Feds' Antitrust Efforts May Ease ACO Formation

BY M. ALEXANDER OTTO

Many physicians have wondered how – and even if – they will be able to work together to form accountable care organizations without violating federal antitrust and fraud and abuse laws.

A federal regulatory meeting held this fall offered possible answers to both questions. Regulators are considering exemptions to those laws that would allow providers who meet certain requirements to form ACOs.

"It is not easy to craft safe harbors that can replace an antitrust review that analyzes the specific facts of each case and market. But we're going to try to do this," said Jon Leibowitz, chairman of the Federal Trade Commission (FTC).

Similarly, Daniel Levinson, inspector general of the U.S. Department of Health and Human Services, noted that the Affordable Care Act gives the HHS secretary the authority to waive some fraud and abuse laws as needed to help ACO programs develop.

The FTC, the HHS Office of Inspector General, and the Centers for Medicare and Medicaid Services conducted the workshop in Baltimore to hear the opinions of panelists and audience members on a variety of ACO issues.

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However, much of the questioning focused on how antitrust and fraud and abuse exemptions could be applied to ACOs.

The Affordable Care Act promotes ACO creation to reduce health-care fragmentation, improve outcomes, and cut health spending by, for instance, keeping patients out of hospitals when possible.

The goal is for providers to come together and contract with the CMS to integrate and manage the care of at least 5,000 patients, and to share a portion of the savings their efforts generate for Medicare, so long as quality parameters are met. Once formed, ACOs could pursue similar types of contracts with commercial insurance companies.

The catch is that encouraging independent providers to jointly negotiate contracts and payment rates with health plans raises concerns about joint price fixing, reduced competition, and other antitrust matters.

Likewise, the shared-savings provision, among others, raises antikickback, self-referral, and other fraud and abuse concerns, according to health care attorney Douglas Hastings, board chair of Epstein Becker & Green, Washington, and a meeting panelist who offered his insights during a later interview.

Regulators are interested in applying to ACOs antitrust protections that already exist for providers who are clinically integrated and jointly accept significant financial risk.

"In those cases, [collaboration is] not viewed as an antitrust matter, since they are behaving as an integrated organization," explained meeting panelist and health policy expert Harold Miller, executive director of the Center for Health Care Quality and Payment Reform, who also offered his insights during a later interview.

Overall, the hope is to spur "coordination [and] cooperation among the people and the entities that provide health care," while at the same time ensure "appropriate corporate behaviors," said Dr. Donald Berwick, CMS Administrator.

Proposed ACO regulations are expected from the CMS in late December.

To make such programs cost effective, however, "a small practice will need to think about how to partner with other practices in order to have enough patients who can benefit," he said.

Mr. Miller added that he does not believe recent election results will derail ACO efforts or other aspects of the Affordable Care Act. Despite Republican victories, "I think it would be a near impossibility to pass a repeal by a veto-proof margin. And the ACO stuff is not really controversial – yet," he noted. ■

IMPLEMENTING HEALTH REFORM

New Covered Preventive Care

One goal of the Affordable Care Act was to boost the use of preventive services. The law attempts to do this by making those services – health screenings, vaccinations, well-baby visits, and dozens more – free to as many people as possible as soon as possible.

Now, new private health plans must offer the services without patient cost sharing. Although the rule covers just a fraction of the population (existing plans were exempted), as of Jan. 1, all Medicare beneficiaries will be offered a new services at no cost.

Medicare beneficiaries 'will receive free preventive care services and a free annual wellness visit.'

DR. SESHAMANI

Dr. Meena Seshamani, the deputy director of the Office of Health Reform at the Department of Health and Human Services, explains how her agency is implementing this provision of the ACA and how HHS hopes it will affect the behavior of patients and physicians.

CARDIOLOGY NEWS: What preventive services will doctors be offering Medicare beneficiaries copayment-free in 2011?

Dr. Seshamani: Medicare beneficiaries with [fee-for-service] Medicare will receive free preventive care services and a free annual wellness visit, or physical. The complete list of preventive services is available in the Medicare & You Handbook, and it includes abdominal aortic aneurysm screening, bone mass measurement, certain colorectal cancer screening tests, immunizations for influenza and hepatitis B, and mammograms. Most Medicare Advantage plans also are offering theses services without cost sharing, so beneficiaries should check with their plan.

CN: This change went into effect for private insurance plans created after health reform was enacted but not plans existing before then. Will long-existing plans, presumably covering most younger patients, ever have to fully cover preventive services under the law?

Dr. Seshamani: The ACA requires new insurance plans to cover an array of preventive services – those I mentioned above plus additional services including well-baby and well-child visits and routine immunizations – without charging a copay, coinsurance, or deductible. These rules do not apply to grandfathered plans, (plans that existed on March 23, 2010, and have not made significant changes since then). If a plan loses its "grandfather status" by making changes that reduce benefits or increase costs to consumers, it will need to comply with the new rules.

CN: How were these services chosen?

Dr. Seshamani: The ACA specifies that Medicare beneficiaries will not have to pay cost-sharing for Medicare-covered services that are recommended with a grade of A or B by the U.S. Preventive Services Task Force. The law also requires private plans to cover without cost-sharing all services that are recommended with a grade of A or B by the task force; routine immunizations recommended by the Advisory Committee on Immunization Practices; services for infants, children, and adolescents recommended by the Health Resources and Services Administration; and additional preventive services for women that are being developed.

CN: How will this change affect primary care physicians? What about specialists?

Dr. Seshamani: Some of the recommended services, like flu shots, are routinely delivered by primary care physicians, while others, like colonoscopies, are more commonly delivered by specialists. All physicians have a role to play in making sure their patients get the preventive care they need to stay healthy.

CN: What fraction of the preventive services have patients been getting in the past, and what do you expect after these changes?

Dr. Seshamani: Before the ACA, Americans used preventive services at about half of the recommended rate. By eliminating copayments for new plans and for Medicare beneficiaries, the law will make preventive care more accessible for many Americans.

CN: Won't these changes increase public and private health care costs, while ACA was supposed to control costs?

Dr. Seshamani: Chronic diseases, such as heart disease, cancer, and diabetes make up 75% of U.S. health spending. These diseases are often preventable, and by improving access to preventive care, more Americans will get the care they need to stay healthy. This can not only improve the health of Americans, but also prevent the need for costly care later. ■

The complete list of preventive services that Medicare and some private plans must offer at no charge is at www.HealthCare.gov/center/regulations/prevention.html.