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I. INTRODUCTION

The Affordable Care Act signed into law in March 2010 has promised that the concept of accountable care organizations (“ACOs”) will transform how medical care is provided and paid for in the United States. As befits their role as enforcers of the antitrust laws, the Federal Trade Commission (“FTC”) and the Department of Justice (“DOJ”) have raised concerns that certain ACOs may reduce competition and harm consumers through higher prices and lower quality of care.²

To address that issue, the antitrust Agencies propose a “shares” screen in their recently published draft Policy Statement to identify and evaluate those ACOs that may be problematic.³ The draft Policy Statement identifies three ranges of shares: one level above which an automatic review by the antitrust Agencies is triggered before participation in the Medicare Shared Savings Program is permitted, one below which a safety zone is in place, and a middle range of shares for which a proposed ACO has the option to request an antitrust review.⁴ Thus the share calculations described in the draft Policy Statement are a critical aspect of achieving the antitrust clearance needed for an ACO to participate in the Shared Savings Program.

Calculating shares is a common aspect of an antitrust analysis, though usually in the context of properly defined antitrust product and geographic markets. The draft Policy Statement uses the concepts of “Common Service” and “Primary Service Area” for determining shares, but it avows that these are not necessarily the same as antitrust product and geographic markets. Indeed, court decisions have affirmed that service areas and geographic markets are not necessarily the same, and at least one decision states that they may even be thought of as opposite concepts.⁵

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² The Agencies seek to protect both commercially insured patients and Medicare beneficiaries.

³ PROPOSED STATEMENT OF ANTITRUST ENFORCEMENT POLICY REGARDING ACCOUNTABLE CARE ORGANIZATIONS PARTICIPATING IN THE MEDICARE SHARED SAVINGS PROGRAM, FEDERAL TRADE COMMISSION AND DEPARTMENT OF JUSTICE (Federal Register, Vol. 76, No. 75, April 19, 2011, pp. 21894-21902) *available at* <http://www.ftc.gov/os/fedreg/2011/03/110331acofrn.pdf> (*hereinafter* Draft Policy Statement).

⁴ The upper share threshold is 50 percent, the lower threshold is 30 percent, and the middle range is between those two. (Draft Policy Statement, *supra* note 3, p. 21897). The draft Policy Statement also includes a list of conducts that, if avoided, will help minimize the likelihood of objections on antitrust grounds. The Agencies assume that organizations that meet the criteria for clinical integration already used by the Centers for Medicare and Medicaid Services (“CMS”) are “reasonably likely to be bona fide arrangements intended to improve the quality, and reduce the costs” of health care services.

⁵ “[A] court would often be mistaken to conclude that a seller’s ‘trade area,’ or the area from which it currently draws its customers, constitutes a relevant geographic market. In fact, the ‘trade area’ and the ‘relevant market’ are precisely reverse concepts.” *Bathke v. Casey’s General Stores, Inc.*, 64 F.3d 340, 346 (8th Cir. 1995) (quoting H. HOVENKAMP, FEDERAL ANTITRUST POLICY § 3.6d, at 113-14).

Nevertheless, a great deal of attention is paid in the draft Policy Statement regarding the details of how the Common Service and PSA are to be determined and how shares within PSAs are to be calculated. Shares must be calculated for each Common Service in each participant's PSA, meaning that, in all likelihood, an ACO will not have a single, simple share but rather, in many cases, an ACO will likely have dozens of shares. Even an ACO with only two parties and one Common Service will be required to make two share calculations. If any of these shares falls above the 50 percent threshold, then an antitrust review by the FTC or DOJ is triggered.

Notwithstanding the draft Policy Statement's disavowals, it seems likely that the Agencies could begin to adopt Common Services and PSAs as antitrust markets more frequently in their full-fledged competition analyses as they become accustomed to reviewing submitted materials that present shares of Common Services in PSAs. Consequently, it makes sense to consider these concepts and the related calculations more carefully.

II. COMMON SERVICES

The draft Policy Statement identifies three general types of services classified as Common Services of an ACO. These include physician services, inpatient services, and outpatient services.

Physician Specialties: The draft Policy Statement explains that the Medicare Specialty Codes used by the Centers for Medicare and Medicaid Services ("CMS") for classifying physicians by specialty will be used for ACO share calculations.⁶ Medicare Specialty Codes, as applied to ACOs, divide physicians into 55 medical and surgical specialties. With one exception, each code corresponds to what might generally be viewed as a physician's specialty. The exception is primary care, for which four specialties are grouped together to calculate shares in an ACO review. Primary care, as defined in the draft Policy Statement, comprises general practice, family practice, internal medicine, and geriatric medicine. Inclusion of geriatric medicine appears to be a holdover from Medicare's focus on the over-65 population, but its inclusion does not do a significant injustice to the concept of primary care. Similarly, the exclusion of pediatrics and obstetrics/gynecology from the definition of primary care may reflect their insignificance to Medicare, and they are less consistently included in primary care in antitrust cluster markets in any event.

The Medicare Specialty Codes apply to both allopathic and osteopathic physicians. They specifically include "osteopathic manipulation" as a specialty and include chiropractors as well. Conversely, the specialty codes do not include hospitalists. Likewise, the specialty codes do not include physician extenders or other licensed professionals.

Inpatient Services: Inpatient services are to be classified using the 25 Major Diagnostic Categories ("MDCs"). MDCs are clusters of as many as 99 Diagnosis Related Groups ("DRGs") (with an average of 29 DRGs per MDC), including both surgical and medical treatments. Some MDCs are defined as diseases and disorders of particular body systems such as the musculoskeletal system or the circulatory system. Other MDCs apply to type of illnesses that can affect different systems (e.g., infectious and parasitic diseases or injuries and poisonings).

Outpatient Services: Outpatient services will be divided into categories that have not been specifically identified by CMS. If CMS's current Health Care Common Procedures Coding System is an indication, there could be 30-35 classifications of services encompassing ambulatory

⁶ Draft Policy Statement, *supra* note 3, Appendix.

surgical procedures, non-invasive procedures, and diagnostic services. The draft Policy Statement makes no reference to outpatient facilities other than hospital outpatient departments and ambulatory surgery centers. Diagnostic facilities and facilities providing non-surgical procedures evidently will not be included in any share calculations for an ACO.

While these service definitions seem straightforward, a closer examination of MDCs reveals some potential complications. Many related medical and surgical services, like those grouped into an MDC, generally cannot substitute for each other in terms of patient care leads. This has led to the notion of “cluster markets,” a concept commonly used to define markets in antitrust analysis of health care services in lieu of the stricter concept of demand-side substitution. In essence, a cluster market is a group of products or services that are produced by multi-product suppliers for consumers who tend to purchase the services as a group and this is done under generally the same market conditions. In the most recent decision in a litigated hospital merger case, for example, the court accepted a cluster market of general acute care services and another cluster market of obstetrics services.⁷

An MDC is a cluster of related services that is narrower than overall acute care services. That narrowness has the advantage of eliminating some of the wide variation inherent in general acute care services, but it does not fundamentally alter the need for a cluster market approach. For example, the DRG for installing a pacemaker is in MDC 05 as is the DRG for coronary artery bypass surgery, but the services in these two DRGs are not substitutes.

The downside to using MDCs is that, by virtue of being narrow, the ACO’s share can be affected significantly by the volume of one hospital that is providing a large amount of a DRG that the other hospital does not provide at all. The result is an artificially high MDC share. For example, one hospital may provide a large amount of open heart surgery while the other hospital provides only medical cardiology services. Since open heart surgery is likely to account for a large portion of the overall MDC, shares for the MDC (i.e., the Common Service) will likely be much higher than the actual activity of the hospitals suggests. This impact on share is likely to be exacerbated if shares are calculated using Medicare revenues rather than discharge counts as the measure of volume

III. PRIMARY SERVICE AREA

Primary Service Area has the benign appearance of simply being the geographic area from which providers draw their patients. In principle it may be benign, but in practice the multiplicity of PSAs can become daunting. The draft Policy Statement explains that “[f]or each common service and each participant, the PSA is defined as the lowest number of contiguous postal zip codes from which the participant draws at least 75 percent of its patients for that service.”⁸

The term “each common service” refers to each of the individual physician MSCs, inpatient MDCs, or outpatient classification codes for which a separate PSA must be defined

⁷ FTC v. ProMedica Health System, Case No. 311-CV-47, N.D. Ohio, Mar. 29, 2011.

⁸ Draft Policy Statement, *supra* note 3, Appendix. The Policy Statement explicitly states that a PSA is not necessarily the same as a geographic market. If a proposed ACO undergoes a full antitrust review (if one of its PSA shares exceeds 50 percent, for example), it is likely that Agencies would define geographic markets at that time.

inasmuch as two or more ACO participants provide those services in common.⁹ The term “each participant” means that separate PSAs are determined for all of the providers of a Common Service. Thus, if three hospitals and two ambulatory surgery centers in an ACO provide outpatient hernia repair, five PSAs (and five shares) must be determined for that Common Service alone.

The “lowest number” criterion is satisfied by sorting zip codes in order of contribution to the provider’s total volume for the Common Service. For many Common Services that do not have large numbers of cases, it is likely that several configurations of zip codes will be equally valid. This will occur when it is necessary to choose among several zip codes with the same number of cases when making the cut-off for the last zip code at the 75th percentile. This distinction may not matter, but it is possible that an ACO could define PSAs by choosing zip codes that yield the lowest share calculations. Since mandatory review is triggered with just one Common Service having a share in excess of 50 percent, the definition of the PSA could make a difference between mandatory and optional review.

“Contiguous” zip codes means that the zip codes must share a common border. From a practical standpoint, each PSA must be mapped to ensure that the all zip codes are contiguous. No explanation is given in the draft Policy Statement as to why this criterion is important, especially since it may conflict with the “lowest number” criterion. With the “contiguous” criterion, a zip code that contributes a large portion of an ACO participant’s patients may be excluded from the PSA in favor of several smaller zip codes simply because the large zip code is not contiguous to the rest of the PSA. The more widespread the service area or the smaller the number of cases by zip codes, the more likely is it that issues of non-contiguous zip codes will arise.

Other aspects of the contiguous criterion merit attention as well.¹⁰ It is not clear whether, for example, zip codes that share only a corner would be considered contiguous. It would also seem that having a large hole in a PSA (i.e., zip codes that fail to meet the “lowest number” criterion but are surrounded by the PSA) is inconsistent with the unstated rationale for contiguous zip codes, i.e. that proximity of zip codes to each other is important. It may also happen, especially for Common Services with small numbers of cases, that the 75 percent threshold cannot be reached without including some non-contiguous zip codes. The mapping in such a circumstance may reveal that there are two or more clusters of zip codes for which zip codes within the cluster are contiguous, but the clusters share no common borders with each other. As with the “lowest number” criterion, the contiguous zip codes criterion may have little impact, but it might also have a significant effect on share.

The “at least 75 percent” criterion means that zip codes are aggregated until the group accounts for 75 percent or more of patient volume. It is clear that insofar as the PSA concept is going to be used for ACO shares, some threshold must be chosen to define the PSA. Nevertheless, the draft Policy Statement does not explain why 75 percent should be chosen for the threshold. An important implication of using a 75 percent threshold is that 25 percent of patients are excluded, and most healthcare providers are likely to view 25 percent as a significant

⁹ A share for a single provider of a service in an ACO will have to be calculated if that share might be over 50 percent under the Dominant Provider Limitation discussed below.

¹⁰ In fairness to the Agencies, it can be recognized that an overall policy statement such as the draft at hand arguably need not address every possible consideration. Still, recognition that these contingencies exist is important.

portion of their patient volume. As long as there is no price discrimination by geographic area, each of the patients in the excluded 25 percent is, on average, as profitable as each of the patients in the 75 percent area. The lack of price discrimination also suggests that the shares of each individual zip code may be more telling than the share of the 75 percent PSA overall.

The draft Policy Statement provides two exceptions to the shares thresholds. In the “Rural Exception,” an ACO with a high share can still fall into the safety zone if the cause of the high share is the inclusion of one physician per specialty from a rural county and those physicians are not exclusive to the ACO.¹¹ Likewise, rural hospitals can be included in an ACO on a non-exclusive basis and not trigger the share threshold for a mandatory review. The second exception is the “Dominant Provider Limitation” in which an ACO that includes a provider with a share in excess of 50 percent share in its PSA for any service can fall within the safety zone if the provider is free to contract with payors outside of the ACO. The Dominant Provider Limitation also states that an ACO with a Dominant Provider cannot require a commercial payor to contract exclusively with the ACO or otherwise restrict the payor’s ability to contract with other ACOs.¹²

IV. SHARE CALCULATIONS

One implication of the draft Policy Statement’s mandate for ACOs to calculate shares that should not be overlooked is the number of share calculations that might be required. Consider a stylized example of an ACO that provides inpatient, outpatient, and physician services. The ACO comprises one large hospital and one mid-sized hospital, two small outpatient care providers with limited services, one multi-specialty physician group, and one smaller limited specialty physician group. Table 1 below shows that this hypothetical ACO would be required to identify 72 PSAs (one for each provider in each Common Service) and make 72 share calculations.

Table 1: Number of PSAs and Share Calculations for ACO with Providers of Mixed Sizes

	Hospital A	Hospital B	Ambulatory K	Ambulatory L	Physician X	Physician Y	Total
	large, full-service	mid-sized, limited service	small, limited service	small, limited service	large, multi-specialty	smaller, limited specialty	
MDCs offered (inpatient)	1 – 25	1 - 12					
ASC types (outpatient)	1 – 31	1 - 9	1 – 9	1			
MSC (physicians)					1 – 55	1 - 10	
Number of PSAs and Share Calculations	21	21	9	1	10	10	72

¹¹ The term “rural county” is defined by the U.S. Census Bureau (Draft Policy Statement, *supra* note 3, p. 21897).

¹² The Agencies have also identified five types of conduct that an ACO with shares in the 30 to 50 percent range should avoid to reduce significantly the likelihood of an antitrust investigation. (See Draft Policy Statement, *supra* note 3, p. 21898)

As Table 2 shows, if the ACO comprises large providers (though still only two of each type of provider) and each offers the maximum number of service categories, the number of PSAs and share calculations required is significantly larger. In that case, the ACO would be required to prepare 284 share calculations.

Table 2: Number of PSAs and Share Calculations for ACO with Large Providers

	Hospital A	Hospital B	Ambulatory K	Ambulatory L	Physician X	Physician Y	Total
	large, full-service	large, full-service	large, multi-specialty	large, multi-specialty	large, multi-specialty	large, multi-specialty	
MDCs offered (inpatient)	1 – 25	1 - 25					
ASC types (outpatient)	1 – 31	1 - 31	1 – 31	1 - 31			
MSC (physicians)					1 – 55	1 - 55	
Number of PSAs and Share Calculations	56	56	31	31	55	55	284

V. DATA LIMITATIONS

The draft Policy Statement recognizes that it would be difficult or impossible to calculate all of the shares that it mandates with currently available information. Some of these data shortages will be addressed by more detailed information to be made available by CMS.¹³ With regard to physician services and outpatient services, CMS will provide Medicare fee-for-service allowed charges by physician specialty and outpatient care category by zip code.¹⁴ The draft Policy Statement states that inpatient shares should be based on numbers of patient discharges as reported in all-payor discharge data available in many states. In states for which those data are not available, Medicare fee-for-service allowed charges can be used. Some categories of services and providers are generally not present in the Medicare data, however, because the Medicare population is overwhelmingly adults aged 65 and older. Most obvious of these services are pediatrics, obstetrics, and neonatal care. The draft Policy Statement recommends using other data, such as the number of physicians within the specialty in the PSA.¹⁵

While Medicare fee-for-service allowed charges data have the distinct advantage of being collected on a national basis in a form that can be provided by CMS at the necessary level of detail, they are not without disadvantages, even aside from the absence of pediatrics, obstetrics, and neonatal care services. A potentially significant distortion concerns providers that are heavily dependent on Medicare patients. For example, a hospital near a large retirement community, such as those in parts of Arizona and Florida, is likely to have a disproportionately large share of its discharges in Medicare patients. In all likelihood, the shares generated by Medicare fee-for-service allowed charges in that scenario would not accurately reflect the hospital's share of commercially insured patients. Indeed, high Medicare shares might not only be a poor indicator of high commercial insurance shares, but they may indicate that commercial insurance shares are

¹³ Draft Policy Statement, *supra* note 3, Appendix.

¹⁴ *Id.*

¹⁵ *Id.*

low. Yet the antitrust review of an ACO is primarily intended to protect commercially insured patients. Thus the use of Medicare data could misrepresent actual shares.

VI. CONCLUSION

Whether ACOs will transform the provision and payment of medical services in the United States as promised remains to be determined. Likewise, the impact of ACOs on competition is uncertain. Through a screening process based largely on shares calculations, the FTC and DOJ propose to sift out ACOs that need detailed review to ensure that no competitive harm arises. Shares must be calculated for each ACO participant in its Primary Service Area for each physician service, inpatient service, or outpatient service it provides in common with another ACO participant. While the share calculations can be simply described, the methodology exhibits some unresolved technical and implementation issues. The dozens, and possibly hundreds, of shares calculated by the ACO are the key to determining whether an ACO can participate in Medicare's Shared Savings Program without a detailed FTC or DOJ review or will require the more extensive, traditional antitrust investigation.