Cutting Edge Antitrust Issues in Health Care Transactions

David Ettinger
Honigman Miller Schwartz & Cohn LLP

December 4, 2015

HONIGMAN®

Hospital Merger Enforcement In The 1990s: The Government Loses

- Poplar Bluff
- Dubuque
- Grand Rapids
- Long Island

Recent Government Successes In Health Antitrust Enforcement

- Evanston
- Inova
- Promedica
- OSF
- St. Luke's
- Renown
- Providence
- Reading

How To Get Your Merger Noticed

- Filing
- Payor complaints
- Doctor complaints
- Competitor complaints
- The press

Importance of Pricing Evidence

- "Between January 2007 and January 2012, St. Luke's acquired 49 physician clinics in the Treasure Valley and at least 28 physician practices in the Magic Valley . . . by 2012 St. Luke's had three of the top five highest paid hospitals [in Idaho]."[1]
- A document written by St. Luke's Regional Medical Center's CEO "under [a] heading of 'Price Increase' was a bullet point stating 'pressure payors for new/directed agreements'."[2]

1. Judge Winmill's Findings of Fact at ¶¶86-88.
2. *Id.* at ¶112.

Other Cases: "Smoking Gun" Evidence On Price

- **Evanston Opinion**: "There is no dispute that ENH substantially raised its prices shortly after the merging parties consummated the transaction." "[W]e find that the merger enabled ENH to exercise market power, and that ENH used this market power to increase its average net prices to MCOs for acute inpatient hospital services by a substantial amount. . ."

- **Inova Complaint:** "[T]he respondents do not dispute that health care prices will increase as a result of the merger."

- **ProMedica Opinion:** "ProMedica or Mercy affiliation could still stick it to employers, that is, to continue forcing high rates on employers and insurance companies." (hospital document)

What is the Product Market?

- Alternatives recognized in the cases and consent decrees:
  - Acute inpatient hospital services
  - Various physician specialties
  - Adult primary care
  - Advanced Imaging Facilities
  - OB facility services
  - Ambulatory surgery facilities
  - Orthopedic surgery facilities
  - Inpatient rehab facilities
  - Primary and secondary inpatient care

The Relevant Geographic Market is Defined by the Needs of Health Plans

- If "health plans must offer Nampa Adult PCP services to Nampa residents to effectively compete . . . Nampa is therefore the relevant geographic market."[1]
- Geographic market is "Lucas County," because, among other things, health plans "would not be able to market health plan networks to Lucas County residents that consist solely of hospitals outside of Lucas County."[2]

1. *Saint Alphonsus*, 2014 WL 407446, at *8.
2. *See also ProMedica*, 2011 WL 1219281, at *10.

[full cites.]

HONIGMAN®

Market Definition and Financial Incentives: Plaintiffs' Argument in *St. Luke's*

- Defendants' claim that patients could shift away from Nampa and Saltzer is based on the imposition of financial incentives that do not now exist, and may never exist.
- Dr. Argue does not know when or if such financial incentives would become widespread in the Treasure Valley.[1]

1. PFOF at ¶ 300; Trial Tr. at 3054:4-13, 3055:9-14 (David Argue).

Physician Transactions: What Market Share is a Problem?

- *St. Luke's*
  - 80% combined share found
  - Court adopted presumption at 2500 HHI, likely exceeded at 45% or less
- Experience in investigations
  - 65% enough
  - 47% may not be enough

Hospital Transactions: What Market Share is a Problem?

- Rockford: 68%
- OSF: 59%
- Univ. Health: 43%
- Promedica: 58%

The Ninth Circuit in *St. Luke's* on Prima Facie Case

- "The extremely high HHI on its own establishes the prima face case."
- In addition, the court found that statements and past actions by the merging parties made it likely that St. Luke's would raise reimbursement rates in a highly concentrated market."
- "And, the court's uncontested finding of high entry barriers 'eliminates the possibility that the reduced competition caused by the merger will be ameliorated by new competition from outsiders and further strengthens the FTC's case.'"

Calculating Market Share: List of Physicians Removed from Dr. Argue's Primary Care Physician Counts

Name	Reason for Removal
Zach Johnson	Deceased
John Freeman	Double counted - practices both pediatrics and internal medicine
Nicholas Lewis	Double counted - practices both pediatrics and internal medicine
Gary Canova	Retired
Hugh Eddy	Retired
James Eshenaur	Retired
Richard Gerber	Retired
Beverly Ludders	Retired
Nancy Mallory	Retired
Allen Neuenschwander	Retired
Charles Reed	Retired
John Ullery	Retired
Donald Whitenack	Retired
John Mohr	Retired
Gerald Bauman	Retired

St. Luke's exhibit.

Calculating Market Share: List of Physicians Removed from Dr. Argue's Primary Care Physician Counts (Cont'd)

Name	Reason for Removal
Kathleen Farrell	Moved out of state
Savita Hegde	Moved out of state
Aaron Jagelski	Moved out of state
Barbara Kissam	Moved out of state
Manisha Mittal	Moved out of state
Lillian Maresca	Moved out of state
Gary Luken	Moved out of state
Richard Gage	Moved out of state
James Gillick	Moved out of state
Beth Malasky	Specialty - Cardiovascular Disease
Stephen Focht	Specialty - Hospitalist
Alex Johnson	Specialty - Interventional Cardiology
Stephen Martinez	Specialty - Occupational Health
Kevin Chicoine	Specialty - Occupational Medicine
Michael Gibson	Specialty - Occupational Medicine
Jacob Kammer	Specialty - Occupational Medicine
Michael Blumhardt	Specialty - Pulmonology
Sherryl Rose	Specialist - Drug/Rehab Center
Jon Baillie	Specialty - Works at addiction clinic and behavioral health clinic

St. Luke's exhibit.

Calculating Market Share: List of Physicians Removed from Dr. Argue's Primary Care Physician Counts (Cont'd)

Name	Reason for Removal
Matthew May	No longer practicing in area
Eric Young	No longer practicing in area
Briant Burke	No longer practicing in area
J. Lauren Chasin	No longer practicing in area
Douglas Orchard	No longer practicing in area
Debra Roman	No longer practicing in area

St. Luke's exhibit.

Number Of Significant Competitors

2 to 1	Stop (?)
3 to 2	Caution
4 to 3	Caution
5 to 4	Go

Reading: What Is A Significant Competitor?

- Hospital to be acquired – Surgical Institute of Reading
  - 15 licensed beds
  - Alleged to be acquiror's "nemesis"
  - FTC alleged would create "virtual duopoly"

Physician Specialty Issues: Unique Features of Primary Care

- Need for local, convenient care.
- Strongest patient loyalty.
- Strongest influence on choice of other health care providers.
- Most important to network selection.

Beyond *St. Luke's*: Market Definition And Market Share

- NPs and PAs?
- UCCs and company clinics?
- Tiered networks and narrow networks?

"Closest Substitute" Analysis

"The Acquisition is not only a merger of the first and second largest providers for primary care services, but is also a merger of each of those providers' closest substitutes."[1]

1. Judge Winmill's Findings of Fact at ¶99.

Barriers to Entry in the Market for Primary Care Physician Services in Nampa

- Patient loyalty to primary care physicians makes it difficult to replace the Saltzer physicians.
- It takes years to successfully recruit to and ramp up new primary care physicians in Nampa.
  - There are 16 general primary care physicians at Saltzer to replace.
  - Replacing Saltzer physicians would require Saint Alphonsus to recruit *twice as many* new physicians as they have hired in the four year period from 2008-2011.

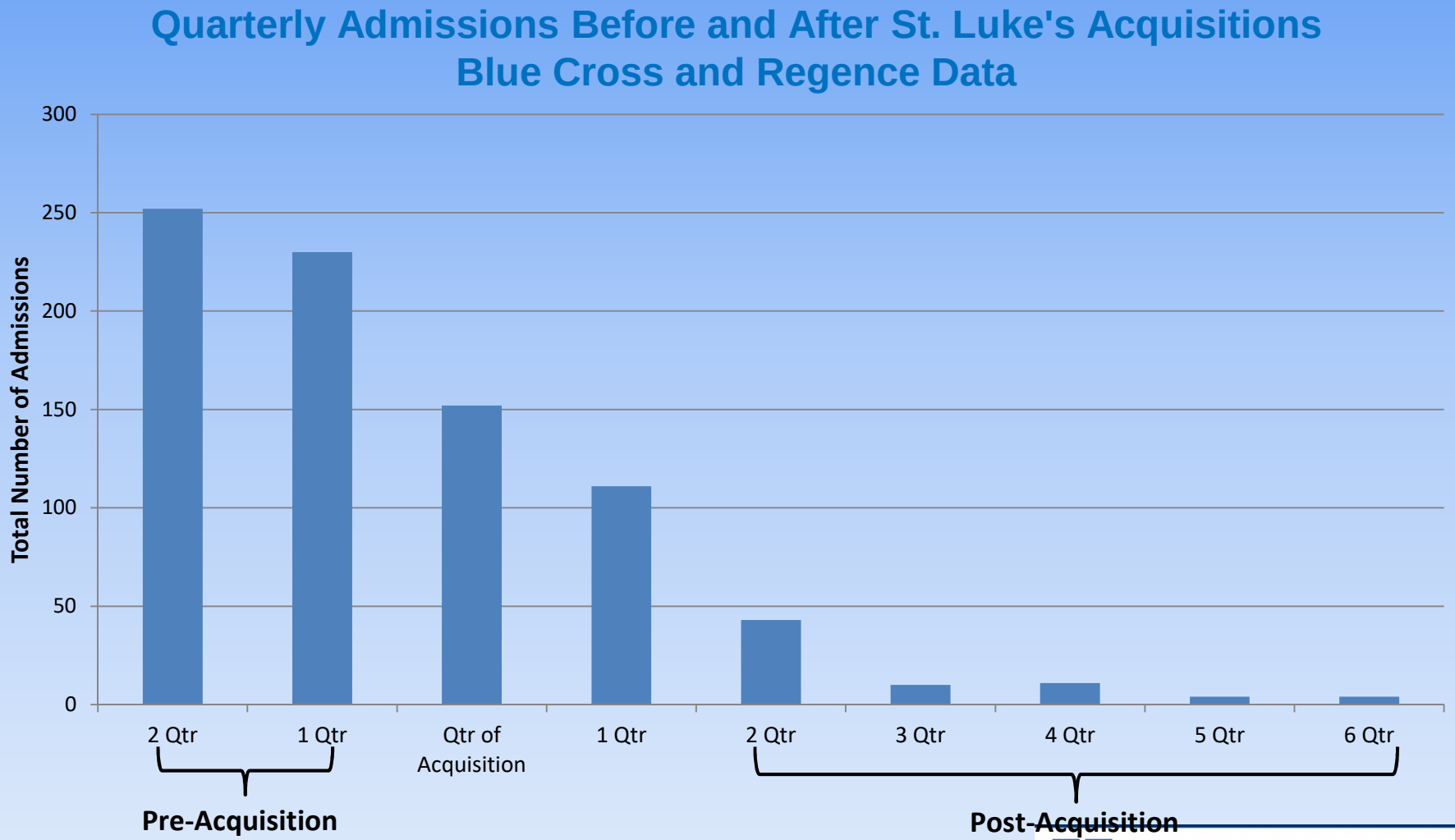
Sources: *St. Luke's*: Haas-Wilson testimony, Judge Winmill's Findings of Fact at ¶¶209, 211-213

Significance Of Referral Evidence

- "Patients largely accept the recommendations of their primary care physicians as to what hospital, specialist and ancillary services they should use."[1]
- "After St. Luke's purchased five specialty practices . . . the amount of business that they did at St. Luke's facilities increased dramatically."[2]
- "After the Acquisition it is virtually certain that . . . Saltzer referrals to St. Luke's will increase."[3]

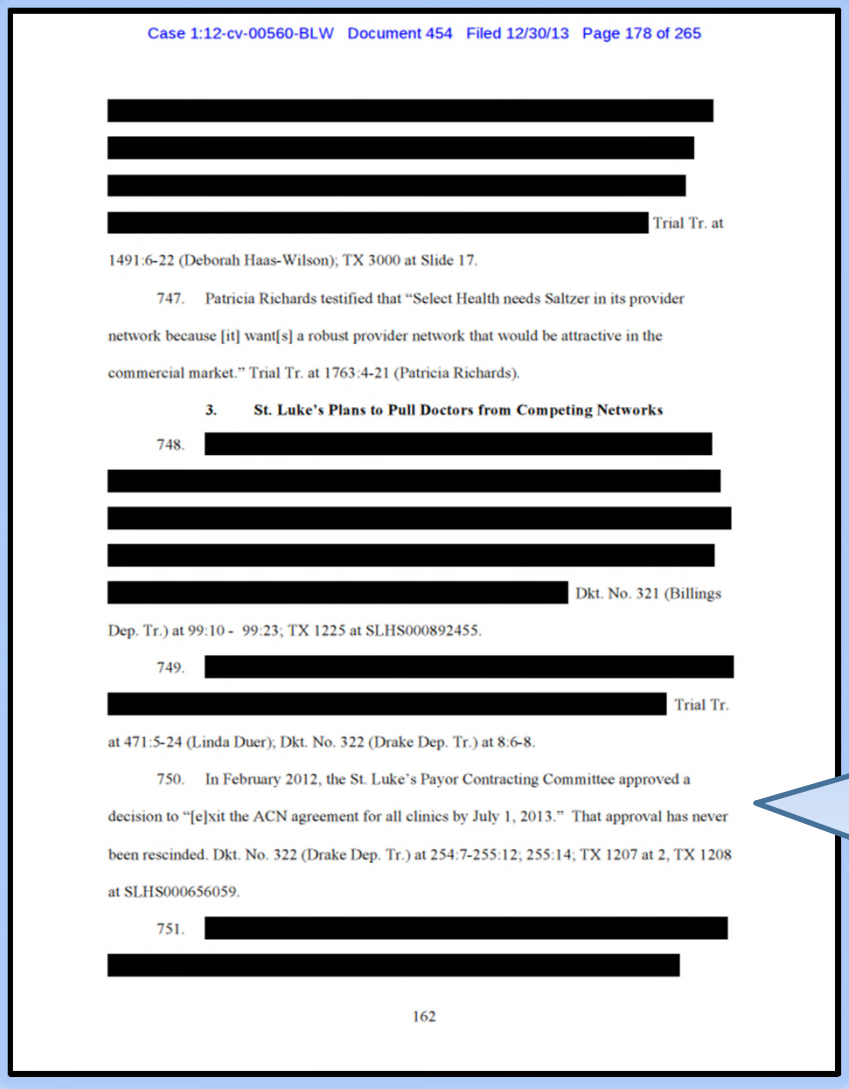
1. *St. Luke's*: Judge Winmill's Findings of Fact at ¶132.
2. *Id.* at ¶136.
3. *Id.* at ¶140.

Cumulative Decline in Inpatient Admissions at Saint Alphonsus-Boise of the Five Acquired Specialty Practices



HONIGMAN®

Impact On Network Competition



Case 1:12-cv-00560-BLW Document 454 Filed 12/30/13 Page 178 of 265

[redacted] Trial Tr. at 1491:6-22 (Deborah Haas-Wilson); TX 3000 at Slide 17.

747. Patricia Richards testified that "Select Health needs Saltzer in its provider network because [it] want[s] a robust provider network that would be attractive in the commercial market." Trial Tr. at 1763:4-21 (Patricia Richards).

3. St. Luke's Plans to Pull Doctors from Competing Networks

748. [redacted] Dkt. No. 321 (Billings Dep. Tr.) at 99:10 - 99:23; TX 1225 at SLHS000892455.

749. [redacted] Trial Tr. at 471:5-24 (Linda Duer); Dkt. No. 322 (Drake Dep. Tr.) at 8:6-8.

750. In February 2012, the St. Luke's Payor Contracting Committee approved a decision to "[e]xit the ACN agreement for all clinics by July 1, 2013." That approval has never been rescinded. Dkt. No. 322 (Drake Dep. Tr.) at 254:7-255:12; 255:14; TX 1207 at 2, TX 1208 at SLHS000656059.

751. [redacted]

162

Steven Drake, St. Luke's System Director of Payer Contracting

In February 2012, the St. Luke's Payor Contracting Committee approved a decision to "[e]xit the ACN agreement for all clinics by July 1, 2013." That approval has never been rescinded.

HONIGMAN®

Efficiencies: Burden

"[A]n '*extraordinary*' showing is necessary when the 'post-merger market's HHI is well above 1800 and the increase is well above 100..[because] the likelihood of a significant price increase is particularly large…"[1]

1. *St. Luke's*, Conclusions of Law ¶ 40 (citing Areeda, ¶ 971f) (emphasis added)

Cognizable Efficiencies: Merger-Specificity

- "Efficiencies must be *merger-specific*—that is, 'they must be efficiencies that cannot be achieved by either company alone because, if they can, then merger's asserted benefits can be achieved without the concomitant loss of a competitor."[1]

1. *St. Luke's*, Conclusions of Law ¶ 42 (quoting *Heinz*, 246 F.3d at 722.)

Judge Winmill's Findings on the "Quality Defense"

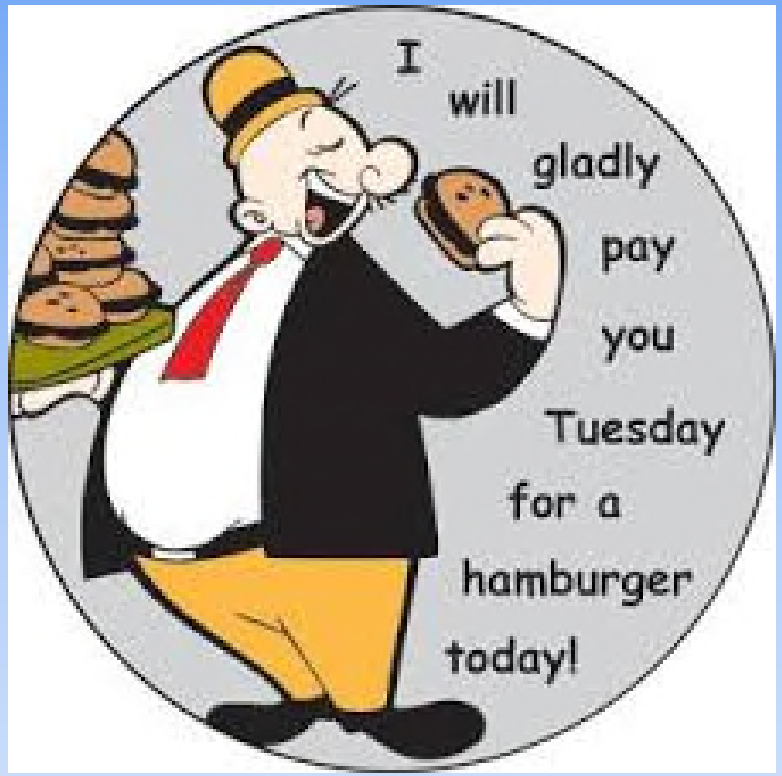
- "Independent physician groups are using risk-based contracting successfully."[1]
- "[T]he efficiencies of a shared electronic record can be achieved without the Acquisition . . ."[2]
- "The same efficiencies [sought to be achieved with employment] have been demonstrated with groups of independent physicians."[3]
- "Because a committed team can be assembled without employing physicians, a committed team is not a merger-specific efficiency of the acquisition."[4]

1. *St. Luke's*: Findings of Fact at ¶ 183.
2. *St. Luke's*: Conclusions of Law at ¶ 48.
3. *Id.* at ¶ 46.
4. *St. Luke's*: Findings of Fact at ¶ 185.

Efficiencies: Ninth Circuit Decision in *St. Luke's*

- "We remain skeptical about the efficiencies defense."
- The district court "expressly did conclude" that the claimed efficiencies "were not merger-specific" and this finding was not "clearly erroneous."
- The burden on merger specificity "is properly part of the defense."
- The "Clayton Act does not excuse mergers that lessen competition . . . simply because the merged entity can improve its operations."

The “Wimpy” Defense



HONIGMAN®

St. Luke's "Wimpy" Defense

- Alain Enthoven: St. Luke's efforts to improve quality involve a "long and complicated path" and "perilous route," which many others have failed at, and which will take 10 years or more.
- Dr. Pate: St. Luke's approach to changing health care is an "experiment."
- St. Luke's will be in a position to raise prices, foreclose competition and pull its physicians from competing networks immediately.

Recent Studies on Physician-Hospital Integration

- "[M]edium-sized and large independent physician groups perform[] consistently better on process measures of quality of care" as compared with large "hospital-based groups."[1]
- Physician-hospital consolidation "associated with higher hospital prices and spending."[2]
- "[L]arge complex structures might increase costs with no gain in quality."[3]

1. J. Michael McWilliams, et al., *Delivery System Integration and Health Care Spending and Quality for Medicare Beneficiaries*, 173 J. Am. Med. Assoc. Intern. Med. 1447, 1451-1452 (2013).
2. Laurence C. Baker, M. Kate Bundorf and Daniel P. Kessler, "Vertical Integration Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending," 33 *Health Affairs* No. 5, 756-763 (2014).
3. John Kralewski, Bryan Dowd, Megan Savage, and Junliang Tong, "Do Integrated Health Care Systems Provide Lower-Cost, Higher-Quality Care?" *Physician Executive Journal (PEJ)*, 14-18 (2014).

Possible Efficiencies Defenses: Physician Practice Acquisitions

- Have joint ventures with physicians failed?
- Have independent physicians failed to achieve quality gains?
- Is there a service line-specific rationale?
- Is there a rationale arising out of the particular physician-hospital relationship, e.g. consequences of existing competition?
- Do efficiencies arise out of subspecialties/low volume issues?

Possible Efficiencies Defenses: Hospital Mergers

- Subspecialty/tertiary (low volume) issues?
- Are smaller hospitals involved?
- Have joint ventures previously failed?
- Are there unit-specific issues?
- Is there a track record of efficiencies?
- Are there clinical benefits from greater volumes?

Defendants' "Hot Documents"

PLAINTIFF'S EXHIBIT 476

From: Randell Page
Sent: Friday, April 22, 2011 3:27 PM
To: Nancy Powell; Mark A. Rasmus; Michael Djernes
Cc: John Kaiser
Subject: RE: Blue Cross consultations

As Nancy said, this was an issue we argued about w/ Blue cross. They won't budge. Nobody is happy about it. They presented some potential gain sharing opportunities for us to consider as a way to make up for these kinds of losses. No follow up from them so far, as usual, but we need to get together and make some proposals to them. Dropping our blue cross participation is an option. We would need to try to estimate what the financial impact of that might be. If our negotiations w/ Luke's go to fruition, this will be something we could try to get back, ie consult codes, as there would be the clout of the entire network . rp

From: Nancy Powell

If our negotiations w/ Luke's go to fruition, this will be something we could try to get back, ie consult codes, as there would be the clout of the entire network . rp

Sent: Friday, April 22, 2011 1:01 PM
To: Nancy Powell
Cc: Randell Page; John Kaiser
Subject: Blue Cross consultations

I'm assuming that they're not paying at the same rates as they would if they were "consults" as o
patient" visits? Were we aware of this when renegotiating our most recent contract with them?
blow for some of us. Does this include all of Blue Cross or just Blue Cross of Idaho?

Mark

From: Stephanie Herman
Sent: Friday, April 22, 2011 12:01 PM
To: Physicians; Mid-Levels; Jeanie Cronrath; Nancy Powell; Deanne Walker; Toni Wright; Margaret
Letcher
Cc: Tami McGee; Dorothy B. Smith; Julie Sullivan; Katherine R. Pehrson; Kathy Barton; Kathy K. A
Samantha A. Booth; Taffy J. Hawley
Subject:

Good Morning
There has been a change in how we are billing consults for Blue Cross patient
Blue Cross is no longer going to accept consult codes. This means that they a
Medicare guidelines. So if a patient is sent to you for an office consult and th
patient you will need to bill the 99201-99205 level CPT codes. If the patient is
you will need to bill out the 99212-99215 level CPT codes. If the consult is perf

CONFIDENTIAL SMG000315458

Plaintiffs' Exhibit 1361

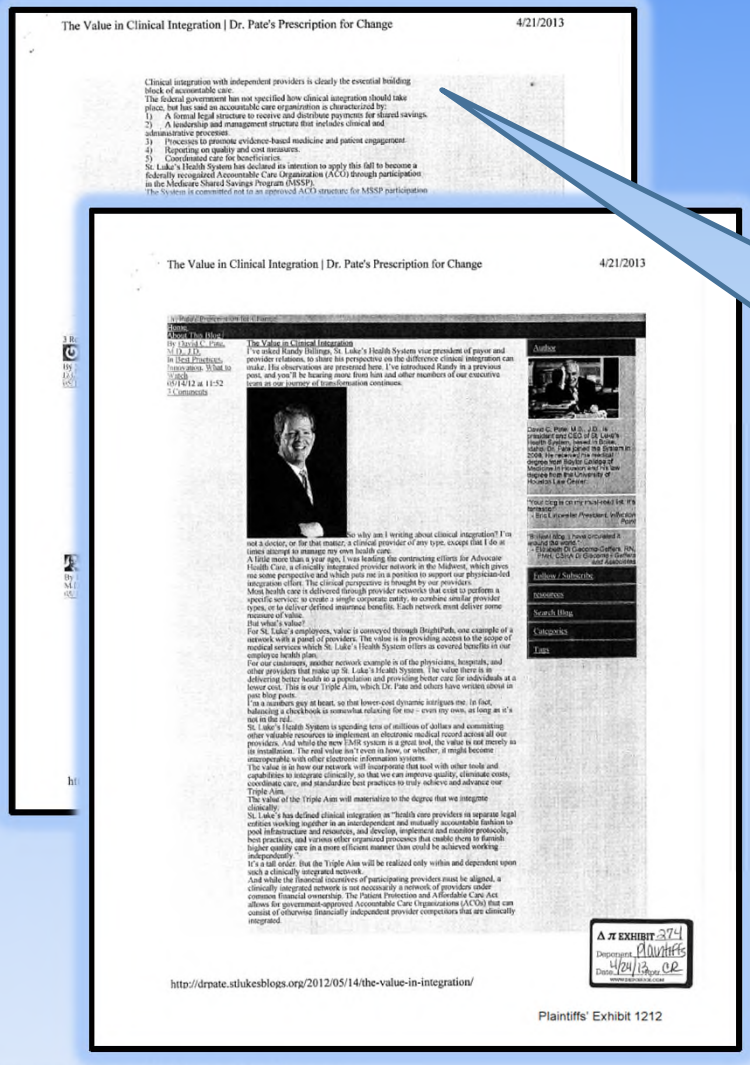
Randell Page
Chairman, Saltzer Contracts Committee

SALTZER MEDICAL GROUP

FOFs at ¶113.

HONIGMAN®

Defendants' Public "Hot Documents"


The Value in Clinical Integration | Dr. Pate's Prescription for Change 4/21/2013

Clinical integration with independent providers is clearly the essential building block of accountable care.
The federal government has not specified how clinical integration should take place, but has said an accountable care organization is characterized by:
1) A formal legal structure to receive and distribute payments for shared savings.
2) A leadership and management structure that includes clinical and administrative processes.
3) Processes to promote evidence-based medicine and patient engagement.
4) Reporting on quality and cost measures.
5) Coordinated care for beneficiaries.
St. Luke's Health System has declared its intention to apply this fall to become a federally recognized Accountable Care Organization (ACO) through participation in the Medicare Shared Savings Program (MSSP).
The System is committed not to an approved ACO structure for MSSP participation

The Value in Clinical Integration | Dr. Pate's Prescription for Change 4/21/2013

The Value in Clinical Integration

I've asked Randy Billings, St. Luke's Health System vice president of payor and provider relations, to share his perspective on the difference clinical integration can make. His observations are presented here. I've introduced Randy in a previous post, and you'll be hearing more from him and other members of our executive team as our journey of transformation continues.

Author

So why am I writing about clinical integration? I'm not a doctor, or for that matter, a clinical provider of any type, except that I do at times attempt to manage my own health care.

A little more than a year ago, I was leading the contracting efforts for Advocate Health Care, a clinically integrated provider network in the Midwest, which gives me some perspective and which puts me in a position to support our physician-led integration effort. The clinical perspective is brought by our providers.

Most health care is delivered through provider networks that exist to perform a specific service: to create a single corporate entity, to combine similar provider types, or to deliver defined insurance benefits. Each network must deliver some measure of value.

But what's value?

For St. Luke's employees, value is conveyed through BrightPath, one example of a network with a panel of providers. The value is in providing access to the scope of medical services which St. Luke's Health System offers as covered benefits in our employee health plan.

For our customers, another network example is of the physicians, hospitals, and other providers that make up St. Luke's Health System. The value there is in delivering better health to a population and providing better care for individuals at a lower cost. This is our Triple Aim, which Dr. Pate and others have written about in past blog posts.

I'm a numbers guy at heart, so that lower-cost dynamic intrigues me. In fact, balancing a checkbook is somewhat relaxing for me – even my own, as long as it's not in the red.

St. Luke's Health System is spending tens of millions of dollars and committing other valuable resources to implement an electronic medical record across all our providers. And while the new EMR system is a great tool, the value is not merely as its installation. The real value isn't even in how, or whether, it might become interoperable with other electronic information systems.

The value is in how our network will incorporate that tool with other tools and capabilities to integrate clinically, so that we can improve quality, eliminate costs, coordinate care, and standardize best practices to truly achieve and advance our Triple Aim.

The value of the Triple Aim will materialize to the degree that we integrate clinically.

St. Luke's has defined clinical integration as "health care providers in separate legal entities working together in an interdependent and mutually accountable fashion to pool infrastructure and resources, and develop, implement and monitor protocols, best practices, and various other organized processes that enable them to furnish higher quality care in a more efficient manner than could be achieved working independently."

It's a tall order. But the Triple Aim will be realized only within and dependent upon such a clinically integrated network.

And while the financial incentives of participating providers must be aligned, a clinically integrated network is not necessarily a network of providers under common financial ownership. The Patient Protection and Affordable Care Act allows for government-approved Accountable Care Organizations (ACOs) that can consist of otherwise financially independent provider competitors that are clinically integrated.

Follow / Subscribe
resources
Search Blog
Categories
Tags

Δ π EXHIBIT 374
Deponent PLAINTIFFS
Date 4/24/13 Type CR

http://drpate.stlukesblogs.org/2012/05/14/the-value-in-integration/

Plaintiffs' Exhibit 1212

Randy Billings, VP of Payor and Provider Relations, St. Luke's

"Clinical integration with independent providers is clearly the essential building block of accountable care."

Source: Haas-Wilson testimony

Defendants' "Hot" Consultant Documents

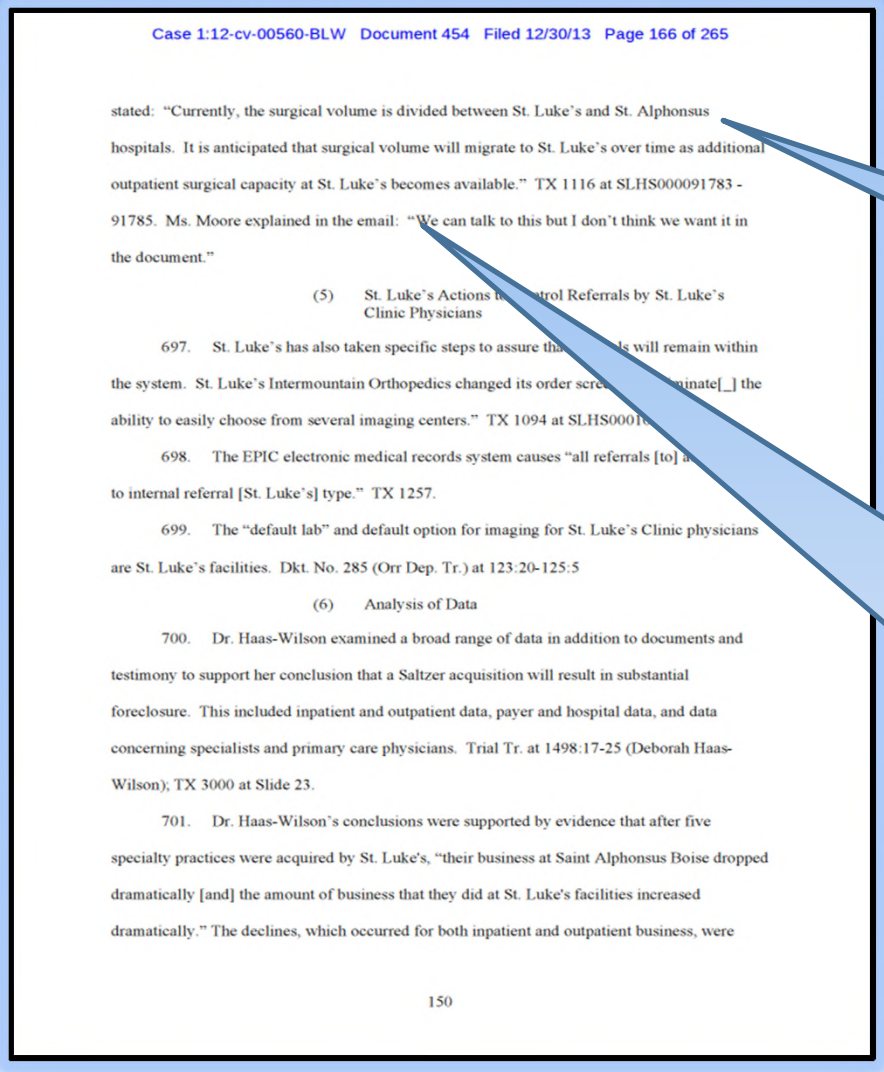
consilium group llc

"Consultant Peter LaFleur prepared an analysis at the direction of St. Luke's showing how office/outpatient visits could be billed for higher amounts if the visit was hospital-based rather than Saltzer-based. The hospital-based billings were more than 60% higher."[1]

1. Judge Winmill's Findings of Fact at ¶ 128.

HONIGMAN®

Defendants' "Hot Documents" About Documents



Case 1:12-cv-00560-BLW Document 454 Filed 12/30/13 Page 166 of 265

stated: "Currently, the surgical volume is divided between St. Luke's and St. Alphonsus hospitals. It is anticipated that surgical volume will migrate to St. Luke's over time as additional outpatient surgical capacity at St. Luke's becomes available." TX 1116 at SLHS000091783 - 91785. Ms. Moore explained in the email: "We can talk to this but I don't think we want it in the document."

(5) St. Luke's Actions t trol Referrals by St. Luke's Clinic Physicians

697. St. Luke's has also taken specific steps to assure tha ls will remain within the system. St. Luke's Intermountain Orthopedics changed its order scre minate[_] the ability to easily choose from several imaging centers." TX 1094 at SLHS0001

698. The EPIC electronic medical records system causes "all referrals [to] a to internal referral [St. Luke's] type." TX 1257.

699. The "default lab" and default option for imaging for St. Luke's Clinic physicians are St. Luke's facilities. Dkt. No. 285 (Orr Dep. Tr.) at 123:20-125:5

(6) Analysis of Data

700. Dr. Haas-Wilson examined a broad range of data in addition to documents and testimony to support her conclusion that a Saltzer acquisition will result in substantial foreclosure. This included inpatient and outpatient data, payer and hospital data, and data concerning specialists and primary care physicians. Trial Tr. at 1498:17-25 (Deborah Haas-Wilson); TX 3000 at Slide 23.

701. Dr. Haas-Wilson's conclusions were supported by evidence that after five specialty practices were acquired by St. Luke's, "their business at Saint Alphonsus Boise dropped dramatically [and] the amount of business that they did at St. Luke's facilities increased dramatically." The declines, which occurred for both inpatient and outpatient business, were

150

Kathy Moore, COO of St. Luke's Treasure Valley

"Currently, the surgical volume is divided between St. Luke's and St. Alphonsus hospitals. It is anticipated that surgical volume will migrate to St. Luke's over time as additional outpatient surgical capacity at St. Luke's becomes available."

"We can talk to this but I don't think we want it in the document."

HONIGMAN®

Possible Remedies

- Order to cease and desist from future acquisitions
- Divestitures
- Rate/referral regulation (State enforcement)
- Treble damages

The Likelihood of Divestiture

- "Once a merger is found illegal, 'an undoing of the acquisition is a natural remedy.'"[1]
- The Court also rejects St. Luke's proposal that divestiture be dropped as a remedy in favor of ordering that St. Luke's and Saltzer negotiate separately with health plans. *Trial Tr.* at 167-68 (Jack Bierig).[2]

1. *ProMedica* (6th Circuit)
2. *St. Luke's*, Conclusions of Law at ¶¶ 50, 59.

The FTC Rejects Other Remedies

- "In an acknowledgement that the proposed Acquisition would produce anticompetitive effects, Respondents attempted to create temporary conduct remedies through Cabell's entry into the [Letter of Agreement with payors] . . . and the [Assurance of Voluntary Compliance] with the West Virginia Attorney General."[1]
- "The remedies that are proposed are temporary and limited in scope-like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off."[1]

1. FTC Complaint in *Cabell Huntington Hospital, Inc.* (Dkt. 9366).

Antitrust: The Issue That Never Dies

- *Evanston*
  - Investigation began 2 years after merger
  - Final FTC decision - 8 years after merger
- *Urology of Central Pennsylvania*
  - Investigation started 2 years after merger
  - Consent order 6 years after merger

David A. Ettinger
Honigman Miller Schwartz & Cohn, LLP
2290 First National Building
660 Woodward Avenue
Detroit, MI 48226
(313) 465-7368
(313) 465-7369 (Fax)
dettinger@honigman.com