Comments on Proposed Statement of Antitrust Enforcement Policy Regarding ACOs Participating in the Medicare Shared Savings Program – Matter V100017

PART I: SUGGESTED CHANGES

1. The final Statement should:

[A] State that the Agencies will consider an ACO's impact on concentration among, and on entry conditions for, managed care physician organizations (as defined in Part II.B below).

[B] Exclude from the Safety Zone an ACO that: (a) combines any preexisting managed care physician organizations in the proxy market; or (b) significantly increases the market share of a preexisting managed care physician organization.

2. The final Statement should:

[A] State that the Agencies will consider an ACO's likely competitive effects in hospital markets.

[B] Exclude from the Safety Zone an ACO that: (a) unites a previously independent managed care physician organization with a 150+ bed hospital; or (b) unites preexisting managed care physician organizations that are affiliated with different 150+ bed hospitals.

3. The final Statement should indicate that, as dictated by market developments, investigations or economic studies, the Agencies may articulate additional exceptions to the Safety Zone (via joint press releases, jointly reviewed Business Review Letters, or enforcement actions) that will be published on the website at which the Statement is available electronically.

4. With the benefit of further input from industry sources, the Agencies should consider replacing the participating practices' PSAs with a different proxy market.

II. PART II: BACKGROUND

A. THE 'HOSPITAL-SERVED METROPOLITAN AREA SECTOR' GEOGRAPHIC MARKET

With respect to a health plan's provider network requirements, a metropolitan area generally can be divided into a number of more or less distinct, hospital-served sectors. A health plan typically will want to develop an ample panel of participating physicians in each of those hospital-served sectors (or, at least, in the great majority of them). In most cases, the health plan also will want to obtain the participation of a hospital (or *the* hospital) in such a hospital-served sector: (a) to satisfy area employers' network *hospital* demands; and/or (b) to enable the health plan to develop an adequate panel of participating *physicians* in that sector.[1]

B. THE 'MANAGED CARE PHYSICIAN ORGANIZATION' PRODUCT MARKET

The term "managed care physician organization" is used here to denote a physician practice or organization that, by virtue of its size, structure, and integration is able and inclined to: (a) enter into comprehensive risk sharing arrangements; and (b) adopt and effectively employ medical protocols that minimize the incidence of unnecessary diagnostic tests or procedures and avoidable hospital admissions.

An ACO can promote those cost-saving benefits by forming a managed care physician organization from physician practices that, acting independently, would not be able to execute such risk sharing arrangements or effectively employ such medical protocols. However, an ACO can instead result in *higher* provider costs if it diminishes or forestalls competition among managed care physician organizations.

That could occur if an ACO: (a) unites a relevant market's only preexisting managed care physician organizations; (b) significantly increases concentration among a relevant market's preexisting managed care physician organizations; or (c) deters entry by virtue of the size of its share of physician practices in a relevant market that are predisposed to form a managed care physician organization.

C. HOSPITAL MARKET EFFECTS

[1] A health plan may need a sector's hospital in order recruit an adequate panel of that sector's participating physicians: (a) because a health plan generally requires its participating physicians to be on staff at one of its participating hospitals; and (b) a large proportion of a sector's physicians may be on staff exclusively at their own sector's hospital(s).

With some recurring exceptions (such as multiple high-level hospitals in a centralized location, or closely located hospitals of different religious denominations), most of a metropolitan area's hospital-served sectors have only one full-size, full service hospital (hereinafter referred-to as a "sole source hospital"). A metropolitan area's sole source hospitals generally enjoy at least some degree of market power.[2] However, a managed care physician organization can be a counterweight to that market power.

An independent (i.e., not hospital-affiliated) managed care physician organization can constrain a sole source hospital's rates (albeit not to the market level) if it encourages its member-physicians who are on staff at a sole source hospital, and whose offices are located in that hospital's sector, to obtain overlapping medical staff privileges at a second hospital that is located in an adjacent hospital-served sector.

That will enhance the bargaining leverage of the organization's client health plans vis-à-vis the sole source hospital in two ways: First, a client health plan will be able drop a price-increasing sole source hospital without losing the participation of the organization's member-physicians whose offices are in the dropped hospital's sector but who have overlapping medical staff privileges at an adjacent-sector hospital.[3] Second, the client health plan will be able to seamlessly redirect its enrollees' admissions from the dropped sole source hospital to the adjacent-sector hospital, via the organization's member-physicians whose offices are in the dropped sole source hospital's sector, but who have overlapping medical staff privileges at the adjacent-sector hospital.[4]

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[2] See Part II.A above.

[3] See n.1 above.

[4] See, e.g., the discussion concerning a price increase by Washington Hospital (in Freemont, CA) in the Defendants' Post Trial Brief in: California v. Sutter Health Sys., 84 F.Supp.2d1057 (N.D. Cal), aff'd mem 200-1 Trade Cas. (CCH) Par. 87,665 (9th Cir. 2000), revised 130 F.Supp.2d 1109 (N.D. Cal. 2001).

D. SAFETY ZONE AMENDMENTS

As ACO's proliferate and market conditions unfold, the Agencies may discover circumstances in which a competitively significant relevant market is considerably smaller than the Statement's proxy market.[5] A 30% market share in the proxy market would be larger in such a smaller but competitively significant relevant market.

It would undermine predictability if the Agencies dealt with such a recurring circumstance by invoking the Safety Zone's "exceptional circumstance" caveat. Hence, the Agencies should consider whether to allow for possible amendments to the Safety Zone in the manner described in Part I.3 above.

E. THE STATEMENT'S PROXY MARKET

There may be some circumstances in which an ACO's PSA market share would significantly understate the ACO's market share in either of two competitively significant markets: (1) the medical staff of a sole source hospital (as defined in Part II.C); or (2) a hospital-served sector of a metropolitan area (as described in Part II.A).

One possible alternative would be to use, as a proxy market, an ACO's share of the physicians on staff at a 150+ bed hospital who provide services in a given specialty. The 150+ bed hospital criterion would encompass a metropolitan area's sole source hospitals, and thereby cover Competitively Significant Market (1) above. And the medical staff of a sole source hospital is, in turn, a reasonable proxy for a hospital-served sector of a metropolitan area; so, the medical staff of a 150+ bed hospital also would cover Competitively Significant Market (2) above.

[5] *Compare,* e.g., the March 8, 1996 DOJ Business Review Letter: Orange Los Angeles Medical Group ("ORLA"), at *"Market Definition," with* the Safety Zone in Statement No. 8 of the September 27, 1994 DOJ/FTC Health Care Antitrust Statements (and Statement 8's Safety Zone in the August 26, 1996 Health Care Antitrust Statements).