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Accountable Care Organizations: A New New Thing with Some Old Problems

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Abstract

When pressed for evidence that the proposed health reform legislation will control costs, proponents invariably cite the numerous pilot programs and other innovations in Medicare payment policy contained in the bill. At first blush, the ACO model seems well designed to foster competition among providers. Not unlike health maintenance organizations and other integrated delivery forms, ACOs assume responsibility for coordinating care and thus have strong incentives to provide cost effective care and to do so in a manner that is transparent and hospitable to comparative shoppers. But at the same time, the path of ACO development could prove profoundly anti-competitive. The concern lies with the possible exacerbation of already-weak competitive conditions prevailing in provider markets. This essay, written at as the Patient Protection and Affordable Care Act was enacted, discusses competition policy issues associated with the Shared Savings Program.

When pressed for evidence that the proposed health reform legislation will control costs, proponents invariably cite the numerous pilot programs and other innovations in Medicare payment policy contained in the bill. Among the most promising of these is the "Shared Savings Program" found in Section 3022 of H.R. 3590,[1] which will test the effectiveness of Accountable Care Organizations (ACOs) in rationalizing the delivery system and controlling costs. The idea, which carries the endorsement of the Medicare Payment Advisory Commission (MedPAC)[2] and the influential health service researchers at Dartmouth,[3] is not entirely novel. In many respects the ACO is the latest in a long line of efforts to develop integrated delivery systems that bear financial responsibility for treatment decisions. In addition, a number of experiments involving

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[1] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3022 (2009) (enacted at Pub. L. No. 111-148, 124 Stat. 119, to be codified at 42 U.S.C. § 1899).

[2] MEDPAC, IMPROVING INCENTIVES IN THE MEDICARE PROGRAM 40–58 (2009), *available at* http://www.medpac.gov/documents/Jun09_EntireReport.pdf.

[3] Elliott S. Fisher et al., *Fostering Accountable Health Care: Moving Forward In Medicare*, 28 HEALTH AFF. w.219 (2009), *available at* http://tdi.dartmouth.edu/documents/publications/HA%20Fisher-McClellan%20art.pdf.

bundled payments to ACOs and to other innovative organizations (as in Medicare's Physician Group Practice demonstration) have been underway for some time.

Supporters contend that as a voluntary pilot program, ACOs can develop in forms suitable to local market conditions and gain acceptance in the physician communities that have proved resistant to managed care structures in the past. In the long run, the aspiration is that private insurers will follow suit and proliferating ACOs will lead the way to delivery system reform.

The ACO concept envisions a legal entity comprised of and controlled by providers that would assume financial responsibility for the cost and care of a defined population of Medicare beneficiaries while being subject to a variety of quality standards and information reporting requirements.[4] The new law leaves much detail to the discretion of the Secretary of the Department of Health and Human Services (HHS),[5] presumably informed by experience and learning as the program progresses. For example, the legislation delegates development of standards for quality, use of evidence-based medicine, and "patient-centeredness" to HHS.[6] In addition, ACOs may take diverse forms, such as local networks of physicians, hospitals, and their affiliated physicians, fully integrated health systems, or "virtual" networks of providers.[7] Notably, the new law 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

[4] Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. § 3022 (2009) (to be codified at 42 U.S.C. § 1899(a)(1)).
[5] *Id.* (to be codified at § 1899(b)(3)).
[6] *Id.*
[7] *Id.* (to be codified at § 1899(b)(1)).

quality and efficiency). Each option poses raises significant questions. For example it is not clear that a shared savings bonus model will effectively counteract the volume-increasing incentives under fee-for-service payment; nor is it clear that partial capitation payment can be implemented without raising issues of under-provision of care and other problems associated with managed care in the past.[8]

A critical problem, largely ignored during the legislative debate, is the likely tension between the legislation's overall reliance on competition and the organizational structures and norms that may be established by ACOs. At first blush, the ACO model seems well designed to foster competition among providers. Not unlike health maintenance organizations and other integrated delivery forms, ACOs assume responsibility for coordinating care and thus have strong incentives to provide cost effective care and to do so in a manner that is transparent and hospitable to comparative shoppers.

But at the same time, the path of ACO development could prove profoundly anti-competitive. The concern lies with the possible exacerbation of already-weak competitive conditions prevailing in provider markets. Owing to indifferent enforcement of antitrust laws by the Federal Trade Commission and Department of Justice over the last ten years and questionable judicial precedents, hospital mergers proceeded at an unprecedented pace.[9] Over ninety-three percent of the nation's population lived in concentrated hospital markets, and the American consumer bore the brunt of the predictable outcome: hospital consolidation in the 1990s raised overall inpatient prices by at least five percent and by forty percent or more when

[8] *See* KELLY DEVERS & ROBERT BERENSON, CAN ACCOUNTABLE CARE ORGANIZATIONS IMPROVE THE VALUE OF HEALTH CARE BY SOLVING THE COST AND QUALITY QUANDARIES? (2009).
[9] *See* Thomas L. Greaney, *Competition Policy and Organizational Fragmentation in Health Care*, 71 U. PITT L. REV.217 (2009).

merging hospitals were closely located.[10] Less well noted is the concentration in specialty physician markets that went unchallenged during recent years, lessening the ability of managed care organizations to negotiate lower prices for their services.[11] Further, even where antitrust prosecutors were active, challenging over seventy-five physician cartels involved in price fixing or efforts to thwart managed care, the relief gained was little more than a wrist slap, an unfortunate dereliction that certainly did little to foster competitive norms in the provider community.[12] Overall, it is fair to characterize the prevailing attitude among providers over the past thirty years as one of seeking first to avoid competition though concentrative mergers and other affiliations and, in some cases, by engaging in illegal collusion.

Encouraging competitive development of ACOs in this market environment may prove challenging. First, it is unclear the extent to which regulators will foster the formation of multiple, competitive ACOs around the country. It is certainly feasible that HHS might determine (as the reform legislation appears to allow) that it is more important to encourage voluntary participation in ACOs than to promote competitive ACOs. An "open door" policy for ACOs (allowing them to include all comers in their markets) would likely lead to concentrated formal and informal affiliations. (As noted above, the FTC has dealt with dozens of proposed physician networks and "super PHOs" of considerable size that proposed to bargain on behalf of physicians and hospitals; efforts to create overinclusive ACOs to lessen rivalry are unlikely to

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[10] CLAUDIA H WILLIAMS ET AL., HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE 2 (2006), *available at* http://www.rwjf.org/files/research/no9policybrief.pdf.

[11] *See Competition in the Health Care Marketplace: Hearing Before the S. Subcomm. on Consumer Protection, Product Safety & Insurance, Comm. on Commerce, Science & Transportation*, 111th Cong. (July 16, 2009) (testimony of Thomas L. Greaney), *available at* http://law.slu.edu/healthlaw/news_stories/statement.pdf.

[12] Thomas L. Greaney, *Thirty Years of Solicitude: Antitrust Law and Physician Cartels,* 7 HOUS. J. HEALTH L. & POL'Y 189, 196–97 (2007).

diminish). It also 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.[13]

Even if the Secretary adopts a policy of encouraging competition among ACOs, there may be competitive obstacles to effectively implementing that goal. First, as discussed above, the highly concentrated state of many provider markets may make it difficult for HHS to secure participants willing to "share" their savings proportionately with other providers. Moreover, if the Medicare ACOs are seen as likely to be adopted by private insurers, dominant providers will not be reticent to exercise their market clout. As Robert Leibenluft, a former FTC official has pointed out, in allocating among themselves the shared savings of their ACO, physicians and hospitals may adversely affect competition in the private market:

> The meetings at which the reallocation of those funds occurs may . . . be the types of meetings in which price collusion can take place. Deciding how ACO revenues should be divided among the ACO participants typically would not raise antitrust concerns, but serious issues would arise if such discussions spill over into how independent providers will contract outside the ACO context.
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> The new arrangements also may make it easier for physicians to exclude potential competitors from entry into the local market.[14]

As I have argued elsewhere,[15] the structure of our health care delivery system gives us the worst of both worlds: fragmentation *and* concentration. Hospital and specialty provider markets are highly concentrated; most primary care physicians remain in "silos" of solo or small

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[13] *See* Robert Pitofsky, Chairman, Fed. Trade Comm'n, Thoughts on "Leveling the Playing Field" in Health Care Markets, Remarks at the Nat'l Health Lawyers Ass'n Twentieth Annual Program on Antitrust in the Health Care Field (Feb. 13, 1997); *see also* William S. Brubaker III, *Will Physician Unions Improve Health System Performance?*, 27 J. HEALTH POL. POL'Y & L. 575, 577–85 (2002).

[14] Robert F. Leibenluft, *Health Reform and Market Competition: Opportunities and Challenges,* 98 Antitrust Trade & Reg. Rep. (BNA) (Mar. 12, 2010).

[15] *See* Greaney, *supra* note 9.

practice groups; and there is scant "vertical integration" among providers of different services. Not only does this phenomenon impede effective bargaining to reduce costs and prevent overutilization of services, but it also has adverse effects on the quality of health services patients receive because it inhibits coordination of care. While ACOs represent the most promising antidote on the horizon to this problem, their success will depend on vigilant monitoring of competitive conditions by HHS and the antitrust enforcement authorities.