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SPECIAL FOCUS: ANTITRUST

Recent Enforcement Actions: Physician Group Mergers

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Typically, physician group mergers have received less attention from the enforcement agencies than hospital mergers, likely because the transactions are usually small and thus are not reportable under the Hart-Scott-Rodino (HSR) Antitrust Improvements Act or simply have not warranted investigation relative to larger transactions. Consequently, no physician merger challenges have been litigated, nor have any resulted, at least recently, in Federal Trade Commission (FTC) or Department of Justice Antitrust Division (DOJ) consent decrees. This appears to be changing, particularly as hospitals increasingly acquire physician groups and employ the formerly independent physicians. Notwithstanding the smaller nature of the transactions, FTC Bureau of Competition Director Richard Feinstein recently stated in connection with the FTC's investigation of one such hospital-physician merger that the FTC would "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." Consistent with his statements, the FTC and states Attorneys General have recently investigated and/or challenged several physician practice-group mergers, and two of those challenges have been resolved by state Attorney General consent decrees.

Providence Health's Acquisition of Spokane, WA, Cardiology Practices

On July 21, 2010, Providence Health & Services (Providence) announced its intention to acquire two cardiology physician clinics, Spokane Cardiology and Heart Clinics Northwest, located in Spokane, Washington, in a merger that did not have to be reported to the FTC because it did not meet the HSR threshold. Providence planned to acquire the assets of each cardiology practice group and subsequently

to employ all, or virtually all, of their affiliated physicians. The FTC and the Washington Attorney General's Office initiated an investigation of the transactions in August 2010.

Providence's proposed acquisition of Heart Clinics Northwest (24 cardiologists) and Spokane Cardiology (15 cardiologists) would have left Spokane without an independent cardiology group, as Community Health Systems (CHS) in 2010 acquired two of the then four independent clinics. CHS is the only other hospital system in Spokane. Striving to compete with CHS in the market for cardiology services, Providence attempted to acquire the remaining two cardiology clinics.

After FTC staff expressed serious concerns to the parties regarding possible anticompetitive effects of the transactions that could increase health care costs in the Spokane area, and faced with the reality of defending a lengthy and expensive antitrust investigation, Providence abandoned its plans to acquire the clinics in mid-February 2011. Subsequently, the FTC voted to close its investigation. Heart Clinics Northwest and Spokane Cardiology did not remain independent for long: Providence ultimately acquired Spokane Cardiology while Heart Clinics Northwest was acquired by an Idaho hospital system. Neither of these subsequent transactions was investigated.

MaineHealth's Acquisition of Southern Maine Cardiology Practices

The Attorney General of the State of Maine (MAG) recently challenged Maine Medical Center's (MCC) proposed acquisition of the two largest cardiology groups in southern Maine: Maine Cardiological Associates (MCA) (21 cardiologists) and Cardiovascular Consultants of Maine (CCM) (18 cardiologists). MMC is controlled by MaineHealth (MH), the largest health system in southern Maine.

Initially, the merging parties applied to the Maine Department of Health and Human Services (Maine DHHS) for a certificate of public advantage for a cooperative agreement, which would immunize the transaction from the federal antitrust laws. Under Maine's Hospital and Health Care Provider Cooperation Act (Maine Act), hospitals and health care providers may enter into a cooperative agreement, such as a joint venture, merger, or other cooperative arrangements, even if the

cooperative agreement produces anticompetitive effects. Maine DHHS is authorized to issue a certificate of public advantage approving the arrangement if the benefits of the cooperative agreement outweigh its anticompetitive effects. The parties applied for a cooperative agreement, but ran into a legislative roadblock. Specifically, although the Maine Act applies to horizontal mergers—a hospital merging with another hospital, or a physician group merging with another physician group—it does not apply to a hospital vertically merging with a physician group. Thus, the Maine DDHS was not authorized to issue the parties a certificate of public advantage.

The parties were therefore required to retool the acquisition, structuring it so that 36 of the 39 cardiologists from MCA and CCM would become employees of a newly formed subsidiary of MH, MaineHealth Cardiology Practice (MaineHealth). In an attempt to assuage any concerns that the market for cardiology services would be overly concentrated as a result of the transaction, the three remaining cardiologists entered into employment agreements with Mercy Hospital, a competitor of MH. Despite restructuring the transaction, the parties still faced regulatory hurdles, as the MAG continued its investigation, ultimately filing a complaint seeking injunctive relief. It is not apparent whether the MAG sought a hold separate agreement. To clear the acquisition, the parties entered into a consent decree with the MAG in December 2011 that imposed stringent conduct remedies, rather than structural relief (i.e., divestiture). The FTC too had previously initiated an investigation into the proposed acquisition and filed a motion to intervene in the DHHS proceeding, but it did not ultimately enter into a consent decree with MH. The state's decree essentially freezes the pre-merger status quo for cardiology-related services in Maine and is binding for five years. It includes many highly restrictive provisions, such as the following:

- MaineHealth must accept as payment for cardiology services (at the commercial payor's option) the standard rate commercial payors offer to other cardiologists in Maine;
- Should MMC increase rates for its cardiology-related services, such increases must not exceed the weighted average increase in charges for all MMC services for the same fiscal year;

- MaineHealth will continue to bill commercial payors for physician services, i.e., it will not seek increases in commercial payments by charging hospital-based rates;
- MaineHealth will not transfer diagnostic testing from an outpatient setting to a hospital inpatient setting that would allow for increased billing rates.
- MaineHealth will not include in its employment contracts with any of its cardiologists a covenant not to compete following termination of employment;
- MaineHealth's base compensation to its employed cardiologists will not in the aggregate exceed an average of $395,000 per full-time employee; and
- Cardiologists employed by MaineHealth must be allowed to participate in physician networks, including accountable care networks.

Here, the strict conduct remedies obtained by the MAG essentially served the same purpose as divestiture by essentially restoring the pre-merger competitive situation.

Urologist Physician Group Merger in Harrisburg, PA

In August 2011, the Pennsylvania Attorney General's Office (PAG) simultaneously filed a complaint and entered a consent decree against a merged group of urologists in the Harrisburg area after a retrospective review of the already-consummated transaction. In 2005, the urologists merged their five independent practice groups to form Urology of Central Pennsylvania (UCPA), which, according to the PAG, enjoyed an 84 percent share of the urology market in Harrisburg. Because this was a retrospective merger review and challenge of a previously consummated merger, a hold separate agreement was not an issue. The PAG's complaint generally alleges post-merger anticompetitive conduct by UCPA, although it does not specifically allege that UCPA raised its prices post-merger to supracompetitive levels. The complaint does allege, however, that UCPA took other anticompetitive activity post-merger. For example, the PAG alleged that UCPA physicians opened their own prostate cancer treatment facility, expanded their output of robotic surgeries, and performed fewer less expensive procedures, such as brachytherapy.

Importantly, the consent decree did not require divestiture. Rather, it contains a laundry list of conduct remedies, which will curtail UCPA's bargaining power with commercial health plans. The conduct remedies are considerably less restrictive than those in MaineHealth, perhaps reflecting the difficulty in remedying competitive issues six years after the merger closed even through conduct remedies, much less divestiture. For example, UCPA agreed to submit any impasse in bargaining over managed-care organization contract negotiations to "last best offer arbitration," which, in the event of an impasse, requires a three-member arbitration panel to select either UCPA's or the commercial health plan's last offer (assuming the parties' final negotiating positions are more than $500,000 apart). This style of arbitration incentivizes evidence-based negotiating positions, as opposed to supracompetitive price demands resulting from market power. The consent decree further requires UCPA to, among other things, honor requests for referrals for services outside of UCPA, provide a list of non-UCPA radiation oncologists and imaging services to patients requiring such services, and other more-typical provisions, such as notifying the PAG of any future acquisitions, filing an annual report with the PAG, and opening its books and records to the PAG. As for civil payments, UCPA agreed to pay $100,000 to a state-run drug program for urological services and $100,000 to the PAG for its investigation costs.

Observations

Merging physicians and hospitals can learn a number of lessons from these enforcement actions. First, the decision whether or not to close the transaction during an Agency investigation can have a significant impact on the merger itself and the Agency's investigation, including the remedies sought and obtained by the Agency. Merging parties should carefully consider and tentatively decide ahead of time whether or not to close or hold separate. Second, conduct remedies, such as those obtained in MaineHealth, can be more severe, and more disruptive and limiting to the merged entity, than structural remedies such as divestiture of some of the acquired physicians. Third, just as in hospital mergers, it is very important to prospectively and affirmatively plan and document efficiencies from physician acquisitions, particularly those intended to respond to the goals of health care reform and other challenges presented by today's reimbursement reductions and other market changes. Finally, merging providers should plan early on for the

possibility of an Agency antitrust investigation, and take affirmative steps to minimize the antitrust risk posed by an investigation and to manage the impact of the investigation on the merger.