

# UPMC HEALTH PLAN

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May 27, 2011

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Federal Trade Commission,  
Office of the Secretary  
Room H-113 (Annex W)  
600 Pennsylvania Avenue, N.W., Washington, D.C. 20580

**Re: Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, Matter V100017**

UPMC is pleased to submit the following comments in response to the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (the "Statement"). UPMC is an integrated payer-provider, which includes a comprehensive provider-based clinical delivery system, a suite of health insurance and health management companies, and a longstanding collaboration with the University of Pittsburgh, a premier academic institution. We believe that organizations such as UPMC and other integrated delivery systems are well positioned to participate in emerging demonstration projects and other payment and clinical delivery system redesign activities, including accountable care organizations (ACOs) and the Medicare Shared Savings Program (MSSP).

We thank the Federal Trade Commission and the Department of Justice (collectively, the "Agencies") for working together in an attempt to provide clear and workable guidance to those entities interested in developing ACOs. We further commend the Agencies for coordinating the release of the Statement to coincide with the Medicare Shared Savings Program Proposed Rule (CMS-1345-P), joint CMS-DHHS OIG guidance on Waiver Designs (CMS-1345-NC2), and the IRS Notice regarding tax exempt organizations participating in the MSSP (Notice 2011-20). We share the Agencies' commitment to adequately balancing the potential threat of reduced competition and consumer harm by entities amassing unmitigated market power with the need to foster a new delivery and payment system that affords providers, health plans and other stakeholders alternatives to existing fee-for-service payment protocols. It is with this fundamental commitment in mind that we respectfully offer the following comments.

While we fully support the Agencies' attempts to establish a review process that protects the purchasing public from anticompetitive provider consolidation, we have grave concerns about the complexity, potential costs and usefulness of the proposed PSA test. The PSA test is arguably so complex that it may dissuade ACOs with multiple small practices and broad scopes of services from participating based upon its complexity alone. It may discourage large provider organizations from participating based upon the cost associated with administering the test to a large number of providers. What's more, the use of the PSA test represents a departure from processes set forth in antitrust case law and in other antitrust guidelines. While the test is suggested by some to favor administrability over precision, it is not designed to predict the outcome of a more intensive antitrust review. As such, entities may invest considerable resources and time in meeting the data and administrative challenges required by PSA analyses, only to find that the results are less than clear and/or that relying upon them may ultimately be to their detriment.

Moreover, from a practical standpoint, the PSA test relies upon data that no one has seen or used before. While we understand that CMS intends to supply ACOs with the data they need to conduct these analyses with respect to the Medicare population, it is unclear to us how a corresponding review of the commercial population can be accomplished. Relying solely upon Medicare data to determine market share may disadvantage providers who have practices heavily weighted toward Medicare patients, even though—if all patients were considered – they would not cross the 50% threshold. Additionally, Medicare data is likely to be unreliable and practically unavailable for services not routinely provided to Medicare beneficiaries (e.g. obstetric and pediatric services).

Further, collecting the necessary information from a large network of independent providers is likely to be exceedingly challenging and time-consuming, and may ultimately produce data of questionable reliability. Even among practices with electronic records, many independent providers may not have the technical capacity to provide the requisite data in an appropriate format. Indeed, the CDC's 2010 National Ambulatory Medical Care Survey indicated that in 2009, only 48-percent of office-based physicians had adopted *any* electronic medical record system. For these reasons, we recommend that the Agencies further consider the utility of the proposed PSA test.

We further note that the PSA test places a considerable burden upon each and every ACO and ACO participant, not just those that are potentially dominant market players. It permits and in fact requires the review of entities even where there is absolutely no evidence of or potential for improper conduct. For example, a prospective applicant with even a single PSA above fifty percent would be required to submit a large number of documents and obtain a time-consuming antitrust analysis from the Agencies; this, even when such PSA is for a non-Medicare service, such as pediatrics. The costs and administrative burdens of subjecting each ACO participant to an independent market analysis are excessive. We recommend that the Agencies consider

limiting the scope of the proposed test to primary care providers, as only they must be exclusive to one ACO. In the alternative, the Agencies may consider requiring only that those providers who will be exclusive to an ACO, either per the regulation itself (primary care physicians) or via private arrangement, be subject to the PSA analysis. We further recommend that, because an ACO will function as a single-entity, the PSA test be required of primary care and or other exclusive providers in the aggregate, rather than provider by provider. Simplifying the test in this manner will allow the FTC and DOJ to continue to meet their enforcement obligations without unduly burdening those dedicated to market and payment reform.

To the extent that the Agencies continue to rely upon the PSA Test for antitrust analyses going forward, we respectfully request that a formal appeal process be identified and communicated to all stakeholders in advance of the implementation of the Test. For the reasons set forth above, we believe that the Test may provide unclear or questionable results and, accordingly, a clearly defined appeal process will be essential.

We additionally believe that imposing a mandatory review upon all entities meeting the 50% threshold is arbitrary and over-reaching. A recent survey conducted by the American Hospital Association of 162 cities indicates that almost every hospital would be subject to mandatory review. At a time when cost-containment is of paramount importance, any requirement that potentially exposes providers to additional costs and federal agencies to countless reviews must be questioned. We recommend instead that potential ACOs seeking certainty as to their antitrust status be provided a means by which to garner such certainty on a voluntary basis. All other ACOs should be closely monitored by CMS and/or other Agencies for any increases in costs or decreases in quality, both in Medicare and commercial lines of business.

The proposed mandatory review requirement is problematic from a pure timing perspective as well. Entities subject to mandatory review wishing to meet the January 2012 start date must assemble required documentation for submission by September 2012, yet final guidance will likely not be published until late summer 2012. We trust that the goal of the federal government with respect to ACO development is to establish a framework which maximizes the number of entities interested in pursuing ACO formation and participation in the MSSP. An adequate number of ACOs must form to reasonably affect medical costs and spending going forward and, as such, everything possible should be done to remove barriers from potential formation, not create them. We submit the current requirement that parties obtain an agency letter *prior to* application to participate in the MSSP is such a barrier. We recommend that, rather than requiring entities to obtain approval from an administrative agency prior to formation, the FTC, DOJ and other Agencies make the antitrust review voluntary while continuing to use their authority to monitor all ACOs for increased costs and/or lowered quality, including, to the greatest extent possible, in the commercial market. By so doing, those interested in forming ACOs will be better able to meet application deadlines and begin offering high quality services

to Medicare beneficiaries and other patients and the FTC and DOJ will be empowered to continue to exercise their charge to monitor and challenge anti-competitive activities going forward.

Further, while we appreciate the timeliness and certainty of a proposed 90-day review period, we believe it is unwise to arbitrarily enforce a static timeframe without any provision for an extension thereof. While it may be the case that most reviews can be completed within an established timeframe, applying such a limitation to every application could result in forced decisions that are a disservice to the public, an ACO, or both. Particularly in the early stages of modern ACO formation, both ACO-forming entities and the Agencies are likely to encounter novel issues that may not be easily resolved within a standard review period, and both sides should be afforded some opportunity to identify and resolve such issues. Where a potential ACO seeks voluntary review or the Agencies believe that full review of a forming entity is warranted, a comprehensive and fair review is of superior importance and value to a quick but potentially incomplete or inaccurate analysis. As with the Agencies' review of many mergers, a preliminary analysis of basic information coupled with allowances for a more comprehensive secondary review would subject ACOs to a familiar procedure of agency interaction. We believe the combination of this staged review coupled with structured timeframes for the various stages of initial and secondary review, and/or any necessary extensions thereof, would appropriately balance competing concerns of timeliness and thoroughness. We respectfully request that the Agencies issue guidance establishing this type of ACO antitrust review process.

Finally, we respectfully assert that not all of the conduct identified by the Agencies as "conduct to avoid" to reduce the likelihood of an antitrust review is necessarily anticompetitive. First, an ACO may prevent or discourage payers from directing patients to certain providers for many reasons, including that such providers fail to provide high-quality services. Likewise, an ACO may contract on an exclusive basis with specialists or hospitals because they provide the highest quality services at the best prices. Arguably not all providers, hospitals and specialists should thrive or even survive going forward. Survival should be limited to those who provide quality services at commercially reasonable prices. As such, any pronouncement by the Agencies that certain conduct will be frowned upon going forward should be issued cautiously as not to unwittingly curb or eliminate conduct directed solely at accomplishing the Triple Aim of better care, better health, and lower costs.

Thank you for providing us the opportunity to offer input into the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. We appreciate your consideration of these comments and look forward to working with you in the future.

Sincerely,

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