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Compliance for integrated provider-payers

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As providers and payers increasingly align to offer integrated products, the bright line that once existed between the two has blurred. While there are considerable benefits to integration, integration presents novel compliance challenges as the parties design and operate their communal ventures. Various federal statutes, regulations, and guidance pose myriad issues for the unwary; as integrated provider-payers share risk, exchange data, produce collaborative marketing, and internally refer beneficiaries, the parties must stay aware of and manage the risks unique to such partnerships.

Payers and providers both see benefits in partnership

Provider-payer partnerships are increasingly common.[1] Major health insurance carriers already have these arrangements. The partnerships have increased across all market segments: commercial, Medicare, and Medicaid/Children's Health Insurance Program. The converse is true as well: as of 2016, nearly 52% of insurance products were represented through plans owned by major health systems.[2]

For payers, integrating with provider practices is a means to improve health outcomes and control cost through care coordination, increased access to care, and incentivizing quality over quantity.

For providers, as payers increasingly transition from fee-for-service to value-based payment (VBP) models, providers must accept risk for the quality of their care. By partnering with payers or creating their own insurance product, providers can increase margins by cutting out insurer overhead costs and profits, giving the providers greater control over their revenue stream.

The shared benefits are also significant: the parties can increase their market strength; together, they can leverage existing experience, infrastructure, data, and resources, including membership base and reach. The parties also can establish new lines of business and experiment with innovative delivery and financing strategies.

With new benefits come novel risks

As providers or payers enter new markets, they must be aware of the regulatory framework in which the other party operates. For instance, generally, payers must meet licensure requirements, financial solvency requirements, and network access and adequacy standards. Medicaid managed care providers often are subject to procurement procedures and contract termination provisions. Many of these arrangements require significant investment in care management services and information technology. In addition, partnership requires committed alignment, cooperation, and integration over an extended period of time. To achieve this, the parties must be willing to integrate decision-making rights. Also, business leaders may need to be educated regarding the new risks and compliance obligations associated with entering into these arrangements.

The focus of compliance for provider-payer partnerships

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Providers and payers that partner must focus on a different group of compliance risks than each would focus on if operating alone, particularly as they implement value-based models. The major healthcare fraud and abuse laws and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) remain at the core of compliance efforts, but the specific focus is on certain risks, including risk sharing, hospital-physician relationships, use, patient inducement, data integrity, and marketing.

- **The Stark Law**. The Stark Law prohibits a physician from referring a patient for inpatient, outpatient, or other "designated health services" covered by Medicare to a hospital or other entity with which the physician has a financial relationship, unless the relationship satisfies a Stark exception.[3]
- **The Anti-Kickback Statute (AKS)**. The AKS makes it illegal for any person to knowingly and willfully exchange remuneration for the referral of a patient for items or services covered by a federal healthcare program.[4]
- **The Civil Monetary Penalties Law (CMPL): Gainsharing**. CMPL prohibits a hospital from knowingly making any payment to induce a physician to reduce or limit medically necessary services covered by Medicare or Medicaid.[5]
- **CMPL: Beneficiary inducement**. CMPL prohibits a person from providing remuneration that they know is likely to influence a patient's selection of a provider or supplier for services covered by Medicare or Medicaid.[6]

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