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SPECIAL FOCUS: ANTITRUST

Final ACO Antitrust Enforcement Statement Won't Deter Procompetitive ACOs

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When the idea of ACOs was floating around prior to enactment of the Affordable Care Act last March, some groups and commentators argued that antitrust enforcement was likely to deter their formation. Some commentators simply had an ox to gore and raised antitrust concern merely as a smokescreen. But the primary concern was that ACOs would constitute clinically integrated provider-controlled contracting networks and that there was too little and uncertain antitrust guidance explaining the circumstances under which networks are sufficiently clinically integrated so that their joint negotiations of contracts with health plans on behalf of their competing participants would not run afoul of the antitrust law's per se ban on horizontal price-fixing agreements.

Probably as a result of this criticism, the Federal Trade Commission, Antitrust Division of the Department of Justice, and Centers for Medicare and Medicaid Services decided that the FTC and DOJ, in conjunction with CMS's issuance of its proposed ACO regulation, would issue an antitrust enforcement statement explaining how they would analyze ACOs under the antitrust laws and, in particular, when clinical integration is sufficient to permit joint negotiations without their constituting a per se violation of Section 1 of the Sherman Act. Thus, in their proposed ACO Antitrust Statement, issued in March 2011, the agencies made it clear that the rule of reason would apply to ACO joint negotiations with Medicare if they met CMS's eligibility requirements for participation in the Medicare Shared-Savings Program. Those requirements, as the agencies opined, are broadly consistent with the requirements for clinical integration as discussed in four FTC Staff Advisory Opinions examining specific contracting networks that proposed to

clinically integrate and then negotiate contracts. The same principle, the statement provided, would apply to ACO joint negotiations with commercial health plans if the ACO used the same clinical-integration program in contracting with private health plans. Merely because an ACO's joint negotiations don't result in a per se horizontal price-fixing violation, however, does not mean that its negotiations are per se legal. Rather, it only means that the effect of the negotiations on competition is assessed under the rule of reason rather than the per se rule; there, the primary question is whether the ACO will have a sufficient degree of market power to raise reimbursement levels above the "competitive" level.

While the proposed ACO Antitrust Statement solved one problem that might deter ACO development — the adequacy of the network's clinical integration — it raised another: Certain ACOs were *required* to obtain a favorable antitrust review letter from one of the agencies as a condition to their ability to participate in the Medicare Shared Savings Program. Specifically, this mandatory review requirement applied to any ACO with any "common service" market share above 50 percent. As a result, every ACO would be required to calculate a plethora of common-service market shares to determine if it were an ACO subject to the mandatory-review requirement.

This may not sound like a problem, but calculating the necessary market shares is a time-consuming, expensive, and complex endeavor. First, the ACO would have to identify all its "common services" — i.e., the same services (e.g., cardiology) offered by two or more ACO participants. Second, for *every* ACO participant providing a common service, the ACO would have to delineate its primary service area or PSA — i.e., the smallest number of ZIP code zones from which the participant draws 75 percent of its patients. Finally, for each participant's PSA, the ACO would have to calculate the combined market share of all ACO participants providing the common service in that PSA. If any one of those exceeded 50 percent, the ACO would have been required to go through the mandatory antitrust-review-letter process with the agencies.

When issuing the proposed ACO Antitrust Statement, the agencies invited public comment recommending improvements. Some 127 persons and groups responded

and, without question, the most frequent and vehement criticism was the requirement for mandatory antitrust review. Commentators argued that the requirement turned the FTC and DOJ into regulators rather than their traditional role as law enforcers; that it raised an invalid implicit rebuttable presumption that any ACO with any market share above 50 percent could exercise market power; that it was simply unnecessary since ACOs remain subject to agency enforcement actions and health plans have not been shy about complaining to the agencies when provider-controlled networks increased reimbursement anticompetitively; and that its effect would be to deter providers from creating ACOs to participate in the Shared Savings Program.

The agencies took these criticisms to heart when issuing their final ACO Antitrust Statement on October 20. The major and most important amendment to the proposed Statement is the final ACO Antitrust Statement's deletion of any mandatory antitrust review requirement. Under the final Statement, any ACO may *voluntarily* request an antitrust review letter, but no ACO is required to obtain one as a condition to participating in CMS's Shared Savings Program. As a result, the agencies have removed one of the major deterrents to ACO formation.

It seems unlikely that many ACOs will request an antitrust review letter, simply because of the time, hassle, and expense involved. But some may still choose to calculate their common-service market shares for two reasons. First, the final ACO Antitrust Statement, like the proposed Statement, provides an "antitrust safety zone" for all ACOs with no market shares in excess of 30 percent. The assumption is that ACOs meeting this requirement are extremely unlikely to have market power. Second, calculating ACO market shares will give the ACO at least a rough idea of whether it does have market power and thus might be vulnerable to an antitrust challenge. Even if there is the potential for the exercise of market power, knowing that, the ACO can adjust its competitive conduct accordingly.

All ACOs (even those meeting the safety zone requirement in the case of "extraordinary circumstances") remain subject to antitrust challenges by the federal enforcement agencies, state attorneys general, and private parties if they have and exercise market power by attempting to raise reimbursement to supracompetitive

levels. But it is a truism that there, the antitrust laws will not have deterred procompetitive, beneficial ACOs but rather those with the effect of raising health care costs, not lowering them as the Affordable Care Act contemplates.