

Payer-Provider Consolidation Post-ACA Comes With New Risks

Law360, New York (January 14, 2015, 10:41 AM ET) --

The Affordable Care Act is accelerating change away from the fee-for-service health care delivery model by directing cost-reduction reforms at health care delivery. But any change in the way health care is delivered will necessarily implicate how it is paid for, which in turn implicates insurance coverage.

These strong economic forces coupled with the anxiety of payers and providers fearing they will be left behind is resulting in a more encompassing type of consolidation — the coming together of providers (hospitals, physicians) with insurers into (closed) systems. Already, several insurers have bought physician practices and even larger integrated health systems (e.g., UHG/Monarch Healthcare; Humana/Concentra). Providers and health systems are acquiring or organizing their own insurance products (e.g., Detroit Medical Center, Piedmont Healthcare and WellStar Health System).



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With this increasing vertical consolidation in health care, both payers and providers face new health care fraud and abuse and antitrust risks that are different from the ones that they previously confronted. We explore these risks and provide practical advice for those health care entities that are entering this new world.

Fraud and Abuse

Any health care entity that submits claims to the federal government, whether it is a health care payer or provider, must comply with the fraud and abuse statutes. Two of the most powerful weapons in the government's arsenal are the False Claims Act and the Anti-Kickback Statute.

The FCA is the government's primary enforcement tool in combating fraud and abuse in federal health care programs, including Medicare and Medicaid. Over the past few years, the government has used the FCA to pull in record-setting recoveries against many health care entities. The FCA is such a powerful tool for the government, and a huge threat for many health care entities because of the enormous liability potential. In addition to treble damages, a penalty ranging from \$5,500 to \$11,000 per claim can add up quickly in a typical investigation where the number of claims at issue can run into the thousands.

While the government can pursue an FCA case based on its own investigation, many cases are first brought by whistleblowers, also known as qui tam plaintiffs. After an action is initiated by a whistleblower, the government will investigate to determine if it wishes to intervene in an action. Previously, when the government declined to intervene, it usually meant the plaintiff would drop his or her action. The qui tam plaintiff's bar is becoming more sophisticated and confident in these cases, however, and health care providers can no longer feel assured that a FCA matter will go away if the government declines to intervene.

The FCA is a potential minefield of new and expanding risks to health care payers and providers in this era of health care reform and consolidation that is, at the very least, accelerated by payment reforms within the Affordable Care Act. First, and probably most strikingly, the ACA explicitly made a whole new "commercially insured" population subject to the False Claims Act. Commercial insurers who never had to be concerned about the FCA's reach, now need to ensure compliance with many new federal requirements. For example, if an insurer made a false statement in connection with its medical loss ratio data, its justification for rate increases, its risk corridor calculations, or its risk adjustment submissions, this may lead to FCA liability.

The ACA also continues the recent pattern of expanding the government's authority under the FCA. For example, it made clear that a violation of the Anti-Kickback Statute can be the basis of FCA liability. Further, the ACA mandated that identified overpayments needed to be reported and returned to the government within 60 days; and the failure to return the overpayment would lead to a per se violation of the FCA.

Further, health care payers who are acquiring providers may never have been concerned about potential risks associated with operating in a fee-for-service environment. Many health plans in the Medicare Advantage Program have long enjoyed very broad safe harbors under the Anti-Kickback Statute and the Stark Law. Yet, when payers acquire providers who do not operate in a managed care or capitated environment, the acquired providers do not have many of the safe-harbor protections with which the payer is accustomed. While integrated delivery systems are protected in some instances in the Medicare program, like those entities that are protected by the fraud and abuse waivers under the Medicare Shared Savings Program, not all of these new financial arrangements are easily protected. Therefore, health plans entering into this new space must exercise caution.

Finally, providers creating new Medicare or Medicaid managed care plans also face risks. As noted above, any false claim, record or statement resulting in the receipt of federal funds can expose a health plan to FCA liability. Such risk areas include the submission of plan bids that are not actuarially sound, false certifications associated with those bids, false health status reports and other data required to be submitted to the government, or improper steering of sicker patients away from health plans.

Antitrust Risks

Given the ACA's imperatives on payers and providers to improve economies of scale and reduce overhead, the success of these recent payer and provider tie-ups hinges on the ability to control health services utilization and prevent waste and redundancies through complete care coordination.

Consolidation of payers with providers is not a new concept, of course. Insurers have managed and/or integrated physician practices in a number of defined markets for years. Indeed with a push to control spiraling health care costs in the 1980s and 1990s, integrated managed care organizations were prevalent. Common cost-control strategies included selective contracting; shifting financial risk (e.g.,

capitation); utilization reviews; and increased cost-sharing through copayments.

Fast-forward to 2015, and there is again recognition that influencing referral patterns can achieve sought after service utilization modifications. The current payer/provider consolidation is premised on the theory that integrated payers/providers will more effectively align the incentives on spending and utilization. The model has been and can be successful see, e.g., Kaiser-Permanente. Depending on the specific facts, however, legitimate selective contracting and referral practices in one market could result in anti-competitive effects in another, particularly as the number of alternative providers and payers decreases.

The Federal Trade Commission and U.S. Department of Justice, however, typically focus their enforcement activities on collaborations between competing providers (e.g., two hospitals in the same service area) or competing payers, looking at competitive effects within a discrete, local area. These are referred to as “horizontal” transactions. Collaborations and consolidations between participants on different levels of the value chain, i.e., a payer acquiring a provider group, are “vertical” transactions. And while FTC Chairwoman Edith Ramirez has indicated the FTC’s interest in understanding the potential for vertical transactions to cause competitive harm,[1] in a recent speech, the former director of the FTC’s Bureau of Economics, acknowledged that the competitive effects of nonhorizontal consolidation across product markets and adjacent geography are “known unknowns.”[2]

Nonetheless, we do know that a vertical transaction that likely would result in higher prices in adjacent markets or one that forecloses necessary inputs to rivals would pique the interest of antitrust enforcers. Whether the agencies would challenge that transaction would depend on whether alternatives in both the payer and the provider segments remain post-merger. For example, a payer acquisition of providers would likely raise concerns if a payer acquired so many physicians in a particular specialty that a competing payer would be unable to offer an adequate competing network because it lacks access to the needed physicians. The viability of bringing a challenge would depend, in part, on entry. That is, whether the foreclosed payer could obtain the services of physicians not currently in the market.

The complaint in *FTC et al v. St. Luke’s Health System Ltd. et al*[3] highlights competitive concerns arising from vertical aspects of a transaction, notwithstanding the fact that the FTC pursued its case as a horizontal combination between direct competitors for the provision of primary care physician services. For example, the FTC alleged the merger would likely allow St. Luke’s to raise its rates “for ancillary services — like labs and X-rays,” areas in which St. Luke’s and Saltzer did not compete prior to the merger. Similarly, the FTC alleged that health plans would also pay higher rates for other services, such as surgeries, as a result of St. Luke’s already higher billing rates and its physician referral policies that would direct patients to St. Luke’s in-house facilities, foreclosing physician referrals to competing inpatient and outpatient facilities.

In dismissing contractual provisions allowing Saltzer physicians to retain discretion to refer patients to any practitioner or facility regardless of its affiliation with St. Luke’s, the court cited referral patterns subsequent to past St. Luke’s physician group acquisitions and determined that the Saltzer physicians would likely change their referral patterns (e.g., for surgery and imaging services) to disfavor St. Luke’s rivals.

Taking It to Your World: Compliance Tips and Best Practices

With so many potential new risks as providers and payers consolidate and take advantage of new opportunities brought about by the Affordable Care Act and health care reform, there are steps health

care entities can take to thrive.

Fraud and Abuse

While the government has new and expanding FCA authorities, the underlying risks have not fundamentally been altered. Instead, many entities are now operating in spaces where they are simply unaware of the risk. Therefore, they must focus on compliance and education, becoming informed as to what is necessary to avoid or mitigate risk.

Providers that are becoming payers need to understand how to submit proper bids and certifications. Payers that are acquiring providers need to understand the Anti-Kickback Statute and the Stark Law. Both payer and providers need to identify when problems occur and report and return overpayments if necessary. Fraud and abuse laws do not need to be a barrier to success. With proper focus on compliance, entities operating in areas new to them, can meet regulatory requirements and avoid FCA risk.

Antitrust

The agencies are attentive to the vertical consolidation in health care. Proper focus on basic antitrust fundamentals can substantially mitigate antitrust risk. These steps include understanding the effects of consolidation on rivals, and addressing ahead of time aspects of the consolidation that could be viewed as unlawful.

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[1] See Remarks of FTC Chairwomen Edith Ramirez at George Washington Univ. Merger Transactions Symposium - Retrospectives at the FTC: Promoting an Antitrust Agenda, at 11 (June 28, 2013) available at http://www.ftc.gov/sites/default/files/documents/public_statements/retrospectives-ftc-promoting-antitrust-agenda/130628aba-antitrust.pdf.

[2] See Prof. Leemore S. Dafny, “Healthcare Provider Consolidation: Facts, Myths, and Unknowns”, at Marshall J. Seidman Lecture at the Harvard Department of Health Care Policy, Cambridge, MA (September 29, 2014) available at <http://www.frequency.com/video/healthcare-provider-consolidation-facts/201482816?cid=5-1>

[3] The court ordered the complete divestiture of the acquired assets. The case is currently under appeal to the Ninth Circuit.

