Antitrust in Healthcare
Bootcamp Part VI:
Hospital-Provider Relations

Sponsored by Antitrust Practice Group
February 9, 2012 12:00 – 2:00 p.m. eastern

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Overview

- Structure of Hospital/Provider Relations
- Basic Antitrust Principles
- Important Defenses
- Credentialing and Peer Review
-Exclusive Contracting/Closure of Medical Staff
- Hospital-Provider Joint Ventures
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Hospital and Providers

Privileges → Coverage Contract → Employment

Facility services (e.g., bed, staff, equipment)

Professional services
Privileging

Applies

Recommends

Approves

Medical Staff

Model Medical Staff Bylaws & Rules

Board of Directors
Economic Relations

Coverage Contract

Employment

- No medical staff
- No medical staff bylaws
Peer Review

- Investigates
- Recommends
- Adverse Action
Peer Review Process

Medical Executive Committee
- Investigate
- Recommend action
- Initiate summary suspension

Hearing Committee
- Hearing officer
- Committee of peers

Appeals Committee
- Board?
- Community?
- Peers?
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Conspiracies: Sherman § 1

- Elements
  - Agreement
  - That unreasonably restrains competition
- Arises in variety of provider/hospital relations
  - Peer review
  - Exclusive contracting
  - Joint ventures/joint negotiations
Conspiracy: Can Hospital Conspire with Medical Staff?

- Per se no capacity to conspire. *E.g.*, *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696, 703 (4th Cir. 1991)
  - Medical staff acts as hospital’s agent
  - Particularly true where board retains and exercises ultimate authority
  - Even if board follows med staff recommendation: “[S]imply because the ‘board is likely to follow the recommendations of the medical staff does not establish, or even reasonably suggest, the existence of a conspiracy.’” *County of Toulumne v. Sonora Cmty Hosp.*, 236 F.3d 1148, 1156 (9th Cir. 2001)
- Factual exception: Excluded providers coerce board into credentialing/contracting decision
  - *Oltz v. St. Peter’s Cmty. Hosp.*, 861 F.2d 1440, 1451 (9th Cir. 1988)
  - Exclusive contract for anesthesiologists (excluding less expensive nurse anesthetists) in Helena, MT
  - Found that board acquiesced to demands of anesthesiologists, who threatened to withhold services if nurses permitted to practice
  - Court found capacity to conspire: essentially, two economic entities
- Per se capacity to conspire. *Bolt v. Halifax Hosp. Med. Ctr.*, 891 F.2d 810, 819 (11th Cir. 1990)
  - Rejected analogy to corporation: physicians retain separate economic interests
Unilateral action: Sherman § 2

- Monopoly itself not prohibited
  - Many rural hospitals are “natural monopolies”
  - Scrutinized, esp. where staff is antagonistic to administration
  - Often, “bilateral monopoly” with provider
    - E.g., single nephrologist
      (Four Corners Nephrology)
Antitrust Standing

- Three elements
  - Injury in fact (article III standing)
  - Antitrust injury
  - Remoteness
Standing: Antitrust Injury

- “[I]njury of the type the antitrust laws were intended to prevent and that flows from that which makes defendants’ acts unlawful.”
- “If the injury flows from the aspects of the defendant’s conduct that are beneficial or neutral to competition, there is no antitrust injury . . . .” *Rebel Oil Co. v. Atlantic Richfield Co.*, 51 F.3d 1421, 1433 (9th Cir. 1995)
- Competition for exclusive contract: no antitrust injury
  - *Balaklaw v. Lovell*, 14 F.3d 793, 799 (2d Cir. 1994) (rejecting challenge to exclusive contract for anesthesia services where contract terminable on six months’ notice)
- No injury in being denied ability to share in hospital’s monopoly
  - *Four Corners Nephrology Assocs., P.C. v. Mercy Med. Ctr. of Durango*, 582 F.3d 1216, 1221 (10th Cir. 2009)
  - *Todorov v. DCH Healthcare Auth.*, 921 F.2d 1438, 1452-54 (11th Cir. 1991) (“The antitrust laws were not enacted to permit one person to profit from the anticompetitive conduct of another.”)
Antitrust Injury & Harm to Competition

- Doctrinally, not equivalent
  - “When a court concludes that no violation has occurred, it has no occasion to consider standing.”
  - “To say that the plaintiff has not shown any injury to competition is to conclude that the antitrust laws have not been violated at all.” IIA Areeda & Hovenkamp ¶ 337a

- However, many courts conflate the two
  - ABA Section of Antitrust Law, Antitrust Law Developments 821 & n. 72 (6th ed. 2007) (“Courts have also refused to recognize antitrust injury where the defendant’s conduct injures the plaintiff without having an adverse effect on competition at large.”)
Harm to Competition (aka Antitrust Injury)

- “The antitrust laws . . . were enacted for ‘the protection of competition, not competitors.’” *Brunswick*, 429 U.S. at 488 (quoting *Brown Shoe Co. v. U.S.*, 370 U.S. 294, 320 (1962))
  - “[T]he fact that a hospital’s decision caused a disappointed physician to practice medicine elsewhere does not of itself constitute an antitrust injury. If the law were otherwise, many a physician’s workplace grievance with a hospital would be elevated to the status of an antitrust action.” *Oksanen v. Page Memorial Hosp.*, 945 F.2d 696, 708 (4th Cir. 1991) (en banc)

- Exclusion of single provider generally not sufficient to show harm to competition
  - E.g., *Bhan v. NME Hosps., Inc.*, 929 F.2d 1404 (9th Cir. 1991)

- Replacing one exclusive provider with another generally not sufficient to show harm to competition
  - E.g., *Coffey v. Healthtrust, Inc.*, 955 F.2d 1388 (10th Cir. 1992)
Standing: Remoteness

- Issue: Is plaintiff most efficient enforcer of antitrust laws?
- Is provider too remote to challenge hospital’s actions, given presence of payers and patients?
Market Definition

- Market definition not an end in itself: “Without a well-defined relevant market, a court cannot determine the effect an allegedly illegal act has on competition.”
  - *Little Rock Cardiology v. Baptist Health*, 591 F.3d 591 (8th Cir. 2009)

- Two dimensions
  - Product market
  - Geographic market

- Plaintiff’s burden to prove relevant market
Product Market

- Test: reasonable interchangeability of products
- Excluded provider: Focus on provider’s services and reasonable substitutes
- E.g., anesthesiologists and nurse anesthetists
- E.g., radiologists and radiology machines in general practitioners’ offices
- Role of Board certifications and sub-specialties?
Geographic Market

- Test: “the area in which the seller operates and to which purchasers can practicably turn for supplies”  
  *Tampa Elec.*, 365 U.S. 320, 327 (1960)
  - Does not equal trade area or hospital’s PSA.  
  *Little Rock Cardiology*, 591 F.3d at 600 (collecting cases)
  - Instead, look where patients *could* turn (not where they currently go)

- Tied to product market
  - Patients likely to travel farther for heart surgery than for primary care
  - Hospital-based physicians: nationwide market?

- Proof of market
  - Patient origin data (state databases, hospital billing records, providers’ billing agents)
    - Good starting point, but largely shows where patients do go (not where they could)
    - May not be available for outpatient of physician services
    - Elzinga-Hogarty or critical loss tests
  - Anecdotal evidence (testimony of payors, common sense observations)
  - “Natural experiment” (e.g., patient responses to actual price increases)

- Particularly relevant in rural markets: hospital may be only one in area
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Health Care Quality Improvement Act of 1986

- 42 U.S.C. §§ 1101-52
- History
  - Congress passed in effort to stem malpractice and improve quality of medical care
  - Noted need to restrict ability of incompetent physicians to move from state to state without disclosure of incompetence
    - Created National Practitioners’ Data Bank
  - Recognized that threat of lawsuits dampened enthusiasm for serving on peer review body
    - Specifically concerned about antitrust suits and treble damages
- Provides protection for professional review actions (i.e., peer review)
  - Applies only to discipline of physicians
  - Doesn’t apply to challenges by non-physician allied health providers
- Eliminates monetary damages; permits injunctive relief
  - Applies to all types of claims, not just antitrust claims
State Action

- Based on state sovereignty – *Parker v. Brown*, 317 U.S. 341 (1943)
  - Complete immunity from antitrust laws

- Relevant to contract and staffing decisions at public hospitals
  - Is hospital a political subdivision of state?
  - Must act pursuant to clearly articulated policy to displace competition

  - “Clearly articulated” if displacement was “foreseeable consequence”

  - Grant of broad contractual powers creates sufficient foreseeability. *E.g., Lafaro v. NY Cardiothoracic Group*, 570 F.3d 471, 477-478 (2d Cir. 2009) (hospital and public corporation running hospital immune from challenge to exclusive contract)
State Action: Private Parties

- E.g., private physicians participating in peer review decisions
- Immunity for private party where (1) clearly articulated state policy to displace competition, and (2) actions are actively supervised by the state
- Mere regulation of and requirement that hospitals establish peer review programs is not “active supervision”
  - *Lafaro*: remanded for proof that hospital district actively supervised complained-of actions under exclusive contract
Local Government Antitrust Act of 1984

- Provides immunity from damages, costs and attorney fees
  - But permits liability, thus permits injunctive relief
- Applicable to public hospital districts
  - Nature of hospital turns on state law. *E.g.*, *Tarabishi v. McAlester Reg’l Hosp.*, 951 F.2d 1558 (10th Cir. 1991) (public trust hospital not a state subdivision)
- Applicable to board members, administrators and staff acting in official capacity
- Applicable to private parties (e.g., doctors participating in peer review decisions)
  - Must meet two-pronged state action test
  - *Cohn v. Bond*, 953 F.2d 154, 158 (4th Cir. 1991) (immunity for peer review participants)
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Credentialing and Peer Review

- Types of decisions
  - Initial decision on staff privileges
  - Renewals of privileges
  - Professional review actions
- Adverse action: NPDB
- Challenges sound in antitrust, as well as common law claims (e.g., tortious interference, defamation, etc.)
  - Watch for precipitous action, bad documents
Adverse Action: NPDB Report

- Hospital obligated to report any adverse action against privileges lasting more than 30 days. 42 U.S.C. § 11133
  - Sanction for failure to report is loss of HCQIA immunity
  - Opens door to common law claims of misrepresentation. *E.g., Kadlec v. Lakeview Anesthesia*, 527 F.3d 412 (5th Cir. 2008) (misrepresentation claim based on failure to communicate doctor’s drug use)

- Impact of report on provider
  - Red flag for future hiring
Roles of Medical Staff and Administration

- “Sham peer review” – allegation that outcome is predetermined by administration or competitors
- Important to follow Medical Staff Bylaws
  - Issue: Do Bylaws constitute a contract?
    - Yes: AL, AK, DC, FL, IL, IN, IA, ME, MD, MN, NE, NJ, NM, NY, NC, PA, SD, TN, TX, UT, WV and WI
    - No: CA, GA, KS, MI, MO, ND and OH
  - Consequence: breach of contract action
HCQIA Immunity

- Immunity from damages, not injunctive relief
- Immunity from antitrust and common law claims
  - Poliner, 537 F.3d 368 (5th Cir. 2008): $360 million judgment for defamation, reversed on appeal; some defendants settled after trial court denied immunity

- Protects “professional review action”
  - Based on competence, professional conduct of physician
    - Restriction or termination of privileges
    - Non-clinical, “disruptive” actions
    - Failure to complete patient charts
    - Review of “private actions” reflecting professional judgment
  - Does not include actions based primarily on economic considerations
    - Fees, competitive actions, participation in certain plans

- Protects “professional review body”
  - Includes individuals
  - Includes hospitals
  - Protects witnesses who provide evidence
HCQIA Burdens

- Statutory presumption of immunity that physician must rebut. 42 U.S.C. § 11112(a)
- Totality of circumstances
- Reasonableness is objective, not subjective
- Hospitals generally win
- Not always
  - *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1996)
  - *Hussein v. Duncan Regional Hospital, Inc.*, 2009 WL 1212278 (W.D. Okla. 2009)
  - *Peper v. St. Mary’s Hospital and Medical Center*, 207 P.3d 881 (Colo. App. 2008)
HCQIA: Four Elements

1. Reasonable belief that the action was in the furtherance of quality health care
2. Action taken after reasonable efforts to obtain facts
3. Action taken after adequate notice and hearing procedures are afforded to the physician involved or after other such procedures as are fair to the physician under the circumstances
4. Action taken in reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts
"Reasonable Belief in Furtherance of Quality"

- Would reviewers, with information available to them at the time, reasonably have concluded that their actions would restrict incompetent behavior or protect patients?
- Does not require actual improvement of quality.
- Good faith or bad faith or reviewers is irrelevant.
- Facts in Poliner: adverse patient event, plus four additional cases calling judgment into question; review of prior cases showed half were questionable
  - Belief found to be objectively reasonable
“Reasonable efforts to obtain facts”

- Requires a reasonable effort, not a perfect effort.
- “HCQIA immunity is not coextensive with an individual hospital’s bylaws.” *Poliner*, 537 F.3d at 380
- Compare facts of *Poliner* and facts of *Smigaj*
“Reasonable Procedures”

- Safe harbor set of procedures. 42 U.S.C. § 11112(b)
  - Notice of action
  - Notice of hearing
  - Conduct of hearing

- Investigations don’t need to comply with statutory procedures in order to be protected. 42 U.S.C. § 11112(c).
  - Poliner: forgave technical noncompliance with statute

- Procedural safeguards need only be “fair under the circumstances.” Wahi v. Charleston Area Med. Ctr., 562 F.3d 599, 609-10 (4th Cir. 2009).

- Compare facts in Wahi and Smigaj
“Reasonable Response”

- Action should be tailored to address the health care concerns that had been raised.
- Information forming basis of action cannot be so obviously mistaken or inadequate as to make reliance on it unreasonable.
- *Poliner*: suspension limited to cath lab, not other privileges
Economic Credentialing

- Privileging based on economic considerations
- May include conflict-of-interest policies or agreements between hospital and plan
  - Response to provider-owned competing facilities
    - Surgeons open an ASC
    - Radiologists open Imaging Center
  - Concern about “cream-skimming,” i.e., treating only insured patients, leaving hospital to treat uninsured, Medicare, Medicaid

- Generally, foreclosure analysis
  - *Little Rock Cardiology*, 591 F.3d 591 (8th Cir. 2009)

- Legislative responses
  - Washington: requires emergency services and Medicare/Medicaid participation
  - Montana: prohibits economic credentialing

- Not protected by HCQIA: doesn’t reach economic decisions

- Employment can provide possible exception to protection of privileges
  - Terminating employment may make privileges worthless
  - Might also include “clean sweep” provision in employment or professional services contract
    - Provider agrees to surrender privileges upon termination of contract
    - Issue purely contractual

- Enforceable?
  - Consistent with physicians’ expectations under bylaws?
  - Corporate practice of medicine may prohibit employment; may need to use foundation model (e.g., CA)
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Exclusive Contracting/Closure of Medical Staff

- Supreme Court and FTC have long recognized efficiencies to be gained from exclusive contracts
  - In re Burnham Hosp., 101 F.T.C. 991, 993 (1983)
- Thus, rule of reason analysis under § 1
- Contract might also supply evidence of exclusionary conduct for § 2 claim against hospital
- Might also support tying claim
- Other considerations
  - Watch for ancillary tort claims (based on precipitous action, bad documents)
  - State law may prohibit closure of departments (e.g., CA)
Foreclosure Analysis

- “Exclusive dealing is an unreasonable restraint on trade only when a significant fraction of buyers or sellers are frozen out of a market by the exclusive deal.”
  - *Jefferson Parish*, 466 U.S. at 45

- Rule of reason analysis
  - Structure of market
  - Procompetitive effects

- Claims routinely fail
  - “The cases involving staffing at a single hospital are legion. Hundreds, perhaps thousands of pages in West publications are devoted to the issues those circumstances present. Those cases invariably analyze those circumstances under the rule of reason—there is nothing obviously anticompetitive about a hospital choosing one staffing pattern over another or in restricting the staffing to some rather than many, or all.”
    - *BCB Anesthesia Care, Ltd.*, 36 F.3d 664, 667 (7th Cir. 1994)
Refusal to Deal Analysis

- *Four Corners Nephrology*, 582 F.3d 1216 (10th Cir. 2009)
  - Paradigmatic facts
  - “A business, even a putative monopolist, has no antitrust duty to deal with its rivals at all.”
    - *Id.* at 1221 (quoting *Linkline*, 555 U.S. 438 (2009))

  - Single firm forsakes short-term profits and consumer goodwill from established course of dealing in hope of recouping long-term monopoly profit
  - “Outer bounds of Section 2 liability” - *Trinko*
Essential Facilities Doctrine

- Questionable whether it is a viable claim
  - May not be appropriate in staffing decisions at hospital due to public policy. *Tarabishi*, 951 F.2d 1558, 1568 n. 14 (10th Cir. 1991)
  - Never adopted by Supreme Court. *Trinko*
  - Areeda & Hovenkamp: “It is not an independent tool of analysis; it is only a label”

- Elements. *E.g., Metronet Servs. v. Qwest*, 383 F.3d 1124 (9th Cir. 2004)
  - Monopolist in control of essential facility
  - Plaintiff cannot duplicate facility
  - Defendant has refused to provide access
  - It is feasible for defendant to provide access
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Joint Ventures

- Hospital may want to offer providers a share of ancillary services
  - ASCs, imaging centers, etc.
- Might also want to form a network with affiliated providers for efficiency
  - ACOs, PHOs
- Issue: joint negotiations with payers
  - Section 1
Joint Ventures: Issues

- Single economic entity? – *Copperweld*

- Financial integration
  - Health Care Statement 9: “sharing substantial financial risk”
  - DOJ Letter to Santa Fe Managed Care Organization (1997)

- Clinical integration
  - Health Care Statement 9
  - FTC Advisory Opinions
ACOs

- Guidance: October, 2011
- Presumed clinical integration
  - comply with CMS eligibility criteria
  - Criteria akin to indicia of clinical integration
- Worth the effort?

“I am skeptical that ACOs will actually lead to any net health care cost savings. The available evidence suggests that the cost savings to Medicare will be very small to nonexistent, and there is a substantial risk that any reduction in Medicare expenditures will simply be shifted to payors in the commercial sector.”

Commissioner Rosch
Nov. 17, 2011
Hospital Acquisition of Provider Practices

- Subject to Clayton § 7
- Even if not subject to HSR Reporting
  - Roanoke, VA (2008): FTC challenged acquisition of imaging center and ASC
  - Spokane, WA (2011): FTC challenged proposed acquisition of two cardiology clinics
  - Harrisburg, PA (2011): Penn. AG consent decree with 13 urologists
- “The Commission will aggressively enforce the antitrust laws to ensure that consolidation among health care providers will not increase health care costs in local communities across the United States.”
Questions?
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