American College of Emergency Physicians®
ADVANCING EMERGENCY CARE

May 31, 2011

SUBMITTED ELECTRONICALLY

Mr. Donald S. Clark
Secretary
Federal Trade Commission
Room H-113 (Annex W)
600 Pennsylvania Avenue, N.W.
Washington, DC 20580

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

Dear Secretary Clark:

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On behalf of the American College of Emergency Physicians' (ACEP) more than 29,000 members, I am pleased to share our comments concerning the competitive effects of the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program as it relates to emergency departments and the provision of emergency care.

BACKGROUND

ACEP is the largest national emergency medical specialty society - one third of our members are employed by hospitals and the rest practice in independent physician groups of varying sizes and contract with hospitals. We are the leading advocate for emergency physicians and their patients and are committed to promoting the highest quality emergency care through continuing education, research and public education.

Emergency departments play a vital role in the provision of health care in the United States and the Affordable Care Act stipulates that: 1) emergency services are "essential benefits" and 2) that access to emergency care using "prudent layperson" definition is now a universal patient protection. The volume of emergency visits has increased every year for over a decade, and the most recent U.S. Centers for Disease Control and Prevention survey statistics show that of the 124 million ER visits in 2008, approximately 92 percent were for conditions that require treatment within two hours. [1] The same survey shows that 50 percent of Medicare admissions come through the emergency department, and the majority of those patients have time-sensitive conditions.

In this high-pressure clinical environment, our members play a critically important role initiating clinical decisions and coordinating patient care. They conduct medical screening examinations and assess the need for patients to be admitted, treated and discharged, or kept in observation before final disposition decisions are made. Approximately 25% of U.S. hospitals have dedicated observation units, and they are

[1] National Hospital Ambulatory Medical Care Survey. NCHS/CDC 2008

generally directed by emergency physicians. If a patient requires inpatient care, the emergency physician contacts the patient's treating physician – primary care and/or specialty – who actually admits the patient. If the patient has no physician, the decision often is made by a hospitalist or other hospital medical staff member. In such cases, at the end of the inpatient stay that started with an emergency department visit, unfortunately, many patients are discharged into the community or to post acute care settings with little or no coordinated follow up.

As you know, administration officials and lawmakers have made the reduction of "expensive, inefficient" emergency visits and the improved continuity and coordination of care primary goals of health reform. The ACO rules attempt to promote these aims and "save money by getting beneficiaries the right care at the right time. . . so that patients can avoid a trip to the emergency room." [2]

Our members agree that patients benefit from a regular source of health care but know they are well-positioned to facilitate coordination with the patient's physician or direct patients to primary care resources in the community because we see so many patients without regular sources of care. Unlike all other medical specialties, emergency physicians have a legal duty under the Emergency Medical Treatment and Labor Act, 42 U.S.C. §§ 1395dd, to screen and stabilize all patients regardless of their ability to pay. This 25-year old unfunded mandate has created major financial strains on hospitals maintaining emergency departments, particularly in areas with high levels of Medicaid and uninsured patients. As a result, from 1990 to 2009, the number of hospital emergency departments in non-rural areas declined by 27%, according to a recently released study. [3] The logical conclusion is that in certain areas where emergency departments have closed, one hospital may be providing emergency services for a significant part of a "Primary Service Area." ACEP is concerned, however, that the Proposed Statement's concerns about market power and competition may have unintended consequences that in fact may harm the ability of Americans to obtain necessary emergency care.

Specifically, given the economic and market environment of emergency medicine, the Proposed Statements may fail to achieve their intended procompetitive results because:

(1) ACOs that include emergency departments may trigger the mandatory review thresholds set forth in the Antitrust Statements on a regular basis when competitive harm is unlikely to result, and

(2) They may further compromise the availability of emergency care at a critical time when coverage is expanding and primary care resources continue to fall short of demand.

For these reasons, we urge the Antitrust Agencies to consider how best to apply the Proposed Antitrust Statements to the unique specialty of emergency medicine so as not to either discourage hospitals with emergency departments from participating in ACOs or harm the nation's ability access emergency care.

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[2] HHS Press Release, Affordable Care Act to Improve Quality of Care for People with Medicare, Mar. 31, 2011.
[3] Hsia, et al. *JAMA*, May 18, 2011—Vol 305, No. 19.

THE POTENTIAL IMPACT OF THE PROPOSED ACO ANTITRUST STATEMENTS

Specialized Practices Likely to Trigger Unnecessary Mandatory Antitrust Reviews

Under the Proposed ACO Antitrust Statements, if two independent ACO participants provide a common service (as determined by overlapping Medicare Specialty Codes- the MSC for Emergency medicine is "93"), the parties are required to determine whether the proposed ACO has a combined share of 50% or more for each common service in each participant's Primary Service Area ("PSA"). If the parties exceed this threshold, in order to be able to participate in the Medicare Shared Savings Program ("SSP"), the parties are required to provide a mandatory notification to the Antitrust Agencies, which must include detailed information about the proposed ACO, and await a formal decision by the Antitrust Agencies concerning whether or not they have a present intent to challenge the ACO. **We urge the FTC and DOJ to recognize that since emergency services are open to everyone, no anti-competitive issues arise.**

As proposed, the Statements may lead to, among other outcomes:

- Hospitals and/or health care organizations opting to merge or acquire emergency care physician practices in order to participate in an ACO;

- Hospitals that provide emergency care opting to form ACOs solely with physician groups (rather than other acute inpatient hospitals), in order to avoid mandatory notification and antitrust review;

- Hospitals opting not to participate in the ACO process because emergency care would trigger mandatory notification and antitrust review; and/or

- Hospitals discontinuing emergency care offerings to ensure satisfactory quality of care and efficiency metrics under the SSP.

All of these outcomes constitute distortions of the health care delivery system that may prevent the full benefit of ACOs from being realized. Emergency medicine should not be singled out for exclusion from ACO participation more than any other specialty. Moreover, emergency physicians should not have their employment or contracting arrangements unnecessarily infringed by the artificial structures of ACO rules.

Discouraging Inclusion of Emergency Services in ACOs Could Further Jeopardize the Availability of This Specialty At A Critical Time

Creating any disincentives for emergency medicine to be included in ACOs not only would be bad policy, but it also risks further reducing the availability of this vital specialty at a time when our citizens need access to safety net providers.

As the Antitrust Agencies know, the **Patient Protection** and Affordable Care Act specifically identifies emergency care as an essential service which underscores its availability to everyone. Further, the law will provide insurance coverage for close to 30 million additional individuals by 2014. This, no doubt, will lead to increased use of

healthcare by formerly uninsured individuals and, this increased demand for healthcare will not be met by a corresponding expansion anytime soon of primary care physicians who might be able to prevent certain emergency room visits. Thus, despite the desired ACO outcome of avoiding "expensive" emergency care, in the near term, we believe the increased number of insured individuals will place an additional burden on the safety net.

CONCLUSION

ACEP recognizes that the Antitrust Agencies have carefully considered the impact of the Proposed Statements on health care generally and how the policy will implement the underlying purpose of the proposed ACO framework. As noted above, however, potential unintended consequences in connection with the unique regulatory and competitive environment concerning emergency care could impede the adoption, implementation and success of ACOs. This would frustrate the fundamental purpose of ACOs – enhanced efficiencies through better care coordination which will require participation by emergency physicians.

Thus, before implementing the Proposed ACO Antitrust Statements, ACEP urges further consideration be given to their potential effects on emergency departments and emergency physician practice so appropriate mechanisms can be developed to minimize negative and unintended effects.

We look forward to discussing our concerns and working with you as you finalize and implement these policies. If you have any questions about our comments, please contact Barbara Tomar, ACEP's Federal Affairs Director at (202) 728-0610, ext. 3017.

Yours truly,

Sandra M. Schneider, MD, FACEP
President