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Phone: +1 646 783 7100 | Fax: +1 646 783 7161 | customerservice@law360.com

Who's Afraid Of ACOs?

Law360, New York (January 19, 2011) -- In the debate over antitrust implications of the formation of accountable care organizations (ACOs), there is fear on both sides. Payors have expressed fears that providers, among other things, will turn collaboration in the context of the Medicare shared savings program into bargaining units for price negotiation for populations covered by commercial contracts. In turn, providers have expressed concerns their future collaboration through the shared savings program requires broad antitrust "safe harbor" protections.

Unfortunately, elements of the payor and provider communities may be reflexively assuming old positions and pushing for the resolution of archetypal issues that need not be resolved to move forward with the antitrust issue at hand. The narrow question presented by Medicare's shared savings program is merely whether competing providers might enter into two types of agreements without, in the words of Section 1 of the Sherman Act, "unreasonably restraining trade."

The first type of agreement to be tested is that by which competing providers resolve to "bend the cost curve." Providers submitting an application to participate in the program must have agreed to participate in processes to promote evidence-based medicine. Additionally, they must have agreed to report on quality and cost management measures. Finally, they will need to agree as to processes through which they will coordinate care.

The second type of agreement to be tested is the agreement among providers to receive shared savings payments and distribute those payments among themselves. This type of agreement would differ depending on whether the participation included downside risk or simply pertained to distribution of "bonus."

The agreements as to the distribution of "back-end bonus" might differ in form depending on whether a formula for distribution was established in advance, or whether the competing providers were delegating the distribution allocation to a body or agent. Agreements implementing downside risk arrangements would necessarily entail agreements as to what interim pricing would be and agreements as to discounts to that pricing, should the risk pool be tapped out.

Under traditional Sherman Act Section 1 analysis, neither type of agreement seems properly classified as

one that would be suspect (e.g., price fixing, market division) and therefore potentially presumptively (per se) unlawful. The agreements around care coordination and cost and quality processes are arguably far removed from agreements as to price.

Agreements around bonus methodology do extend to price, but they are inherently based on how to distribute the fruits of efficiencies that the collaboration creates. Agreements as to pricing to facilitate the assumption of financial risk clearly implicate price; however, they are only those necessary to achieve the efficiency enhancing collaboration.

In either case, the agreements concerned are most likely to be subject to a facts-and-circumstances analysis, to gauge their purpose and whether they might unreasonably affect competition in the relevant market. The narrowest market affected by these agreements might be posited as the market for the sale of health care services to Medicare.

Providers would be quick to assert that the Medicare program is "big enough to take care of itself." Through this type of agreement, they are unlikely to be able to raise the price paid by Medicare, or lower the quality of the services they provide to the program. Given its power as a buyer of services, if Medicare does not like the nature of the care coordination and cost management collaboration proffered by the otherwise competing providers, it can "just say no." It seems unlikely that a reviewing court would conclude that, as a result of these agreements, Medicare will pay more than a market price for services, since the evidence is likely to be that Medicare "makes this market."

Perhaps the most salient part of this analysis would be an inquiry into any spillover effects. It is here, no doubt, that fears most frequently arise. Of course, to the extent that the agreement among competitors deals only with processes and bonus distribution in fee-for-service Medicare, it does not have negative spillover effects. The efficiencies created by the care coordination and quality-enhancing processes might affect costs and quality for commercial or other governmental payor populations. However, that spillover is likely to be judged to be efficiency enhancing and not increasing price or decrease quality.

Competing providers may well wish to reach a different agreement, one that offers the efficiencies of their collaboration to commercial payors — particularly since care paths developed in the Medicare context may well affect the rendering of services for commercial populations. To be clear, this is not an antitrust question necessarily reached to effect participation in Medicare shared savings program. One should be able to test the agreements inherent in Medicare shared savings, independent of hopes and fears relative to additional agreements connected to commercial markets.

In commercial markets, there is no simple antitrust answer, such as there is in Medicare fee-for-service where the buyer will dictate terms and is therefore protected against supra-competitive pricing or quality derogation. However, in applying the rule of reason in these markets, one need not presume either anti-competitive purpose or anti-competitive effects.

Moreover, if the agreements do not involve exclusivity, claims of potential anti-competitive effect will always be countered by an assertion that the payor can choose to deal with the competing providers in their collaborative form, or individually. Indeed, a payor could develop its own view of what an

integrated provider network should look like and contract with those providers as an alternative to an ACO presented.

While there is undoubtedly fear and suspicion around the ability of a payor to bargain with the ACO providers independently, the ability to do so can be tested factually. Antitrust enforcement agencies need not presume the answer either way. Most importantly, neither the Centers for Medicare and Medicaid Services nor the antitrust enforcement agencies need seek an answer to that question concurrent with the application of ACOs to participate in a shared savings program.

Antitrust enforcers can monitor the behavior of ACOs, just as they've monitored the behavior of other networks in the commercial market. As noted, in the Medicare fee-for-service realm, the seminal financial and clinical integration questions need not be resolved to permit a finding that agreements on care coordination processes and on how to distribute any "savings" distributed by Medicare do not "unreasonably restrain trade," so as to be violative of antitrust law.

--By Mark E. Lutes and Patricia M. Wagner, EpsteinBeckerGreen

Mark Lutes (mlutes@ebglaw.com) is a member in EpsteinBeckerGreen's Washington, D.C., office and a former legislative adviser to the Federal Trade Commission. Patricia Wagner (pwagner@ebglaw.com) is a member in the firm's Washington office.