MISSOURI HOSPITAL ASSOCIATION
Herb B. Kuhn, President and Chief Executive Officer

May 26, 2011

The Honorable Jon Leibowitz
Chairman
Federal Trade Commission
600 Pennsylvania Avenue NW
Washington, D.C. 20580

Re: Proposed Statement of Antitrust Enforcement Policy Regarding ACOs
Participating in the Medicare Shared Savings Program, Matter V100017

Dear Commissioner Leibowitz:

The Missouri Hospital Association appreciates the opportunity to comment on the proposed guidance for acceptable behavior under federal antitrust law for accountable care organizations, particularly those accepted by the Center for Medicare & Medicaid Services pursuant to proposed regulations issued under the Medicare Shared Savings Program. MHA is a statewide trade association representing approximately 151 hospitals. This number includes virtually all of the acute care hospitals in the state.

Endorsement of American Hospital Association Position

MHA wishes to go on record as endorsing comments filed by the American Hospital Association regarding the notice. However, we wish to provide additional comments that underscore particular concerns and add a different perspective that should be considered from the unique position of a state level association.

MHA Perspective

General Thoughts

The notice in its tone and detail amounts to an effort to look out for the "bad guys" rather than a sincere effort to affect change in the delivery of health care, including promoting necessary and appropriate provider integration. The agencies' role is changing from regulator to gateway. This is a historic shift for the agencies and will create obstacles for fulfilling the intent and spirit of the Affordable Care Act. We urge the agencies to reconsider this change and revert to their more traditional roles as regulators.

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Geographic Market

Missouri hospitals have been the subject of significant Federal Trade Commission antitrust enforcement during the past 25 years. A critical issue in these cases has been the definition of geographic market. In simplest terms, the courts have found that, based on ample judicial precedent, geographic market analysis examines where patients may reasonably come from rather than where they historically have come from in purchasing products or obtaining services. This concept also appears in the 1996 Joint FTC/Department of Justice Antitrust Enforcement Guidelines. The primary service area analysis in the proposed guidance amounts to an end run around established criteria for determining geographic market share.

Further, the proposed approach fails to account for the lack of physician-based data for determining market share in a reasonably accurate manner. The default to Medicare claims data creates uncertainty because physicians do not have to serve Medicare patients, and some classes of patients, such as obstetrical and pediatric patients, will not be reflected in Medicare claims.

Finally, this new approach does not really capture the notion of consumer choice, which is a fundamental underpinning of antitrust law. The issue is not what consumers have chosen in the past but what consumers are able to choose in the future. The proposal will not afford the protection to consumers envisioned by traditional antitrust analysis. In this way, we believe the agencies will better serve the notion of improved quality and efficiency in the delivery of health care by abandoning the PSA approach and relying on traditional geographic market analysis.

Clinical Integration Criteria

Acceptance of an ACO by CMS is deemed to be evidence of adequate levels of integration to avoid antitrust scrutiny for what would otherwise be viewed as possible violations, such as joint price negotiation by competitors with payers. Although this makes sense from CMS' qualified ACO perspective, it leaves much to be desired when viewing the public policy behind ACO development.

The Affordable Care Act, both in its technical provisions and its spirit, recognizes the need for alignment of hospitals, physicians and other health care providers to provide improved quality of care at lower cost. However, as suggested by CMS in its proposed rules for regulating ACOs, only 75 to 150 ACOs are initially predicted to be created, covering from 5 to15 percent of Medicare beneficiaries. In Missouri, there may be only three to five ACOs.

We recommend creation of clear guidelines for ACOs that decline or are unable to, for good reasons, become part of Medicare's shared savings program. Reasons for this may be the inability to meet the minimum Medicare beneficiary threshold or limited capital to support a smaller organization that might be found in rural or mid-market areas, of which there are many in Missouri. The business advisory process is inadequate for addressing this issue and would act as a barrier to ACO creation and, thus, clinical integration.

Conclusion

The antitrust laws are designed to protect consumers and enhance their opportunities to obtain quality products and services in the market place. The policy underlying accountable care organizations is to enhance the ability of all patients, not just government-sponsored beneficiaries, to obtain high quality care at low cost. One way to accomplish this is through the vehicle of a highly integrated health care system, one example of which is an ACO. The proposed guidance starts the discussion for government beneficiaries but creates barriers for including a greater population, which would better achieve the goals of both the antitrust laws and the policy underlying ACOs.

Kindest Regards,

Gerald M. Sill
Senior Vice President and General Counsel

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