Alaska Native Tribal Health Consortium

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May 31, 2011

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

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

Greetings:

These comments to the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) Participating in the Medicare Shared Savings Program (MSSP) (Proposed Statement) are submitted on behalf of the Alaska Native Tribal Health Consortium (ANTHC), a tax-exempt 501(c)(3) organization formed pursuant to Section 325 of Pub. L. 105-83, to carry out statewide programs of the Indian Health Service (IHS) pursuant to the self-governance provisions of Title V of the Indian Self-Determination and Education Assistance Act. It serves Alaska Natives and American Indians (AI/ANs) and their villages throughout the vast expanse of Alaska and provides a unique health delivery model even within the already unique Indian health system. Among its functions is co-management of the Alaska Native Medical Center (ANMC), including its tertiary care hospital in Anchorage, Alaska that serves AN/AIs throughout the state and is the state's only level II trauma center. ANTHC also provides a wide range of statewide public health, community health, environmental health and other programs and services for Alaska Natives and their communities.

Thank you for the opportunity to comment on the Proposed Statement. While we commend the Federal Trade Commission (FTC) and Antitrust Division of the Department of Justice (DOJ) on the effort to clarify the complex antitrust issues that could otherwise impede formation of ACOs, ANTHC does offer several comments and questions for consideration.

As a preliminary matter, ANTHC urges the FTC and DOJ (collectively "the agencies") to engage in meaningful tribal consultation on the Proposed Statement. As discussed below, we believe that the proposed framework is unduly burdensome with respect to many IHS and tribal health systems, which are often the primary (if not sole) provider of health services in many rural areas and remote communities and which have unique responsibilities to provide health care to AI/ANs to whom the United States owes a special trust responsibility.[1] Far from competing with other providers for a market share in well-served communities, they typically struggle to find ways to make health care accessible to people who would otherwise go without, even in communities in which there are other health providers.

In addition to serving an important policy-making factor, tribal consultation is a legal requirement. Congress recently reaffirmed that the United States owes a special trust responsibility and legal obligation toensure the highest possible health status for AN/AIs, to provide all resources to effect that policy, and to ensure that the United States works in a government-to-government relationship to ensure quality health care for all AN/AIs.[2] President Obama similarly renewed this commitment to the government-to-government relationship between the United States and the Tribes in his November 5, 2009, Memorandum on Tribal Consultation that pronounced tribal consultations to be "a critical ingredient of a sound and productive Federal-tribal relationship." The Presidential Memorandum also directs all federal agencies to fully implement President Clinton's Executive Order 13175 on "Consultation and Coordination with Indian Tribal Governments" which requires establishment of "regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have tribal implications."

It is clear that any potential enforcement resulting from tribal providers' participation in the ACOs and MSSPs would have "tribal implications" and thus should be subject to tribal consultation. The Indian health system, including IHS and tribally operated health care programs are interdependent in many parts of the United States, with one entity providing hospital services and one or more others providing a range of outpatient clinic services. This is especially true within the tribal health system in Alaska.

The coordination of services among Indian health providers assures continuity of care for patients, regardless of whether they are covered by Medicare, Medicaid, commercial coverage, tribal self-insurance, or have no payment source and the rely on the IHS funding to their health program. Any enforcement policy that might be interpreted to limit the interaction among Indian

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[1] 25 U.S.C. § 1602.

[2] 25 U.S.C. § 1602.

health programs, including urban Indian organizations,[3] would interfere in achievement of the objectives of the Indian Health Care Improvement Act, Pub. L. 94-437, as amended. We understand that the agencies are tasked with establishing and enforcing a policy of broad application with the MSSP implementation. We further recognize that tribal health programs might only comprise a small fraction of the total health care providers participating in the MSSP. However, third party payers, such as Medicare, comprise a significant portion[4] of the critically underfunded tribal health system.[5] Any changes, and especially any limitations, on the ability of tribal health programs to maximize their participation in and reimbursement from Medicare have a direct and significant consequence on tribal health programs. These are precisely the type of policy changes that require meaningful, pre-drafting consultation in fulfillment of the government-to-government relationship, as the opportunity to comment after a policy is already adopted simply does not sufficiently fulfill the federal government's consultation requirements.

From a substantive perspective, IHS and tribal providers do not compete for a market share in the same way other providers might. Instead, they typically struggle to find ways to make health care accessible to people who would otherwise go without. This is true of both ANTHC and the Alaska Tribal Health System generally. Many communities in Alaska have a population of only a few hundred or thousand people. Many remote communities, and even the state capital, Juneau, are not on the road system and can only be accessed by airplane, boat and/or dogsled. Some villages are so small that they cannot recruit, retain, and/or sustain a full-time provider for themselves. In many of these communities, and essentially all of the smaller Alaska Native villages, tribal organizations have 100% of the "market" because they are the only health care provider that serves the area.

Nor do the few truly urban centers in Alaska fit within the agencies' proposed antitrust criteria. Although ANMC is located in Anchorage, Alaska, where there are two other hospitals and a number of other health care providers, it makes little sense to evaluate its potential ACO application to improve clinical integration and coordination with other tribal facilities in Alaska using the commercial criteria that are described in the Proposed Statement.

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[3] These terms are used as defined in 25 U.S.C. § 1603.

[4] Third party collections brought in an estimated $829 million to IHS programs in FY 2010.U.S. Department of Health and Human Services, Indian Health Service, Year 2009 Profile, January 2010, *available at* http://info.ihs.gov/Profile09.asp.

[5] Although President Obama requested to increase IHS appropriations by 8.7 percent to $4.4 billion in FY 2011, this is still inadequate to meet IHS's goal of providing comprehensive services. NATIONAL INDIAN HEALTH BOARD, FY 2011 TRIBAL BUDGET RECOMMENDATIONS TO THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, STANDING ON PRINCIPLES: A NEW ERA IN TRIBAL GOVERNMENT RELATIONS.

The IHS built ANMC to provide tertiary inpatient and specialty care to AI/ANs, an extraordinarily underserved population based largely in rural Alaska. Trauma and other emergency patients are flown directly by air ambulance to ANMC from villages and other rural locations, while others are referred by regional tribal organizations. For regional organizations that administer their own hospitals, ANMC provides a higher, more specialized level of care. For tribal organizations that do not have a hospital, ANMC also serves as their community hospital. Essentially, ANMC and other tribal health providers in Alaska exist precisely because it is not commercially viable to provide services in many Alaskan communities. The economic incentives are completely different than those that drive most health care providers. As a result, the participation of these providers in an ACO does not pose any risk whatsoever of the "substantial anticompetitive effects" that the Proposed Statement attempts to mitigate: rather, if we are able to qualify as an ACO, we hope it will provide a critical step in ANMC and others' attempts to bridge the tremendous disparity in health care services between AN/AIs and the general American population. Going through even the streamlined process outlined in the Proposed Statement is an unnecessary expense and an unreasonable burden for these Indian health providers.

For these reasons, we urge that the agencies include an additional "Safety Zone" for Indian health programs and urban Indian organizations (as those terms are defined in 25 U.S.C. § 1603) that serve predominantly IHS beneficiaries. Doing so would lower the barriers and potential costs of Indian health programs seeking to form an ACO under the MSSP. Finally, as suggested above, we believe that the agencies would greatly benefit from hearing the views of other tribes and tribal organizations that provide health care services and ask that you engage in meaningful tribal consultation prior to finalizing the Proposed Statement, as well as prior to any subsequent notices and proposed or final rules. Welook forward to participating in these and future dialogues so as to ensure mutually agreeable outcomes in furtherance of the federal government's trust responsibility towards AN/AIs.

Thank you for your consideration of our comments.

Sincerely,

Don Kashevaroff
Chief Executive Officer