Coordination or Consolidation? Accountable Care Organizations and Antitrust Policy Under the Medicare Shared Savings Program

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The U.S. health care system is expensive, fragmented, poorly organized, and fails too often to deliver high quality care that is both accessible and cost efficient. In 2014, Americans spent an estimated $3.1 trillion on health care, averaging $9695 per capita and accounting for 17.8% of gross domestic product ("GDP"). Over the course of the next decade, these figures are projected to increase by an average of 5.8% per year, reaching an estimated $5.4 trillion and 19.8% of GDP by 2024. In an effort to curb this unsustainable trend of rising health care costs, Congress enacted the Medicare Shared Savings Program ("MSSP") in conjunction with the Affordable Care Act ("ACA") in 2010. The MSSP created a Medicare framework for Accountable Care Organizations ("ACOs"), a new health care delivery model that promotes health care provider accountability, cost efficiency, and higher quality care. At the same time, the program raises serious antitrust concerns in that it facilitates horizontal integration between competitors, thus perpetuating increased concentrations of provider market power that allow providers to drive up health care prices. This Note argues that there is a need for increased vigilance on the part of Centers for Medicare and Medicaid Services in regulating ACOs participating in the MSSP to prevent the acquisition and exercise of pricing power. Antitrust enforcement alone remains an inadequate solution to the problem of provider market power and, accordingly, additional regulatory efforts are necessary to promote competition and, at the very least, mitigate and contain the anticompetitive effects of health care market consolidation under the MSSP.

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Introduction

The U.S. health care system is expensive, fragmented, poorly organized, and fails too often to deliver high quality care that is both accessible and cost efficient. In 2014, Americans spent an estimated $3.1 trillion on health care, averaging $9695 per capita and accounting for 17.8% of gross domestic product ("GDP").[1] Over the course of the next decade, these figures are projected to increase by an average of 5.8% per year, reaching an estimated $5.4 trillion and 19.8% of GDP by 2024.[2] At the same time, international comparative studies have shown that although the United States spends by far the most on health care, the overall quality of care provided is no better, and is in many respects worse, than that of most other industrialized countries.[3] Indeed, despite ranking highest in how healthy its citizens perceive themselves, the United States consistently underperforms on most quality measures relative to other wealthy and developed countries.[4]

1. *See* Press Release, Ctrs. for Medicare & Medicaid Servs., 2014–2024 Projections of National Health Expenditures Data Released (July 28, 2015) (on file with author).

2. *Id.*

3. Org. for Econ. Co-Operation & Dev., Health at a Glance 2013: OECD Indicators 107–57 (2013).

4. *Id.* at 40–41.

Health policy experts attribute this excess spending to two major factors: (1) misaligned provider incentives and (2) provider consolidation. First, under the prevailing "fee-for-service" model for health care delivery, physicians and hospitals are paid a fee for each test, procedure, or other service performed. The result is that providers are financially incentivized to increase the volume of services they deliver, as well as to recommend unnecessary, duplicative, or more expensive tests and procedures that tend to pay higher insurance reimbursements.[5] Thus, rather than motivating providers to coordinate care more efficiently, reduce costs, and focus on quality, the current system fosters a fragmented, wasteful, and dangerous culture of overutilizing health care services.[6] Second, an ever-growing trend of consolidation among health care providers has led to problematic concentrations of market power, which dominant providers can and have leveraged to inflate prices and frustrate market entry by competitors.[7] The consequences of such a lack of competition and pricing power are reflected in the already irrational pricing of hospital services, which seldom bears any relation to the cost or quality of the care provided, and instead fluctuates based on relative bargaining power.[8]

In an effort to resolve the issues of misaligned provider incentives, inefficiency, and fragmentation, Congress passed the Medicare Shared Savings Program ("MSSP") as a part of the Affordable Care Act ("ACA") in 2010.[9] The MSSP provides a Medicare framework to facilitate the formation of Accountable Care Organizations ("ACOs"), groups of health care providers and suppliers that work jointly to manage and coordinate the entire continuum of care for defined patient populations.[10] By offering financial incentives to cut costs and achieve quality benchmarks in the treatment of Medicare beneficiaries, ACOs under the MSSP promote provider accountability and move health care payment and delivery toward a more cost-efficient model that provides

5. *See* INST. OF MED. OF THE NAT'L ACADS., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE 4 (2007) ("The current Medicare fee-for-service payment system is unlikely to promote quality improvement because it tends to reward excessive use of services; high-cost, complex procedures; and lower-quality care.").

6. *See id.*; *see also* Einer Elhauge, *Why We Should Care About Health Care Fragmentation and How to Fix It*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1 (Einer Elhauge ed., 2010) ("Individual decision makers responsible for only one fragment of a relevant set of health care decisions may fail to understand the full picture, may lack the power to take all the appropriate actions given what they know, or may even have affirmative incentives to shift costs onto others.").

7. *See* Robert Berenson, *Addressing Pricing Power in Integrated Delivery: The Limits of Antitrust*, 40 J. HEALTH POL., POL'Y & L. 709, 709–10 (2015).

8. *See* Erin C. Fuse Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL'Y 11, 57 (2014).

9. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj (2016).

10. S*ee* Andrew J. Barnes et al., *Accountable Care Organizations in the USA: Types, Developments and Challenges*, 118 HEALTH POL. 1, 2 (2014). For a further discussion of ACOs, see *infra* Part I.

higher quality care.[11] However, at the same time, the statutory requirements that govern Medicare Shared Savings Program Accountable Care Organizations ("MSSP ACOs") not only encourage, but in some respects, arguably require consolidation among providers.[12] Thus, while the MSSP has the potential to shift the U.S. health care system toward more cost-efficient and patient-centered care, it simultaneously threatens to spur consolidation and further aggravate the problem of provider market power.[13]

The Centers for Medicare and Medicaid Services ("CMS"),[14] the administrative agency that oversees the MSSP and other Medicare programs, has at least acknowledged the potential for the MSSP to advance problematic market power.[15] For example, within a set of regulatory amendments to the MSSP in 2011, CMS noted that "the consolidation of providers to form ACOs could have a significant impact on the commercial market," and that hospitals may "use any market power they have to . . . obtain higher rates."[16] However, the resulting regulations have done little to nothing to prevent or discourage provider consolidation in the formation of MSSP ACOs and, moreover, have not done nearly enough to mitigate the potential to exercise market power once acquired.[17] As opposed to instituting regulatory controls within the MSSP, CMS instead deferred and entrusted this issue to federal antitrust enforcement.[18] To be sure, the Antitrust Division of the U.S. Department of Justice ("DOJ") and the Federal Trade Commission ("FTC") (collectively "Antitrust Agencies") have provided useful guidance outlining their antitrust review process, including specific safe harbors[19] and details on what might trigger a more in-depth review.[20] Yet, the problem with solely relying on this approach is that the efforts of the Antitrust Agencies to address consolidation and pricing power in the context of ACOs are inherently limited by the resource and fact-

11. *See* Barnes et al., *supra* note 10.

12. *See* 42 U.S.C. § 1395jjj(b)(2)(D) (2016) (requiring that prospective ACOs have at least 5000 beneficiaries to be eligible to participate in the MSSP); *see also* Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 35 (2014).

13. *See* Greaney, *supra* note 12, at 22.

14. The CMS was created to administer the Medicare Program and the federal portion of the Medicaid Program. CMS is also responsible for administering the State Children's Health Insurance Program ("SCHIP"), the Health Insurance Portability and Accountability Act ("HIPAA"), and several other health-related programs.

15. Medicare Shared Savings Program, 76 Fed. Reg. 67,802, 67,841–43 (Nov. 2, 2011) (discussing commentator concerns over consolidation and market power encouraged by the MSSP).

16. *Id.* at 67,843.

17. *See* Medicare Shared Savings Program, 42 C.F.R. § 425 (2016).

18. *See* Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67,026 (Oct. 28, 2011) [hereinafter Statement of Antitrust Enforcement Policy].

19. *Id.* at 67,032.

20. *Id.*

intensive nature of antitrust analysis, as well as the narrow scope of remedies available where anticompetitive conduct is found.[21] In other words, even though providers forming an ACO might have a number of compelling justifications to consolidate—and thus, to survive antitrust scrutiny—the resulting entity might, nonetheless, end up in a position to later raise prices legitimately, or in a way that is difficult for antitrust remedies to counteract.[22]

Consequently, while antitrust enforcement and policy should continue to play a significant role, it should not be the only, or even primary, mode of addressing the consolidation and pricing power associated with the formation of ACOs. Rather, this Note argues that there is a need for increased vigilance on the part of CMS in regulating the entry and ongoing behavior of ACOs participating in the MSSP. Considering the experimental nature of ACOs and the promise they have demonstrated thus far, it is important to emphasize that, to the extent possible, additional regulations should not be so overly prescriptive as to chill MSSP participation. Instead, new regulations should focus on establishing protections that prevent the exercise of pricing power and streamline the antitrust review process whenever necessary. Given the success and growth of the MSSP in just three years,[23] CMS could leverage eligibility to participate on a number of mandatory disclosures and agreements that aim to mitigate the potential harms of exercising market power. In doing so, CMS and the Antitrust Agencies could better synergize their regulatory and enforcement schemes to strike the appropriate balance between the rigidity of mandatory antitrust review and the impracticality of an unused system of voluntary review. Antitrust enforcement alone remains an inadequate solution to the problem of provider market power. Accordingly, these additional regulatory efforts will be necessary to promote competition and, at the very least, mitigate and contain the anticompetitive effects of health care market consolidation under the MSSP.

Part I of this Note provides a brief overview of the origins, structure, results, and prospects of ACOs under the MSSP. Part II introduces the problems associated with provider market power in the health care industry and relates these issues to the implementation of the MSSP. It then discusses the effectiveness and limitations of the Antitrust Agencies in addressing the competitive consequences of provider consolidation associated with ACO formation. Part III recommends modifications to

21. *See* Greaney, *supra* note 12, at 38 n.159.

22. As discussed below in Part II.B, the increase in a firm's scale following a merger may result in cost-saving efficiencies the Antitrust Agencies must consider in reviewing the transaction's overall anticompetitive potential. *See* Berenson, *supra* note 7, at 720.

23. *Growth and Dispersion of Accountable Care Organizations in 2015*, HEALTH AFF. BLOG (Mar. 31, 2015), http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/.

the current MSSP regulatory scheme that focus on leveraging eligibility to participate on producing mandatory disclosure and agreements that would mitigate the potential harms of ACO provider pricing power.

I. Accountable Care Organizations

This Part provides a general overview of ACOs. First, it explains the concept of ACOs, why they were developed, and how they differ from similar models of integrated health care delivery. Second, it discusses how ACOs are structured and operate in the MSSP. Third, it surveys current empirical data available on the success of ACOs and notes several key criticisms and challenges the ACO model faces.

A. ACOs: Theory and Origins

The concept of the ACO originated largely in response to the findings of Professor Elliot S. Fisher and a team of researchers through the Dartmouth Atlas of Health Care project.[24] Published in 2003, a study by the Dartmouth researchers documented wide geographic variations in health care spending and outcomes across the United States throughout the early 1990s.[25] Significantly, because this study was based on Medicare spending in which prices are fixed, and because it was able to rule out other potentially substantial factors such as population health, patient preferences, or the cost of malpractice,[26] the Dartmouth project found that these deviations were instead the result of differences in supply-sensitive care utilization and practice style.[27] What is more, the study established that this greater volume of care, and thus higher Medicare spending, was associated with neither improved health outcomes nor increased access to health care services.[28] Accordingly, the Dartmouth researchers concluded that by reducing discretionary geographic

24. *See generally* Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care*, 138 Annals Internal Med. 273 (2003) [hereinafter Fisher et al., *Regional Variations Part 1*] (determining if regions with enhanced Medicare spending provide better care); Elliott S. Fisher et al., *The Implications of Regional Variations in Medicare Spending. Part 2: Health Outcomes and Satisfaction with Care*, 138 Annals Internal Med. 288 (2003) [hereinafter Fisher et al., *Regional Variations Part 2*] (determining if regions with enhanced Medicare spending achieve better survival, functioning, and patient satisfaction).

25. Fisher et al., *Regional Variations Part 1*, *supra* note 24; Fisher et al., *Regional Variations Part 2*, *supra* note 24.

26. Differences in the malpractice environment account for less than ten percent of state variations in spending. *See* Fisher et al., *Regional Variations Part 1*, *supra* note 24, at 285–86.

27. Supply-sensitive care is a category of discretionary care that varies with a populations per capita supply of health care resources. In other words, the Dartmouth study showed that where there were more hospital beds per capita, patients in higher spending regions were hospitalized more frequently, and that where there were more intensive care unit ("ICU") beds or computed tomography ("CT") scanners available, more patients would be cared for in the ICU or receive CT scans. *Id.* at 286.

28. *Id.* at 273.

variations in the volume of services provided, the United States could cut Medicare spending by approximately thirty percent without adversely impacting health outcomes.[29]

Responding to these findings, the Dartmouth researchers formulated an organizational model intended to restructure the delivery of health care, as well as shift financial incentives in a way that would move high-spending geographic regions toward the practices of more cost-efficient ones.[30] The embodiment of this vision was the ACO, a term coined by Professor Fisher at a public meeting of the Medicare Payment Advisory Commission ("MedPAC") in 2006.[31] While providers may form either public or private ACOs, the basic construct envisions a local entity consisting of a set of health care providers, including primary care physicians, specialists, and hospitals, that are "accountable for the cost and quality of the entire continuum of care delivered to a defined population."[32] Private ACOs can take on manifold organizational and operational structures, and are outside the scope of this Note.[33] In comparison, most public ACOs are structured and governed under the framework of the MSSP, as discussed below in Part I.B.[34]

The general concept of an MSSP ACO is perhaps best illustrated by a comparison to Health Management Organizations ("HMOs"), in that they offer a network of providers, who will have financial incentives to economize on care.[35] There are, however, significant differences between MSSP ACOs and HMOs.[36] First, providers, not insurers, control MSSP ACOs, and beneficiaries can go to providers outside of their networks.[37] Second, providers in MSSP ACOs do not bear nearly as much financial risk as providers in HMOs, who carry as much as 100% of the risk if

29. *Id.*

30. *See generally* Transcript of Public Meeting of the Medicare Payment Advisory Commission (Nov. 8, 2006).

31. *See id.* at 326; *see also* Elliott S. Fisher et al., *Creating Accountable Care Organizations: The Extended Hospital Medical Staff*, 26 HEALTH AFF. w44 (2007).

32. *See* Greaney, *supra* note 12, at 6.

33. For a discussion of the various structures of private ACOs, see Valerie A. Lewis et al., *ACO Contracting with Private and Public Payers: A Baseline Comparative Analysis*, 20 AM. J. MANAGED CARE 1008, 1009 (2014).

34. *See infra* Part I.B. The other less prevalent ACO models include: (1) the Pioneer ACO Model; (2) the Advance Payment ACO Model; and (3) the Next-Generation ACO Model. For more information on these models, see *Innovation Models*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives (last visited Apr. 8, 2016).

35. HMOs are a type of managed care organization ("MCO") that emerged in the United States in the 1980s with the goal of lowering costs while improving quality. The basic structure consisted of integrating the insuring of patients with managing the provision of health care to those patients. The HMO model has faced criticisms for the reimbursement and management frameworks which exacted a large degree of control over physician autonomy and placed much of the financial risk on physicians. *See* Barnes et al., *supra* note 10, at 4.

36. *See* Barnes et al., *supra* note 10, at 4–6; *see also* Greaney, *supra* note 12, at 5–7.

37. *See* Greaney, *supra* note 12, at 5–7.

under global capitation arrangements.[38] Third, MSSP ACOs consist of groups of providers who are directly incentivized through financial rewards to improve performance, as opposed to HMOs where providers are mandated to perform a specific way and share a portion of savings with the HMO.[39] Finally, MSSP ACOs are more truly integrated, operating around shared electronic records, health care guidelines, quality metrics, and pricing information in a manner that is rare among HMOs.[40] As a result, MSSP ACOs have an increased emphasis on incentivizing providers to coordinate care and work toward measurable outcomes.[41] Through emphasizing primary care, integrating delivery systems, pooling resources, and coordinating care, the MSSP ACO model thus aims to realize care that is not only more efficient and cost-effective, but also of better quality.

However, while attractive in theory, implementation of the MSSP ACO model has met resistance and implicates a number of practical challenges.[42] For example, ACO participants, for the most part, continue to be paid on a fee-for-service basis, meaning conflicts of interests might arise where hospitals own and operate an ACO.[43] For example, notwithstanding the potential for shared savings, successful ACOs save money by reducing unnecessary care, which means that hospitals may stand to lose revenue when ACOs succeed.[44] Similar concerns arise with respect to high-earning specialists who have far more compelling incentives to maintain high volumes (and incomes), than do, for example, primary care physicians who use less sophisticated and much less expensive technology.[45] Furthermore, the financial and clinical integration of diverse groups of entities consisting of physicians in various specialties raises the question of how to fairly redistribute shared savings earnings in a manner that can reasonably incentivize a range of health care providers in a given ACO.[46] Policy experts have also posited that providers' main purpose in forming ACOs might not be to achieve shared savings at all,

38. *See* Barnes et al., *supra* note 10, at 5.

39. *Id.*

40. *Id.*

41. *Id.*

42. Fisher et al., *supra* note 31, at w45. *See generally* Wasif Ali Khan, *Accountable Care Organizations: A Response to Critical Voices*, 14 DEPAUL J. HEALTH CARE L. 309 (2012) (arguing that despite challenging criticisms, MSSP and CMS-sanctioned ACOs can be successful).

43. *See* Farzad Mostashari, *Health Reform and Physician-Led Accountable Care: The Paradox of Primary Care Physician Leadership*, 311 JAMA 1855, 1855 (2014) (explaining that although hospital-based ACOs also receive shared savings for reducing unnecessary care, those cost reductions are lost revenue for the hospital).

44. *Id.*

45. Jeff Goldsmith, *Accountable Care Organizations: The Case for Flexible Partnerships Between Health Plans and Providers*, 30 HEALTH AFF. 32, 33 (2011).

46. *See id.* at 35 (noting that the ability to redistribute incomes within physician communities was "a challenge that doomed many provider-sponsored managed care efforts in the past"); *see also* Greaney, *supra* note 12, at 9–10.

but to consolidate and strengthen market power to raise prices.[47] Moreover, even where market power is not the primary motivation for a new ACO, it can easily become a difficult to reverse by-product of otherwise procompetitive consolidation permitted between large providers.[48]

While these are real concerns, proponents of the ACO model stress that these obstacles are surmountable and should not preclude the organizations from realizing their potential benefits.[49] For example, Francis J. Crosson, M.D., a senior fellow at the Kaiser Permanente Institute for Health Policy, contends that the ACO concept is "too vitally important to fail"—that the model remains the last best hope for a market-driven rationalization of our health care system.[50] If the misaligned incentives in health care do not change, Dr. Crosson and other health policy analysts warn, payers will likely be forced into systematic reductions in payment rates to providers. In response, under the current fee-for-service environment, providers would likely seek to balance these lower rates by increasing their output of services.[51] Thus, it is perhaps "in our common interest" to see that ACOs succeed and deliver on their promise of better care at a lower cost.[52] The next Subpart discusses in depth how ACOs are formed, structured, and operated under the MSSP to achieve these goals.

B. THE MEDICARE MODEL: ACOS UNDER THE MSSP

The MSSP, authorized under the ACA, establishes a statutory framework to test and promote the formation of ACOs serving defined populations of Medicare fee-for-service beneficiaries.[53] In exchange for reducing medical costs and maintaining quality of care at or beyond standards specified by CMS, MSSP ACO providers and suppliers receive a percentage share of any cost savings to Medicare.[54] The goal is that these "shared savings" will incentivize and encourage providers to

47. *See* Clark C. Havighurst & Barak D. Richman, *The Provider Monopoly Problem in Health Care*, 89 OR. L. REV. 847, 872 (2011).

48. *See* Berenson, *supra* note 7, at 720.

49. Francis J. Crosson, *The Accountable Care Organization: Whatever Its Growing Pains, the Concept Is Too Vitally Important to Fail*, 30 HEALTH AFF. 1250, 1253 (2011).

50. *Id.* at 1250.

51. Greaney, *supra* note 12, at 10.

52. Crosson, *supra* note 49, at 1254.

53. BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS, AND PROBLEMS 802–03 (7th ed. 2013). Medicare beneficiaries are "attributed" to the primary care physician from whom they receive most of their primary care services and assigned to that physician's ACO. *Id.* at 803. It is also worth noting that a beneficiary is not restricted from receiving health benefits from providers outside the ACO to which she is assigned. *See* 42 C.F.R. § 425.402 (2016) ("Basic Beneficiary Assignment Methodology"); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS., SHARED SAVINGS AND LOSSES AND ASSIGNMENT METHODOLOGY SPECIFICATIONS 12 (2015).

54. Medicare Shared Savings Program, 42 U.S.C. § 1395jjj(d)(2) (2016).

implement various service delivery reforms, including the effectuation of evidence-based medicine, shared electronic health records, joint governance and decisionmaking, and the coordination of care.[55] As discussed below, while participating ACOs share some core requirements, the resulting entities can look very different both in structure and organization.

In a broad sense, the MSSP requires participating ACOs to promote accountability, encourage investment in infrastructure, coordinate the provision of services, and redesign care processes for high quality and cost-efficient service delivery.[56] Accordingly, the MSSP establishes a number of eligibility requirements, including that ACOs have: (1) at least 5000 Medicare fee-for-service beneficiaries and sufficient primary care physicians for the number of beneficiaries; (2) a formal legal structure that would allow the ACO to receive and distribute payments for shared savings; (3) a leadership and management structure that includes clinical and administrative systems; and (4) processes to promote evidence-based medicine, report on quality and cost measures, and coordinate care.[57] These criteria—particularly the minimum beneficiary and reporting requirements—suggest that the MSSP favors larger, more complex providers such as hospitals.[58] Unless partnering with a hospital, small to mid-size practices such as a group of physicians would have to make significant investments to develop the infrastructure necessary to qualify for the MSSP.

However, despite the fixed eligibility requirements, there is some flexibility as to how MSSP ACOs may organize themselves in terms of membership, legal structure, and governance. First, so long as it satisfies the eligibility prerequisites, the MSSP ACO may consist of any number and assortment of provider participants, including hospitals, physicians, or specialty groups.[59] For example, the MSSP ACO may be an entire regional hospital system that owns all participating hospitals and physician practices, an integrated delivery network that also owns health plans, or a joint venture arrangement between hospitals and physician practice groups.[60] Alternatively, an MSSP ACO might take the form of a single independent medical practice association of physicians or a multi-specialty group practice that owns no hospitals at all.[61] Second, an MSSP ACO's legal entity may be structured a variety of ways, including as a

55. *See* FURROW ET AL., *supra* note 53, at 803.

56. Medicare Shared Savings Program § 1395jjj(a)(1).

57. *Id.* § (b)(2).

58. *See* Christopher Bays, *Scenario Analysis for ACOs and Antitrust* 23 (Seton Hall L., Working Paper No. 151, 2012).

59. *See* Medicare Shared Savings Program § 1395jjj.

60. *See* Benjamin Holland Able, *The Stark Physician Self-Referral Law and Accountable Care Organizations: Collision Course or Opportunity to Reconcile Federal Anti-Abuse and Cost-Saving Legislation?*, 26 J.L. & HEALTH 315, 318–20 (2013).

61. *Id.* at 318–19.

corporation, foundation, partnership, or any other form permitted by state law.[62] Lastly, the MSSP requires that the ACO formed establish a separate legal entity with a unique tax identification number ("TIN") and a governing body of its own.[63] Participants of an ACO must control at least seventy-five percent of that governing body, including at least one Medicare beneficiary that does not have a conflict of interest with the ACO.[64]

Finally, MSSP ACOs may choose between three risk models of potential gain sharing and loss, where the more downside risk an ACO is willing to take on, the higher the maximum percentage of shared savings it can potentially earn.[65] In the one-sided model ("Track One"), ACOs bear no financial risk, but are only eligible to receive up to fifty percent of total shared savings.[66] By contrast, ACOs participating in Track Two share in up to sixty percent of any savings or losses realized, and those in Track Three share the most financial risk at up to seventy-five percent of losses or savings.[67] CMS determines the total amount of savings an ACO will actually retain based on a combination of factors. First, CMS calculates the shared savings or losses relative to a benchmark estimating the total fee-for-service expenditures beneficiaries would have paid in the absence of the ACO.[68] Second, it determines the percentage of shared savings in each track based on the ACO's performance on thirty-three quality metrics.[69] Lastly, CMS adjusts for the relevant minimum and maximum savings or loss rates—percentages of the benchmark an ACO's savings or losses must exceed to begin qualifying as savings or loss.[70] Thus far, the overwhelming majority of MSSP ACOs have been reluctant to take on financial risk, and consequently, most opted for and remain in the one-sided risk model.[71] The next Subpart surveys data on how these ACOs have fared in operating under the MSSP thus far.

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62. *Id.* at 318.

63. *See* Medicare Shared Savings Program, 42 C.F.R. § 425.104(b) (2016) ("An ACO formed by two or more ACO participants, each of which is identified by a unique TIN, must be a legal entity separate from any of its ACO participants."). *But see id.* § 425.104(c) ("An ACO formed by a single ACO participant may use its existing legal entity and governing body, provided it satisfies the other requirements in §§ 425.104 and 425.106.").

64. *See id.* § 425.106(c)(1)–(3).

65. *See id.*

66. *Id.* § 425.604(d).

67. *Id.* §§ 425.606(d), 425.604(d).

68. *Id.* §§ 425.604(d), 425.606(d), 425.610(d) (outlining how to calculate shared savings in each respective track).

69. *Id.*

70. *Id.*

71. CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE SHARED SAVINGS PROGRAM 2013 QUALITY RESULTS (Sept. 23, 2014), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-PY1-Quality-Performance.pdf.

C. MSSP Results and Prospects for Success

While the performance of MSSP ACOs throughout the first two years of the program is promising, the results have been mixed.[72] Of the 220 MSSP ACOs that participated in 2013, most operated under Track One, with fifty-eight (twenty-six percent) being able to reduce spending enough to qualify for a total shared savings of $315 million.[73] Roughly another fifty ACOs reduced spending compared to their benchmarks, but not enough to qualify for shared savings.[74] Of the few MSSP ACOs that opted for Track Two, one exceeded its benchmark by $10 million and owed shared losses of $4 million back to CMS.[75] Two others, however, each saved Medicare $20 million and $8.5 million, pocketing $12 million and $5 million, respectively.[76] Collectively, MSSP ACOs were able to reduce spending by $705 million below their financial benchmarks and, accounting for any losses, saved the Medicare Trust Fund $383 million.[77] As for quality performance, MSSP ACOs were able to improve in twenty-seven of thirty-three quality measures compared to fee-for-service Medicare.[78]

In 2014, 333 ACOs participated in the program, with all but three ACOs operating under the Track One model.[79] Of these 333 ACOs, ninety-two contained spending at $806 million below their targets, earning shared savings payments of more than $341 million.[80] Additionally, no Track Two ACOs owed CMS losses in 2014, and in total, the MSSP saved the Medicare Trust Fund a net $465 million.[81] No ACOs are currently participating in Track Three, which was finalized in the August 2015 regulations[82] and only became available for MSSP contract years beginning in 2016.

These early results can either be promising or disappointing, depending on one's perspective.[83] On the one hand, about a quarter of

72. *See* Ctrs. for Medicare & Medicaid Servs., Medicare Shared Savings Program Performance Year 1 Results (Sept. 23, 2014), http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/MSSP-PY1-Final-Performance-ACO.pdf; *see also* Ctrs. for Medicare & Medicaid Servs., *supra* note 71.

73. Ctrs. for Medicare & Medicaid Servs., *Medicare ACOs Provide Improved Care While Slowing Cost Growth in 2014* (Aug. 25, 2015), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html.

74. *Id.*

75. *Id.*

76. *See* Ctrs. for Medicare & Medicaid Servs., *supra* note 72.

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. Medicare Shared Savings Program, 42 C.F.R. § 425 (2015).

83. Scott Heiser et al., *Unpacking the Medicare Shared Savings Proposed Rule: Geography and Policy*, Health Aff. Blog (Jan. 22, 2015), http://healthaffairs.org/blog/2015/01/22/unpacking-the-medicare-shared-savings-proposed-rule-geography-and-policy/.

participating ACOs in 2013 achieved shared savings in their first year, reducing the overall cost of care for MSSP ACO beneficiaries by approximately one percent.[84] And on an especially positive note, the 2014 results reflected that ACOs with more experience in the program are much more likely to generate shared savings, suggesting that increased success under MSSP programs may only be a matter of time.[85] On the other hand, approximately three-quarters of participating ACOs either failed to lower spending or did not exceed the minimum savings rate, and failure to meet quality reporting requirements resulted in ACOs leaving millions in shared savings on the table.[86] To put this into perspective, under the more rigorous quality benchmark standards that will take effect in Year Three of the program, CMS would have withheld an additional $71.1 million of the shared savings distributed in 2013.[87] Thus, while MSSP ACOs generally did well above average for quality, they stand to lose a significant portion of their expected shared savings if providers do not make significant improvements in cost and quality performance. Considering that mandatory transition from one-sided to two-sided risk models, the sustainability of the entire program could be at risk if long-term financial success remains an uncertainty for prospective participants.[88]

Another looming concern is whether CMS can strike a balance between serving its reform goals of lower costs and higher quality health care in the Medicare program while also preventing anticompetitive spillover into the private sector such as cost shifting.[89] While there are shared common interests in promoting higher quality care at lower costs, the regulatory mission of CMS is centered on advancing the goals of Medicare, and it is at least questionable whether the MSSP will go out of its way to protect the interest of the private market.[90] More specifically, MSSP ACOs rely upon administrative pricing and command regulation to control costs, and can be regulated with little concern over promoting provider competition.[91] As a result, in a market where providers are consolidating and aggregating excess market power in the form of ACOs, it makes good economic sense that dominant providers with extant market power might raise prices for private payers to account for lower

84. Mark McClellan et al., *Early Evidence on Medicare ACOs and Next Steps for the Medicare ACO Program*, HEALTH AFF. BLOG (Jan. 22, 2015), http://healthaffairs.org/blog/2015/01/22/early-evidence-on-medicare-acos-and-next-steps-for-the-medicare-aco-program/.

85. *Id.*

86. *Id.*

87. David Muhlestein & Chase Hall, *ACO Quality Results: Good but Not Great*, HEALTH AFF. BLOG (Dec. 18, 2014), http://healthaffairs.org/blog/2014/12/18/aco-quality-results-good-but-not-great/.

88. 42 C.F.R. § 425.600(b) (2016) ("ACOs may operate under the one-sided model for a maximum of two agreement periods.").

89. Greaney, *supra* note 12, at 15.

90. *Id.* at 17.

91. *Id.*

reimbursements under Medicare programs.[92] As discussed below, competition policy surrounding MSSP ACOs has done little to account for the risks and implications of facilitating market consolidation. Although the shared savings model offers a promising transition from traditional fee-for-service to value-based reimbursements that incentivize efficiency and quality care, this transformation might prove detrimental if regulators fail to aggressively prevent or at the least address and mitigate increasing provider market power.

II. ACOs, Antitrust, and Competition Policy

While aggregation does not generally equal accountability, success under the MSSP ACO model is to some extent premised on the size and scale of participating organizations. ACOs must be sufficiently large to efficiently provide the entire continuum of care to a population; they need to have the structural framework and capital resources to build infrastructure and make the investments necessary to achieve integration; and they need to administer collaborative care that implements evidence-based medicine, electronic health records, and quality metrics, all of which must be measured and analyzed to assess past performance and set future goals. In other words, the MSSP presupposes at least some degree of provider consolidation in achieving its vision of integrated and coordinated care.[93]

Accordingly, although Congress enacted the MSSP to promote efficiency and other benefits of vertical integration for Medicare and its beneficiaries, the program raises serious antitrust concerns in that it facilitates horizontal integration between competitors, thus perpetuating increased concentrations of provider market power.[94] Where providers have market power and face less competition, they can and do charge substantially higher prices, regardless of whether they are not-for-profit. These increased prices are generally passed off to consumers in the form of higher insurance premiums, increased cost sharing, and overall reductions in compensation for those with employer health benefit plans.[95] Furthermore, while Medicare administratively sets public health prices and generally is not susceptible to pressure from market power, most MSSP ACOs consist of providers that operate in both the public and the private market. In other words, if provider consolidation among large MSSP ACO participants is left unchecked, the market power of the resulting entity could allow it to raise prices in the private sector that counteract and overwhelm the goal of reducing costs under the MSSP.

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92. *See id.* at 18–19.

93. *See* Havighurst & Richman, *supra* note 47, at 871–72.

94. *See id.* at 872.

95. Martin Gaynor, *Competition Policy in Healthcare Markets: Navigating the Enforcement and Policy Maze*, 33 Health Aff. 1088, 1090 (2014).

This Part introduces antitrust concerns surrounding provider consolidation in the health care industry and discusses how the Antitrust Agencies have approached health care antitrust enforcement. First, it discusses the problems of excess market power and how it can lead to anticompetitive behavior such as supracompetitive pricing and collusion. It then provides an overview and analysis of how both the courts and the Antitrust Agencies have treated health care consolidation, concluding that antitrust regulation should not be the only, nor the primary, tool in curtailing consolidation under the MSSP.

A. Antitrust Concerns: Market Power, Collusion, and Unfair Competition

This Subpart introduces the problems associated with provider consolidation and market power in the health care industry and relates these issues to the implementation of the MSSP. First, it provides a background on the direct relationship between provider market power and health care prices, explaining how the MSSP could potentially contribute to the problem and impact the private sector. It then highlights the risks that come with direct competitors exchanging large quantities of information on a regular basis, including potentially anticompetitive behavior such as collusion and price fixing.

1. Provider Consolidation and Market Power

Provider consolidation and market power pose the biggest obstacles to the success of the MSSP. Over the past several decades, providers have substantially increased hospital concentration, leaving the vast majority of Americans subject to monopoly power in their local hospital markets.[96] According to studies by health economists William Vogt and Robert Town, there is a strong correlation between hospital market concentration and the growing costs of health insurance, with hospital consolidation in the 1990s being responsible for inpatient price increases of at least five and as much as forty percent or more where nearby hospitals merged.[97] In a more recent study, the Massachusetts Attorney General documented the effects of provider leverage on health care costs and insurance premiums, finding that "wide disparities in prices are not explained by differences in quality [or] complexity of services . . . [but] instead . . . reflect relative market leverage of health insurers and health

96. Barak D. Richman, Am. Enterprise Inst., Beyond Repeal and Replace: Concentration in Health Care Markets: Chronic Problems and Better Solutions 9 (2012).

97. *See* Claudia H. Williams et al., Synthesis Project, How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?, 1, 4 (2006); *see also* Greaney, *supra* note 12, at 20.

providers."[98] Such increased concentrations of market power translate to excess bargaining power, enabling dominant providers to raise prices or reduce quality and innovation without consequence.[99]

Because MSSP ACOs might well encourage some mergers, joint ventures, and alliances that otherwise might not take place, they can exacerbate the problem of market concentration and reduce competition.[100] This dynamic is made worse by the fact that large hospitals have so far been the dominant providers in the formation of many MSSP ACOs.[101] For example, in 2013, CMS approved for MSSP participation an integrated physician organization in Houston, Texas that included two previously independent hospitals, establishing an ACO with a thirty-four percent share of the local inpatient market.[102] Often deemed "must-have providers," these large hospitals carry additional leverage against health insurers in that consumers will refuse to purchase insurance plans that do not include them within their network.[103] With ACOs thus far being dominated by large hospitals, "the likely result will be a concentration of power not in the most efficient and highest quality health care organizations, but in the largest—simply because they control large segments of the market share."[104]

At the same time, the unique characteristics of health care markets place dominant providers in an even stronger bargaining position to markup health care prices, practically eliminating any constraints on pricing that might ordinarily be tied to consumers' willingness or ability to pay.[105] Even in the absence of monopoly, the combination of health insurance and a lack in price transparency enables and encourages consumers and providers to overspend on costly health care by shielding them from and largely removing the immediate cost factor from treatment decisions that are paid for by insurers.[106] To add to this, for legal and regulatory reasons, health insurers in the United States must typically reimburse whatever service is deemed "medically necessary"

98. MASS. ATT'Y GEN., EXAMINATION OF HEALTH CARE COST TRENDS AND COST DRIVERS PURSUANT TO G.L. C. 118G, § 6½ (B) (2011).

99. *See* Havighurst & Richman, *supra* note 47, at 871–72.

100. Thomas L. Greaney, *Accountable Care Organizations—The Fork in the Road*, 364 NEW ENG. J. MED., at e1(1), e1(2) (2011).

101. Shaun E. Werbelow, Note, *Rule of Reason Without a Rhyme: Using "Big Data" to Better Analyze Accountable Care Organizations Under the Medicare Shared Savings Program*, 90 N.Y.U. L. REV. 361, 380 (2015).

102. *See* Christopher Lloyd, *Moving Ahead with Memorial Hermann ACO and Beyond*, MEMORIAL HERMANN PHYSICIAN NETWORK NEWSLINK, Winter 2013, at 1; *see also* Werbelow, *supra* note 101, at 379.

103. Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 973 (2012).

104. Rita E. Numerof, *Why Accountable Care Organizations Won't Deliver Better Health Care—and Market Innovation Will*, BACKGROUNDER, Apr. 18, 2011, at 2.

105. *See* Havighurst & Richman, *supra* note 47, at 862.

106. *Id.*

and "cannot refuse to pay the high prices imposed by health care organizations, even when the price exceeds the likely value of the service to the patient."[107] Indeed, due to confidentiality clauses and "gag clauses" in provider insurer contracts, these prices are seldom disclosed to the public, individual patients, or even the physicians that refer or provide the health care services, and are often protected as trade secrets.[108]

Although increases in pricing power might not impact Medicare's negotiated rates directly, they will have serious implications for the private market. Because CMS dictates its own reimbursement rates to doctors and hospitals, MSSP ACOs cannot exert market power by simply raising Medicare prices. Medicare's rates notwithstanding, most ACOs are expected to operate in both the public and private market. As a result, even if MSSP ACO providers are unable to use their market power to increase prices for reimbursements to Medicare, there remains a legitimate concern that they will then be able to shift costs to private non-Medicare health insurance plans, and indeed, even be rewarded in the form of shared savings.[109] Moreover, Medicare is not without a stake in these outcomes, as private market competition can have significant impacts on Medicare programs, the MSSP included.[110] To be sure, in a study on the effect of provider concentration on Medicare payments, MedPAC found that high hospital margins on private payer patients lead to more construction and higher hospital costs, and that "when non-Medicare margins are high, hospitals face less pressure to constrain costs."[111] MedPAC concluded that this association explains why hospital Medicare margins tend to be low in the most concentrated markets, while margins are higher where competition is greater.[112] In addition, low Medicare margins resulting from exercises of market power by dominant providers may lead to higher Medicare costs because updates to hospital administered pricing under prospective payment are sensitive to these margins.[113] Ultimately, if the risks of provider consolidation and market concentration—justified under the auspices of the MSSP—are not adequately addressed, they could undermine the very crux of the

107. *See* Barak D. Richman & Kevin A. Schulman, *A Cautious Path Forward on Accountable Care Organizations*, 305 JAMA 602, 602 (2011).

108. *See* Morgan A. Muir et al., *Clarifying Costs: Can Increased Price Transparency Reduce Healthcare Spending?*, 4 WM. & MARY POL'Y REV. 319, 327 (2013).

109. *See* Havighurst & Richman, *supra* note 47, at 875.

110. *See* Thomas L. Greaney, *Medicare Advantage, Accountable Care Organizations, and Traditional Medicare: Synchronization or Collision?* 15 YALE J. HEALTH POL'Y L. & ETHICS 37 (2014); *see also* MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: ASSESSING ALTERNATIVES TO THE SUSTAINABLE GROWTH RATE SYSTEM, at xiv, 93–94 (2014).

111. *See* Greaney, *supra* note 110, at 53; *see also* MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 110.

112. *See* Greaney, *supra* note 110; *see also* MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 110.

113. *See* Greaney, *supra* note 110, at 54; *see also* MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 110.

program and in turn, reduce or eliminate competitive incentives to increase access and quality and lower costs.[114]

2. *Horizontal Price Fixing and Collusion*

The consolidation of providers into ACOs also increases the risks of horizontal price fixing, which "result[s] when competitors selling the same products or services in the same or overlapping geographic markets, agree, either directly or through a common agent negotiating on their behalf, on the prices they will charge for their products or services."[115] The risk of horizontal price fixing and other forms of collusion is especially prominent among ACOs, which by definition are encouraged to integrate, collaborate, and share information that might include prices.[116] Because ACOs are typically comprised of otherwise independent competing providers, encouraging this collaboration might incentivize and allow providers to fix prices when negotiating contracts with commercial health plans.[117] Although CMS administratively sets provider reimbursement rates for Medicare beneficiaries, most MSSP ACOs are expected to operate in both public and private markets, and thus, even those ACOs participating in the MSSP can present a heightened risk of horizontal price fixing and price collusion.[118]

Considering that price fixing arrangements and other forms of collusion implicated by the MSSP are per se illegal under the Sherman Act,[119] some might argue that existing antitrust laws are sufficient to deter ACOs from engaging in this behavior.[120] As discussed below in Part II.B, however, current antitrust enforcement policy might allow for price fixing in ACO arrangements, provided that network integration results in net efficiencies and that the price agreements are necessary to achieve those efficiencies.[121] Additionally, even if ACO providers do not engage in express horizontal price fixing, they may nonetheless negotiate jointly

114. *See* Greaney, *supra* note 12, at 22.

115. Patricia M. Bruns, *An Antitrust Analysis of Accountable Care Organizations: Potential Abuses from Allowing Reduced Scrutiny Under the Affordable Care Act*, 28 J. CONTEMP. HEALTH L. & POL'Y 268, 271 (2012).

116. Bruns, *supra* note 115, at 271; *see also* Werbelow, *supra* note 101, at 375.

117. *See* Bruns, *supra* note 115, at 271.

118. *See* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE 49–52 (1996), http://www.justice.gov/atr/public/guidelines/0000.pdf (discussing antitrust safety zones for provider participation in exchanges of price and cost information).

119. Generally, the Sherman Act prohibits contracts, combinations, and conspiracies which unreasonably restrain competition. Sherman Antitrust Act, 15 U.S.C. § 1 (2016). Under the Sherman Act, certain business practices are considered so inherently anticompetitive that they are presumed "per se illegal" without any additional inquiry as to the actual effect on the market. Alternatively, other matters of concern are reviewed under the "rule of reason" standard which, as discussed *infra* Part II.B.1, requires a more searching analysis that evaluates overall whether a practice is anticompetitive.

120. *See, e.g.*, United States v. Socony-Vacuum Oil Co., 310 U.S. 150, 223 (1940).

121. *See* Bruns, *supra* note 115, at 278.

and collude on prices with private payers.[122] Short of reaching an actual agreement on prices, competing providers within ACOs are well positioned to exchange or disseminate information that either relates to or might affect the prices they charge.[123] For example, ACOs may share pricing and reimbursement surveys of all member provider charges and dealings with health plans, allowing competing providers within the ACO to use this information in negotiations with health plans.[124] ACOs that include multiple hospitals might also foster an environment in which hospitals competing for specific types of employees would be able to exchange information about wages, or in which competing hospitals might exchange cost and price information on goods and services from vendors.[125] Given the ambiguities and related difficulties of current health care antitrust enforcement, such conduct raises similar anticompetitive concerns, but would not be as easily detectable and perhaps not be even permitted under antitrust law.[126]

B. Antitrust Treatment of MSSP ACOs

Many, if not most, provider markets today are characterized by high levels of concentration due to repeated waves of increased merger and acquisition activity stretching over the last thirty years.[127] Some legal analysts have attributed this failure to contain provider consolidation to inconsistency and underenforcement of antitrust law by the federal agencies.[128] With respect to MSSP ACOs, there appears to be at least a slight relaxation of typical antitrust enforcement, likely as a pragmatic effort to avoid chilling provider participation in the program.[129] However, the primary concern with antitrust law might be that it is inherently limited in its ability to alone deal with consolidation and market power in the ACO context. This Subpart analyzes the current enforcement policy guidance available for the MSSP, highlighting the aspects that reflect relaxed antitrust treatment for MSSP ACOs. It then goes on to discuss why it is difficult for antitrust law to address provider consolidation that has already occurred and explains why antitrust law may not be the best approach to prevent and address market power concerns that arise as a result of the MSSP.

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122. *See* Werbelow, *supra* note 101, at 376.

123. John J. Miles, 2 Health Care and Antitrust Law § 15:4 (2015).

124. *Id.*

125. *Id.*

126. Werbelow, *supra* note 101, at 376.

127. *See* Thomas L. Greaney, *The Tangled Web: Integration, Exclusivity, and Market Power in Provider Contracting*, 14 Hous. J. Health L. & Pol'y 59, 62 (2014).

128. *Id.*

129. *Id.* at 60.

1. Antitrust Enforcement Policy

The agencies tasked with enforcing federal antitrust law, the DOJ and the FTC, rely on rule-oriented regulation in their enforcement of health care laws. Through policy statements, negotiated consent decrees, advisory opinions and speeches, these agencies provide business stakeholders guidance to outline and clarify their enforcement approach to investigating particular types of transactions.[130] Yet, in providing this guidance, the agencies tread carefully so as to avoid being overly prescriptive, occasionally resulting in ambiguous and uncertain enforcement policies.[131] As Professor Thomas Greaney has commented, this ambiguity can cut two ways: "it can result in overdeterrence in the sense that providers are reluctant to undertake procompetitive arrangements, or it can cause under-deterrence, meaning providers will form over-inclusive networks that have the power to charge supra competitive prices and inhibit formation of rivalrous networks or ACOs."[132] Current federal health care antitrust enforcement policies and practices suggest that the latter approach seems to be the case thus far, and as this Subpart discusses, the Antitrust Agencies may be affording too much special treatment to MSSP ACOs.

Federal health care antitrust enforcement policy is, for the most part, laid out in the Antitrust Agencies' joint Statements of Antitrust Enforcement Policy in Health Care ("Health Care Statement").[133] In reviewing most health care provider mergers and collaborations, the enforcement agencies consider several threshold questions: (1) Whether the proposed arrangements offer the potential for consumer cost savings or health care quality improvements; (2) Whether providers are seeking to establish a bona fide integration, or merely seeking to enhance leverage with payers through joint negotiation; and (3) Whether any price agreements or other agreements regarding dealing with insurers are reasonably necessary to achieve the efficiencies and other benefits of the arrangement.[134] If the answer to each of these questions is "yes," the arrangement is not considered per se illegal, and instead is evaluated under the "rule of reason" standard, which assesses whether the likely procompetitive effects of the arrangement outweigh the anticompetitive harms.[135] This rule of reason analysis generally follows the same framework outlined in the Antitrust Agencies' joint Horizontal Merger

130. *Id.* at 88–89.

131. *Id.* at 89.

132. *Id.* at 88.

133. U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, *supra* note 118.

134. Deborah L. Feinstein, Dir., Bureau of Competition, Fed. Trade Comm'n, Address at Fifth National Accountable Care Organization Summit—Washington, D.C.: Antitrust Enforcement in Health Care: Proscription, Not Prescription 4 (June 19, 2014).

135. *Id.*

Guidelines,[136] "defining relevant product and geographic markets, identifying market participants, calculating market shares and concentration, considering the likelihood of expansion by existing players or entry by new players, and determining whether efficiencies will likely result."[137]

The Antitrust Agencies relaxed these policies for evaluating health care transactions even further in considering the antitrust implications of MSSP ACOs. The enforcement policies applied specifically to the MSSP are outlined in the Antitrust Agencies joint "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program" ("MSSP Statement").[138] Through this statement, the Agencies attempt to strike a balance between (1) clarifying review procedures and standards to encourage, rather than deter, procompetitive arrangements; and (2) exercising effective oversight over anticompetitive effects, such as consolidation, that might lessen competition in private markets.[139] As stated in a portion of the MSSP Statement:

> The antitrust laws treat naked price-fixing and market-allocation agreements among competitors as per se illegal. Joint price agreements among competing health care providers are evaluated under the rule of reason, however, if the providers are financially or clinically integrated and the agreement is reasonably necessary to accomplish the procompetitive benefits of the integration.[140]

On the issue of clinical integration, the agencies chose to defer to CMS's eligibility criteria, determining that meeting these requirements is largely "consistent with the indicia of clinical integration" set forth in prior antitrust advisory opinions, and that organizations eligible for the MSSP "are reasonably likely to be bona fide arrangements intended to improve the quality and reduce the costs, of providing medical and other health care services."[141] Accordingly, ACOs meeting CMS's standard for participation in the MSSP are presumed to meet the above threshold considerations and are automatically reviewed under the rule of reason standard as opposed to the per se standard of illegality.[142] Furthermore, where ACOs are deemed eligible for the MSSP, joint negotiations with private payers will be treated as reasonably necessary to an ACO's

136. The Horizontal Merger Guidelines are the set of policies published as guidance by the Antitrust Agencies concerning their approach to investigating and reviewing horizontal acquisitions and mergers for antitrust issues. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010).

137. Feinstein, *supra* note 134.

138. Statement of Antitrust Enforcement Policy, *supra* note 18.

139. *See* Greaney, *supra* note 12, at 22.

140. Statement of Antitrust Enforcement Policy, *supra* note 18, at 67,027.

141. *Id.* at 67,027–28.

142. *Id.* at 67,027.

primary purpose of improving health care delivery.[143] Thus, through these statements, the antitrust enforcement agencies afford special relaxed treatment to mergers and collaborations among health care providers to form MSSP ACOs, assuming that once an ACO is formed, such transactions were adequately geared toward—and essential to—legitimate goals of increased efficiency.

The MSSP Statement represents a significant departure from prior agency enforcement policies. Previously, the FTC was responsible for making these sorts of determinations regarding clinical integration on a case-by-case basis.[144] Under the MSSP Statement, however, the decision is largely taken out of the agencies' hands, such that CMS eligibility approval "essentially amounts to an ex ante finding of sufficient integration—and procompetitive justification—to their analysis of commercial markets."[145] By adopting this deferential approach, the enforcement agencies have opted for a more pragmatic standard. While less rigorous, it encourages program participation by dispelling the uncertainty of a multifactor, case-by-case evaluation.[146]

The Enforcement Statement also establishes a "safety zone" for MSSP ACOs consisting of multiple independent participants, including ACOs that plan to operate in the private commercial market.[147] For an MSSP ACO to fall within the safety zone, "independent ACO participants that provide the same service . . . must have a combined share of 30 percent or less of each common service in each participant's [primary service area], wherever two or more ACO participants provide that service to patients from that PSA."[148] A primary service area ("PSA") is defined as "the lowest number of postal zip codes from which the [ACO participant] draws at least 75 percent of its [patients]" and is the metric the Antitrust Agencies uses to define the geographic limits in which market concentration is measured.[149] Additionally, regardless of its PSA, "any hospital or ambulatory surgery center ("ASC") participating in an ACO must be nonexclusive to the ACO to fall within the safety zone."[150] ACOs meeting these requirements are deemed "highly unlikely to raise significant competitive concerns," and except under extraordinary circumstances, the enforcement agencies will not challenge

143. *See* Greaney, *supra* note 12, at 23.

144. Douglas E. Rosenthal et al., *Affordable Care Act Signals New Direction for Antitrust Enforcement in Healthcar*e, BUREAU NAT'L AFF. ANTITRUST & TRADE REG. REP., June 24, 2011, at 5.

145. *Id.*

146. *See* Greaney, *supra* note 12, at 25.

147. Statement of Antitrust Enforcement Policy, *supra* note 18, at 67,032.

148. *Id.* at 67,028.

149. *Id.* The geographic region a PSA defines has no relationship to the "geographic market" defined in a standard antitrust merger review.

150. *Id.* at 67,028–29.

them.[151] Nonetheless, ACOs that fall outside of the safety zone might still be procompetitive and legal.[152]

First, the MSSP Statement describes conduct to avoid regardless of whether PSA shares fall inside or outside the safety zones:

> Regardless of an ACO's PSA shares or other indicia of market power, significant competitive concerns can arise when an ACO's operations lead to price-fixing or other collusion among ACO participants in their sale of competing services outside the ACO. For example, improper exchanges of prices or other competitively sensitive information among competing participants could facilitate collusion and reduce competition in the provision of services outside the ACO, leading to increased prices or reduced quality or availability of health care services. ACOs should refrain from, and implement appropriate firewalls or other safeguards against, conduct that may facilitate collusion among ACO participants in the sale of competing services outside the ACO.[153]

For ACOs with high PSA shares or signs of market power, the Antitrust Agencies identify four types of conduct that may raise anticompetitive concerns because they "may prevent private payers from obtaining lower prices and better quality service for their enrollees."[154] The conduct to avoid includes:

> (1) Preventing or discouraging private payers from directing or incentivizing patients to choose certain providers, including providers that do not participate in the ACO, through "anti-steering," "anti-tiering," "guaranteed inclusion," "most-favored-nation," or similar contractual clauses or provisions.
>
> (2) Tying sales (either explicitly or implicitly through pricing policies) of the ACO's services to the private payer's purchase of other services from providers outside the ACO (and vice versa), including providers affiliated with an ACO participant (for example, an ACO should not require a purchaser to contract with all of the hospitals under common ownership with a hospital that participates in the ACO).
>
> (3) Contracting on an exclusive basis with ACO physicians, hospitals, ASCs, or other providers, thereby preventing or discouraging those providers from contracting with private payers outside the ACO, either individually or through other ACOs or analogous collaborations.
>
> (4) Restricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan, if that information is similar to the cost, quality, efficiency, and performance measures used in the Shared Savings Program.[155]

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151. "Extraordinary circumstances" may include, "for example, ACO participants engaging in collusion or improper exchanges of price information or other competitively sensitive information with respect to their sale of competing services outside the ACO." *Id.* at 67,028 n.24.

152. *Id.* at 67,028.

153. *Id.* at 67,029.

154. *Id.* at 67,030.

155. *Id.*

Overall, stakeholders and commentators view the provisions delineating antitrust safety zones and other high risk behavior as a slight to moderate relaxation of the antitrust laws.[156] Of particular concern is the use of PSA as the primary measure of market power in the safety zones, as the Antitrust Agencies admittedly state that PSA "does not necessarily constitute a relevant antitrust geographic market."[157] As one commentator has warned, this could "inevitably result in unintended consequences not stemming from competitive influences," and that, for example, PSA shares might be sensitive to changes in patient demographics.[158] Furthermore, Thomas Greaney notes that the areas of conduct identified as raising competitive concerns require "notoriously high evidentiary burdens" and that these issues involve unsettled areas of the law that will be even more complicated in the ACO context.[159]

Critics of the MSSP regulatory framework also emphasize that neither the Enforcement Statement nor other existing regulations impose any form of premerger review by the enforcement agencies, and instead, any newly formed ACO seeking additional guidance must voluntarily request expedited review.[160] As a result, antitrust review is relegated to the aftermath of provider consolidation and any anticompetitive effects that result.[161] Considering many anticompetitive effects might not be apparent until well after providers consolidate under the MSSP, participating providers might ultimately enhance their bargaining power with little danger of later being broken up.[162] Overall, current antitrust enforcement policy, as reflected in the MSSP Statement and the regulatory efforts of CMS, does not go far enough to prevent consolidation. The next Subpart explains why the Antitrust Agencies have and will continue to find it inherently difficult to limit providers that are permitted to consolidate from acting on any resulting increases in market power.

2. The Limits of Antitrust Law

As discussed above, relatively light antitrust enforcement policy will allow most MSSP ACOs, including those involving potentially dangerous provider mergers, to survive agency review. Once a merged entity has gained market power, however, the Antitrust Agencies might find it extremely difficult to later either undo the underlying merger or prevent the exercise of that market power. Indeed, a common misunderstanding

156. *See* Bruns, *supra* note 115, at 271; *see also* Greaney, *supra* note 12, at 5–6.
157. Bruns, *supra* note 115, at 281.
158. *Id.* at 282.
159. Bruns, *supra* note 115, at 284–87; *see also* Greaney, *supra* note 12, at 31.
160. Statement of Antitrust Enforcement Policy, *supra* note 18, at 67,030.
161. *See* Werbelow, *supra* note 101, at 389.
162. *See* Greaney, *supra* note 12, at 27.

among policymakers is that antitrust law can reliably counteract legally acquired monopoly power.[163] Thus far, no MSSP ACOs have been the subject of antitrust challenges. However, several antitrust actions in the health care industry within the past several years reflect the difficulty in addressing consolidation after it has already occurred.

Once a merger has been consummated and is later found to be anticompetitive, the Antitrust Agencies' preferred remedy is to require that a portion of the surviving entity be divested, or sold, to reduce the merged entities market power. While the Agencies have each had some success in bringing actions for divestiture, this particular remedy can have limited applicability and effectiveness in restoring competition.[164] This is best demonstrated by the FTC's retrospective challenge of Evanston Northwestern Healthcare Corporation's ("Evanston") acquisition of Highland Park Hospital in the Chicago, Illinois, area in 2000.[165] After bringing the challenge in 2004, the FTC found strong evidence that Evanston had significantly raised prices throughout the local market without improving the quality of care.[166] By the time the FTC resolved the action in 2007, however, significant integration had already occurred and divestiture posed a potential risk to patient safety. As a result, the FTC ultimately concluded that it would be impossible to return the two providers to their premerger status and had little choice but to allow the merger to persist.[167] In the context of the MSSP, there is the same possibility that "strong evidence" of anticompetitive effects will not be available until years after formation and operation, especially considering the fact that MSSP ACOs are not required to collect and disclose data pertaining to non-Medicare beneficiaries.[168] As in the *Evanston* case, divestitures among MSSP ACO providers might not even be a practical remedy to reverse problematic consolidation where substantial and irreversible integration has occurred, and will depend on the availability of data and other evidence of anticompetitive effects.

More recently, the FTC's challenge of a merger between two physician groups in Idaho illustrated the complications that can arise even in the aftermath of a divestiture order.[169] In 2012, St. Luke's Health System, a system with four hospitals and both employed and affiliated physicians throughout Idaho, acquired Saltzer Medical Group, the largest multi-specialty physician group in Idaho.[170] The resulting entity

163. *See id.* at 27–28.

164. *See* Feinstein, *supra* note 134, at 14.

165. *See In re* Evanston Nw. Healthcare Corp., No. 9315, slip op. at 35 (F.T.C. Aug. 6, 2007).

166. *Id.*

167. *See* Bays, *supra* note 58, at 15.

168. *See* Medicare Shared Savings Program, 42 C.F.R. § 425 (2016); Medicare Shared Savings Program, 76 Fed. Reg. 67,802, 67,841–43 (Nov. 2, 2011).

169. *See* St. Alphonsus Med. Ctr. v. St. Luke's Health Sys., 778 F.3d 775, 781–82 (9th Cir. 2015).

170. *Id.*

both had a strong reputation and possessed eighty percent of the adult primary care physicians in Nampa, Idaho, empowering it with significant bargaining leverage over health insurance companies to negotiate higher reimbursement rates.[171] The court agreed with the FTC that this would produce anticompetitive effects in the form of higher premiums for consumers and ordered a divestiture, a decision that was affirmed by the Ninth Circuit in February of 2012.[172] With nearly a year having passed since that order, and three years since the merger was consummated, St. Luke's has yet to comply with the order and recently reported that "'what may have seemed like a simple, straightforward process at the time that divestiture was ordered, has proven not to be so.'"[173]

This dispute reflects the primary difficulty with the divestiture of a large health care entity: finding an appropriate buyer that has the resources to not only purchase, but also to maintain, a complex network of relationships among payers and patients.[174] To add to these complications, there is increasing evidence that divestitures often fail to fully restore competition. For example, a recent study by Northeastern University Professor John Kwoka examined decades of reliable empirical studies of the effect of mergers, finding that divestitures often failed to preserve competition and were not generally effective in restraining price increases.[175] Most of the mergers Professor Kwoka examined resulted in competitive harm, which usually took the form of increased prices. In fact, "[f]or all cases in which the agencies challenged mergers, the outcome was . . . an average price increase of 7.71[%]."[176] More specifically, divestiture remedies were associated with price increases of 6.11%, indicating they are at least moderately inadequate, while conduct remedies resulted in price increases of 12.81%, "suggesting that these are largely ineffective in restraining post-merger price increases."[177] Other significant findings included an estimated 4% decrease in quality and a

171. *Id.*

172. *Id.*

173. Lisa Schencker, *Court-Ordered Breakup Is Still Hard to Do*, MODERN HEALTHCARE (July 17, 2015), http://www.modernhealthcare.com/article/20150717/NEWS/150719929. On December 10, 2015, the Federal District Court of Idaho issued an order setting a deadline of sixty days to complete St. Luke's divestiture of its Saltzer assets and appointing a trustee to facilitate the transaction in the event St. Luke's fails to do so. *See* Order to Maintain Assets and Appointing a Monitor and a Divestiture Tr., Nos. 1:12-cv-00560-BLW, 1:13-cv-00116-BLW (Dist. Ct. Idaho, Dec. 10, 2015).

174. *The State of Competition in the Health Care Marketplace: The Patient Protection and Affordable Care Act's Impact on Competition: Hearing on Health Consolidation Before the Comm. on the Judiciary*, 114th Cong. (2015) (statement of Thomas L Greaney, Professor of Law at Saint Louis University School of Law).

175. JOHN KWOKA, MERGERS, MERGER CONTROL, AND REMEDIES: A RETROSPECTIVE ANALYSIS OF U.S. POLICY 156 (2015) (discussing divestiture remedies in product markets associated with price increases).

176. *Id.* at 159.

177. *Id.*

9.73% decrease in research and development.[178] Tellingly, challenged mergers that were eventually permitted through consent agreements resulted in price increases that, on average, were no less than those where a merger was cleared from the start.[179] As these results make clear, Professor Kwoka's study supports the inference that enforcement actions by the Antitrust Agencies "are not demonstrably effective in preventing post-merger harm."[180]

Thus, divestiture might not always provide a reliable solution for consolidation under the MSSP that is later found to be anticompetitive, especially considering the complex nature of ACO arrangements among providers, Medicare, and other private health plans. Where structural remedies such as divestiture are not practical, the Antitrust Agencies resort to "conduct" or "behavioral" remedies that place conditions on the merged entity, including price caps, limits on future acquisitions, rules for contracting with providers, and government monitoring and oversight.[181] The Antitrust Agencies, however, have rarely employed conduct remedies such as these because they not only rely on resource-intensive enforcement, but also fail to address the underlying problem of reduced competition where a merger is permitted.[182]

The success of health care reform will largely depend on competitive markets, and if the MSSP is to achieve its goal of controlling health care costs and improving quality, it will require stricter antitrust enforcement. Given the inherent difficulties that antitrust law will face in both imposing and implementing such remedies, the simple conclusion might be to "just say no" to consolidation where large providers are involved.[183] Nonetheless, some degree of consolidation might be beneficial and in line with the goals of health care reform. Keeping this in mind, the next Part proposes modifications to the current MSSP regulatory scheme that would not only improve regulatory efforts to

178. *Id.* at 156–57.

179. *Id.* at 159.

180. *Id.*

181. *See* Feinstein, *supra* note 134, at 14–15.

182. For example, earlier this year, in *Commonwealth v. Partners Healthcare System, Inc.*, a Massachusetts court rejected a settlement agreement between merging hospitals and the state attorney general. Commonwealth v. Partners Healthcare Sys., Inc., No. SUCV2014-02033-BLS2, 2015 WL 500995 (Mass. Super. Ct., Jan. 30, 2015). The court explained that such a conduct remedy "permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior" and thus "require[s] constant and vigilant monitoring." *Id.* at 22, 25. The court further stated that "the remedies that are proposed are temporary and limited in scope—like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off." *Id.* at 2. *See also* Press Release, Martha Healey Mass. Att'y Gen., AG Final Resolution with Partners Would Alter Provider's Negotiating Power, Restrict Growth and Health Costs (June 24, 2014) (on file with author).

183. *See* David A. Balto, *Health Insurance Merger Frenzy: Why DOJ Must Just Say 'No,'* LAW360 (Aug. 17, 2015, 5:59 PM), http://www.law360.com/articles/683500/health-insurance-merger-frenzy-why-doj-must-just-say-no.

prevent anticompetitive consolidation, but also better position CMS and the Antitrust Agencies to jointly mitigate harms that might arise where consolidation is permitted.

III. Leveraging MSSP Eligibility to Address Pricing Power

Certainly, the DOJ and FTC have a critical role to play in the ongoing health care reforms, but it is important to recognize what these agencies can and cannot do. As the previous Part makes clear, the Antitrust Agencies' enforcement efforts may serve a crucial role in preventing mergers outside the MSSP Statement safety zones, as well as specific types of anticompetitive conduct within MSSP ACOs. Yet, where providers have already consolidated, an antitrust approach is inherently limited in that it cannot address legitimate exercises of pricing power and will encounter difficulty in reversing or applying other remedies to a merger that is later found to be anticompetitive.[184] Furthermore, relying on antitrust litigation for issues of anticompetitive contractual agreements, tying arrangements, and exclusionary contracting involves unsettled areas of the law that are perhaps too fact intensive, expensive, and time consuming to be practical.[185] Ultimately, both the antitrust policy outlined in the MSSP Statement first discussed in Part II of this Note as well as current MSSP regulations focus too much on post-merger remedies that are not well suited to address the underlying problems associated with extant provider market power. Considering the difficulties of resolving these issues with antitrust law alone, the best solution for preventing anticompetitive consolidation and market power is a more comprehensive regulatory approach to the MSSP framework itself.

In June 2015, CMS issued the second Final Rule to the MSSP ("2015 Final Rule"), amending regulations last updated in November 2011 ("2011 Final Rule").[186] Among the key provisions, the rule allowed MSSP ACOs in the Track One to remain there for a total of up to six years, refined the beneficiary assignment model, established a new Track Three risk model, and introduced alternative methods for establishing and updating financial benchmarks.[187] Understandably, policymakers were concerned with maintaining and encouraging further participation in the MSSP program, and for good reason. Despite proposing many much needed adjustments to the program, however, the 2015 Final Rule falls short in that it again dismissed the problem of market consolidation and pricing power among MSSP ACOs.

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184. Greaney, *supra* note 12, at 34–35.

185. *Id.* at 35.

186. Medicare Shared Savings Program, 42 C.F.R. § 425 (2015).

187. Jessica L. Russell, *Will the ACO Proposed Rule Save the Shared Savings Program?*, Lexology (Feb. 20, 2015), http://www.lexology.com/library/detail.aspx?g=5c26d36a-4b6c-4693-91c3-640445d0d05d.

As discussed above in Part I, the ACO model is unique, has already enjoyed a moderate degree of success, and has the potential to transform the U.S. health care system to not only deliver better quality, but also more affordable health care. And because ACOs are experimental in nature, some relaxation of antitrust policy and a cautious regulatory framework are not only reasonable, but to an extent necessary. However, this deferential system of antitrust review should not be allowed to continue in this fashion considering the risk of potentially irreversible effects on health care competition and pricing.[188] Under these circumstances, the MSSP is severely in need of protections that not only scrutinize and prohibit potentially anticompetitive consolidation, but also position both CMS and the Antitrust Agencies to more effectively mitigate the risks of consolidation where it is permitted.

Given the success and growth in the MSSP in just its first three years, this Note proposes that CMS address the provider consolidation and market power problem by revising its eligibility requirements. More specifically, CMS should further condition a prospective ACO's participation in the MSSP on the ACO's disclosure of additional data, information, and agreements, relating to both public and private payers and patients. This Part first details the concepts of mandatory and voluntary antitrust review under the MSSP, the two mechanisms that were intended—but in their own ways, have failed—to address antitrust concerns. It then proposes that CMS draw from both review systems in modeling a framework for mandatory disclosures and discusses what these might include. These recommendations attempt to strike the appropriate balance between the rigidity of mandatory antitrust review, and the impracticality of an unused system of voluntary review. In doing so, regulation and enforcement efforts by CMS and the Antitrust Agencies could better synergize to avoid chilling potentially procompetitive ACO arrangements while also accounting for the limits of antitrust policy in reversing or preventing the exercise of provider pricing power.

A. "Mandatory" and "Voluntary" Antitrust Review

Throughout the notice and comment period preceding the 2015 Final Rule, many commentators suggested that a possible solution for addressing the consolidation and pricing power problem could be to evaluate ACOs for market power as a condition of acceptance into the program.[189] This notion of "mandatory review," however, is not necessarily a new suggestion. Indeed, one of the most significant shortcomings of the original 2011 Final Rule was CMS's decision to drop

188. *See* Berenson, *supra* note 7, at 720.

189. Travis Broome, *Stakeholders Agree on Major Updates to the Medicare Shared Savings Program*, Am. J. Accountable Care (Mar. 18, 2015), http://www.ajmc.com/publications/AJAC/2015/2015-vol3-n1/Stakeholders-Agree-on-Major-Updates-to-the-Medicare-Shared-Savings-Program#sthash.1Cobi4Pw.dpuf.

a proposed mandatory antitrust review process as a prerequisite for entry to the MSSP.[190] CMS originally envisioned mandatory review as a way to subject ACOs comprised of dominant providers to close antitrust scrutiny.[191] In doing so, such a process would discourage and prevent the formation of ACOs poised to gain significant market power, while also providing the antitrust agencies with additional information to deal with anticompetitive conduct early on.[192] In the proposed 2011 rule,[193] CMS asserted that such a process would encourage private market competition while upholding the interest of Medicare:

> First, it would ensure that ACOs participating in the Shared Savings Program would not present competitive problems that could subject them to antitrust challenge that may prevent them from completing the term of their agreement with us. Second, it would maintain competition for the benefit of Medicare beneficiaries by reducing the potential for the creation of ACOs with market power. In this context market power refers to the ability of an ACO to reduce the quality of care furnished to Medicare beneficiaries and/or to raise prices or reduce the quality for commercial health plans and enrollees, thereby potentially increasing providers' incentives to provide care for private enrollees of higher-paying health plans rather than for Medicare beneficiaries . . . . Furthermore, competition benefits the Shared Savings Program by allowing the opportunity for the formation of two or more ACOs in an area. Competition among ACOs can accelerate advancements in quality and efficiency. All of these benefits to Medicare patients would be reduced or eliminated if we were to allow ACOs to participate in the Shared Savings Program when their formation and participation would create market power.[194]

In its 2011 Final Rule, however, CMS and the enforcement agencies withdrew the mandatory review requirement after receiving a number of criticisms.[195] Some commenters argued that mandatory review presented subdelegation concerns under the Administrative Procedure Act by conveying unreviewable authority to the Antitrust Agencies to refuse MSSP applicants, when the U.S. Department of Health and Human Services alone was attributed oversight of the program.[196] Others objected that the process would be time-consuming and costly for the Agencies, while also imposing entry-inhibiting costs on ACOs.[197] Finally,

190. Medicare Shared Savings Program, 76 Fed. Reg. 67,802, 67,841–44 (Nov. 2, 2011).

191. *Id.*

192. Greaney, *supra* note 12, at 32.

193. Medicare Shared Savings Program, 76 Fed. Reg. at 67,841–42.

194. *Id.*

195. *See* Greaney, *supra* note 12, at 33.

196. Under the "subdelegation doctrine," courts limited the ability of federal agencies to transfer their statutory authority to third-party entities, including other federal agencies. Richard D. Raskin et al., *Delegation Dilemma: Can HHS Require Medicare ACOs to Undergo Pre-Clearance by the Antitrust Agencies?*, HEALTH L. REP. (BNA), June 23, 2011, at 2; *see also* Greaney, *supra* note 12, at 33.

197. *See* Medicare Shared Savings Program, 76 Fed. Reg. at 67,841–42; *see also* Greaney, *supra* note 12, at 33.

some commenters argued that it would simply be "bad public policy to change the nature of antitrust enforcement from law enforcement to a regulatory regime."[198] For the most part, the critics of mandatory review made a number of legitimate points; however, by completely discarding this mandatory review process, CMS precluded the opportunity to negotiate with prospective MSSP participants and insist upon binding conditions of participation as is commonly done in consent decrees and merger cases, as discussed further below.[199]

In place of mandatory review, CMS implemented a system of voluntary expedited antitrust review.[200] Under voluntary review, newly formed MSSP ACOs seeking additional guidance can voluntarily request expedited review to be completed within ninety days.[201] Then, to the extent possible in the ninety day review period, the Antitrust Agencies will consider factors in the rule of reason analysis and provide guidance as to whether the MSSP ACO presents any concern for further review.[202] The advantage of a voluntary system of antitrust review is immediately apparent: it is significantly less burdensome for both the ACOs and the Antitrust Agencies. Furthermore, the voluntary disclosure process requires that ACOs monitor and produce a wealth of documentation and other information, including: (1) the MSSP application and all supporting documents that the ACO plans to submit, or has submitted, to CMS; (2) documents discussing the ACO's business strategies or plans to compete in the Medicare and commercial markets; and (3) any other documents and information an ACO believes might be helpful to the Agency in assessing the ACO's likely impact on competition.[203]

In opting for the voluntary review process, CMS lost a crucial opportunity to screen potentially anticompetitive ACOs, as well as to negotiate agreements to prevent these organizations from using their size to drive up prices in the commercial market. Furthermore, opting for this process precluded CMS from streamlining the collection of the types of data listed above. Despite the many useful items of information listed as required in the voluntary review process, as one legal analyst observed, "it is highly unlikely that an ACO engaging in anticompetitive behaviors is going to voluntarily seek expedited review."[204] Since the inception of

198. *See* Medicare Shared Savings Program, 76 Fed. Reg. at 67,841–42.

199. *Id.*

200. *See* Statement of Antitrust Enforcement Policy, *supra* note 18.

201. *Id.*

202. *Id.*

203. Examples of such documents include those relating to the ACO's likely impact on the prices, cost, or quality of any service provided by the ACO to Medicare beneficiaries, commercial health plans, or other payers, and the level and nature of competition among participants in the ACO, and the competitive significance of the ACO and ACO participants in the markets in which they provide services. *Id.* at 67,031.

204. *See* Bruns, *supra* note 115, at 286.

voluntary expedited review, only two ACOs have requested review,[205] and of those two applicants, one withdrew its request prior to the actual review, and the other was not eligible because the applicant did not intend to operate in any commercial market.[206] Thus, despite the fact that voluntary review can potentially gather useful information and is generally less burdensome, it does not serve the purpose preliminary review intended.

B. Implementing a Policy of Mandatory Disclosures

While imposing either mandatory or voluntary antitrust review upon prospective MSSP ACOs entails a number of tradeoffs, the reality is that neither is a practical solution to the ACO consolidation problem. As noted in the above Subpart, CMS instituting a system of mandatory review is complicated by the constitutional issue of nondelegation, while the current practice of voluntary review has yet to be used and thus serves more of a guiding role than a structured protection against either consolidation or market power. Accordingly, regardless of whether voluntary review remains an option, there is a need for regulatory requirements that are systematically imposed upon applicant ACOs in a way that prevents the harms of pricing power before they become irreversible or unavoidable.

Drawing from both the mandatory and voluntary review processes outlined above, the most promising quality they collectively offer in combatting provider market power is the disclosure and compiling of empirical data and other information. By requiring mandatory disclosures of select information similar to that required in the voluntary review process, CMS could better monitor and make possible additional and more effective regulatory actions. For example, as opposed to a voluntary disclosure to an antitrust agency, CMS could require that applicants provide documentation in support of their purported business goals and strategies in both the Medicare and commercial markets. This information might include the ACO's expected impact on prices, cost, or quality in both public and private markets, as well as an overview of the competition the ACO expects to face. Indeed, already in the 2015 Final Rule, CMS imposed a requirement that ACOs monitor, collect, and disclose claims data with respect to its Medicare beneficiaries.[207]

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205. Deborah L. Feinstein et al., *Accountable Care Organizations and Antitrust Enforcement: Promoting Competition and Innovation*, 40 J. Health Pol., Pol'y & L. 873, 875 n.2 (2015).

206. FTC & Dep't of Justice ACO Working Grp., Summary of Activities Following Issuance of the Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program (2013).

207. *See* 42 C.F.R. § 425 (2016); *see also* Medicare Shared Savings Program, 80 Fed. Reg. 32,692, 32,818–19 (2015).

Moreover, CMS also conditioned MSSP participation on an ACO's agreement that this claims information be disclosed to the Antitrust Agencies.[208] By expanding the scope of the MSSP Participation Agreement in manners such as these, CMS would be able to accomplish two major goals. First, CMS would be able to proactively and more reliably track the progress and development of MSSP ACOs in a way that would hold participants more accountable for the program's mission for health care reform, and such that CMS could intervene before substantial harm results from acquisition of market power. Second, as discussed in Part II above, antitrust rule of reason analysis is extremely fact specific and resource intensive. By gathering select information, CMS would be in a better position to not only flag arrangements of potential concern, but to streamline the process for antitrust review by sharing that information with the Antitrust Agencies.

CMS should also consider imposing a number of affirmative obligations on the part of participant ACOs where, unless an ACO engaged in certain anticompetitive behaviors or abuses of pricing power, these obligations would not burden its operations or prospects for success. For example, requiring commitments, such as price increase caps, would account for the inherent difficulty in providing antitrust remedies down the road, as was the result in the *Evanston* case discussed above in Part II.B. A number of commentators have raised several possible measures since the MSSP came into effect. First, CMS might also demand a heightened showing that ACO proposals will produce identifiable and quantifiable efficiencies, as well as perhaps placing the burden of showing an absence of significant horizontal anticompetitive effects on the applicant.[209] Another approach might involve punitive action to ensure ACO participants were entering into the MSSP for the right reasons. For example, CMS could set limits on price increases in the commercial market and require that increases exceeding certain benchmarks be justified in the way an insurance rate review commission might operate.[210] Alternatively, CMS might incorporate monetary penalties to shared savings not only where quality or financial benchmarks are not met, but where prices to private payers increase beyond a certain extent and cannot be justified.[211] And lastly, CMS could expand upon its gatekeeper role of accepting ACOs into the program to include conditional renewals or denials for future years based on whether participants were raising prices or consolidating market power.[212]

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208. Medicare Shared Savings Program, 80 Fed. Reg. at 32,818–19.

209. *See* RICHMAN, *supra* note 96, at 11.

210. *See* Erin Fuse Brown & Jaime King, State Oversight of Vertical Integration in Health Care (Dec. 7, 2015) (unpublished manuscript) (on file with authors).

211. *Id.*

212. *See* Greaney, *supra* note 12, at 38.

Overall, the regulatory framework governing the MSSP is in need of serious revisions that address provider consolidation and market power from the onset. By conditioning MSSP eligibility on the disclosure of data, information, and various agreements extending to the private sector as discussed above, CMS could better detect, preclude, and respond to antitrust concerns that have historically correlated with increases in provider concentration.[213] Providers would likely raise concerns that tightening and adding to the MSSP regulations could make it overly burdensome, thereby chilling participation. Any burden in additional data collection, however, could likely be minimized with the use of existing medical and claims data that is already routinely and automatically generated for private patients by hospitals and health insurance companies.[214] More importantly, the limited burden of information and data disclosures would greatly improve both CMS and the Antitrust Agencies' ability to work jointly in addressing unintended concentrations of pricing power that could undermine the MSSP's "three-part aim" of improved care delivery, improved health, and reduced growth in costs.[215]

CONCLUSION

Under the MSSP, ACOs have the potential to lead the transformation of the U.S. health care system from fragmented and costly to integrated and cost efficient. Yet, the same integration that promises coordination and efficiency stands to aggregate and concentrate market power in a way that diminishes competition and drives up prices. As this Note argues, enforcement by the Antitrust Agencies alone remains inadequate and is not even the best solution to the MSSP's provider market power problem. While there is perhaps a need for stricter antitrust policy, additional regulatory efforts by CMS are necessary to prevent excessive and unnecessary health care provider consolidation, and at the very least, to place both CMS and the Antitrust Agencies in a better position to monitor, mitigate, and contain anticompetitive exercises of market power.

213. *See supra* Part II.A.

214. PATRICK B. MILLER ET AL., ALL-PAYER CLAIMS DATABASES: AN OVERVIEW FOR POLICYMAKERS 7–8 (2010) (discussing challenges to data collection for all-payer claims databases, state established databases that collect health insurance claims information for every health care payer in a given state).

215. *Accountable Care Organization (ACO)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/Aco (last visited Apr. 8, 2016).