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Can Antitrust and Health Care Reform Policies Converge?

Monica Noether
Charles River Associates

www.competitionpolicyinternational.com

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I. INTRODUCTION

Earlier this year, a federal judge sided with the Federal Trade Commission ("FTC") and the Idaho Attorney General and enjoined the acquisition of a physician practice that included 16 adult primary care physicians ("PCP"s) by a hospital that already employed eight adult PCPs. The ruling was based only on the alleged lessening of competition attributable to the horizontal overlap in adult PCP services, despite the transaction's obvious concomitant vertical implications.

Notwithstanding its small scale, this case has attracted considerable national attention in health care antitrust circles as it raises policy questions that are fundamental to the pressures facing the health care industry in the era of reform.

II. BACKGROUND

The acquisition involved St. Luke's Health System (St. Luke's) and Saltzer Medical Group (Saltzer) and the physicians they both employ in the city of Nampa, Idaho. Nampa, a city of about 85,000 residents, is located approximately 20 miles west of Boise.

St. Luke's operates seven acute care hospitals with almost 900 beds combined, all in Idaho. Its largest, flagship facility is in Boise. It also operates a full-service emergency department (limited to outpatient services) in Nampa itself. St. Luke's has exclusive arrangements with approximately 500 physicians (both affiliated and employed) across southern Idaho and eastern Oregon. It has acquired all of its adult PCPs in Nampa since 2011.

Saltzer was the largest multi-specialty physician group in Idaho, including 41 physicians at the time of its acquisition. These physicians were primarily located in Nampa, although some also practiced in the surrounding area.

The acquisition of Saltzer by St. Luke's was completed in December 2012 after Judge B. Lynn Winmill denied St. Luke's' competitors, St. Alphonsus Health System and Treasure Valley Hospital, their preliminary injunction to enjoin the transaction. These private plaintiffs had alleged vertical foreclosure, arguing that the proposed transaction would harm competition by blocking physician referrals, but the Court found that the transaction would not cause

[1] Monica Noether is Vice President, Charles River Associates, where she specializes in antitrust analysis and other competitive issues related to the health care industry.

irreparable harm.[2] Judge Winmill relied on assertions by the defendant that it would take time to "scramble the eggs," and that therefore the transaction could be subsequently undone if the full review of the merits indicated this was in the consumers' best interests.

Subsequently, the FTC and the Idaho Attorney General entered the fray, filing a complaint in March 2013 that focused purely on the horizontal overlap of adult PCPs in Nampa. The cases were consolidated, and a full trial on the merits spanned four weeks in the fall of 2013. On January 24, 2014, Judge Winmill found for the plaintiffs and ordered that St. Luke's divest the entire Saltzer Medical Group.

III. ISSUES

Judge Winmill clearly recognized the complexity of the issues that he was asked to address in this case.

> ….Americans spend more on health care than the next 10 biggest spenders combined…yet we lag behind many of them on quality and patient outcomes….[The experts] advocate moving away from our present fee-for-service health insurance reimbursement system that rewards providers…for billing high volumes of expensive medical procedures. A far better system would focus on…rewarding successful patient outcomes and innovation….It will require a major shift away from our fragmented delivery system and toward a more integrated system where primary care physicians supervise the work of a team of specialists, all committed to a common goal of improving a patient's health.

The Court also noted "the Acquisition was intended by St. Luke's and Saltzer primarily to improve patient outcomes. The Court is convinced that it would have that effect if left intact, and St. Luke's is to be applauded for its efforts to improve the delivery of health care in the Treasure Valley."[3]

While recognizing the need for integrated provider systems, however, Judge Winmill did not accept defendants' arguments (nor the views of many other consolidating providers nationwide) that such integration is most effective when accomplished through ownership. He found that "there are other ways to achieve the same [beneficial] effect," i.e., he disputed the merger specificity of the likely efficiencies.

The extent to which ownership is superior to looser affiliations in facilitating achievement of the goal of delivering higher value care through greater provider coordination was the key issue of this litigation. The Court's decision reflects the tension that many providers articulate between what they perceive as conflicting directives to, on the one hand, coordinate effectively across an entire care delivery team, and to, on the other, continue to compete as atomistic providers.

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[2] Saint Alphonsus Medical Center – Nampa, Inc., Treasure Valley Hospital, Limited Partnership, Saint Alphonsus Health System, Inc., and Saint Alphonsus Regional Medical Center, Inc. v. St. Luke's Health System, Ltd. Case no. 1:12-CV-560-BLW. Memorandum and Order, December 20, 2012.

[3] Saint Alphonsus Medical Center – Nampa, Inc., Treasure Valley Hospital, Limited Partnership, Saint Alphonsus Health System, Inc., and Saint Alphonsus Regional Medical Center, Inc. v. St. Luke's Health System, Ltd. Case no. 1:12-CV-560-BLW. Federal Trade Commission; State of Idaho v. St. Luke's Health System, Ltd.; Saltzer Medical Group, P.A. Case No. 1:13-CV-00116-BLW. Memorandum Decision and Order. January 24, 2014.

The St. Luke's case raises a second issue that has also been echoed in several other settings nationwide. This concern involves the cost-increasing byproduct of a regulatory policy that reimburses hospital-based services at higher rates than "comparable" services provided outside the hospital setting. This long-standing Medicare reimbursement policy, mimicked by many private payors, led the Court to conclude that an effect of the transaction would be to "raise rates for ancillary services (like x-rays) to the higher hospital-billing rates." While such a change may have nothing to do with any merger-related increase in market power, this case highlights an increased focus on the extent to which such differential reimbursement rates are justified.

In the remainder of this article, I discuss each of these issues in greater detail in the context of the current health care reform debate.

IV. WHAT EXTENT OF INTEGRATION IS REQUIRED TO FULLY ACHIEVE THE BENEFITS OF "VALUE-BASED CARE"?

A variety of forces have led to substantial horizontal and vertical consolidation of the health care industry over the last several years. While much of the credit (or blame) has been attributed to the passage of the Affordable Care Act in 2010, and the associated creation of federally-sponsored Accountable Care Organizations, increasing private sector concern over continued growth in health care spending has played at least as significant a role.

Efforts to "bend the cost curve" advocate replacing traditional "fee-for-service" reimbursement of health care providers with mechanisms that "pay for value" and organize around population, rather than individual, health goals. Such efforts rely on integrated provider delivery systems that place incentives on their provider participants to coordinate to ensure that high-value care is delivered to a patient population. Under this paradigm, individual providers are not paid more simply for delivering more services, but rather they are compensated only if the services they deliver contribute cost effectively to maintaining the health of the population that they serve.

Physicians, among other providers, are responding to these pressures by affiliating with larger organizations, particularly hospitals. Physicians seek larger organizations to absorb the risk of becoming responsible for the cost of maintaining or restoring their patients' health. At the same time, hospitals recognize that physicians serve as the gatekeepers for all the services that their patients consume. There are conflicting reports on the proportion of physicians employed by hospitals, but all accounts indicate that it has been increasing in the last several years and likely exceeds 25 percent of all practicing physicians.[4]

Health reform initiatives directed toward improving quality while reducing the rate of cost growth require scale for at least three reasons:

[4] *See*, for example, Elisabeth Rosenthal, *Apprehensive, Many Doctors Shift to Jobs with Salaries*, N.Y. TIMES (February 13, 2014), *available at* http://www.nytimes.com/2014/02/14/us/salaried-doctors-may-not-lead-to-cheaper-health-care.html; Robert Kocher & Nikhil Sahni, *Hospitals' Race to Employ Physicians—The Logic behind a Money-Losing Proposition*, 364 (19) N. ENGLAND J. MEDICINE 1790-1793 (May 12, 2011); Beth Kutscher, *Making physicians pay off*, MODERN HEALTHCARE (February 22, 2014), *available at* http://www.modernhealthcare.com/article/20140222/MAGAZINE/302229986/making-physicians-pay-off.

1. In order to control costs effectively while delivering high quality care, all members of a care team must face a common incentive to provide the most cost-effective, high quality bundle of services to each patient in their care. This implies that compensation schemes must cause each provider to recognize itself as a cost center, rather than a revenue center.
2. Related to the first point, providers must be responsible for all treatment costs, regardless of whether or not they reflect efficient care patterns or not. However, given that reimbursement adjustment methodologies designed to account for severity differences across patient populations are imperfect, it is important to mitigate the financial risk caused by a few very sick "outlier" patients through the "law of large numbers."
3. Care coordination across a variety of providers and settings requires a health data information technology that links clinical information with cost data from all providers in the system and permits usage of the data to measure resources and outcomes. The fixed costs associated with installing and operating such a system can total many hundreds of millions of dollars and therefore depend on sufficient scale to be affordable.[5]

The ultimate question raised in the St. Luke's case is the extent to which common ownership or employment to create scale and align financial and quality incentives is necessary to address these factors, or whether looser clinical affiliations are sufficient to achieve the same objectives. Testimony at the trial focused extensively on the evidence relating to this question, and both sides presented well-known quality experts to opine on the topic.

This question has its roots in fundamental economic theory relating to the trade-offs of "making versus buying" or "owning versus contracting." It was first raised by Ronald Coase in his 1937 article, *The Theory of the Firm*.[6] A substantial subsequent literature notes that when transaction costs of contracting are high, either because there are too many contingencies to anticipate or articulate in writing the contract, or because monitoring and enforcement of the contract are difficult, then internal organization (making or owning) is more likely. Such situations are most likely to result, all else constant, when products are specialized, market conditions are changing, and information is imperfect.[7] Many would say that these are all conditions that describe the health care sector.

Judge Winmill clearly believed that integration of physicians and hospitals short of merger is sufficient to achieve the benefits of coordinated care. However, many providers appear to believe that, while affiliations can help, they can accomplish much more through complete ownership. Plaintiffs cited Chicago-based Advocate Healthcare as the poster child for a system

[5] Costs for a large health care system to fully implement an integrated health data system can cost up to $1 billion. *See*, *Epic Challenge: What The Emergence of an EMR Giant Means For the Future of Healthcare Innovation*, FORBES (June 9, 2012), *available at* http://www.forbes.com/sites/davidshaywitz/2012/06/09/epic-challenge-what-the-emergence-of-an-emr-giant-means-for-the-future-of-healthcare-innovation/#./?&_suid=139828115743601117460735829352, and *Will Neal Patterson make Americans Healthier?* FORBES (June 8, 2012), *available at* http://forbesindia.com/printcontent/33028.

[6] Ronald Coase, *The Theory of the Firm*, 4 ECONOMICA 386-405 (1937).

[7] *See*, JEAN TIROLE, THE THEORY OF INDUSTRIAL ORGANIZATION, 21-34 (1988) or DENNIS CARLTON & JEFFREY PERLOFF, MODERN INDUSTRIAL ORGANIZATION, 17-24 (1994) for summaries of this literature.

that successfully reduced costs through a collaboration with independent physicians where they jointly shared risk for a patient population.[8]

However, it is important to note that while Advocate works with independent affiliated physicians in its Advocate Physician Partners program, it also employs over 1,000 physicians,[9] and the CEO of Advocate noted, "the secret sauce is alignment—and financial incentives toward alignment get physicians' attention."[10] Also in Chicago, Northwestern Memorial HealthCare recently acquired the 900-physician Northwestern Medical Faculty Foundation, even though the group had already been historically affiliated with the hospital system. This move suggests that Northwestern, the health system, believed that greater control of the affiliated physician group was worth the cost.

Other evidence also supports the greater effectiveness of the employment model. The Catalyst for Payment Reform, a non-profit group representing employers, recently compared the extent of commercial payments that were "value-oriented" nationwide with those in California, which has long been recognized as ahead of the rest of the country in terms of integrated delivery. Nationwide in 2013, the percentage of commercial payments received by providers was less than 11 percent, with less than 6 percent of payments based on financial risk contracts, while in California, 42 percent were value-based, almost all of which were at risk.

It is likely not coincidental that Kaiser Permanente, an integrated health plan-provider organization that owns the hospitals it uses and whose physicians are effectively employed by Kaiser[11] covers 40 percent of all privately insured lives in the state,[12] and most of the rest of California's physician population is organized into large groups of employed physicians. As defendants noted, in other parts of the country, providers such as Intermountain Healthcare, Geisinger Health System, Mayo Clinic, or the Cleveland Clinic—which each employ hundreds, if not thousands, of physicians—are all frequently cited as exemplars of cost-effective, high quality integrated delivery systems.[13]

It also appears that the propensity of physician groups to take on risk-based reimbursement contracts is associated with compensation mechanisms that do not reward volume. A recent study of 21 large physician groups found that those that earned a larger proportion of their revenue from risk-based contracts were more likely to pay their physicians by salary or performance metrics (e.g., efficiency, quality) while those that received primarily fee-for-service payments tended to rely more on individual productivity based compensation

[8] Trial Transcript, November 7, 2013, page 3677.

[9] Advocate Medical Group, *available at* https://amgdoctors.com/about-us/.

[10] *Inventing the Future of Healthcare: Top CEOs on the Real Work of Transforming the Healthcare Industry*, (2013).

[11] Technically, California prohibits the corporate practice of medicine. As a result, Kaiser physicians are employed by the Permanente Medical Group, which contracts exclusively with Kaiser Permanente.

[12] CALIFORNIA HEALTHCARE FOUNDATION, CALIFORNIA HEALTH PLANS AND INSURERS: A SHIFTING LANDSCAPE (March 2013).

[13] Trial Transcript, November 7, 2013, p. 3783.

systems.[14] This pattern illuminates the importance of organizational structures that facilitate compensation arrangements that foster incentives to deliver value.

In sum, rigorous, controlled studies do not exist at this point in time to demonstrate conclusively that ownership is more effective than contracting in organizing providers to deliver the "value-based care" that health care reform envisions. But those that participate in the industry clearly sense that strong alignment across the continuum of providers is necessary.

V. HIGHER REIMBURSEMENT OF HOSPITAL-BASED MEDICAL SERVICES

Judge Winmill's second concern regarding the acquisition of Saltzer by St. Luke's related to the regulatory effect that physician services provided under the auspices of a hospital are reimbursed at higher levels by the Medicare program, and by many private payors, than when they are provided by independent physicians. Higher reimbursements for services delivered in the hospital setting are defended by the higher overhead costs that hospitals must incur, the necessity that services be available 24-7, and the greater average severity of the patients they treat. However, in recent years, both the Medicare Payment Advisory Commission and the Office of the Inspector General have recommended that the differential be reduced, if not eliminated.[15]

Judge Winmill's concern over regulatory-sanctioned rate increases resulting from mergers is shared in the review of several other recent transactions. The Connecticut Attorney General, for example, recently issued a report examining "hospitals' ability to engage in provider-based billing" as a result of their acquisition of physician practices.[16] Similarly, the Massachusetts Health Policy Commission expressed concern that one result of Partners Healthcare System's acquisition of South Shore Hospital could be that the affiliated Harbor Medical Associates would begin to charge facility fees.[17]

It is true that when hospitals acquire physician groups, these acquired physicians can in certain circumstances claim higher reimbursement rates than when they were independent. But this is not the result of enhanced market power accruing from the acquisition. Rather, as noted earlier, in the case of Medicare, it is based on established payment policy. When private payor contracts also contain provisions for higher reimbursement rates for services delivered in a hospital-affiliated setting, any immediate rate increase results from transferring the acquired

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[14] Robert Mechanic & Darren Zinner, *Many Large Medical Groups Will Need to Acquire New Skills and Tools to be Ready for Payment Reform*, 31 HEALTH AFFAIRS 1984-1992 (2012).

[15] Department of Health and Human Services Office of Inspector General, *Medicare and Beneficiaries Could Save Billions of CMS Reduces Hospital Outpatient Department Payment Rates for Ambulatory Surgical Center-Approved Procedures to Ambulatory Surgical Center Payment Rates*, A-05-12-00020 (April 2014); MEDICARE PAYMENT ADVISORY COMMISSION. REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY, Ch. 3 (March 2014).

[16] State of Connecticut Attorney General George Jepsen, *Report of the Connecticut Attorney General Concerning Hospital Physician Practice Acquisitions and Hospital-Based Facility Fees* (April 16, 2014).

[17] Commonwealth of Massachusetts Health Policy Commission, *Review of Partners HealthCare System's Proposed Acquisitions of South Shore Hospital* (HPC-CMIR-2013-1) and Harbor Medical Associates (HPC-CMIR-2013-2), *Final Report* (February 19, 2014) *available at* http://www.mass.gov/anf/docs/hpc/20140219-final-cmir-report-phs-ssh-hmc.pdf.

physician group to the existing hospital contract. It does not reflect the exercise of market power in negotiating a new contract.

In fact, this situation is identical to one in which one hospital is acquired by another hospital that has existing higher rates, and the two hospitals are combined into a single license number that moves both onto the acquiring hospital's existing payor contracts. In this situation, the price increase is contractually sanctioned for the remaining duration of the contract, and, again, does not reflect the exercise of market power, since both contracts were negotiated before the acquisition occurred. Only when the contract is renegotiated can market power, if it exists, be exercised, but this is a separate concern relating to the competitive effects of the transaction as a whole rather than to the specifics of the existing contracts.

VI. CONCLUSION

Casual observers may wonder why so much attention and resources have been paid on a transaction involving 24 physicians in a relatively small city. In fact, St. Luke's acquisition of Saltzer epitomizes the fundamental debate raised at the intersection of antitrust policy and health care reform. In the many markets that are not large enough to support multiple scaled integrated delivery systems, how can providers organize and operate in a way that allows them to accomplish the goals of health care reform while at the same time convincing the antitrust agencies that they will not exercise market power?

A recent report authored by several leading health economists and policy makers recommends that:

> the antitrust enforcement framework [be updated] to place greater emphasis on favoring clinical integration activities that are accompanied by financing reforms that move away from FFS payments and place providers at financial risk for quality gaps and higher costs…. Many clinical coordination arrangements or even mergers among high market-share organizations could be considered safer if the merged organizations…implement contracts with payers that place substantial emphasis on reducing overall costs while improving quality and if subsequent performance on these measures improves significantly. We view this as more meaningful evidence on the value of care than analysis that focuses on prices for specific services.[18]

Implementing such a recommendation implies that the antitrust agencies must recognize that significant merger-specific benefits result from many provider combinations, while the merging parties must clearly and concretely articulate that they are using their combination to foster the goals of health care reform.

[18] Engelberg Center for Health Care Reform at Brookings, *Bending the Curve—Person-Centered Health Care Reform: A Framework for Improving Care and Slowing Health Care Cost Growth*, pp. 8 and 31 (April 2013).