UNITED STATES OF AMERICA
Federal Trade Commission
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

April 22, 2015

Center for Health Care Policy and Resource Development
Office of Primary Care and Health Systems Management
New York State Department of Health
Corning Tower - Room 1815
Empire State Plaza
Albany, New York 12237

Re: Certificate of Public Advantage Applications Filed Pursuant to New York Public Health Law, 10 NYCRR, Subpart 83-1

Dear Sir or Madam:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] respectfully submit this public comment regarding the potential competitive impact of the Certificate of Public Advantage ("COPA") applications submitted by three newly formed performing provider systems ("PPSs") under the Delivery System Reform Incentive Program ("DSRIP") – Adirondack Health Institute Performing Provider System,[2] Advocate Community Partners Performing Provider System,[3] and Staten Island Performing Provider System.[4] For each of the three DSRIP PPSs, a COPA purportedly would provide federal antitrust immunity for certain collaborative activities among participating health care providers, including joint price negotiations.

FTC staff fully recognizes that collaborations among health care providers often are procompetitive. We write to express strong concerns that the COPA regulations, as well as the underlying authorizing legislation, are based on inaccurate premises about the antitrust laws and the value of competition among health care providers.

A COPA is unnecessary for these three DSRIP PPSs to engage in procompetitive collaborative activities. The antitrust laws are not a barrier to the formation of efficient health care collaborations that benefit health care consumers, as explained in extensive guidance issued by the federal antitrust agencies. Indeed, very few health care provider mergers, joint ventures, or other types of collaborations are challenged by the federal antitrust agencies. Because procompetitive health care collaborations already are permissible under the antitrust laws, the main effect of the COPA regulations is to immunize conduct that would *not* generate efficiencies and therefore would *not* pass muster under the antitrust laws. Therefore, COPAs are likely to lead to increased health care costs and decreased access to health care services for New York consumers.

I. Interest and Experience of the Federal Trade Commission

Congress has charged the FTC with enforcing the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[5] Competition is at the core of America's economy,[6] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[7] Pursuant to its statutory mandate, the FTC seeks to identify business practices, laws, and regulations that may impede competition without providing countervailing benefits to consumers.

Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,[8] research,[9] and advocacy.[10] Of particular relevance, the Commission and its staff have long advocated against federal and state legislative proposals that seek to create antitrust exemptions for collective negotiations by health care providers, as such exemptions are likely to harm consumers.[11]

II. The New York DSRIP Program and COPA Regulations

The DSRIP program, announced in April 2014, is intended to promote community-level collaborations among New York health care providers in an effort to achieve system reform, quality improvements, and cost reductions.[12] The DSRIP program ties New York's Medicaid funding to performance benchmarks, and our understanding is that New York health care providers are required to participate in the DSRIP program to receive Medicaid funding. It is also our understanding that the DSRIP PPS networks are comprised of substantial portions of competing health care providers within their respective geographic regions.

DSRIP PPS networks may apply for a COPA, which purports to provide antitrust immunity to approved health care collaboratives.[13] The COPA regulations implement Article 29-F of New York's Public Health Law, as amended in 2011.[14] According to the regulations, the New York Department of Health is required to review COPA applications in consultation with the New York Attorney General's office ("NYAG"). This review must consider several factors, including a detailed competitive analysis of the market and the potential benefits and anticompetitive effects of the proposed collaborative arrangement.[15] Consistent with the authorizing legislation, the COPA regulations state that the NYAG may seek relief under state antitrust law if the challenged conduct is inconsistent with or beyond the scope of the COPA, or if the NYAG determines that the anticompetitive effects of the conduct or collaborative arrangement outweigh the benefits.[16]

III. Concerns Regarding Potential Anticompetitive Effects of New York's COPA Approach

Putting aside the issue of the sufficiency of the state's oversight of the COPA process,[17] FTC staff is concerned that combining the DSRIP program with the COPA regulations will encourage health care providers to share competitively sensitive information and engage in joint negotiations with payers in ways that will not yield efficiencies or benefit consumers. Furthermore, although the DSRIP program applies only to Medicaid patients, the potential anticompetitive effects of information sharing and joint payment negotiations under a COPA may extend to commercial and Medicare patients as well.[18] For example, it is possible that participating PPS providers would need to share information about all of their patient populations – including commercial, Medicare, and Medicaid patients – in order to properly implement the value-based payment models contemplated under the DSRIP program.[19]

A. COPA Is Unnecessary Because the Antitrust Laws Already Permit Efficient Health Care Collaborations

The COPA regulations are based on two fundamentally flawed premises: that efficient, procompetitive collaborations among otherwise independent health care providers are prohibited under the antitrust laws, and that COPA regulations are necessary to encourage such collaborations. Indeed, when the New York state legislature passed the underlying legislation that authorizes the COPA regulation, it emphasized the need for greater integration and coordination of health services to achieve the reform goals of the Patient Protection and Affordable Care Act ("ACA").[20] The legislature went on to state that federal and state antitrust laws may prohibit or discourage collaboration or consolidation among health care providers that could be beneficial to New York residents.[21] FTC staff disagrees with the legislature's improper characterization of the antitrust laws.

The antitrust laws already recognize, and, indeed, have long stood for the proposition that competitor collaborations can be procompetitive. As explained in numerous sources of guidance issued by the federal antitrust agencies,[22] this position extends to collaborations among competing health care providers. FTC officials have recently emphasized that "[t]he FTC supports the key aims of health care reform, and . . . recognize[s] that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that practitioners seek and patients deserve."[23] The federal antitrust agencies have challenged very few of the thousands of health care provider mergers, joint ventures, and other types of collaborations that have occurred in recent years, and have "brought those challenges only after rigorous analysis of market conditions showed that the acquisition was likely to substantially lessen competition."[24]

Moreover, the goals of antitrust are consistent with the goals of the ACA. Despite what some health care industry participants have claimed, the antitrust laws do not

prohibit the kinds of collaboration necessary to achieve the health care reforms contemplated by the ACA.[25] Specifically, antitrust is not a barrier to New York health care providers who seek to form procompetitive collaborative arrangements that are likely to reduce costs and benefit health care consumers through increased efficiency and improved coordination of care.

B. Antitrust Exemptions That Immunize Otherwise Anticompetitive Conduct Pose a Substantial Risk of Consumer Harm and Are Disfavored

Because antitrust law permits procompetitive collaborations among health care providers, no special "exemption" or "immunity" from existing antitrust laws is necessary to ensure that such procompetitive collaborations occur. The U.S. Supreme Court recently reiterated its long-standing position that "the antitrust laws' values of free enterprise and economic competition" make such special exemptions or immunities "disfavored."[26] There is no reason to treat the health care industry differently with regard to application of the antitrust laws. Indeed, in the health care industry, just like in other industries, consumers benefit from vigorous competition and are harmed by anticompetitive conduct.[27]

Health care providers have repeatedly sought antitrust immunity for various forms of joint conduct, including agreements on the prices they will accept from payers, asserting that immunity for joint bargaining is necessary to "level the playing field" so that providers can create and exercise countervailing market power.[28] In a 2004 report on health care competition, the federal antitrust agencies jointly responded to and countered this argument, explaining that antitrust exemptions "are likely to harm consumers by increasing costs without improving quality of care."[29] In its 2007 report, the bipartisan Antitrust Modernization Commission succinctly stated a widely recognized proposition: "[t]ypically, antitrust exemptions create economic benefits that flow to small, concentrated interest groups, while the costs of the exemption are widely dispersed, usually passed on to a large population of consumers through higher prices, reduced output, lower quality and reduced innovation."[30] In other words, antitrust exemptions threaten broad consumer harm while benefitting only certain market participants.

FTC officials further have noted that state legislation aimed at exempting health care providers engaging in collaborative activities from antitrust scrutiny may "encourage providers to negotiate collectively with health plans in order to extract higher rates, in effect allowing providers to fix their prices. By permitting conduct that would ordinarily violate antitrust laws, the bills would lead to higher prices and lower-quality care – undercutting the very objectives they aim to achieve."[31] While FTC officials have acknowledged that "[c]ollaboration designed to promote beneficial integrated care can benefit consumers," they also have warned that "collaboration that eliminates or reduces price competition or allows providers to gain increased bargaining leverage with payers raises significant antitrust concerns. Antitrust concerns can arise if integration involves a substantial portion of the competing providers of any particular service or specialty[.]"[32] All three of the DSRIP PPS networks that have applied for COPAs appear to involve

substantial portions of competing health care providers in their respective geographic regions,[33] thereby increasing the potential for anticompetitive harm. Furthermore, their applications specifically reference the antitrust risks they may face unless they receive COPA status[34] and appear to contemplate collective contract negotiations with payers.[35]

Given that efficient collaborations among health care providers likely to benefit consumers are already consistent with the antitrust laws, FTC staff is concerned that New York's COPA regulations will encourage precisely the types of agreements among competitors that likely would *not* pass muster under the antitrust laws – conduct that would reduce competition, raise prices, and provide few or no benefits to consumers. Any effort to shield such harmful conduct from antitrust enforcement, including attempts to confer state action immunity, is likely to harm New York health care consumers.

IV. Conclusion

In summary, FTC staff not only believes that New York's COPA regulations are unnecessary to promote the goals of health care reform, but also is concerned that the COPA scheme is likely to foster anticompetitive conduct to the detriment of New York health care consumers.

Given the limited duration of the public comment period for COPA applications, FTC staff has not conducted an independent antitrust analysis of the three specific DSRIP PPSs that have applied for COPAs. As part of the COPA review process, we urge the Department of Health to carefully consider each PPS's potential impact on competition, including the likelihood that any procompetitive benefits of collaboration among the DSRIP PPS participants would be outweighed by the anticompetitive effects of immunizing potentially unlawful conduct.

The FTC will continue to investigate and challenge transactions that are anticompetitive. In addition, we will continue to challenge defenses based on asserted state action immunity where the state fails to provide adequate active supervision.

Respectfully submitted,

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[1] This letter expresses the views of the FTC's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] *See* Adirondack Health Institute DSRIP PPS Organizational Application (Dec. 22, 2014), http://health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/adirondack_health_institute/adirondack_org_application.pdf (Reference COPA-AHIPPS, DSRIP PPS ID: 23).

[3] *See* Advocate Community Partners DSRIP PPS Organizational Application (Dec. 22, 2014), http://health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/advocate_community_partners_awmedical/advocate_community_partners_org_app.pdf (Reference COPA-ACPPPS, PPS ID: 25).

[4] *See* Staten Island DSRIP PPS Organizational Application (Dec. 22, 2014), http://health.ny.gov/health_care/medicaid/redesign/dsrip/pps_applications/docs/richmond_med_ctr_staten_island_hospital/richmond_staten_island_hosp_org_app.pdf (Reference COPA-SIPPS, PPS ID: 43).

[5] Federal Trade Commission Act, 15 U.S.C. § 45.

[6] Standard Oil Co. v. FTC, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[7] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[8] *See generally* FED. TRADE COMM'N, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (Mar. 2013), https://www.ftc.gov/sites/default/files/attachments/competition-policy-guidance/hcupdate.pdf. *See also Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care ("Cases").

[9] *See, e.g.*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [hereinafter FTC & DOJ, IMPROVING HEALTH CARE]. The report was based on, among other things, 27 days of formal hearings on competitive issues in health care, an FTC sponsored workshop, independent research, and the Agencies' enforcement experience. *See also* FTC-DOJ workshop series, *Examining Health Care Competition*, Mar. 20-21, 2014 and Feb. 24-25, 2015, https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition.

[10] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus

briefs, or reports.

[11] *See, e.g.*, FTC Staff Comment to Sen. John J. Bonacic, N.Y. State Senate, Concerning N.Y. Senate Bill S.3186-A, Intended to Permit Collective Negotiations by Health Care Providers (Oct. 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-honorable-john-j.bonacic-concerning-new-york-s.b.3186-allow-health-care-providers-negotiate-collectively-health-plans/111024nyhealthcare.pdf; FTC Staff Comment to Sen. Catherine Osten and Rep. Peter Tercyak, Conn. Gen. Assembly, Concerning H.B. 6431, Intended to Exempt Health Care Collaboratives from the Antitrust Laws (June 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-connecticut-general-assembly-labor-and-employees-committee-regarding-connecticut/130605conncoopcomment.pdf; FTC Staff Comment to Sens. Coleman and Kissel and Reps. Fox and Hetherington, Conn. Gen. Assembly, Concerning Connecticut H.B. 6343, Intended to Exempt Members of Certified Cooperative Arrangements from the Antitrust Laws (June 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-senatorscoleman-andkissel-and-representativesfox-and-hetherington-concerning.b.6343intended-toexempt-members-certified-cooperative-arrangements-antitrust-laws/110608chc.pdf; FTC Staff Comment to the Hon. Elliott Naishtat Concerning Tex. S.B. 8 to Exempt Certified Health Care Collaboratives from the Antitrust Laws (May 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.elliot-naishtat-concerning-texas-s.b.8-exempt-certified-health-care-collaboratives-antitrust-laws/1105texashealthcare.pdf; FTC Staff Comment to Rep. Tom Emmer of the Minn. House of Reps. Concerning Minn. H.F. No. 120 and Senate Bill S.F. No. 203 on Health Care Cooperatives (Mar. 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-representative-tom-emmer-minnesota-house-representatives-concerning-minnesota-ok-h.f.no.120-and-senate-bill-s.f.no.203-health-care-cooperatives/v090003.pdf; FTC Staff Comment to the Hon. William J. Seitz Concerning Ohio Executive Order 2007-23S to Establish Collective Bargaining for Home Health Care Workers (Feb. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-hon.william-j.seitz-concerning-ohio-executive-order-2007-23s-establish-collective-bargaining-home-health-care/v080001homecare.pdf; FTC Staff Comment before the P.R. House of Reps. Concerning S.B. 2190 to Permit Collective Bargaining by Health Care Providers (Jan. 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-puerto-rico-house-representatives-concerning-s.b.2190-permit-collective-bargaining-health-care-providers/v080003puerto.pdf. All advocacies are available at https://www.ftc.gov/policy/advocacy/advocacy-filings.

[12] For more information about the DSRIP program, *see* DSRIP Overview, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm.

[13] *See* DSRIP FAQs, https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_faq.pdf, at 16 ("Q: Will PPS networks be protected from laws on anti-competitive behavior? A: Yes, in instances where a DSRIP PPS can show that a potential collaboration between providers will benefit the community, there will be an opportunity

for the state to provide protections for a PPS. This protection will come in the form of a Certificate of Public Advantage (COPA), which will be granted if it appears that the benefits of a collaboration between PPS partners will outweigh any disadvantages attributable to their anticompetitive effects and will be subject to active state supervision. COPA regulations are explicated in Article 29-F of New York's Public Health Law.").

[14] *See* New York Public Health Law, Article 29-F, § 2999-aa (Antitrust Provisions, State Oversight) and § 2999-bb (Department Authority), *available at* http://nys.law.streaver.net/PBH/a2564.html.

[15] *See* 10 NYCRR, Subpart 83-1.5 (describing the review process for COPA applications), *available at* http://www.health.ny.gov/regulations/recently_adopted/docs/2014-12-17_certificate_of_public_advantage.pdf.

[16] *See* 10 NYCRR, Subpart 83-1.2 (describing the effect and application process of COPA), *available at* http://www.health.ny.gov/regulations/recently_adopted/docs/2014-12-17_certificate_of_public_advantage.pdf.

[17] States may provide antitrust immunity for certain activities when there is a clearly articulated state policy to displace competition and there is active state supervision of the policy or activity. *See Parker v. Brown*, 317 U.S. 341 (1943), *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003 (2013), and *North Carolina State Bd. Of Dental Exam'rs v. FTC*, 135 S. Ct. 1101 (2015). FTC staff takes no position at this time on whether the COPA regulations would satisfy the active supervision prong of the state action doctrine.

[18] *See, e.g.*, DSRIP FAQs at 10 ("The DSRIP Program is an initiative is specifically targeted to the Medicaid and uninsured population. However, as PPS entities work to transform their service delivery system and payment structure, the state expects that the DSRIP program will act as a catalyst for change to other parts of a provider's book of business. In addition, pay for performance or value based purchasing by government and private insurers is becoming much more widespread, supporting the transformative changes from DSRIP.").

[19] FTC staff recognizes that, theoretically, it may be possible for health care providers participating in a PPS network to implement an organizational structure that would minimize the sharing of information regarding commercial and Medicare patients, thereby mitigating potential antitrust concerns relating to joint contract negotiations, information exchanges, or other forms of coordination among PPS participants. At this time, FTC staff takes no position on whether these three DSRIP PPSs employ such structures.

[20] Pub. L. No. 111-148, § 3022, 14 Stat. 119, 395 ("Affordable Care Act").

[21] New York State Senate Bill 2809D (2011), § 50: Legislative Findings, http://open.nysenate.gov/legislation/bill/S2809D-2011.

[22] To assist the business community in distinguishing between lawful and potentially harmful forms of competitor collaboration, the FTC and its sister federal antitrust agency, the DOJ, have issued considerable guidance over the years. Key sources of guidance include the Agencies' general guidelines on collaborations among competitors, as well as

joint statements specifically addressing the application of the antitrust laws to the health care industry, including physician network joint ventures and other provider collaborations. FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS (2000), https://www.ftc.gov/sites/default/files/documents/public_events/joint-venture-hearings-antitrust-guidelines-collaboration-among-competitors/ftcdojguidelines-2.pdf; U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (*see, e.g., id.* at Statement 8 regarding physician network joint ventures, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 6 regarding provider participation in exchanges of price and cost information).

In addition, FTC staff has issued and made public numerous advisory opinion letters containing detailed analyses of specific proposed health care collaborations. These letters have helped the requesting parties avoid potentially unlawful conduct as they seek to devise new ways of responding to the demands of the marketplace. They also have provided further guidance to the health care industry as a whole. *See, e.g.*, Letter from Markus H. Meier, Fed. Trade Comm'n, to Michael E. Joseph, Esq., McAfee & Taft, Re: Norman PHO Advisory Opinion, Feb. 13, 2013, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/norman-physician-hospital-organization/130213normanphoadvltr_0.pdf; Letter from Markus H. Meier, Fed. Trade Comm'n, to Christi Braun, Ober, Kaler, Grimes & Shriver, Re: TriState Health Partners, Inc. Advisory Opinion, Apr. 13, 2009, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/tristate-health-partners-inc./090413tristateaoletter.pdf; Letter from Markus Meier, Fed. Trade Comm'n, to Christi Braun & John J. Miles, Ober, Kaler, Grimes & Shriver, Re: Greater Rochester Independent Practice Association, Inc. Advisory Opinion, Sept. 17, 2007, https://www.ftc.gov/sites/default/files/documents/advisory-opinions/greater-rochester-independent-practice-association-inc./gripa.pdf.

[23] Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245 (2014), http://www.nejm.org/doi/pdf/10.1056/NEJMp1408009. *See also* Deborah L. Feinstein, Dir., Bureau of Competition, Remarks at the Fifth National Accountable Care Organization Summit in Washington, DC: Antitrust Enforcement in Health Care: Proscription, not Prescription (June 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf ("We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws."); Commissioner Julie Brill, Fed. Trade Comm'n, Keynote Address at the Catalyst For Payment Reform 2013 National Summit on Provider Market Power: Promoting Healthy Competition in Health Care Markets: Antitrust, the ACA, and ACOs (June 11, 2013), https://www.ftc.gov/sites/default/files/documents/public_statements/promoting-healthy-competition-health-care-markets-antitrust-aca-and-acos/

130611cprspeech.pdf.

[24] Feinstein, *supra* note 23.

[25] *See* Brill, *supra* note 23 ("Antitrust law permits providers to engage in a wide array of legitimate collaborative activities, including ACO [Accountable Care Organization] arrangements, as well as many mergers and consolidations, so long as the conduct is likely to promote consumer welfare through lower cost or improved quality.").

[26] *Phoebe Putney*, 133 S. Ct. at 1010 (quoting *FTC v. Ticor Title Ins. Co.*, 504 U. S. 621, 636 (1992)). *See also North Carolina State Bd. of Dental Exam'rs*, 135 S. Ct. at 1117 ("The Sherman Act protects competition while also respecting federalism. It does not authorize the States to abandon markets to the unsupervised control of active market participants, whether trade associations or hybrid agencies. If a State wants to rely on active market participants as regulators, it must provide active supervision if state-action immunity under *Parker* is to be invoked.").

[27] *Phoebe Putney*, 133 S. Ct. at 1015 (state legislature's objective of improving access to affordable health care does not logically suggest contemplation of anticompetitive means, and "restrictions [imposed upon hospital authorities] should be read to suggest more modest aims."). As the U.S. Court of Appeals for the Fourth Circuit has observed, "[f]orewarned by the [Supreme Court's] decision in *National Society of Professional Engineers* . . . that it is not the function of a group of professionals to decide that competition is not beneficial in their line of work, we are not inclined to condone anticompetitive conduct upon an incantation of 'good medical practice.'" Va. Acad. of Clinical Psychologists v. Blue Shield of Va., 624 F.2d 476, 485 (4th Cir. 1980).

[28] In general, the Supreme Court has flatly rejected the notion that members of the learned professions should be free from antitrust scrutiny: "The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public-service aspect of professional practice controlling in determining whether § 1 includes professions." *Goldfarb v. Va. State Bar*, 421 U.S. 773, 787 (1975). *See also Nat'l Soc'y Prof'l Eng'rs*, 435 U.S. at 695 (Supreme Court rejection of argument that competition itself poses a "potential threat . . . to the public safety"); *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447 (1986).

[29] FTC & DOJ, IMPROVING HEALTH CARE, *supra* note 9, at 14.

[30] ANTITRUST MODERNIZATION COMM'N, REPORT AND RECOMMENDATIONS 335 (2007), http://govinfo.library.unt.edu/amc/report_recommendation/amc_final_report.pdf.

[31] Ramirez, *supra* note 23.

[32] Feinstein, *supra* note 23. There is a growing body of empirical research showing that increased concentration among health care providers results in higher prices without offsetting improvements in quality. *See, e.g.*, Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation – Update* (Robert Wood Johnson Found., Synthesis Project Report, June 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

[33] *See* Adirondack Health Institute PPS Organizational Application, *supra* note 2, at 44-

45, 54-63 (listing 95 participating health care providers, including 9 of the 13 hospitals and more than half of the primary care physicians in this region); Advocate Community Partners PPS Organizational Application, *supra* note 3, at 20 (describing this as "one of New York's largest PPSs" consisting of: AW Medical Office, PC, a primary care medical practice representing over 2,500 providers, including over 2,000 physicians, belonging to 8 IPAs and 3 Medicare ACOs; New York Community Preferred Partners, which is formed by AW's IPAs and ACOs, in partnership with a Federally Qualified Health Center; North Shore Long Island Jewish Health System, a premier health system with 17 hospitals, including 5 in this PPS's region, and a broad range of other facilities; MediSys Health Network (the sole corporate member of Jamaica Hospital and Flushing Hospital); St. Barnabas Hospital; Lutheran Medical Center; New York Methodist Hospital; Mt. Sinai Hospital; and Montefiore Medical Center); and Staten Island PPS Organizational Application, *supra* note 4, at 6 (stating that this PPS would include Staten Island's only two acute care hospitals, which have a combined share of 86 percent of all Medicaid discharges and 90 percent of all self-pay discharges); *id*. at 10 (stating that in addition to these two hospitals, the Staten Island PPS partners will include over 50 health care providers, including skilled nursing facilities, mental health and substance abuse providers, home care agencies, primary care practitioners, Federally Qualified Health Centers, and community based organizations).

Many other DSRIP PPSs also include huge numbers of participating health care providers, but they have not applied for COPA status. It is possible that the FTC could have concerns about some of these PPSs if they engage in activities that violate the antitrust laws.

[34] *See* Adirondack Health Institute PPS Organizational Application, *supra* note 2, at 7 (describing how "negotiating with private entities increases anti-trust risk" and that "[t]here are ongoing anti-trust concerns for the PPS.").

[35] *See* Adirondack Health Institute PPS Organizational Application, *supra* note 2, at 39 (referencing anticipated collaboration on pay-for-performance initiatives and contract negotiations); Advocate Community Partners PPS Organizational Application, *supra* note 3, at 76-77 (describing the intention of the PPS participants to collectively enter into value-based contractual arrangements with Medicaid managed care organizations); and Staten Island PPS Organizational Application, *supra* note 4, at 70 and 72 ("The SI PPS has already initiated discussion with MCOs around the transition to value based reimbursement and will continue discussions to specifically develop reimbursement models to support PPS providers, particular[ly] fragile safety net providers.").