Robinson+Cole

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In this issue:

FTC DENIED IN BID TO BLOCK HOSPITAL MERGER

On June 14, 2016, a federal district court in the Northern District of Illinois denied a request from the Federal Trade Commission (FTC) for a preliminary injunction to enjoin the pending merger of Advocate Health Care Network (Advocate) and NorthShore University HealthSystem (NorthShore). This decision represents a second recent health care antitrust loss for the FTC after a federal district court in Pennsylvania similarly denied an FTC request to block a pending hospital merger on May 9, 2016 (see related Pulse mailing).

This case concerns a proposed merger between Advocate and NorthShore (the Systems) that would create a 15-hospital system (Merger) in northern Chicago, Illinois and its suburbs. The FTC challenged the Merger in December 2015, alleging in part that it violated Section 5 of the FTC Act (15 U.S.C. § 45) and Section 7 of the Clayton Act (15 U.S.C. § 18) because, if consummated, it would substantially lessen competition in the market for general acute care inpatient hospital services reimbursed by commercial payors. The FTC, joined by the State of Illinois, subsequently sought a preliminary injunction in federal court to stay the Merger until completion of the FTC's administrative trial on its antitrust claims.

To prevail on a motion for a preliminary injunction, the FTC was required to demonstrate that the Merger was against the public interest, and the court was obligated to (1) determine the likelihood that the FTC would ultimately succeed on the merits and (2) balance the equities involved in the case. Determining the likelihood of success on the merits requires consideration of the relevant product and geographic markets. The parties agreed that the relevant product market was general acute care inpatient hospital services. Consequently, this decision turned on the parties' divergent arguments regarding the relevant geographic market for such services.

The FTC argued, in pertinent part, that the relevant geographic market consisted of six of the Systems' hospitals as well as five unrelated hospitals on the north shore of Chicago. The FTC devised its geographic market by including local hospitals, hospitals with at least a 2 percent market share in the area where the Systems attract patients, and hospitals whose service areas overlap with both Advocate and NorthShore (for example, areas from which both of the Systems draw patients). The FTC excluded certain "destination hospitals," such as University of Chicago Hospital and Cancer Treatment Centers of America, on the basis that they were not equivalent competitive substitutes for commercial payors establishing provider networks in the northern Chicago suburbs. The Systems

countered that the FTC's proposed geographic market was too narrow because it arbitrarily excluded the destination hospitals and failed to include hospitals outside the market associated with outpatient facilities or physicians' offices located within the market that can significantly affect hospital inpatient volume.

The court agreed with the Systems and concluded that the FTC's proposed geographic market definition ignores the current commercial realities of the health care industry, that there is no economic basis for excluding destination hospitals, and that there is no support for including only hospitals that draw patients from the same area as both Systems (rather than just one). Therefore, the court denied the FTC's request for injunctive relief, finding that the FTC failed to demonstrate a likelihood of success on the merits because it did not meet its burden of establishing the relevant geographic market for the Merger.

Consistent with its approach in the Pennsylvania case, the FTC has announced that it will appeal the district court's refusal to enjoin the Merger. Notably, this case represents a second successive antitrust setback for the FTC predicated on perceived deficiencies in the FTC's antitrust market analysis. If upheld, this decision may provide particularly valuable guidance for health care organizations seeking to consolidate in urban markets.

Robinson+Cole's Health Law Group will continue to closely follow and report on this case and its significance to health care consolidation.

U.S. DEPARTMENT OF JUSTICE INCREASES FALSE CLAIMS ACT PENALTIES

On June 30, 2016, the U.S. Department of Justice (DOJ) published an interim final rule increasing the civil monetary penalties assessed under the False Claims Act (FCA). Effective August 1, 2016, the minimum per claim penalties under the FCA will increase from $5,500 to $10,781 and maximum per claim penalties will increase from $11,000 to $21,563. The increased penalties apply to violations that occur after November 2, 2015, the date the Bipartisan Budget Act of 2015 was enacted.

The FCA is often invoked in health care cases involving Stark law violations, anti-kickback statute violations, and other claims related to submitting false Medicare or Medicaid claims. The increase in penalties was made in accordance with the Bipartisan Budget Act of 2015, which required inflation adjustments tied to an index reflecting the cost-of-living increase since the year in which the civil penalty was established or last adjusted, which for the FCA was 1986.

The near doubling of the per claim penalties under the FCA increases the risk that total fines will soar for FCA cases, since each FCA case can involve hundreds of allegedly fraudulent claims, with each claim trigging separate penalties.

If you have any questions, please contact a member of Robinson+Cole's Health Law Group:

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