Accountable Care Organizations and Antitrust
Restructuring the Health Care Market

ON OCTOBER 20, 2011, THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) released the final rules for accountable care organizations (ACOs), a highly publicized initiative of the Affordable Care Act. Accountable care organizations are part of the Medicare Shared Savings Program, which is charged with improving quality of care for Medicare patients. The CMS provided incentives for ACOs to deliver high-quality care at reduced rates of spending by providing a more coordinated team approach to health care delivery.

On the same day, the Federal Trade Commission and Department of Justice provided guidelines addressing antitrust issues involving the formation of ACOs.1 The concern is that ACOs can result in a reduced number of competitors in health care markets, which could potentially increase prices and have negative consequences for consumers and purchasers of care. The Federal Trade Commission and Department of Justice guidelines require that ACOs meet the Medicare Shared Savings Program’s clinical integration requirements and suggest potentially anticompetitive actions to avoid. In crafting the Medicare Shared Savings Program, the CMS, the Federal Trade Commission, and the Department of Justice are seeking balance between integration efficiencies and market power.

Physician leaders and policy makers will need to consider 5 major issues in the creation of ACOs. These include the following: market definition and power, efficiency and quality metrics, physician and hospital exclusivity, public-private cost shifting, and monitoring.2

Market Definition and Power
The guidelines create a safety zone in which ACOs that have less than a 30% market share in each independent service within a geographic market are highly unlikely to raise antitrust concerns. The guidelines include a “Rural Exception” allowing ACOs to include 1 nonexclusive physician or group practice per specialty from each rural area even if that service exceeds the 30% market share. Independent service is defined by the 99 physician codes from CMS and 25 major hospital diagnostic categories, segmenting each specialty physician service.3

The empirical evidence supporting a 30% market share benchmark is limited but aligns with the Federal Trade Commission’s definition of highly concentrated markets. Nevertheless, differences in health care markets mean that a 30% share in one market could have vastly different implications in terms of concentration and power than a 30% share in another. This complicates attempts to establish a single benchmark for all markets, and states may choose to adapt their own policies tailored toward local health care markets.

Efficiency and Quality Metrics
To ensure a broader and more measurable effect, the Medicare Shared Savings Program requires ACOs to serve a minimum of 5000 patients. The CMS is encouraging larger ACOs by using a graduated savings schedule, whereby ACOs with larger numbers of beneficiaries will have lower minimum savings rates than ACOs with fewer beneficiaries. The CMS has estimated that between 1 million and 5 million Medicare beneficiaries will participate in 50 to 270 ACOs across the country, which suggests an average ACO size of approximately 15,000 patients.4 The Brookings-Dartmouth ACO model recommends 10,000 Medicare patients and 15,000 commercial insurance patients as the minimum patient pool for ACOs to support the necessary investment in measurement and statistical reliability of performance metrics.5

Antitrust efforts are intended not only to prioritize lower prices but also to encourage other components of consumer welfare such as quality-enhancing product innovation. The Medicare Shared Savings Program includes quality reporting requirements and ties shared savings to performance on 33 quality measures. All health care purchasers are challenged with finding quality measures that are effective and easy to use in purchasing decisions and reimbursement. Increased transparency and consumer-friendly ways of sharing quality scores may help reward higher-quality physicians and hospitals.

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Physician and Hospital Exclusivity
Although recommending that all ACOs avoid exclusive contracting with hospitals, the guidelines suggest that ACOs considered to have high market share avoid exclusive contracting with physicians as well. Exclusive relationships, particularly those involving highly sought after or high-quality specialist physicians and hospitals, could give an ACO undue leverage. Exclusivity may also promote increased internal ACO referrals, which could lead to increased market power in the entire patient care process.

There are, however, potential efficiency benefits to exclusivity. Increased internal referrals and communication among dedicated physicians is expected to facilitate coordinated, clinically integrated, and high-quality care. If physicians are expected to implement care practices that stem from ACO participation, they are much more likely to do so if the majority of a physician’s patients are in the ACO. Furthermore, sufficient incentives for information technology infrastructure and process innovation are more likely if that investment cannot be easily shared with competing ACOs.

Public-Private Cost-Shifting
There is concern that the Medicare Shared Savings Program may exacerbate cost shifting, with private payers facing higher rates to recoup reductions in reimbursement from Medicare and Medicaid. Furthermore, physicians and hospitals may have increased leverage in rate negotiations with private payers due to increased market power stemming from ACO collaborations. The Medicare Payment Advisory Commission has suggested that “[o]ne danger [of ACOs] is that physician groups consolidate into larger entities and use this negotiating power to increase prices charged to private insurers.” The National Business Group on Health suggested that the CMS consider limiting shared bonuses if additional cost shifting to private payers is identified.

Monitoring
The Medicare Shared Savings Program does not require mandatory antitrust review prior to ACO admission to the program but allows for voluntary review. Nevertheless, few organizations are expected to request voluntary review. Most ACOs will probably seek private legal counsel rather than a public and uncertain Federal Trade Commission or Department of Justice review process. The CMS plans to risk-adjust beneficiaries in ACOs to ensure that ACOs are not simply selecting the healthiest patients. It will use the CMS–Hierarchical Category Coding mechanism developed to reimburse capitated Medicare Managed Care Plans. To prevent physicians from upcoding or changing their practices to code an equivalent patient as higher risk, the CMS will not health-adjust a continuously enrolled patient’s risk score. The CMS plans to evaluate coding practices for future rule-making. It must also monitor ACOs for attempts to “game” the risk-adjustment scheme based on serving favorable-risk populations using the CMS–Hierarchical Category Coding criteria.

Conclusions
Accountable care organizations represent a major experiment in health care delivery and financing. Two major questions remain unanswered. How can clinical integration be encouraged while preventing excessive antitrust risk; and how can cost shifting from federal to private payers be mitigated? Achieving the appropriate balance between market power and efficiencies is critical to that experiment. A significant challenge will be in those instances for which there is evidence of increased prices due to market power of large ACOs but also evidence of increased efficiencies in care coordination and patient experience with their care. Whether the relevant parties involved will regard this type of outcome as acceptable remains to be seen.

Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Scheffler reported receiving institutional grant and pending grant support from the Robert Wood Johnson Foundation and travel support from the National Institutes of Health; personal payment for consultancy for the Robert Wood Foundation, World Health Organization, World Bank, and Stanford University; and book royalties from Stanford Press. Dr Wilensky reported serving as a board of director for US Health Group Quest Diagnostics, Geisinger Health System; owning stock in US Health Group and Quest Diagnostics, and receiving payment for serving on the speakers bureau for Washington Speakers Bureau, Versant Ventures, Key Speakers Bureau, the Lundberg Institute, and McKinsey and Co. Dr Shortell reported no financial conflicts.

Funding/Support: This work was supported by the Institute for Research on Labor and Employment and the Robert Wood Johnson Scholars in Health Policy Research Program at UC Berkeley.

Additional Contributions: We thank Liora G. Bowers, MBA, MPH, University of California Berkeley School of Public Health, and H. E. Frelch III, PhD, Department of Economics University of California Santa Barbara, for their helpful input and comments, for which they received no compensation.

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