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# When the Antitrust Laws May Not Allow Healthcare Providers to Pursue Merger-Specific Efficiencies—And What Healthcare Providers Can Do About It


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# When the Antitrust Laws May Not Allow Healthcare Providers to Pursue Merger-Specific Efficiencies—And What Healthcare Providers Can Do About It

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## I. INTRODUCTION

As hospitals and health systems continue to prepare for value-based reimbursement and other reforms of the Patient Protection and Affordable Care Act[2] ("ACA"), many independent hospitals are left wondering how they can seek to achieve meaningful efficiencies—improvements in quality and access, and reductions in cost—mandated by those reforms if the antitrust laws may not allow them to seek to achieve those efficiencies by merging with another hospital in their service area. This article explores the issue facing healthcare providers—as well as the alternatives providers may have in today's antitrust enforcement climate.

## II. HEALTH REFORM MANDATES

Improving the United States healthcare delivery system through reductions in unnecessary costs and quality improvements is one of the key goals of health reform. ACA establishes both financial incentives for healthcare providers who reduce costs and increase quality outcomes and financial penalties for those who do not.

Financial incentives for hospitals to reduce unnecessary costs and improve quality include the Hospital Value-Based Purchasing Program.[3] Under this program, beginning for the Medicare fiscal year commencing October 1, 2012, the United States Department of Health and Human Services ("HHS") will make value-based incentive payments to hospitals that meet certain performance standards. Also, as required by ACA,[4] HHS has established a shared savings program that: (i) promotes accountability for a patient population and coordinates items and services under Parts A and B of the Medicare program and (ii) encourages investment in infrastructure and redesigned care processes for high quality and efficient care delivery. Under the shared savings program, accountable care organizations ("ACOs") that meet quality performance standards are eligible to receive shared savings payments.

Financial penalties for hospitals that do not reduce unnecessary costs and improve quality include those under the Hospital Readmissions Reduction Program.[5] Under this program, beginning October 1, 2012, HHS will reduce payments to hospitals for potentially preventable Medicare readmissions for certain conditions. Beginning October 1, 2015, HHS will also reduce

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[2] Public Law No. 111-148b (March 23, 2010).

[3] §3001 of ACA.

[4] §3022 of ACA.

[5] §3022 of ACA.

payments to hospitals in the top 25th percentile for all hospitals for certain hospital-acquired conditions.[6]

In addition, ACA encourages providers along the continuum of care to work together to achieve cost and efficiency goals. ACA establishes a pilot program for integrated care during an episode of care provided to a beneficiary around hospitalization in order to improve the coordination, quality, and efficiency of care and also provides for a bundled payment for inpatient hospital, outpatient hospital, physician services, and post-acute care (e.g. home health).[7] The reduction of unnecessary costs for Part A and Part B services under the shared savings program will also require coordination between hospitals and physicians.

ACA also established the Center for Medicare & Medicaid Innovation ("CMMI)[8] to test innovative payment and service delivery models to reduce Medicare costs and improve the quality of care, and provided for appropriations for the design, implementation, and evaluation of these models. Examples of such models include: (i) medical homes, (ii) chronic care management, (iii) home-based primary care, (iv) health information technology-enabled provider networks, (v) medication therapy management, and (vi) other quality, cost-effectiveness and evidence-based medicine initiatives. Hospitals will need capital to purchase and implement the infrastructure and systems required to pursue these alternative payment and service delivery models.

While the most significant from the standpoint of creating financial incentives for healthcare providers to make investments designed to foster improvements in quality and cost, ACA is not the only federal legislation that creates these incentives. The HITECH Act[9] establishes financial incentives for hospitals to adopt electronic health records systems ("EHRS") and will penalize those that do not. Beginning with the Medicare fiscal year commencing October 1, 2010, Medicare and Medicaid distributed incentive payments to hospitals that used certified EHRS consistent with the "meaningful use" standards, and, beginning with the Medicare fiscal year commencing October 1, 2014, Medicare will reduce the reimbursement paid to hospitals that fail to use certified EHRS consistent with the "meaningful use" standards.[10] The acquisition and implementation of an EHRS requires significant capital and other resources that may be beyond the reach of many smaller, independent hospitals and physician practices.

## III. EFFICIENCIES

Squeezed financially by declining reimbursement and increased costs to provide care, and faced with a further decline in reimbursement if unable to achieve the financial incentives or avoid the financial penalties of health reform, many independent hospitals are considering affiliation strategies for the obvious economies of scale and capital that a combination with another health system offers. Some cost efficiencies, such as reductions in: (i) certain back office administrative support staff, (ii) the cost of borrowing through an improved credit rating, and (iii) supply costs through increased purchasing power, may be achievable from a combination

[6] §3008 of ACA.

[7] §3023 of ACA.

[8] §3021 of ACA.

[9] 42 U.S.C. 1395WW(n).

[10] Section 4102 of the HITECH Act.

with another health system irrespective of where the system's health facilities are located. However, many efficiencies—and typically where the greatest opportunity for dollar savings is—can only be achieved by combining with another health system in the hospital's service area. These opportunities are typically through the consolidation of clinical service lines, and capital expenditure avoidance or reallocation.

When two hospitals offer the same secondary or tertiary clinical service, and the service lines collectively have excess capacity, the hospitals can free up significant resources by combining those service lines and deploying the underutilized assets to other uses. Similarly, when one hospital has plans to invest in a new technology, equipment, or service line, the hospitals collectively can free up that capital by avoiding the investment if the other hospital has already invested in that technology, equipment, or service line.

It is impractical to combine clinical service lines unless the hospital where consolidation occurs is a reasonable alternative for the former patients of the other hospital for that service line. Hospitals that are not geographically proximate to one another likely are not reasonable alternatives for patients. Similarly, it is impracticable for one hospital to avoid an investment in that technology, equipment, or service line unless the other hospital that already made the investment is a reasonable alternative for patients. Experience shows that neither clinical service line consolidation nor capital avoidance savings will occur unless the hospitals are part of an integrated health system.

The scale created by hospital mergers also facilitates quality improvements. A larger patient population can support the recruitment of subspecialists who need a sufficient number of patients to support a full practice. A larger patient population also enables a more robust dashboard of clinical quality data for performance measures. Merging hospitals can also exchange and implement best practices and quality protocols. Since some HHS financial incentives and penalties will turn on provider performance against benchmarks, many providers will be unwilling to share clinical protocols and best practices with their competitors against which they will be benchmarked.

Many hospitals conclude that they cannot seek to achieve these efficiencies with another hospital or health system partner unless the economic interests of the parties are aligned. Otherwise, each party will be incentivized to take action—or inaction—that benefits the economic interests of that party alone. As a result, many hospitals around the country are lamenting that the antitrust laws are prohibiting them from achieving the very efficiencies that health reform is requiring them to achieve.

## IV. ANTITRUST ENFORCEMENT

The federal antitrust enforcement agencies ("Agencies") continue to challenge transactions in the health industry that they view as anticompetitive. In the past five years, the Federal Trade Commission ("FTC") has challenged four hospital transactions by filing administrative complaints seeking to enjoin or unwind the mergers, and three of these challenges have been in the past 18 months.[11] Although not public information, one can reasonably assume

[11] See *In the Matter of Inova Health System Foundation and Prince William Health System,* FTC Docket No. 9326 (administrative and federal complaints filed May 8 and 13, 2008, respectively; dismissed one month later after

that the Agencies conducted non-public investigations of other hospital mergers that did not lead to administrative complaints being filed, either because the parties decided not to pursue their transaction in the face of regulatory scrutiny, or ultimately the Agencies declined to challenge the transaction at that point in time.

In recent public remarks,[12] Jon Leibowitz, Chairman of the FTC, stated that these challenges represent only a small percentage of the overall hospital mergers that have occurred in the United States during the five-year period. Of the approximately 330 hospital mergers during this period, roughly one-third were reportable to the Agencies under the Hart-Scott-Rodino ("HSR") Act. The FTC issued a second request in approximately one-tenth of the reportable transactions (and also conducted non-public investigations of at least some hospital mergers that were not HSR-reportable). The time, cost, and diversion of resources required to respond to a second request or investigation, or defend an agency challenge, can deter potential merging parties from continuing to pursue their transaction.

## V. ANTITRUST IMPLICATIONS

Independent hospitals seeking to affiliate with another hospital or health system in their service area to seek to achieve health reform mandates may wonder how or why the antitrust laws could be applied to enjoin a merger when the intended purpose of the merger is to pursue cost and quality objectives that are pro-competitive. The Horizontal Merger Guidelines issued by the FTC and Department of Justice ("DOJ") in August of 2010 recognize that a primary benefit of mergers is their potential to generate significant efficiencies and enhance the merged entity's ability to compete—which could lead to lower prices, improved quality, enhanced service, or new products. However, the Horizontal Merger Guidelines provide that "even when efficiencies generated through a merger enhance a firm's ability to compete…, a merger may have other effects that may lessen competition and make the merger anticompetitive."[13]

In other words, although the parties may be pursuing an affiliation for efficiency goals, the Agencies continue to examine anticompetitive effects. Further, the Agencies will credit only those efficiencies that are merger-specific—that is, unlikely to be accomplished without a merger between the parties—and that are identifiable, quantifiable, and verifiable. The Agencies examine whether these "cognizable efficiencies" likely would be sufficient to reverse the merger's potential for anticompetitive harm (e.g., the ability to raise prices). The greater the potential for anticompetitive effects, the greater the merger-specific cognizable efficiencies must be. In addition, the Agencies state that the efficiencies must be passed through to customers for the Agencies to conclude that the merger will not have anticompetitive effects. The Agencies state

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parties abandoned transaction); *In the Matter of ProMedica Health System, Inc.* (administrative and federal complaints filed Jan. 6 and Jan 7, 2011, respectively; preliminary injunction granted, FTC ruled that transaction unlawful and hospitals appealing); *In the Matter of Phoebe Putney Health System, Inc., et al.*, FTC Docket No. 9348 (administrative and federal complaints filed April 20, 2011; in federal proceeding, FTC petition for writ of certiorari to Supreme Court of the United States on issue of state-action immunity granted); *In the Matter of OSF Healthcare System and Rockford Health System*, FTC Docket No. 9359 (administrative and federal complaints filed Nov. 18, 2011; transaction abandoned following issuance of preliminary injunction).

[12] Antitrust in Healthcare Conference co-sponsored by the American Bar Association and the American Health Lawyers Association, Arlington, Virginia, May 3-4, 2012.

[13] Section 10 of the FTC/DOJ Horizontal Merger Guidelines (2010).

that in their experience, "efficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great. Efficiencies almost never justify a merger to monopoly or near-monopoly."[14]

## VI. ALTERNATIVES

Several alternative forms of provider collaboration may allow competitors to seek to achieve certain quality and cost goals without raising the same antitrust concerns that a merger might raise. Some examples include:

1. *Clinical service line joint ventures and co-management arrangements*. Hospitals may identify an opportunity to integrate with other hospitals in a limited number of clinical service lines while retaining competitive relationships in all other respects. This partial integration could, among other things, create efficient scale, reduce costs, add volume, attract qualified specialists, and develop better data—any or all of which can lead to better outcomes and higher quality. Such arrangements would be subject to a "market power screen" (based in part on shares in those service lines) and antitrust compliance protocols pertaining to access to confidential information and other competitively sensitive functions.
2. *Health IT collaborations*. Competitors might look to develop programs to share electronic medical records and coordinate on other health IT initiatives to reduce costs and enhance care by utilizing information available from a more robust pool of clinical data—again, subject to appropriate antitrust-based protections.
3. *Joint introduction of a new service*. Certain health care providers might compete in one set of services but not another—such as in certain tertiary or quaternary care procedures, or in outpatient care. A joint venture that introduces a new service to the community, or that creates new competition for a service currently offered only by others, is much less likely to trigger antitrust concern than a venture between rivals in a service they both offer.
4. *Alliances with out-of-market organizations*. Hospitals with reputations that span only their local area might be able to achieve strategic, operational, and financial benefits by aligning with a more well-known hospital system with a strong reputation that exists outside the local area, such as an academic medical center. An affiliation that does not involve collaboration between systems serving the same geographic area or the same level of services is unlikely to create significant antitrust concerns.
5. *ACOs, clinical integration, and financial risk-sharing ventures*. Innovation is an important feature of a dynamic economy that antitrust laws protect. Health care providers are able to develop new models for care delivery that enhance quality, reduce costs, and make markets more competitive. Whatever name is used to describe a particular model, if it involves competitors that will price together, then the antitrust framework is well-established: Will the venture likely achieve benefits for consumers? If so, is joint price-setting reasonably necessary to achieve the benefits? Will the benefits outweigh any potential anticompetitive effects—typically initially assessed as a function of the

[14] *Id.*

combined market share of the venture's participants? If the answer is "yes" to *each* of those questions, then the arrangement complies with the antitrust laws.

6. *Other alliances*. Providers of health care services may determine that different types of alliances are necessary—such as collaborations specifically designed for access to capital, whether from other health care provider systems, from private equity firms, or from other types of organizations. Antitrust is an unlikely roadblock to those transactions absent the involvement of a significant competitor. "Non-horizontal" mergers, such as between a physician group and a hospital (which does not employ competing physicians) or between a hospital and commercial insurer may also be transactions that, based on the applicable facts, meet the parties' strategic goals without creating insurmountable antitrust hurdles.

If carefully structured, virtually all health care organizations have opportunities through collaborations to achieve their strategic goals in a manner consistent and compliant with the antitrust laws. These include transactions less encompassing than a full merger or acquisition—arrangements that involve only the partial integration of certain operations, with firms that may be rivals or providers of complementary services or products. This principle holds true even during a period, like today, of aggressive antitrust enforcement and enhanced government scrutiny of competition in the health care sector.