Balancing Competition and Health Care Policy: Antitrust Considerations and Provider Integration

Elinor R. Hoffmann

Key Statutes: Federal

- The Sherman Act § 1 forbids contracts, combinations and conspiracies in [unreasonable] restraint of trade.
- The FTC Act § 5 incorporates Sherman Act § 1.
- The Clayton Act § 7 prohibits mergers, the effect of which may be substantially to lessen competition, or to tend to create a monopoly.

Key Statutes: New York State

- The Donnelly Act (NY GBL §340 et seq.) forbids agreements and arrangements in restraint of trade.
- The New York Attorney General, like other Attorneys General, has enforcement powers under both state and federal law.

A little bit of history . . . .

Health care provide are all subject to antitrust scrutiny, just like other professionals.

- ***Arizona v. Maricopa County Medical Society,*** *457 U.S. 332 (1982)*

  State of Arizona sued respondent medical societies, saying that they had engaged in illegal price-fixing. Theory was that physicians, who competed with each other for patients, had set ***maximum fees*** *for reimbursement, and that was illegal per se.*

  -- Physicians were neither financially nor clinically integrated.

FTC/DOJ Health Care Statements: 1993, 1996

- Recognized that the health care markets should be permitted to innovate.
- Created safety zones for collaborations of providers that did not have significant market power and/or were non-exclusive; AND shared financial risk.

FTC/DOJ Health Care Statements

Left the door open to networks that do not share financial risk, but "create significant efficiencies, and on balance, are not anticompetitive."

FTC/DOJ Health Care Statements

FTC Advisory Opinions:

- Is the clinical integration likely to generate meaningful efficiencies/lower cost/improve quality/increase access?
- Are joint negotiations with payors reasonably necessary to achieve these goals?

FTC Advisory Opinions

- Medsouth; Medsouth retrospective; role of exclusivity.
- SHO
- GRIPA
- Tri-State
- Norman

All given a green light except SHO.

Accountable Care Organizations

- Medicare Shared Savings Program by January 1, 2012. (PPACA 3022)
- Groups of providers coordinate care for Medicare beneficiaries.
- Large enough to service 5,000 Medicare beneficiaries.
- Qualified ACOs receive "payments for shared savings."

Who is Eligible to Participate?

- Professionals in group practices
- Individual practices
- Partnerships or joint ventures including professionals and hospitals
- Hospitals employing providers
- Other groups of providers of services or suppliers in HHS discretion

Clinical Integration

- Standards for ACOs are consistent with Health Care Statements and FTC Advisory Opinions

-- a formal legal structure that allows the ACO to receive and distribute payments for shared savings

-- a leadership and management structure that includes clinical and administrative processes;

-- processes to promote evidence-based medicine and patient engagement;

-- reporting on quality and cost measures; and

-- coordinated care for beneficiaries

-

How Long and How Large?

- Minimum three years.
- Big enough to service a minimum of 5,000 Medicare beneficiaries

GOAL: Achieve meaningful, not random efficiencies

BUT: Facilitates the acquisition of market power.

Federal Guidance for ACOs

- Creates safe harbors for ACOs with participant market shares below 30% in Primary Service Area
- If a transaction does not fall within a safe harbor, that does NOT MEAN IT IS ILLEGAL. It means it is subject to further analysis.
- Creates voluntary approval process
- Standard of review will be rule of reason for all arrangements that are part of the Medicare Shared Savings Program.
- Articulates what conduct to avoid.

Federal Status-Commercial Markets

- "Further, if a CMS-approved ACO provides the same or essentially the same services in the commercial market, the Agencies have determined that the integration criteria are sufficiently rigorous that joint negotiations with private-sector payers will be treated as subordinate and reasonably related to the ACO's primary purpose of improving health care services."

What about New York law?

- New York's antitrust law, the Donnelly Act, applies to health care providers, too.
- New York generally follows federal law.
- New York has its own health care policy.

New Legislation in New York

- New York enacted its own ACO statute in April 2011 as part of the budget.
- DOH will be drafting implementing regulations. (Public Health Law § 29-E).
- At the same time, New York enacted statutes dealing with other types of provider consolidations. Public Health Law 29-F (providing for COPAs).
- DOH has published for comment implementing regs for these as well.

DSRIP

- 2014: Medicaid Waiver—conditioned on meeting the goals of the DSRIP program for Medicaid patients.
- Encourages the formation of Performing Provider Organizations composed of large institutions and community health services that treat Medicaid patients.

What are the Goals of DSRIP?

- "to promote community-level collaborations and focus on system reform . . . to achieve a 25 % reduction in avoidable hospital use over five years. Safety net providers will be required to collaborate . . . focusing on system transformation, clinical improvement and population health improvement."

So What raises antitrust questions?

- Spillover into the commercial sector.
- A PPS may negotiate on behalf of all providers in the PPS, eliminating price and non-price competition.
- DSRIP encourages a single PPS in a geographic area. In some cases, that could involve the collaboration of the only two hospitals in the area.

Don’t the benefits outweigh any anticompetitive effects?

- The goals of DSRIP—collaborating to innovate better delivery systems—are goals also encouraged by competition policy.
- But we know that joint negotiation leads to higher prices and often a reduction in non-price competition.
- Antitrust is not likely to be an issue for many PPS. Some may raise concerns.

How do COPAs fit in?

- N.Y. Pub. Health Law Art. 29-F.
- Invokes "state action immunity" for recipients of a COPA.
- "State Action Immunity" is a defense to a federal antitrust claim provided that there is a clear articulation to substitute state regulation for competition and there is actual *active* supervision by the state.

Do I need a COPA to be part of a PPS or ACO?

- There's nothing in any statute that requires it.
- The standards for a COPA in DOH's draft regulation promote procompetitive effects that often will not be outweighed by anticompetitive effects.
- DOH must actively supervise.

Conclusion

The goals of health care policy and competition policy are not at odds with one another.

Useful Sites

www.ag.ny.gov

www.ftc.gov

www.usdoj.gov

https://www.health.ny.gov/health_care/medicaid/redesign/delivery_system_reform_incentive_payment_program.htm

http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf