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Emerging Litigation Threats for Physician Relationships in a Post-ACA World

By Emre N. Ilter and Thomas A. Ryan – December 9, 2014

Four years after its adoption, the Patient Protection and Affordable Care Act (ACA) has transformed the landscape of litigation for healthcare providers. Those who have watched the healthcare market have seen the major wave of consolidation that has been triggered by the ACA. Despite the additional patients now in the system, providers are vying for a diminished pool of revenue. This has placed substantial pressure on individual doctors and small practices to consolidate with larger entities to survive. But with these increased market pressures, litigation risks have increased as well, and the past years have seen an apparent uptick in large-scale litigation against healthcare providers. Many of these cases have been brought by physicians, often in the role of “whistleblower,” against both competitors and colleagues for a variety of financial and emotional motivations. Although it is perhaps not surprising that litigation by physicians and hospitals against new “competitors” created by ACA-inspired consolidation is increasing, what is perhaps surprising is that the litigation is increasingly targeting business models.

ACA-Inspired Consolidation Is Likely “Creating” Physician Whistleblowers

Many healthcare providers are aware of the risk a whistleblower poses, but they have historically not viewed physicians as likely whistleblowers. That is changing. Fear over deals received by colleagues or competitors is increasingly acting as a catalyst to initiate litigation, as well purely cynical strategic litigation brought in an effort to eliminate competitors.

The U.S. Department of Justice and the Department of Health and Human Services’ Office of Inspector General (OIG) have taken a very aggressive approach to enforcement of the federal False Claims Act, Stark law, and anti-kickback statute in recent years. *See, e.g.*, Press Release, U.S. Dep’t of Justice, [Justice Department Recovers \\$3.8 Billion from False Claims Act Cases in Fiscal Year 2013](#) (Dec. 20, 2013).

It is no overstatement to say that the massive penalties being handed down in these cases—through judgments and settlements—can bankrupt providers and destroy careers. Simultaneously, litigation costs and expenses continue to rise through expert fees, electronic discovery, and other legal defense necessities. Providers must also be cognizant of the “avalanche effect” of litigation—namely, that one suit can trigger others, whether as a result of the whistleblower recruiting allies or others being inspired by visions of dollar signs and whispers in their ears from aggressive plaintiffs’ lawyers. Providers therefore cannot count on “containing” such a case or whistleblower, and must be prepared for a “worst-case” situation when faced with healthcare fraud allegations.

Whistleblower Life Is Also Getting Easier under ACA Provisions

The anti-kickback statute has changed in the wake of the ACA, and providers are now faced with more risk than ever. Specifically, the ACA eliminated the requirement of specific intent to induce referrals, thereby lowering the government's burden of proof in such cases. For example, 42 U.S.C. § 1320a-7b(h), titled "Actual knowledge or specific intent not required," provides: "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section." Providers now need not have actual knowledge of the anti-kickback statute or any specific intent to violate the law to be found guilty.

The powers of the OIG have also been expanding dramatically. On May 12, 2014, the Department of Health and Human Services proposed a rule that would expand the OIG's authority to impose civil penalties on providers and that would clarify some of the OIG's existing authorities. *See* 79 Fed. Reg. 27,080 (May 12, 2014) (to be codified at 42 C.F.R. §§ 1003, 1005).

Specifically, the new rule seeks to clarify that a provider who has received overpayment must report and return such overpayment within either 60 days of the date of identification of the overpayment or the date any corresponding cost report is due, whichever date is later. A failure to return overpayment is known as a "reverse false claim" and, under the new rule, would be subject to either a penalty of \$10,000 per day per overpayment or a penalty of \$10,000 per item or service. There remains a marked lack of clarity as to when an overpayment is deemed to be "identified" under the False Claims Act. A rule proposed in February 2012 indicated that identification of an overpayment occurs when actual knowledge or reckless disregard is present. But the recent rule proposed in May 2014 describes the standard as when a provider determined, or should have determined, receipt of overpayment.

The risks resulting from these changes are encouraging the consolidation of hospitals, hospital systems, and practices. At the same time, while there are now more patients in the system, pressures to contain healthcare costs have kept reimbursements from climbing. As a result, many physicians have been at a crossroads in recent years. While some are calling it quits and leaving the practice of medicine, others are turning away from private practice toward large providers to survive. These power players can provide the physicians with better leverage in negotiations with health insurers and payers, improved risk sharing, and other strategic affiliations. But despite the wave of consolidations, rivalries persist between physicians and practices with respect to compensation schemes—many physicians feel they are being muscled out and may lash out at rivals and hospitals in an effort to survive. As a result, the use of litigation as a strategic maneuver in the marketplace to improve competitive standing remains a popular option. For example, a small provider losing market share to a consolidated entity may seek to block the deal by triggering an antitrust investigation.

Civil litigation based on the False Claims Act is also being pursued by differing players in the healthcare industry. This includes the aforementioned internal whistleblowers, as well as patients alleging that profits are being prioritized over patient well-being. In addition, competitors are

seeking to recruit cooperators and flip them against their current employer. The expanding business relationships between physicians and hospitals are motivating some nonparticipating physicians and competing entities to challenge those arrangements in the form of antitrust-based actions seeking to block mergers. Once brought, these actions can last years before any sort of resolution is reached, and require millions in legal expenses. These circumstances present an ongoing minefield of risks for healthcare providers.

An Upsurge in Attacks on Business Models

There are a number of different varieties of attacks on business models arising out of ACA-inspired consolidations:

- patient-based attacks, such as putative patient class actions against medical groups and affiliated medical service organizations, alleging that risk sharing leads to prioritizing profits over patient well-being
- competitor-based attacks (hospitals), such as fights between two hospitals over alignment with a physician group
- competitor-based attacks (physician groups), such as actions by one physician group against another physician group over recruitment of primary-care physicians with exclusivity restrictions
- physician attacks on the narrowing of providers, such as actions by physician groups to block hospital mergers that could result in a physician group being “squeezed” out in favor of a competitor
- physician attacks on the narrowing of insurers, such as actions brought by medical associations against insurers that terminate large numbers of physicians from the Medicare Advantage Network

These disputes all have in common plaintiffs who believe that the current wave of consolidations occurring in connection with the ACA is either aligning powerful interests against them or leaving them without a seat at the table in the new healthcare marketplace. In some cases, they may be right.

Key Considerations

In this evolving landscape, there are key considerations for healthcare providers to focus on with respect to mitigation of litigation risk from physicians, whether whistleblowers or not, or other providers who are increasingly viewing litigation as a strategic tool against another provider.

- Keep your friends close—maintain strong physician/employee relationships.
- Keep your “enemies” closer—monitor the pulse of the market and competitors, and keep an eye out for red flags in recruiting efforts and alliances.
- Bolster compliance efforts—active, robust compliance departments and procedures are critical in preventing any conduct that could trigger healthcare fraud allegations.
- Promptly and thoroughly address and investigate internal complaints of wrongdoing—responding with silence is imprudent and could encourage the

complainer to become a whistleblower, even if the complainer's allegations were found to be wrong.

- Structure consolidation and alliance deals very carefully, with an eye toward litigation risk, including the possibility of antitrust or general anti-competitive allegations.
- Carefully monitor the ongoing changes to the OIG's powers.

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