

# Acquiring Hospitals and Physician Groups - - Antitrust and Other Implications

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## Overview of Topic

- What factors are driving the trend toward more acquisitions and closer strategic partnerships?
- What different models are being used?
- What antitrust issues are involved?

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## What Factors Are Driving the Trend Toward More Acquisitions and Strategic Partnerships?

- A desire to increase the number of patients who view the health system as their care provider, which provides the following benefits:
  - Allows the health system to accept more financial risk if it has more covered lives (e.g., accountable care organizations)
  - Provides more data regarding patient health and a better ability to plan (e.g., disease management)
  - Facilitates the ability to integrate care along vertical lines (e.g., common protocols and pathways for specialty care)

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## Factors Driving the Trend Toward More Acquisitions – Con't

- Supports expensive new technologies
- Supports research and the training and education of residents
- Provides greater access to capital; larger base for borrowing and bonding
- The opportunity to gain a strategic partner with solid reputation for quality care in region
- Reduce the possibility that the partner might choose to affiliate with someone else
- For smaller hospitals (e.g., rural hospitals), consolidation may be driven by a concern that it may lose business to larger systems and be left with lower-paying Medicaid and Medicare patients
- For governmental hospitals (e.g., city/county hospitals), consolidation may be driven by a concern that the taxpayers should not potentially be on the hook for subsidizing the hospital
- For physician groups, concerns regarding the lack of access to capital (e.g., for EMR), declining fee-for-service reimbursement (and physician compensation)

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## Factors Driving the Trend Toward More Acquisitions – Con't

- Laws (other than antitrust) encourage consolidation (e.g., Stark law requirement that services, space and equipment be provided at fair market value; Medicare anti-kickback safe harbor for employment agreements)
- Market appeal of co-brands (“Sky Team Alliance”)

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## Affiliation/Partnership Models

- Contractual Joint Venture Models
- ACO-type Models
- Merger Models
- Other Models

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## Contractual Joint Venture Models

- One organization provides professional and/or management services to another (may be a prelude to a closer affiliation later)
- Antitrust issue is whether those activities amount to a per se violation (e.g., group boycott or price fixing) or have sufficient integration to pass muster under the “rule of reason” analysis
  - Management services agreements usually won’t create an issue unless the organization providing the services will be involved in negotiating payor contracts and establishing fee schedules
  - In that case, excluding those functions from the services being provided or providing those functions with safeguards in place may avoid per se violation

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## Contractual Joint Ventures – Con’t

- So-called “virtual joint ventures,” where revenues and expenses of agreed upon service lines are combined and the profits or losses shared based on ownership interests in the service lines
  - E.g., combine revenues and expenses of one health system’s new born infant hospital and physician services with another hospital’s obstetric service
  - No actual merger takes place
  - If the two health systems are combining revenues and expenses from areas of their businesses that do not overlap (e.g., mother/baby above), then the antitrust issues would be less significant than if the businesses did compete

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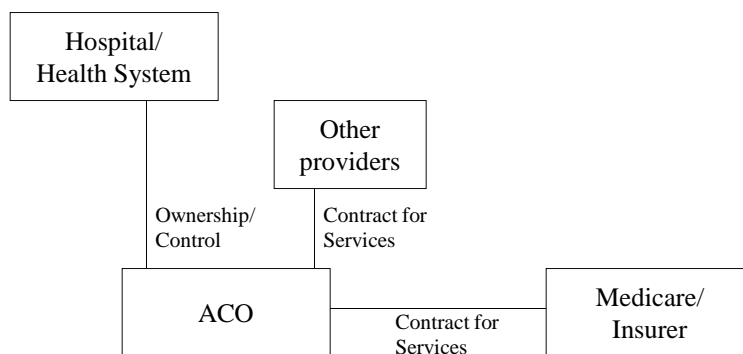
## ACO-type Models

- New entity is formed to contract with third party payors
- May be owned and controlled by a health system
- Independent providers contract with the entity as needed to fill gaps and provide coverage
- Antitrust issues addressed in the proposed ACO antitrust guidelines
- Viewed as largely unworkable

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## Typical ACO/Provider Network Model



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## Merger Models

- Statutory merger of one organization into another, where the organization being acquired ceases to exist and its assets and liabilities are absorbed by the acquiring organization
- Asset acquisition, where one organization acquires the assets of another (more common between selling physician practices and health systems)
- Antitrust issues involve the question whether the combination results in a monopoly. More discussion of this is below.

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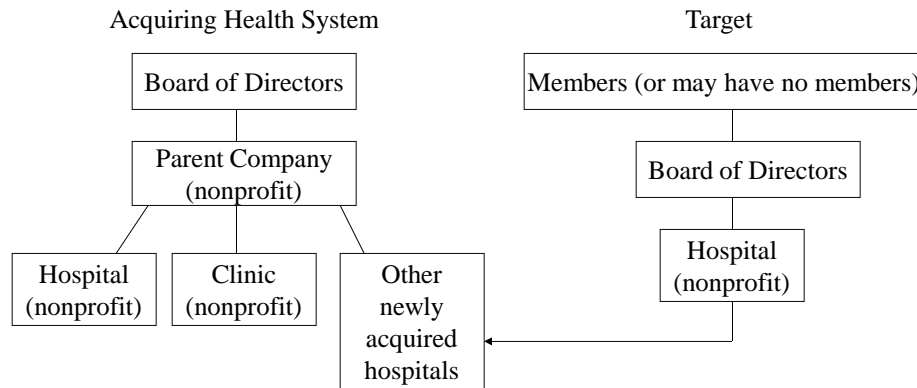
## Merger Models – Con't

- Change of nonprofit organization's governing documents to give another organization effective ownership and control.
  - Acquired hospital continues to operate as a "subsidiary" of the acquiring health system or under a newly formed common parent.
- Stock purchase, where one organization purchases all or some of the stock of another
  - Acquired hospital (if it has stock) or physician clinic operates as a wholly-owned subsidiary of acquiring health system
  - Purchase of a right of first refusal
  - Co-ownership of physician practice
  - Professional Services Agreement

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## Typical Acquisition Model for Nonprofit Hospital Systems



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## Other Models

- Purchase of right of first refusal / right of first negotiation
  - Gives the acquiring health system the right to acquire the hospital or physician group if that organization received an offer to sell that it was prepared to accept (right of first refusal) or the organization decided to seek an affiliation with another system (right of first negotiation)
  - Amount paid for ROFR/ROFN must be consistent with fair market value for that right (value of the restraint on marketability)
  - If the hospital or physician group could not be acquired due to antitrust considerations, then the fair market value of the ROFR/ROFN is diminished

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## Other Merger Models – Con't

- Purchase of a portion of a physician group's stock or rights to participate in the governance and control of a nonprofit hospital
  - Still separate entities and thus able to commit per se violations
- Professional Service Agreements
  - Most common model today in physician group affiliations

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## Antitrust Issues

- Section 1 of the Sherman Act
- Addresses collaboration/joint negotiation of prices by independent providers
- General Rule: Absent some economic or clinical integration of the parties, antitrust laws prohibit competitors from jointly negotiating with purchasers of their services. Per se illegal.
- FTC and DOJ have brought more than 20 cases against IPAs and groups of providers who have engaged in collective rate negotiations in the last 10 years
- Recent comments by the FTC before the House Subcommittee on Courts and Competition Policy (December, 2010)

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## Existing Law: Single Entity

- If the merger model results in a single entity or subsidiary that is owned and controlled by the parent, should be viewed as one entity – (and you can't conspire with yourself)
- U.S. Supreme Court American Needle decision
- But can run afoul of antitrust laws in becoming one entity

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## Merger Models and Antitrust

- Section 7 of the Clayton Act prohibits mergers “in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such an acquisition may be substantially to lessen competition, or to tend to create a monopoly.”
- DOJ and FTC enforce
- State attorney generals may also enforce under state antitrust laws
- Mergers are classified as horizontal, vertical or conglomerate

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## Merger Models and Antitrust – Con't

- Types of mergers
  - Horizontal involve entities which offer the same products/services in the same geographic market
  - Vertical involve entities which offer different (although often related) products/services in the same geographic market
  - Conglomerate mergers involve mergers of entities that are not competitors but have the potential to become competitors
- Most mergers of physician groups and mergers between hospitals are horizontal mergers
- Mergers between hospitals that already employ physicians and other hospitals and/or physician groups may have elements of both

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## Horizontal Merger Guidelines

- FTC/DOJ published Horizontal Merger Guidelines in 1992 (revised in 2010) which summarize federal antitrust law and the Agencies' enforcement policy
- FTC/DOJ also published in August 1996 Statements of Antitrust Policy in Healthcare
  - Addresses mergers between hospitals
  - Mergers of small general acute-care hospitals (fewer than 100 licensed beds with fewer than 40 inpatients daily) generally not challenged
  - Analysis of other hospital mergers follow the five steps set forth in the 1992 (2010) Horizontal Merger Guidelines

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## Horizontal Merger Guidelines – Con't

- What is the relevant product or products (e.g., professional urology services; general acute hospital services; inpatient OB services)?
- What is the relevant geographic market in which those services are provided?
- Is the market concentrated and what will be the possible impact on competition as a result of the merger?
- If prices increase, will other providers enter the market in a timely way?
- Will the merger create any efficiencies that may result in lower prices or otherwise encourage competition?
- Is either entity on the brink of failure and likely to leave the market?

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## Product/Service Market

- Is it dollars, practitioners, services?
- Note guidance in proposed ACO antitrust guidelines
- Agencies have noted that the services provided by a particular physician specialty may often be a relevant service market (e.g., physician urology services)
- Other physicians that provide similar services may also be in the same service market (e.g., radiologists/interventional cardiologists). “If an anticompetitive price increase could result in patients choosing other providers for similar services, then those other providers are part of the relevant product market.” (California v. Sutter Health)

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## Product/Service Market – Con't

- E.g., services provided to adults and children have been viewed as being in different service lines
- Hospitals also provide different products/services (e.g., rehabilitation hospital as compared to other hospitals)

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## Geographic Market

- After considering the relevant product/service, the next question is what the geographic market is for each product/service
- The geographic market “encompasses the geographic area to which consumers can practically turn for alternative sources of the product and in which antitrust defendants face competition.” (Morgenstern v. Wilson)
- The relevant market may be determined with reference to zip code data (see ACO proposed guidelines)

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## Geographic Market – Con't

- Relevant factors include:
  - the location of the health system's offices and hospitals where the physicians practice
  - Where patients of the organizations reside
  - The extent to which the organizations treat the same areas as their market (e.g., as shown by advertising)
- Patients generally travel farther to see specialists and receive specialty hospital services; therefore, the geographic market for those services is broader than for primary care (e.g., market for cardiac surgical services for Lincoln, Nebraska patients included Omaha, 58 miles away in Morgenstern v. Wilson, and the market for specialty physician services in Dubuque, Iowa was considered to include Iowa City due to the location of the University of Iowa Hospitals and Clinics, 90 miles away in United States v. Mercy Health Services)

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## Market Concentration

- After determining the relevant products/services, the next consideration is whether the market is concentrated and what impact the merger will have on competition
- Herfindahl-Hirschman Index ("HHI") of market concentration is frequently used

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## Herfindahl-Hirschman Index

- Sum the squares of the market shares of the providers in the market for the relevant product/service
- E.g., Clinic A has a 50% market share, Clinic B has 30% and Clinic C has 20%
- The HHI for that market would be:
  - $(50 \times 50) + (30 \times 30) + (20 \times 20) = 3,800$

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## Herfindahl-Hirschman Index – Con't

- Unconcentrated markets: HHI below 1,500
- Moderately concentrated markets: HHI between 1,500 and 2,500
- Highly concentrated markets: HHI above 2,500
- In the above example where the HHI was 3,800, we have a highly concentrated market

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## More on the Herfindahl-Hirschman Index

- “Small Change in Concentration: Mergers involving an increase in the HHI of less than 100 points are unlikely to have adverse competitive effects and ordinarily require no further analysis.”
- “Unconcentrated Markets: Mergers resulting in unconcentrated markets are unlikely to have adverse competitive effects and ordinarily require no further analysis.”
- “Moderately Concentrated Markets: Mergers resulting in moderately concentrated markets that involve an increase in the HHI of more than 100 points potentially raise significant competitive concerns and often warrant scrutiny.”
- “Highly Concentrated Markets: Mergers resulting in highly concentrated markets that involve an increase in the HHI between 100 points and 200 points potentially raise significant competitive concerns and often warrant scrutiny. Mergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power. The presumption may be rebutted by persuasive evidence showing that the merger is unlikely to enhance market power.”

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## Use of the HHI

- While the HHI is not intended to be a rigid screen to separate acceptable mergers from anticompetitive ones, they do provide an important tool the Agencies use to determine whether a merger will harm competition.
- “The higher the post-merger HHI and the increase in the HHI, the greater the likelihood that the Agencies will request additional information to conduct their analysis.”

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## Other Factors

- **Entry by Other Providers**
  - Can others rapidly and easily enter the market in a response to an increase in prices?
  - E.g., other large health systems in the area that already provide similar products/services that could move in
- **Efficiencies**
  - “A primary benefit of mergers to the economy is their potential to generate significant efficiencies and thus enhance the merged firm’s ability and incentive to compete, which may result in lower prices
  - Important note: you are only given credit for those efficiencies that would not likely be accomplished without the merger
  - Specifying the reasons for the merger in the normal course of the discussions will be more helpful than “documents created as advocacy materials in merger review.”

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## Other Factors – Con’t

- **Potential Failure**
  - Difficult standard to meet; must be on the brink of financial failure, not just that times are tough
- **Have the merging entities been or will likely become, absent the merger, substantial head-to-head competitors? Or are the product/service markets more complimentary than competitive?**

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## Other Factors – Con't

- Agencies will consider information from patients and third party payors. If payors believe that the merger will result in higher prices, that will have a significant influence on the Agencies. On the other hand, if payors believe the merger offers opportunities to reduce prices or gain other efficiencies, then the Agencies will be less concerned.
- Payors are beginning to take notice of the acquisition trend and some are expressing concerns
- The higher the percentage of care paid for by Medicare and other governmental plans (where payment is fixed), the less of a concern

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## Other Agency Guidance

- May ask the Agencies ahead of time whether they will oppose a merger (a business review letter)
- Some examples:
  - 32% of the orthopaedic surgeons in greater Mobile, Alabama were accepted because no payor expressed concern
  - 66.7% of the gastroenterologists in Allentown and Bethlehem, Pennsylvania could not merge; the market was not as broad as contended
  - 1994 Guidelines for IPAs (updated in 1996) stated that the Agencies would not challenge a non-exclusive physician network joint venture that involved shared financial risk and 30% or less of the physicians in the relevant market
  - ACO guidelines likewise provide a safety zone for nonexclusive arrangements if it involves 30% or less of each common service in each participant's primary service area, whenever 2 or more participants provide that service to patients in that area

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## Antitrust Enforcement

- What happens if a merger is later found to violate state or federal antitrust laws?
- May be required to unwind the merger/acquisition
- Or the health system may continue to operate but contracting functions would need to be separated so each hospital in the overall organization separately negotiates its own payor contracts

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## Examples of Antitrust Enforcement Activity

- FTC complaint against ProMedica Health System's 2010 acquisition of St. Luke's Hospital (Maumee, OH)
- Carilion Clinic's divestiture of Center for Advanced Imaging and Center for Surgical Excellence (March, 2010)
- Scott & White Healthcare/King's Daughters Hospital (investigation closed December, 2009)
- FTC complaint filed against Inova Health System Foundation's bid to acquire Prince William Health System (May, 2008)
- Evanston Northwestern Healthcare Corporation (FTC Commission opinion August, 2007)
- Providence Health's abandonment of its plan to acquire Spokane Cardiology and Heart Clinic Northwest (July, 2010)
- Phoebe Putney Health System's proposed acquisition of Palmyra Park Hospital (April, 2011)

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