FOURTH QUARTER: 2012

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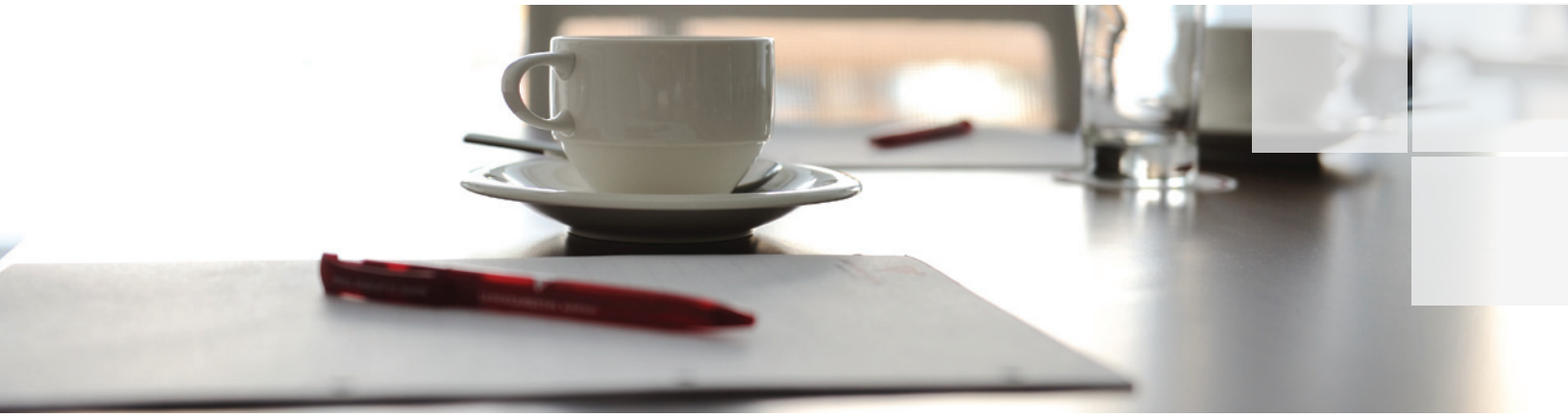

This Transaction Will Improve Quality

Deconstructing the Ever-Present Antitrust "Defense" to Provider Consolidation

Providers need to recognize that the FTC will scrutinize all quality arguments offered in defense of an otherwise anticompetitive transaction.

The press release always contains a variation on the same theme: "This transaction will provide the citizens of this community with higher quality health care." It sounds like a winning proposition that everyone can support. But behind such bold statements should be detailed and recognizable results because the federal antitrust enforcement agencies continue to say, "Show me the quality."

In this era of health care reform, providers are looking for ways to lower health care costs while simultaneously improving quality. Provider consolidation continues to be a go-to solution. But as provider consolidation picks up, the federal antitrust enforcement agencies, including the Federal Trade Commission ("FTC"), continue to scrutinize deals for anticompetitive harm. The FTC is worried that provider consolidation will lead to enhanced market power, less competition and higher prices, all of which may negatively impact patients. As part of their defense, providers inevitably wave the quality flag—that the proposed transaction will allow the parties to share best practices, coordinate care, benefit from increased procedural volumes, make technological improvements and recruit new and better specialists. Recently, the FTC, in its hospital merger enforcement activity, has taken the quality defense head-on and pushed back on such claims while vigorously investigating the supporting facts and evidence. CONTINUED ON PAGE 2

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This Transaction Will Improve Quality

Deconstructing the Ever-Present Antitrust "Defense" to Provider Consolidation (Continued)

The following are quality arguments made by providers and the likely FTC responses, based on recent enforcement trends:

Argument 1: This transaction will allow us to share best practices and improve patient outcomes.

FTC Response 1: Certain empirical evidence shows that hospital mergers can actually decrease quality. Where two hospitals had vigorously competed on non-price items such as quality and service, a merger of the two would eliminate this non-price competition, potentially leading to a decreased emphasis on quality. Further, if the parties are already providing similar levels of quality care, the transaction is unlikely to change anything. The parties should ask themselves whether the same best practices can be shared and patient outcomes accomplished through a more competitively neutral transaction. In other words, explain why a merger is necessary to share best practices.

Argument 2: This transaction will allow us to create Centers of Excellence by consolidating service lines, which will lead to increased procedure volumes and increased quality.

FTC Response 2: Certain empirical evidence suggests that there is not necessarily a positive correlation between increased volume and increased quality. In addition, procedural volume needs to increase per physician or clinical team as opposed to per facility; otherwise, the individuals performing the service are gaining no further experience, and quality is unlikely to change. Further, service line consolidation is often risky and politically difficult. For example, there might be differences in physician culture, protests from the community in relocating service lines or a need for certain complementary service lines to stay at the current facility. And the physical layout of the facilities might not permit the proposed consolidation or relocation of services without significant capital cost. Without concrete plans in place for service line consolidation, little weight will be given to these potential "benefits" as they will likely be perceived as purely speculative.

Argument 3: This transaction will allow us to coordinate care among more providers and allow us to form an Accountable Care Organization ("ACO").

FTC Response 3: Most hospital systems already have sufficient resources to coordinate care between hospital services, primary care physician services, specialist physician services and ancillary services. Even small community hospitals can implement significant quality improvements by coordinating care with their physicians. Further, the ACO regulations expect competition between provider networks to promote quality of care; eliminating competition by forming a mega-ACO is contrary to the purpose of the regulations, regardless of any touted increase in quality.

Argument 4: This transaction will allow us to recruit new and better specialists because our new consolidated system will offer more services and larger volumes.

FTC Response 4: Certain empirical evidence shows that hospital consolidation does not help recruitment because population is the key factor to recruitment. Specialists are attracted to large population bases to support their practices. Because the consolidation itself will not lead to any demographic change, there is no true attraction created by the consolidation to recruit new specialists. While the consolidated entity may offer new services, these new services should be supported by patient demand and not be speculative. And with respect to combining two programs with suboptimal volumes, the consolidated program must have sufficient critical mass to attract quality physicians. Further, the parties should be prepared to show that recruitment of specialists historically has been problematic and that the community has unmet needs for these services.

Conclusion: Providers need to recognize that the FTC will scrutinize all quality arguments offered in defense of an otherwise anticompetitive transaction. Anticipating the FTC's response will help providers vet the transaction upfront and guide the decision to move forward or rethink the structure, nature or purpose of the transaction. ■

What's the Most Expensive Item on the Cracker Barrel Menu?

Company Pays $850,000 Fine After Failing to Report Acquisition of Cracker Barrel Stock

Biglari Holdings Inc., owner of Steak 'n Shake and Western Sizzlin restaurants, recently agreed to pay a civil penalty of $850,000 because it failed to file a required Hart-Scott-Rodino ("HSR") premerger notification form for its 2011 acquisition of a stake in Cracker Barrel. Unfortunately for Biglari, the company failed to meet the "passive" investment exemption to the statute because it intended to participate actively in the management of Cracker Barrel.

Generally, the HSR Act requires most parties engaging in a transaction exceeding an inflation adjusted $68.2 million to file a premerger notification form with the FTC and the Department of Justice ("DOJ") at least 30 days before closing. Many hospital mergers and some physician practice acquisitions meet this filing threshold. The HSR form allows the FTC and DOJ to review the transaction from a competition standpoint and determine whether the transaction might violate the federal antitrust laws before the proverbial eggs are scrambled. The acquiring firm cannot exercise any control over the assets to be acquired pending the expiration of the 30-day waiting period. HSR filing fees range from $45,000 to $280,000 depending upon the size of the transaction. While a few exemptions exist, they are narrowly construed.

If a party fails to file the HSR premerger notification form or observe the applicable waiting period, the U.S. government may impose a civil penalty of up to $16,000 per day of violation. The penalty accumulates from the date of the infraction until a corrective filing is filed and its waiting period expires.

When contemplating a large transaction, providers need to understand the potential HSR filing obligations and recognize that a failure to meet these obligations could result in a large civil penalty. ■

Provider Price-Fixing: Who Brings a Price-Fixing Action and What Are the Consequences?

Price-fixing is an agreement among competitors that raises, lowers or stabilizes prices or competitive terms. Not surprisingly, price-fixing is illegal under the antitrust laws. It is also illegal to agree with competitors to restrict production, sales or output.

Traditionally, most provider price-fixing cases have been brought by the FTC. Because the FTC cannot sue for monetary damages, history shows that providers sued by the FTC generally sign a consent decree that requires the providers to cease their unlawful price-fixing in the future. Typically the only monetary consequences borne by the providers, albeit not insignificant, are the legal fees associated with defending the challenge.

But, in addition to claims brought by the FTC, there is also a private right of action for price-fixing claims under the federal antitrust laws. These private actions may have more severe consequences for providers because, under the federal antitrust laws, injured parties can ask for treble damages, attorneys' fees and costs.

Recently, Humana Health Plans of Puerto Rico, Inc. ("Humana") filed a price-fixing complaint against eight nephrology physicians. According to Humana's complaint, the physicians demanded (in identical letters) that Humana pay a particular coordination of benefits percentage or else they would terminate their contracts with Humana. Because Humana refused, the physicians began to deny nephrology services to Humana beneficiaries. Humana claimed that the physicians, through concerted action, had the ability to force Humana to pay rates above otherwise competitive levels.

Humana's lawsuit against the physicians sought an urgent preliminary injunction, as well as attorneys' fees, costs and actual, compensatory and punitive damages. Humana asserted its damages to be approximately $2,000,000 at the time the suit was filed. The case has survived a motion to dismiss and, if successful, could prove to be very expensive for the physicians.

Providers must understand that any type of agreement to raise or stabilize prices among their competitors could lead not only to a government investigation but also to a costly and time-consuming private lawsuit. ■

Be Careful What You Say: The Perils of Bad Documents Discovered in an Antitrust Investigation

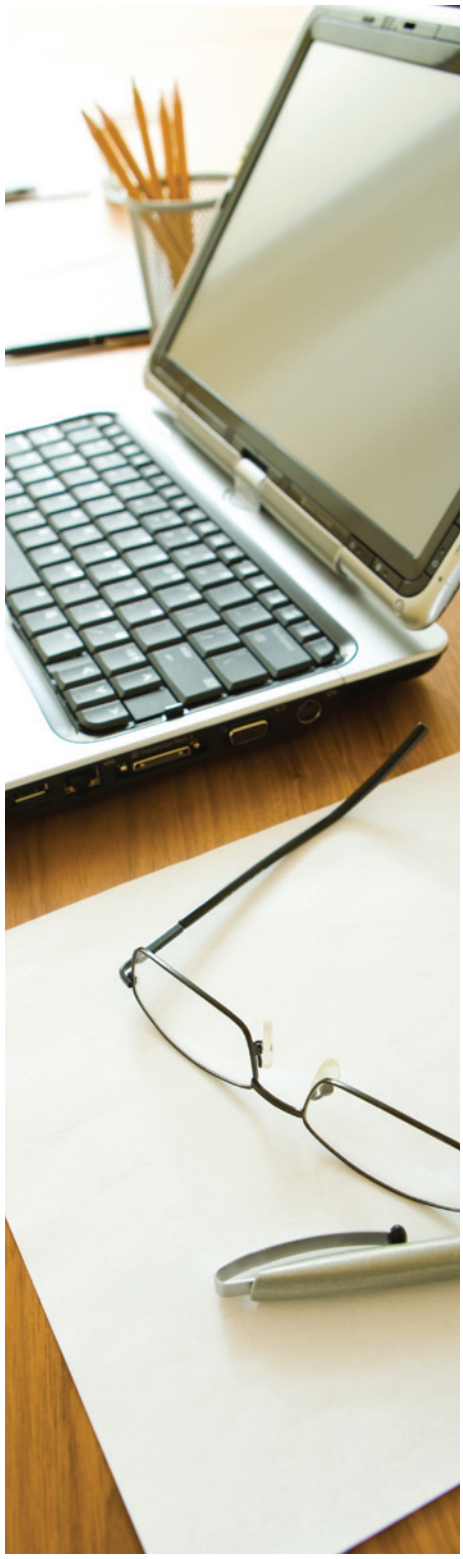
When an antitrust enforcement agency is scrutinizing a proposed provider merger, documents touting "payer leverage" and "potential for higher hospital rates" are aces in the hole for the government. Yet, these and similar statements have been discovered as part of the FTC's investigation into two recent hospital mergers. Such documents, ranging from board minutes to emails and draft PowerPoint presentations, may arise early in the merger process and may seem innocuous at the time but still have embarrassing and negative consequences.

The FTC challenged both hospital mergers and used the parties' own words to support its assertion that the transactions would lead to enhanced market power for the providers, decreased competition and higher prices.

Some of the most flagrant examples include:

- In a PowerPoint presentation by the target hospital, "payer system leverage" was one of ten reasons given for the transaction.
- In a PowerPoint presentation by the target hospital, "strong managed care contracts" was a highlighted reason for the transaction.
- Another slide stated, "[A]ffiliation with [the acquiring entity] has the greatest potential for higher hospital rates."
- In an email to the board, the target hospital CEO observed, "Two things [the acquirer] brings to the table are strong market/capital position and incredible access to outstanding pricing on managed care agreements."
- In a planning session, the director of marketing and strategic planning of the target hospital noted that managed care companies should care about the target's independence because the target "keeps the [other systems in town] a little more honest. The [health plans] lose clout if [the target hospital] is no longer independent."
- Minutes of the target's board meeting recorded that the target viewed the transaction as an opportunity "to join forces and grow together rather than compete with each other."
- Post-transaction, management reported that "the larger market share created by adding [the target hospital] has translated to better managed care contracts."

Providers must be aware of the long-term sensitivity of wording in documents. The above examples provide a stark demonstration of how bad documents can help the government kill a deal. ■



Quarterly Check-Up

HHS Announces HIPAA Settlement with Massachusetts Providers for $1.5 Million. HHS settled with two health care providers who were operating as a single affiliated covered entity after the theft of an unencrypted, personal laptop that contained electronic protected health information of thousands of patients and research subjects.
http://tinyurl.com/cp7rqko

CMS Publishes CY 2013 OPPS/ASC Proposed Rule – Summary of Key Provisions. CMS released the hospital outpatient prospective payment system and ambulatory surgical center proposed rule, which included the following key provisions: OPPS and ASC payment increases, adjustment for rural facilities and cancer hospitals, change in OPPS payment methodology, supervision issues, additional pharmaceutical-related payments, quality reporting program updates, quality improvement regulations revisions and pilot programs and demonstration projects. **http://tinyurl.com/bvsj695**

Pharmacies and Drug Distributors Take Note: DEA Revokes Registration of Two CVS Pharmacies. The DEA revoked Certificates of Registration of two pharmacies, prohibiting them from dispensing controlled substances. This is the first time the DEA has revoked the Registration of a pharmacy affiliated with a national pharmacy chain.
http://tinyurl.com/d8uu3dc

OIG Advisory Opinion 12-10: OIG Approves Free Insurance Pre-Authorization Service Program. On August 23, 2012, the OIG issued an opinion allowing the provision of free insurance pre-authorization services to referring physicians, concluding that while the free services potentially could be characterized as prohibited remuneration with the necessary intent, the OIG would not impose sanctions under the facts and circumstances presented for the opinion. **http://tinyurl.com/bbhuzxm**

OIG Reminds Pharmacies of Proper Schedule II Billing Practices. On September 27, 2012, the OIG issued findings resulting from a study on Medicare Part D billings and payments for Schedule II drug refills. Although federal law prohibits refilling prescriptions for Schedule II drugs, the OIG discovered that Medicare Part D paid $25 million for Schedule II drugs billed as refills in 2009. **http://tinyurl.com/aoyh8yg**

Hospital Value-Based Purchasing Payment Adjustments Now Effective. As of October 1, 2012, CMS will withhold 1% of Medicare reimbursement payments as part of the Value-Based Purchasing Program. This money will be used to fund incentive payments for participating hospitals in the Program. **http://tinyurl.com/anxufkb**

Summary of the OIG 2013 Work Plan. On October 2, 2012, the OIG published its Work Plan for Fiscal Year 2013. The plan illustrates that the following new areas will be the focus of the OIG's audit and enforcement priorities: compliance with Medicare's transfer policy, payments for discharges to swing beds in other hospitals, payments for canceled surgical procedures, payments for mechanical ventilation and payments for interrupted stays.
http://tinyurl.com/8jljnbg

OIG Advisory Opinion 12-14: OIG Approves Retail Rewards Program That Includes Purchases at In-Store Pharmacies. The OIG reviewed a proposed arrangement involving a retail supermarket rewards program that included rewards for a customer's out-of-pocket amounts spent on prescriptions covered by federally funded health care programs purchased at in-store pharmacies. The OIG concluded that it would not impose sanctions under the facts and circumstances presented by the party requesting the opinion.
http://tinyurl.com/a8v5mwy

CMS Extends "Extraordinary Circumstances" Hospice Exemption. CMS has adopted, and extended until September 30, 2014, a policy to permit individual hospices to utilize contracted staff members to supplement hospice employees during periods of peak patient loads or extraordinary circumstances.
http://tinyurl.com/azbh7om

NLRB Makes It Official—Requiring Employees to Be Courteous Is Unlawful. The NLRB determined that an employer's decision to fire an employee for his postings on Facebook did not violate the NLRA. However, the NLRB also concluded that the requirement that employees not be 'disrespectful' and refrain from damaging the employer's reputation violated the NLRA because it proscribed the content of employee speech.
http://tinyurl.com/b9kjlp4

Indiana Court of Appeals Allows Plaintiff to Proceed Against a Hospital for the Actions of Independent, Non-Employed Physicians Even if Not Named as Defendants. The Indiana Court of Appeals has allowed a plaintiff to proceed against the hospital for the actions of physicians on staff as apparent agents even though the physicians were not named in the lawsuit. The court determined that the physicians were apparent agents of the hospital; therefore, the hospital may be responsible for their actions.
http://tinyurl.com/agq7tnu

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With more than 160 attorneys, Hall Render partners with clients to direct them through the ever-changing business landscape of today's health care industry. Health law is our business.

CONTRIBUTING AUTHORS

MICHAEL GREER

Michael focuses his practice in the areas of health law and regulatory issues as they relate to physician groups, hospitals and health systems. He routinely counsels clients on the specifics of joint venture formations between hospitals and physicians, including antitrust issues, regulatory compliance and general business formation.

CLIFF JOHNSON

Cliff concentrates his practice in the areas of antitrust and managed care law. He has served as antitrust counsel for hospital mergers, physician practice acquisitions and provider networks; defended providers in government antitrust investigations; and advised hospitals, physicians, PHOs and trade associations on antitrust compliance matters.

JOEL SWIDER

Joel practices health care law with a focus on regulatory and corporate compliance, hospital/physician contracting, taxation and various corporate transactional issues. He received his bachelor's degree from the University of Virginia in 2008. Following graduation, Joel was appointed to serve under the Bush Administration as Agency Coordinator in the Office of Presidential Correspondence, functioning as a liaison between the White House and the various federal agencies.

ELIZABETH MITCHELL

Elizabeth practices health care law, focusing on regulatory and corporate compliance, physician agreements, corporate transactions and various tax issues. Elizabeth received her bachelor's degree from Vassar College and attended the University of Iowa thereafter, receiving her law degree and a Master of Health Administration.

ALYSSA CONLEY JAMES, Law Clerk, also contributing.

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