May 31, 2011

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex W)
600 Pennsylvania Avenue, NW
Washington, DC 20580

United States Department of Justice
Antitrust Division
Office of the Assistant Attorney General
950 Pennsylvania Avenue, NW
Washington, DC 20530

RE: Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program

Dear Sir or Madam:

The 22 undersigned organizations are leading consumer, labor, and employer organizations committed to improving quality and affordability of health care through the use of performance information to inform consumer choice, payment, and quality improvement. We appreciate the opportunity to provide comments on the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program.

We believe that ACOs have significant potential to advance the "Triple Aim" of improving health care for individuals and the general population as well as affordability through the redesign of the health care delivery system, promotion of provider accountability and acceleration of payment reform. Therefore, we strongly support their development and want them to succeed. However, care must be taken to not exacerbate an already serious problem of providers having a disproportionate share of market power in many, if not most areas of the country. In particular, ACOs could garner market power that enables them to both increase prices for the private sector and cost-shift due to limits in Medicare payments. Purchasers absorb some of the price increases by paying more for health insurance, and some increases get passed on to consumers in the form of higher premiums and co-payments. In some instances, health plan benefits are scaled back to make them more affordable. There is evidence this has been occurring for some time; many markets have experienced increased prices after hospital consolidation.[1,2] Recent trends in hospital consolidation and purchasing of physician practices

[1] RA Berenson, PB Ginsburg, N Kemper. Unchecked Provider Clout In California Foreshadows Challenges To Health Reform. *Health Affairs*, 29, no.4 (2010):699-705 Feb 2010.

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further heighten our concern that this will only continue in the current environment. Additionally, hospital payment rates for private payers can be as much as 400% higher than Medicare[3] and some studies estimate cost-shifting from Medicare to private payers can be as high as 40% in some markets.[4,5,6] It is important to make sure that the ACO program does not exacerbate the problems due to existing market concentration and cost shifting.

We greatly appreciate the FTC and DOJ being proactive on antitrust issues related to the Medicare Shared Savings program and developing a "screening" program to identify ACOs that would create an anticompetitive market place, in advance of them participating in the program. We believe this approach is on the right path and provide some suggestions below to improve the ability to detect potentially anticompetitive environments. Additionally, there needs to be flexibility with this guidance so the policy can reflect lessons learned as more experience is gained. We recognize this does not preclude ACOs from falling under your current antitrust review processes.

In addition to the screening program and current antitrust reviews, it is imperative to establish an ongoing program to monitor the impact of increased market power that could result from ACO formations. At the end of this letter we provide recommendations for requirements CMS should add to the ACO program that will help monitor price increases in the private sector and any cost-shifting. We expect the FTC and DOJ will play a central role in this monitoring as well.

Improvements to the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program

We strongly support the FTC and DOJ conducting expedited reviews of proposed ACOs prior to participation in the program to avoid potential market concentration issues. However, we are concerned that the policy may not be effective in deterring price increases that result from ACOs having greater market power and engaging in cost-shifting. Initially, it is important to err on the side of caution, given the potential for harm to consumers (e.g., increased out-of-pocket health care costs, less robust benefits, etc), which will be difficult to fix or ameliorate after market concentration has occurred. Below we provide comments on topics in the same order they appear in the Policy Statement.

Applicability of the Policy Statement

The Policy Statement applies to independent providers and provider groups formed after March 23, 2010, the date the Affordable Care Act was signed into law. Given our stated concerns with the anticompetitive price increases already occurring in the market, we believe this Policy

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[2] CH Williams, WB Vogt, R Town. How has hospital consolidation affected the price and quality of hospital care? Princeton (NJ): Robert Wood Johnson Foundation; 2006 Feb.
[3] P Ginsburg. Wide Variation in Hospital and Physician Payment Rates Evidence of Provider Market Power. Center for Studying Health System Change, Research Brief No 16, November 2010
[4] W Fox & J Pickering. Cost Efficiency at Hospital Facilities in California: A Report Based on Publicly Available Data. Millman. Oct 2007.
[5] Analysis of Hospital Cost Shift in Arizona. The Lewin Group. March 2009.
[6] Health Care Trends in America. BlueCross BlueShield Association. 2009 Edition.

Statement should be relevant to any ACO applying to the Medicare Shared Savings Program, regardless of its date of formation. Furthermore, we are concerned that the proposed Statement applies only to independent organizations coming together to form an ACO. The Statement does not address mergers, which are evaluated under the Horizontal Merger Guidelines. Not all mergers, though, fall under this evaluation (e.g., do not meet size of transaction test); we recommend those that do not should be evaluated under this Policy Statement.

The Antitrust Safety Zone for ACOs in the Shared Savings Program

The Policy Statement places ACOs into three categories based on market share of common services in a Primary Service Area (PSA): safety zone, mandatory review, and in between the previous categories. It acknowledges that the greater the market share, the higher the risk that the ACO will be anticompetitive.

The use of PSAs to calculate market share is different from what is currently used in antitrust investigations. We appreciate the desire to use a process that requires less effort than current practices, knowing that a more thorough investigation can be initiated. More important than effort, however, is the potential for consumer harm, which should weigh heavily in determining the screening process for expedited review. As more experience is gained with the use of PSAs, the FTC and DOJ can adjust guidance based on lessons learned.

ACOs that fall within the antitrust safety zone are considered highly unlikely to raise competitive concerns, and the agencies, "absent extraordinary circumstances," will not conduct an initial competitive review. For the safety zone, ACO participants that provide common services must have a combined share of 30% or less. We believe the FTC and DOJ should be cautious about which organizations fall into the safety zone and recommend reducing the threshold for the combined share of common services to 20% or less. Given the new and untested nature both of the Shared Savings Program and the Policy Statement, this will reduce the likelihood that the safety zone will generate significant consumer harm by not submitting enough entities to any review.

This requirement, however, does not address ACO participants that do not have common services but are dominant in their market. ACOs that have a dominant provider, defined by 50% or more PSA of service no other ACO participant provides, can fall within the safety zone if the provider is non-exclusive. We strongly support non-exclusivity but feel the threshold should be lowered to 20%. Moreover, we completely agree with the policy statement that "an ACO with a dominant provider cannot require a commercial payer to contract exclusively with the ACO or otherwise restrict a commercial payer's ability to contract or deal with other ACOs or provider networks." This is an opportunity to strengthen proactive monitoring and enforcement of both newly formed ACOs and already dominant providers.

Mandatory Antitrust Agency Review of ACOs Exceeding the 50 Percent PSA Share Threshold

For reasons stated above, we recommend the PSA share threshold for mandatory antitrust agency review be lowered to 40%. Again, as the FTC and DOJ gain more experience with this Policy Statement the threshold can be adjusted as appropriate.

ACOs Below the 50 Percent Mandatory Review Threshold and Outside the Safety Zone

For ACOs that fall between the safety zone and mandatory review, we appreciate the guidance on conduct that ACOs should avoid to reduce the likelihood of an antitrust investigation. We believe this guidance recognizes the many ways market power can lead to consumer harm besides price increases. This guidance, however, is appropriate for all ACOs, not just those between the safety zone and mandatory review thresholds. In California, we have seen the impact market power can have on purchasers' ability to provide cost and quality information to consumers (i.e., gag clauses providers impose on health plans).

Related to this, conduct #4 (restricting a commercial payer's ability to make available to enrollees performance information) should not be restricted to cost, quality, efficiency, and performance measures *used in the Shared Savings Program*. While there is overlap in performance measures that can be used to assess Medicare and commercial patient populations, there are some differences. An obvious example is maternity care, but even measures that address the same condition may need to be different due to risk adjustment issues. Consumers should have access to performance information, whether or not the measures are in the Shared Savings Program.

Other Comments

First, the majority of the analysis for primary service area and common services will be based on Medicare fee for service data; this Policy Statement does not account for private sector market concentration. The threshold for participation in the Shared Savings Program is 5,000 Medicare beneficiaries so it is plausible for an ACO with a small Medicare market share but large commercial market share to participate. This is a weakness of the Policy Statement and provides further justification for more caution. We recommend in the short-term that FTC and DOJ conduct analyses of private sector market concentration based on data from self-insured employers or proprietary databases.

Second, we strongly encourage the FTC and DOJ to exert a greater level of scrutiny in markets that already have dominant providers. ACOs should not be allowed to extend the reach of already dominant providers. We are concerned this will make matters worse by legitimizing even larger aggregations of supply in the market. In addition to greater scrutiny during the screening process, ACOs with non-dominant providers should be favored in the selection process for the program.

Third, ACO participants undergoing review should inform the three most affected employers and/or labor organizations in their area, which means those with the highest concentration of employees/members served by the ACO. This will provide an opportunity for purchasers to come forward with evidence that may be relevant to the review.

Requirements CMS should include in the ACO program to monitor adverse consequences of increased prices for the private sector and cost-shifting

The Patient Protection and Affordable Care Act seeks to improve the quality and reduce the costs of health care services for all Americans through a variety of mechanisms, including the Medicare Shared Savings Program for ACOs. Although the Medicare ACO proposed rule is geared toward the Medicare population, this new model of care will require infrastructure changes that will affect, and hopefully benefit the entire patient population served by the ACO – including Medicare, Medicaid, or Commercially insured patients. Clearly, the Affordable Care Act's intent is not to reduce costs for one sector at the expense of another. Therefore, it is not only important to address inappropriate cost-shifting within Medicare, it is imperative to address it across sectors as well so that consumers are not harmed by resulting increases in premiums or reductions in benefits.

To do so, we need a system for ongoing monitoring of potential cost-shifting between sectors and within sectors. Per the Shared Savings proposed rule, we support having CMS conduct data analyses to look at patterns in the use of health care services inside and outside ACOs. Even so, what currently is in the proposed rule is not enough to measure progress towards the goal of reducing costs. We think it is vitally important for CMS to add requirements to the ACO program to build a more robust monitoring system and we expect the FTC and DOJ will play a central role in this monitoring as well. In particular, CMS should do the following:

1. Require all selected ACOs to have a mechanism in place for assessing performance on private sector per capita costs. A mechanism should be developed by the second year of the program. An ACO itself does not necessarily have to have a mechanism in place, but could work with other stakeholders to make sure this can be done (e.g., using data from local purchasers or all-payer claims databases).
2. Gather data regarding current market shares, market entries and exits, and pricing trends for the ACOs. This information should be collected initially in the application process to establish a baseline, and then on an annual basis to monitor and report publicly on potentially adverse market impacts of ACOs.
3. Set expectations for resource stewardship and waste reduction, including public reporting of quality *and* cost metrics (e.g., cost to charge ratios, professional fee billing rates, prices for episodes of care, etc.).
4. Specify a standardized set of measures for costs, with input from consumers, purchasers, and other stakeholders.
5. Hold ACOs in Shared Savings Program to a maximum threshold of price increase with their commercial market clients.

6. Move to requiring private sector ACO participants to take part in all-payer claims databases (APCD). The APCD is a database comprised of medical, pharmacy, and dental claims, and information from the member eligibility, provider, and product files encompassing fully-insured, self-insured, Medicare, and Medicaid data.

On behalf of the millions of Americans represented by the undersigned organizations, thank you for your efforts and your responsiveness to our comments. If you have any questions, please contact either of the Consumer-Purchaser Disclosure Project's co-chairs, Bill Kramer, Executive Director for National Health Policy at the Pacific Business Group on Health or Debra L. Ness, President of the National Partnership for Women & Families.

Sincerely,

AFL-CIO
American Benefits Council
American Hospice Foundation
Catalyst for Payment Reform
Consumers' CHECKBOOK/Center for the Study of Services
Employers Health Purchasing Corporation of Ohio
Employers Health Coalition of Ohio, Inc.
The Empowered Patient Coalition
Health Care Incentives Improvement Institute
Health Policy Corporation of Iowa
HR Policy Association
Iowa Health Buyers Alliance
The Leapfrog Group
Midwest Business Group on Health
National Business Coalition on Health
National Partnership for Women & Families
Northeast Business Group on Health
PULSE of America
Pacific Business Group on Health
Puget Sound Health Alliance
St. Louis Area Business Health Coalition
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