

March 10, 2014

Patricia Shultheiss, Attorney Advisor
Karen Goldman, Attorney Advisor
Office of Policy Planning
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

RE: Health Care Workshop, Project No. P131207

Dear Ms. Shultheiss and Ms. Goldman:

Thank you for the opportunity to submit comments as you prepare for the workshop you are holding on March 20-21 to review activities and trends affecting competition in healthcare.

One of the most important factors that will shape the future of healthcare in the country is how quickly physicians and hospitals move to different methods of payment that effectively support higher-value care. The legislation currently pending in Congress that would repeal the Sustainable Growth Rate formula specifically encourages the development and use of “alternative payment models.” Many physician groups, health systems, medical specialty societies, health plans, and Regional Health Improvement Collaboratives in communities across the country are also currently working to develop better payment models for physicians and hospitals.

A key element of effective payment reforms will be basing payment on how well physicians and hospitals achieve successful *outcomes* for patients, rather than on how many patients they treat or how many tests and procedures they perform. For example, primary care physicians should be paid on how successfully they help their patients manage their chronic conditions and avoid hospitalizations rather than how often the patients make a visit to the doctor’s office, and cardiologists should be paid based on how effectively they can help patients with heart disease avoid heart attacks and minimize the symptoms of angina without unnecessary tests or invasive procedures.

Because of both the inherent variability across patients and some degree of economies of scale needed for certain services, physicians will need to have a minimum number of the patients who qualify for a payment model in order to successfully manage under these condition-based or population-based payment models. For example, one of the best ways for a primary care practice to help its chronic disease patients stay well and avoid hospitalizations is to hire a nurse care manager to work with them. But the practice has to have enough patients with chronic disease to justify hiring a nurse to help them. Larger practices will be able to justify hiring a nurse on their own, but smaller practices will need a way to work with other small practices to share a nurse across their combined patient populations.

Moreover, for most physicians, only a portion of their patients will qualify for any particular payment model, and only a subset of those patients will be insured by any one payer. Consequently, small practices may not have enough patients to participate in new payment models with any individual payer. The minimum number of patients needed for success is much smaller than many people believe –

generally only hundreds of patients, not thousands or tens of thousands. However, this still means that several small physician practices will generally need to work together to achieve this level of patient volume for each payer. This can be done through Independent Practice Associations; it does not require the physician practices to consolidate with each other nor does it require them to merge with a hospital.

There is considerable evidence that better care and lower costs can result from having several small independent physician practices collaborating with each other to share resources and coordinate care. However, under current law and policy, if these practices jointly price their services in order to support their collaborative efforts, they are viewed as having committed “naked price fixing” and a *per se* violation of antitrust law. In contrast, if two independent physicians choose to abandon their independent practices and join the payroll of a large group or hospital which jointly provides and prices its services, there would be no antitrust problem at all. Thus, it is likely that the primary impact of the current policy is to discourage more coordinated care among small providers rather than to discourage genuinely anti-competitive collusions.

Although exceptions have been defined for physician practices that are “clinically integrated,” in many cases these standards are far more burdensome than necessary to implement the improvements in care the physicians want to make and the specific payment reforms that will support those improvements. Most physicians are not able to afford the administrative expenses to implement these unnecessary standards, the large legal expenses needed to advise them on navigating the laws and regulations, or the lengthy delays usually involved in gaining approval.

As a result of these barriers, far less progress is being made in advancing payment reforms than is needed. Moreover, because of the lack of better payment models, a rapidly growing number of physician practices are being acquired by hospitals. Although these acquisitions are often portrayed as achieving “clinical integration,” in many cases, it is merely *corporate* integration and it is being used as a way of controlling market share and increasing prices rather than reducing costs and improving quality.

In place of policies which *discourage* the formation of Independent Practice Associations, I would urge the FTC to identify and support changes in laws, regulations, and policies that would *encourage* independent physicians to work together through IPAs in order to implement new payment models. There are a number of examples across the country of small independent physician practices working together to manage bundled and global payments while remaining organizationally independent, and these providers are delivering higher quality outcomes at lower costs than many large integrated delivery systems. I would encourage you to invite them to your workshop so that you can hear from them directly. IPAs can be the most pro-competitive of any of the ways physicians can collaborate, because unlike integrated delivery systems and even large physician groups, the individual providers in an IPA retain the ability to withdraw and form new competitive structures at any time.

The best way to promote competition on prices and to control the market power of large providers is to remove the barriers to entry for smaller providers and the barriers to successful competition with larger providers. **Two types of actions by the Federal Trade Commission (FTC), the Department of Justice (DOJ), and other federal agencies would be desirable:**

- **Providing an automatic safe harbor from antitrust enforcement for small providers working together to participate in public or private payment reforms.** Although the FTC and DOJ have issued a number of antitrust policy statements which define circumstances in which they will not challenge multi-provider networks and joint ventures, these policies still create burdens for small physician practices that do not exist for large health systems. For example, the agencies established a “safe harbor” for small Accountable Care Organizations (ACOs) in conjunction with regulations implementing the Medicare Shared Savings Program, but this safe

harbor requires independent providers to conduct analyses of the local market to justify the safe harbor; this still places a heavy burden on the small providers (in effect, declaring them guilty until they prove they are innocent), while imposing no similar requirement on existing consolidated entities. A simpler safe harbor standard should be established, and it should be expanded to include providers participating in other kinds of payment reforms, including those implemented by private health plans, rather than limiting it only to providers that become Medicare ACOs.

- **Challenging anti-competitive behaviors by large providers.** Clearer federal policies and more aggressive enforcement are needed to counteract anti-competitive behaviors by large providers, such as refusal by large providers to contract with payers who implement tiered benefit designs that explicitly encourage use of lower-cost providers and services. The FTC and DOJ issued a list of such behaviors that it cautioned providers against engaging in as part of its Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations that accompanied the Medicare Shared Savings Program, but this list needs to be issued as a more comprehensive policy and more proactively enforced.

In addition to the standards for “clinical integration” currently required by the FTC in order for physician practices to collaborate, the standards established by the Centers for Medicare and Medicaid Services and by private accrediting bodies as to the qualifications needed by providers to participate in new payment models also tend to favor large provider organizations that can more easily afford to comply with many structural and process requirements. These standards can serve as a barrier to entry for small providers and discourage competition, yet the FTC implicitly endorsed the standards when it made its safe harbor rules available only to organizations that met the CMS standards. If costs are to be reduced and competition is to be supported, **federal policies should only impose requirements for the structure or internal systems of providers if there is clear evidence that high-quality, affordable care *cannot* be provided without those structures or systems.**

I commend the FTC for proactively examining ways to support successful competition in healthcare. I hope these comments will be useful to you in that process. If I can provide additional information or assistance, please let me know.

Sincerely,

Harold D. Miller
President and CEO