Comments of Professor Thomas L. Greaney

Workshop Regarding Accountable Care Organizations

I am pleased to present this comment for the public workshop sponsored by the Federal Trade Commission, the Office of the Inspector General and Centers for Medicare and Medicaid Services. I am the Chester A. Myers Professor and Co-Director of the Center for Health Care Studies at Saint Louis University School of Law. I have written extensively on health care competition policy and antitrust law issues; some of my recent articles relevant to the antitrust issues under consideration at this workshop are listed at the end of this comment.

Market Structure and Concentration

My analyses of the current state of American health care provider markets emphasize that they are plagued by *both* fragmentation *and* concentration. ACOs offer a much-needed vehicle for integrating health care delivery and reducing the system's well-documented shortcomings in the affordability and quality of health care. At the same time, ACOs do little to deal with the issue of concentration. Indeed, the ACO phenomenon may well encourage some mergers, joint ventures and alliances that will exacerbate this significant problem. Anecdotal evidence suggests that a "post-reform merger wave" may already be under way.

There is considerable evidence that extensive concentration in physician and hospital markets impairs the effectiveness of competition in health markets. Medicare Accountable Care Organizations that aggregate overly broad provider participation are likely to spill over into private markets and may also adversely affect competition among Medicare Advantage plans. Therefore, in reviewing and approving applications for participation in the Shared Savings Program of the Affordable Care Act, CMS should carefully evaluate whether ACO proposals will entrench or increase market power. It may also be desirable for CMS and the FTC to provide generalized policy statements regarding concentration to assist those considering forming ACOs, such as presumptive standards discouraging horizontal affiliations between hospitals or large physician specialty groups.

Clinical Integration

The FTC and Antitrust Division of the Department of Justice have provided extensive guidance on clinical integration. Potential ACO participants should not encounter significant difficulty in ascertaining the steps needed to achieve sufficient integration to avoid price fixing allegations. Moreover, the requirements of the Shared Savings Program closely parallel the standard for meaningful clinical integration under antitrust law. Proposals to water down these requirements would likely encourage providers to regard ACOs as "just another network" and not devote the human and capital resources necessary to improve quality, change practice

patterns and reduce costs. It should also be noted that financial risk sharing offers stronger and more enduring incentives for participants to commit to adopting the methods and infrastructure for improving care delivery than loosely organized arrangements to integrate clinically.

Notably, the Patient Protection and Affordable Care Act (ACA) allows the Secretary of HHS to implement several alternative incentive payment methodologies including a "shared savings" performance bonus arrangements based on the ACOs net savings from traditional Medicare payment; "partial captitation" of some or all of Part A and B costs; and such other methodologies that the Secretary determines will improve quality and efficiency. Looking at the nation's experience with preferred provider organizations, it is far from clear that the shared savings bonus model will effectively counteract the volume-increasing incentives of fee-for-service payment. Under such payment methodologies, ACOs that rely on clinically integrated networks and do not share financial risk seem poorly designed to realize the objectives of the ACO experiment. From the perspective of competition policy, this is troubling, as incentives to innovate are greatly diluted. Therefore, CMS should consider "tiering" incentives in a manner that will reward and encourage greater financial integration.[1]

Antitrust Enforcement

The Affordable Care Act relies on vigorously competitive markets to deliver affordable, high quality health services. It bears remembering that provider groups have lobbied incessantly for many years for exemptions from antitrust laws, arguing at various times that a "level playing field" justified collective bargaining by physicians, or that efficiency would be improved by such immunity. It would be a profound mistake to accede to renewed calls for exemption or loosened enforcement of the antitrust laws in connection with ACO development. Indeed, the risk that dominant providers and dominant insurers may exercise their market power (individually or jointly) has never been greater. And as noted, merger and joint venture activity has accelerated significantly since the passage of ACA; while much of this consolidation is procompetitive, some will undeniably prove harmful to competition. Vigilant scrutiny of conduct and market structure by antitrust enforcers is therefore critical to the success of the Shared Savings Program.

[1] *See e.g.*, Stephen Shortell et al., *How the Center for Medicare and Medicaid Innovation Should Test Accountable Care Organizations*, 29 Health Aff. 7 (July, 2010).

Selected Articles by Thomas L. Greaney

(Available at SSRN authors page http://ssrn.com/author=138959)

The Affordable Care Act and Competition Policy: Antitdote or Placebo? (forthcoming, Oregon Law Rev. 2010).

Accountable Care Organizations: A New, New Thing with Old Problems, Health Care Outlook (2010).

Competition Policy and Organizational Fragmentation in Health Care, 71 U. Pitt. L. Rev 217 (2009)

Economic Regulation of Physicians: A Behavioral Economics Perspective, 53 St. Louis U. L. Rev. 1189 (2009).

Thirty Years of Solicitude: Antitrust Law and Physician Cartels, 7 Hous. J. Health L. & Pol'y 189 (2007).