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ANTITRUST IMPLICATIONS FOR ACOS: FTC/DOJ DETERMINE ACOS ARE CONSISTENT WITH INDICIA OF CLINICAL INTEGRATION – IS THIS A FUNDAMENTAL SHIFT IN ANTITRUST POLICY?

With the advent of the Patient Protection and Affordable Care Act ("ACA"), we are entering a new era of clinical integration and coordinated care. The government is interested in actively facilitating better care for patients, better health for populations and lower health care costs. To achieve this three part objective, CMS is championing the Medicare Shared Savings Program ("MSSP") and the formation of Accountable Care Organizations ("ACOs") as provider contracting vehicles under the MSSP. But ACOs are creating a certain tension. On one hand, CMS views the formation of large ACOs as a way to coordinate care and achieve the three part objective. On the other hand, the FTC/DOJ are concerned that large ACOs will obtain market power leading to the unintended consequence of decreasing quality and increasing costs.

In an unusual degree of coordination between the FTC/DOJ and CMS, the antitrust enforcement agencies have determined that CMS's eligibility criteria for participation in the MSSP are consistent with the FTC's "indicia of clinical integration." Moreover, ACOs participating in the MSSP will be allowed to negotiate contracts jointly with private payors. In the past, before a provider organization could be assured it could collectively negotiate non-risk contracts with payors, the provider organization would need to follow FTC guidance and perhaps even go through the lengthy Advisory Opinion process to be cleared as clinically integrated. Now, a provider organization need only apply to CMS and be accepted into the MSSP to be cleared as clinically integrated and allowed to negotiate jointly, even with private payors.

Does this represent a change in antitrust policy? A loosening of requirements to be considered clinically integrated? Unfortunately, it depends, but most likely no. Even though CMS will not be reviewing ACOs through clinical integration glasses like the FTC, there are still a number of factors to consider. First, CMS has enunciated four processes with respect to clinical processes and patient centeredness that an ACO must define, establish, implement, evaluate and periodically update: (1) evidence-based medicine; (2) beneficiary engagement; (3) internal reporting on quality and cost metrics; and (4) promotion of coordination of care. To allow for flexibility and innovation, CMS has kept its guidance broad on how to structure these processes. But CMS will monitor 33 Quality Performance Standards. Thus, an ACO should use the broad principles to create a structure that allows for measurement and tracking of the Quality Performance Standards. Second, CMS is committed to monitoring ACOs and will share the results with the FTC/DOJ. If ACOs do not show sufficient success in improving quality and lowering costs, it may result in the FTC/DOJ revisiting its acquiescence of joint negotiations for ACOs. Third, there is still much skepticism with respect to ACOs at the FTC. At least one FTC Commissioner thinks ACOs are suspect at best and has vowed that the FTC will monitor complaints and bring enforcement actions if necessary. Thus, if an ACO gains market power and increases prices without any corresponding increase in quality, then an enforcement action may be imminent.

Although it may seem like antitrust policy is shifting and loosening, the FTC/DOJ are focused on ACOs and will continue to challenge entities that unreasonably use market power to harm consumers. If you or your organization is interested in pursuing joint negotiations with private payors or forming an ACO, be wary of antitrust issues and tread carefully.

PRACTICAL TAKEAWAYS

From a practical perspective, how does an ACO meet CMS's eligibility criteria with respect to clinical processes and patient centeredness?

- In order to allow for innovation and flexibility, CMS has purposefully been broad in describing the exact structure of the four processes: (1) evidence-based medicine; (2) beneficiary engagement; (3) internal reporting on quality and cost metrics; and (4) promotion of coordination of care.

- An ACO should adopt and implement the broad principles of the four processes to create a structure that allows for measurement and tracking at least the 33 CMS-designated Quality Performance Standards, as well as measures requested by local employers or managed care plans.

- An ACO should have both PCPs and specialists working together to develop care management programs and coordinate patient care.

- An ACO should have an IT infrastructure that can track the Quality Performance Standards and allow real-time exchange of information between providers and facilities.

- An ACO should provide continuous performance monitoring and timely feedback to providers. And it should create meaningful penalties for providers not meeting the Quality Performance Standards, including potential expulsion from the ACO.

CONTACT INFORMATION

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