Out of the Frying Pan and Into the Fire:

Antitrust Issues in Mergers, Joint Ventures, and Contracting

Rob Kidwell
Mintz Levin
Washington, DC
Where Does the "Urge to Merge" Come From?

Pressure, Pressure, Pressure, Pressure!

- Declining reimbursements
- Increasing administrative burden
- Increasing focus on shifting risk to providers
Three Degrees of Provider Integration:

- Merger
- Joint Contracting via Joint Venture or Clinical Integration (including ACOs)
- Clinical Affiliation Without Joint Contracting

Different models have different antitrust issues
If you are considering teaming up with someone else, whether through merger, JV, or other integration, there may be important choices and antitrust tradeoffs to make; it essential that you

**CHOOSE WISELY**!

This seems like common sense, but it is a very difficult step where many tie-ups fail.
Choices? What Choices?

- Should we merge? With whom?
- Should we clinically integrate? With whom?
- We can’t buy both Hospital A and Hospital B; which one should we buy?
- Should we open an ASC in concert with that group down the road? With another group?
- Do we really need that specialty group in order to succeed?
Why is This an Antitrust Issue?
Because Antitrust Increasingly Sets Boundaries

- Sometimes doing one Thing One means that you cannot do Thing Two—you must choose one or the other
- Sometimes doing Thing One will have no effect on Things Five through Seven
- Sometimes the window to do Thing Three is closing—does that send it to the front of the line?
- Sometimes doing Thing Four means that you get to do nothing else at all after that—do you want to shoot the moon?
What Do You Mean by "Choose Wisely"?

Your actions must be

Conscious

and

Strategic
What Do You Mean by "Choose Wisely"?

- **Conscious:** the chooser is carefully considering the options and is making a conscious, thoughtful choice to do **this particular thing at this particular time**, rather than just letting things happen and going along with the flow.

- **Strategic:** the chooser is thinking about the choices that it faces with respect to **all** of its goals and **all** of its stakeholders, and has set clear priorities, understanding that **this choice** may have an impact on its future options in other areas and for other stakeholders.
Who is the "Chooser"?

- The physicians in your practice group?
  - If so, do you need unanimity?
  - Are all votes equal?

- The President(s) of your hospital(s)?
  - Do all of your stakeholders agree that this person gets to be the chooser?

- A Board or Committee of stakeholders?
  - How much actual stakeholder buy-in do you need in addition to the Board or Committee?
If You Don’t Have a Chooser, Then You Need to Get One!

- It is impossible to engage in a conscious, strategic decision-making process without a chooser who has authority to make a conscious, strategic decision.
- Doesn’t matter whether the chooser is a person or a group of people.
- Doesn’t matter whether the chooser is democratically elected by the stakeholders or imposed from above as a dictator.
- What matters is that the chooser can identify relevant goals, set priorities for the organization, and make the hard choices on trade-offs.
A ship will run on its own

But it won't steer without a captain
The Seeds of Doom are Often Sown at the Choice Stage

- When things fall apart, it is usually due to a failure to choose wisely
  - Frequently, a course of action will be taken through inertia or imposed by a combination of events and a failure to act
  - If you don’t make the hard choices, then they will be made for you
- It is shocking how often there is no "chooser" on one or both sides
  - No one is empowered with authority to choose
  - Don’t want to step on others' toes
  - Don’t want to be responsible for letting someone know that their primary goal is not the organization's primary goal
- Even when there is a chooser, decisions are often made reflexively rather than consciously and strategically
We have **got** to bring the Jones OB/GYN group into our contracts!

If we don't buy Hospital X, our general surgery referrals will plummet!

Build my outpatient Ortho center, or I'll find a partner who will!

I have been courting the Smith pediatrics group for three years, we have to bring them in NOW!

If we don't merge with System X, we'll be left behind!

It's time to terminate our Blue Cross contract until we get rates we can live with!

**COLLEGIALITY**
OK, we get it with all the choosing!

What are the antitrust rules we have to follow?
The Full Monty:
How Mergers are Analyzed
How Mergers are Analyzed

• FTC typically reviews provider mergers, along with the local state attorney general (plus private plaintiffs)
  –But DOJ has not ceded the territory completely

• Analyzed under FTC/DOJ Horizontal Merger Guidelines
Merger Analysis: Product Market

- Who is it that is merging, and do they compete for the same customers? In other words, are they substitutes?
  - We would not care if a hospital buys an ice cream shop
  - We might care if a hospital buys an ASC
  - We would probably care if the only two practice groups in the region merge

- For hospital mergers, focus is typically on inpatient general acute care (GAC) services
  - But other services could also be relevant, e.g., OB

- For physician groups, focus will be on relevant specialty/specialties—again, are they substitutes?
Merger Analysis: Geographic Market

- The starting point for any antitrust analysis is determining the geographic market
  - Where do the merging parties' patients come from, and where else could they go to seek care other than to the merging parties?
- Geographic market = patient's set of actual choices and/or payers' set of choices to build a network with sufficient access
- Focus will be on the local primary service areas (PSAs) of the merging providers, and what other providers draw from those PSAs, typically based on discharge data
- Evidence will include competitor locations, patient drive times
Merger Analysis: Concentration

- Focus is usually on market shares of competitors pre- and post-merger

- Typically analyzed using "HHI," or Herfindahl-Hirschman Index
  - $HHI = \text{sum of the squares of the market shares of every competitor in the geographic market} - \text{measures the concentration of the market before and after, plus the magnitude of the change (delta)}$

  - Why is the delta important?
    - If a provider with 50% share wants to buy a provider with 1% share, probably not an issue
    - If a provider with 40% share wants to buy a provider with 35% share, then antitrust authorities will probably take a look
Standard HHI Presumptions

- In a market where the pre-merger HHI is unconcentrated, or where there is an increase in HHI of zero to 100, there is presumptively no issue.
- Mergers that increase the HHI by more than 100 and result in a post-merger HHI of 1500 or more will warrant further scrutiny.
- Mergers that increase the HHI by between 100 and 200 and will result in a post-merger HHI above 2500 will raise competitive concerns and warrant additional scrutiny.
- Mergers that increase the HHI by more than 200 and result in a post-merger HHI over 2500 will be presumed unlawful.
Some Examples of Challenged Deals

- **Toledo, OH: ProMedica/St. Luke's**
  - Post-merger HHI would be 4,392 with a delta of 1,078 (resulting market share of 58%, 80.5% in OB)

- **Rockford, IL: Rockford Memorial/St. Anthony's**
  - Post-merger HHI would be 5,177 with a delta of 1,764 (resulting market share of 59%)

- **Northern Virginia: Inova/Prince William**
  - Post-merger HHI would be 5,562 with a delta of 974 (resulting market share of 74%)
Merger Analysis: Predicted Effect on Competition

- Concentration is *usually* only an indicator of potential future effects, not proof that the deal is anticompetitive.

- Enforcer must attempt to predict: based on concentration and other relevant factors, what will happen to competition post-merger?

- Other relevant factors include whether the merging parties are each other's "closest competitor," and/or internal documents that discuss the parties' intentions post-merger.

- Because it's all about predicting the future, economic modeling is common.

  - Current economic fad, "willingness to pay" analysis, is wrong at least 1/3 of the time—and yet enforcers believe it a success.
Merger Analysis: Efficiencies

- There are various ways that merging parties can defend an otherwise problematic merger, but the important one for today is the defense of **efficiency**

- If the merger would result in real, measurable, merger-specific competitive benefits that could not be achieved in a different way, then those benefits should be weighed against the predicted harms
  
  —Each of the criteria in that last bullet is essential
Merger Analysis: Efficiencies

The $64,000 question:

Does the new world of health care delivery require providers to merge in order to secure the benefits?
The FTC View: Not Just No, But *Hell No*

- FTC has doubled down on its position that mergers are unnecessary to achieve the benefits of coordinated care, risk-sharing, and population health management
  - Interconnect your EHRs!
  - Coordinate care with independent physicians!
  - But don’t contract together!! (more on that later)

- And some courts have agreed—but not all

"We remain skeptical about the efficiencies defense in general and about its scope in particular... it is not enough to show that the merger would allow St. Luke’s to better serve patients."

• Court rejected the parties' argument that merger was necessary to achieve the level of coordination required in the new age—employment of MDs, shared EMR, shared risk
...Although the Documents Didn't Help


Better cost is a worthy goal and I totally back that. I also understand market forces involved. But - let's be realistic. Employing physicians is not achieving better cost, it's achieving better profit.

Dr. Thomas Huntington, St. Luke’s Treasure Valley Board Member
On the Yes Side: U.S. District Court in Hershey

“We find it no small irony that the same federal government under which the FTC operates has created a climate that virtually compels institutions to seek alliances such as the Hospitals intend here. Like the corner store, the community medical center is a charming but increasingly antiquated concept. It is better for the people they treat that such hospitals unite and survive rather than remain divided and wither.”

FTC has appealed, Third Circuit stayed the merger pending appeal—watch this space!
On the *Maybe, But You Didn’t Even Try* Side: Sixth Circuit in ProMedica

"ProMedica did not even attempt to argue...that this merger would benefit consumers (as opposed only to the merging parties themselves) in any way. To the contrary, St. Luke's CEO admitted that a merger with ProMedica might '[h]arm the community by forcing higher rates on them.'"
How to Structure Your Deal For Success

- Choose your partner wisely: consider the post-merger market share of the combined entity, and know what you are getting yourself into
  
  – Not saying don’t do a huge deal, but do your deal with eyes open; draft deal documents to assign the antitrust risk appropriately

- Focus your deal planning on efficiencies and **document** them—better care for patients, lower costs to payers
  
  – Hint: your deal **IS NOT** about extracting higher reimbursements from payers
  
  – Don’t say one thing to regulators and another in your E-mails

- Have your efficiencies well-planned and provable **before** you announce

- Assemble a good team and make a disciplined game plan as soon as you start having serious talks—antitrust counsel, perhaps an economist
  
  – That first CEO-to-CEO conversation will be relived 1,000 times, so talk to your counsel **before** you have it!
Joint Ventures/Joint Contracting:
Working Together Without Merging Groups
The Starting Point: Price Fixing is Illegal

- It is unlawful for two or more competitors to agree on pricing—Section 1 of the Sherman Act prohibits it
  
  - That includes physicians and hospitals
  
  - So, Hospital A cannot call up Hospital B and suggest that they both agree to charge $5,000 for Service C
  
  - Physician A cannot agree with Physician B that they will each charge $200 for a standard office visit

- Remember the "Messenger Model"?
But Independent Members of a Joint Venture MAY be Able to Contract Together

- Jointly setting prices can sometimes be OK if it is "reasonably ancillary" to an otherwise beneficial venture
  - "Reasonably ancillary" = the venture really wouldn't work without it
  - May not be "reasonable" if there are other, equally effective ways to accomplish your goals without joint contracting (called "less restrictive means")—and FTC thinks there are a lot of those
- The venture itself needs to be substantial, and have substantial benefits, apart from being a joint contracting vehicle
- FTC/DOJ Statements of Healthcare Enforcement Policy set the (informal) standard
This is NOT "Reasonably Ancillary"

I hear those guys over there get better rates... we should find a way to get onto their contracts!
There Are Different Types of Joint Venture

- A JV can knit the participants together so tightly that they become in effect a single entity, akin to a merger
  - Shorthand is to refer to this as a "Copperweld" entity, meaning that the participants are not actually separate competitors—they are a single entity, and a single entity cannot conspire with itself, as it "takes two to tango"
  - Governance, finances, asset ownership, clinical practice management all centralized

- A JV can integrate the participants in some ways but not others (e.g., a JV to open a specialty cancer center)

- Or a JV can be a series of clinically integrated independent providers

- FTC says ACOs are just another type of JV, uses same basic analysis
Some Characteristics of a Healthy, Appropriate Joint Venture

- The participants in the JV share substantial financial risk
  - Could be pure capitation risk, could be distribution of withhold or shared savings
- There are clear goals for quality/utilization/performance across participants
- Adherence to/achievement of those goals is monitored and actually enforced
- Other indicators of an appropriate joint venture:
  - Case management and utilization review
  - Clinical practice standards, physician committees, Medical Director
  - Capex spent on systems that facilitate clinical integration—e.g., EMR
There Are Some Catches

- A JV is size-limited, and cannot be used to end-run around a merger analysis
  - JV cannot grow to a size that the parties would be blocked from achieving via merger; 30% share or less is quite safe, more is possible

- The JV participants are not immune from the antitrust laws—they could still be liable for "conspiring" with other JV participants on matters outside of the JV
  - Cancer center JV does not justify network-wide joint contracting
  - Open question: can a JV that is formed to share risk also negotiate PPO contracts on behalf of the participants?
The Dayton Example
(Using the facts from the Sixth Circuit Court of Appeals opinion)

• Four Dayton-area hospitals joined forces to create a JV called Premier Health Partners

• Premiere managed much of the business of the participating hospitals—billing and collections, property management, practice management, looking for and achieving efficiencies

• The JV participants shared profits and losses, but contracted separately

• As a result, the Premier participants felt themselves to be a Copperweld entity, so tightly knit that they are a single entity and therefore cannot be accused of conspiring with themselves

• Looks like a duck, walks like a duck, so it's a duck, right?
The Claim

- Plaintiff The Medical Center at Elizabeth Place (TMC) claimed that the four Premier hospitals conspired with one another to exclude it from the market by threatening doctors and negotiating exclusivity with payers.
- Premier responded that the JV participants cannot be found liable for conspiring because they are a single entity.
- The District Court agreed with that argument.
- But the Sixth Circuit Court of Appeals disagreed.
- The only question that the Sixth Circuit addressed was this: on the facts as they existed in the case, is it \textit{at least possible} that the Premier participants function independently enough that they are NOT a single entity?
Facts the Court Relied On

- This is one of those cases where the parties' documents and testimony did the defendants no favors:
  - Allegedly, an EVP of Premier called the head of TMC and more or less said he would squash them
  - Allegedly, Premier warned payers against contracting with TMC and warned docs against working with TMC
  - A Premier consultant had written that the Premier participants "do not collaborate or act as a system today, more often [they] find themselves competing with each other."
  - Consultant also stated that Premier is a “confederation of autonomous organizations” that cooperate in certain areas; “[t]he brand is the hospital, not [Premier];” defendant hospitals “do their own thing and act in their own self interest above that of [Premier];” and the joint venture structure was “designed to keep everyone separate.”
What the Court Held

- There is enough evidence here that this thing might possibly not be a duck—reversed the grant of summary judgment

- Fact that each hospital retained its own governance structure and competed with other participants for market share deemed relevant by Sixth Circuit

- Told the District Court to pick the case back up and delve into these issues

- This begs the question: can there ever be a Copperweld JV, as opposed to a merger, under this standard?
Tips for Forming Joint Ventures

• Make a clear plan for what you are going to do and how you are going to do it
  – Getting into the other guy's contracts is NOT a JV plan
  – There must be concrete benefits to the public—rationalizing site of care, integrating health records, coordinating care, sharing risk to achieve cost savings, et cetera
  – There must be goals, a means of measuring those goals, and a means for getting people on track when they fall short of the goals

• Document, document, document! Document the plan and the benefits—and don’t document any impure thoughts
Tips for Forming Joint Ventures

• Stick to the plan—don’t collude on things that fall outside of the four corners of the JV
  – It's tough to argue that JV members are a Copperweld single entity—so don’t try it unless you have good counsel and a strong plan; instead, stay within the bounds of your JV

• Think about cultural barriers from the outset—entering into a JV that is sufficiently robust as to allow joint contracting requires each participant to relinquish some autonomy, both financially and clinically
  – *Marriage is hard work, it requires humility and a lot of give-and-take*

• Don’t draw attention to yourself for the wrong reasons
  – Threatening payers
  – Punishing providers
  – Attacking rivals
"OK, it's settled. We are going to add Smith Medical Group to our network in the next cycle. They're good for 250 referrals a year."

"I thought they wanted to stay independent?"

"They do; we'll just add them to the EMR."

"But the lawyers say we need to have a clinical integration plan!"

"Well, then tell our lawyer to make us a plan. In the meantime, Bill you start putting together a P&L for the next 2-year contracting cycle with Smith Medical in it at full rates. I want to see the lift analysis by next week's Chiefs meeting."
A Special Case: Clinical Affiliation Without Joint Contracting

- So long as the participants aren't contracting together or otherwise divvying up the market among them, it's an antitrust greenfield.

- Making it easier for patients to move among providers or to benefit from better care is a good thing.

- More patient and payer choice = GOOD!

- Excluding competitors from the affiliation could in theory raise antitrust issues if the affiliation has a large market share.
“If you fail to plan, you are planning to fail.”

- Benjamin Franklin
Rob Kidwell
rgkidwell@mintz.com
(202) 661-8752