However, some sparsely populated areas are located within large counties that carry an OMB designation as a Metropolitan Area. The Rural Urban Commuting Area Codes (RUCAs) developed by the WWAMI Rural Research Center at the University of Washington and the Department of Agriculture's Economic Research Service were developed to address this issue.[7] RUCA codes are based on census tract data and identify rural/urban patterns within counties that carry an OMB classification of metropolitan. RUCA codes 4-10 identify small towns and rural areas within large metropolitan counties. In addition, census tracts within metropolitan areas with RUCA codes 2 and 3 that are larger than 400 square miles and have population density of less than 30 people per square mile are also considered rural.[8]

SUGGESTED CHANGE: The RUPRI Rural Health Panel proposes that the Joint Policy Statement use the RUCA Adjustment to the OMB Metropolitan and Nonmetropolitan Definition to define rural. This two-part definition incorporates both the Office of Management and Budget's (OMB) definition of "rural" and the Rural Urban Commuting Area Codes (RUCAs) developed by the WWAMI Rural Research Center at the University of Washington and the Department of Agriculture's Economic Research Service. This definition of "rural" is used by the U.S. Department of H.H.S. Office of Rural Health Policy when it makes grants.[9]

Under the RUPRI Rural Health Panel's suggestion the Joint Policy Statement would read: "An ACO may include one physician per specialty in any rural county or area (as defined by the RUCA Adjustment to the OMB Metropolitan and Nonmetropolitan Definition).... "

#2. Definition of a Rural Hospital

PROPOSED GUIDANCE: The proposed Guidance provides that the Rural Exception will apply to an ACO that includes "Rural Hospitals on a non-exclusive basis even if the ACO's share of any common service to exceed 30%." The proposed Guidance defines a Rural Hospital as "a Sole Community Hospital or a Critical Access Hospital."

COMMENT: Not all essential hospitals located in rural areas are Sole Community Hospitals or Critical Access Hospitals. Essential rural-based hospitals also include Medicare Dependant Small Rural Hospitals, Rural Referral Centers, and hospitals with no special designation. More-over, some urban-

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[6] *Id.* at 2.
[7] *See Measuring Rurality: Rural-Urban Commuting Area Codes*, ERS/USDA BRIEFING ROOM, http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/ or *Rural Urban Commuting Area Codes,* WWAMI RURAL HEALTH RESEARCH CENTER, http://depts.washington.edu/uwruca/.
[8] *See* Coburn, supra note 3, at 4 (for a detailed discussion).
[9] *See*, Coburn, supra note 3, at 4.

based hospitals are designated as Sole Community Hospitals or Critical Access Hospitals.[10]

SUGGESTED CHANGE: The RUPRI Rural Health Panel suggests that the Rural Exemption use the same placed-based definition to define "Rural Hospital" as proposed for the rural physician exception: "For purposes of this policy statement, a Rural Hospital is defined as a hospital located in a rural area as designated by the RUCA Adjustment to the OMB Metropolitan and Nonmetropolitan Definition."

A place-based definition of rural would treat all hospitals in sparsely populated areas consistently for purposes of the antitrust review. It would assure that the rural exemption applies only to hospitals that are located in rural communities, the locations the Rural Exception is intended to address.

#3. Lack of a Rural Exception or a Dominant Provider Limitation for Primary Care Physicians

PROPOSED GUIDANCE: The Rural Exception applies only to physicians who participate in the ACO "on a non-exclusive basis." Similarly, the Dominant Provider Limitation only applies to ACO participants who participate "on a non-exclusive basis" who have more than 50% PSA market share for any service that no other ACO participant provides to patients in that PSA.

COMMENT: CMS's Proposed Rule for ACO-MSSPs provides that primary care physicians (defined for purposes of the ACO-MSSP as internal medicine, geriatric medicine, family practice and general practice) must be exclusive to one ACO. On the other hand, CMS's Proposed Rule provides that all other providers—professionals and institutions—may only participate in an ACO-MSSP on a non-exclusive basis. This means that the Joint Proposed Policy Statement's Rural Exception does not create an antitrust safety zone for rural primary care physicians who have more than 30% market share in their PSA. Neither does the Dominant Provider Limitation for providers with more than 50% share in its PSA of a common service offered by no other ACO participant apply to primary care physicians.

The shortage of primary care physicians in rural America makes it likely that rural primary care physicians who wish to participate in an ACO-MSSP will fall outside the 30% PSA safety zone.[11] Without a Rural Exception and the Dominant Provider Limitation, every ACO-MSSP that includes such rural primary care providers will fall outside the safety net and likely above the 50% PSA market share that requires agency review. While DOJ and FTC have committed to an expedited antitrust review within 90 days of receipt of required documentation from an ACO-MSSP, the lack of a Rural Exception and Dominant Provider Limitation is likely to serve as a disincentive for rural primary care doctors to participate in ACO-MSSPs and rural patients will miss the opportunity to be part of these new initiatives designed to better coordinate care, leading to better quality care and lower costs.

SUGGESTED CHANGE: The RUPRI Rural Health Panel suggests that the agencies consider extending both the Rural Exception and the Dominant Provider Limitation to primary care physicians that are

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[10] *See Hospital Classification*, TRICARE Management Activity, http://www.tricare.mil/hospitalclassification/(lists Sole Community Hospitals, CAHs and Small Rural Hospitals by city).

[11] *See* Meredith A. Fordyce, et al., *2005 Physician Supply and Distribution in Rural Areas of the United States*, the University of Washington Rural Health Research Center (Nov. 2007), http://depts.washington.edu/uwrhrc/uploads/RHRC%20FR116%20Fordyce.pdf (noting that rural areas have only about half the number of primary care physicians and specialists as urban areas).

exclusive to one MSSA-HMO. Such a rule removes a potential barrier to rural participation in ACOs. The provision in the Dominant Provider Limitation that prohibits a dominant provider from requiring a commercial payer to contract exclusively with the ACO or otherwise restrict a commercial payer's ability to contract with other ACOs or provider networks provides protection against anticompetitive behavior by rural primary care physicians.

#4. Does the Rural Exception apply to only one physician per specialty or one physician specialty practice per specialty?

PROPOSED GUIDANCE: The proposed Rural Exception allows an ACO to include "one physician per specialty" from each rural county on a non-exclusive basis.

COMMENT: It is not clear whether the Proposed Statement is meant to allow the ACO to have one physician or one physician practice per county.

SUGGESTED CHANGE: For antitrust purposes, it would seem appropriate to treat a group practice as "one physician" for purposes of the Rural Exception. The RUPRI Rural Health Panel proposes that the Rural Exception read "...one physician (or physician practice) per specialty... "

Thank you for your consideration of these comments. Please do not hesitate to contact us with questions.

Sidney D. Watson on behalf of
The Rural Policy Research Institute Health Panel

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