

Antitrust Implications of Physician Owned Facilities vs. General Hospitals: How *Heartland* Has Changed the Landscape and Considerations for the Future

There is an ongoing debate amongst hospital administrators, physicians, and purchasers of hospital services about the financial impact of *physician owned facilities* (POFs) on general hospitals located in the same geographic markets. *Proponents* of POFs cite benefits such as improved competition leading to lower costs; higher quality; better outcomes; increased efficiency derived from more focus on specific services; more convenient services than offered by general hospitals; better amenities; greater physician control over delivery of service; and, the ability of physician to supplement their otherwise decreasing revenues. Critics of POFs have argued that POFs present an inherent conflict of interest where physician owners of facilities that compete with the hospitals engage in “*cream skimming*”, where physicians refer patients with higher reimbursement rates to their POF, and leave the more costly patients in the care of the general hospital (the converse of this is called “*patient dumping*” which, critics argue, also occurs).¹ Additionally, critics argue that general hospitals rely on these higher reimbursement patients to cross-subsidize other unprofitable services such as emergency room services. Other criticisms include the arguments that POFs duplicate facilities, resulting in overcapacity of the market; that they create incentives for upcoding or overpricing; that they exacerbate staff shortages and result in diminished ER call coverage; that conflicts of interest result in abused or ignored peer review obligations; and, that they result in overall deterioration of hospital board-medical staff relationships.¹

In addition to this ongoing debate, many general hospitals have come under scrutiny by *antitrust* authorities for engaging in potentially *exclusionary practices* in what general hospitals cite as, an effort to respond to the negative financial impact POFs have on general hospitals. In situations where POFs are owned in whole or in part by physicians with privileges on the medical staff of a general acute care hospital, and where the POF competes with that hospital either on an inpatient or outpatient basis, many hospitals have engaged in activities that attempt to shut the POF (e.g., specialty hospital) out of the market. Some of these practices include refusing to assist or cooperate with specialty hospitals; pressuring other members of the medical staff and/or community physicians to not do

business with the specialty hospital; pressuring payors to exclude specialty hospitals from the payors’ networks; and, limiting or terminating physician-investors’ privileges and medical staff membership (“*conflict of interest credentialing*”).¹ In response to these practices, some POFs have initiated antitrust suits, claiming that the general hospitals are engaging in illegal exclusionary boycotts. The two most common claims are that hospitals have denied or restricted staff privileges to physicians that have an ownership interest in a POF that competes with the hospital and that hospitals have engaged in exclusive arrangements designed to restrict the POF’s access to payors.¹

Despite increased antitrust scrutiny in this sector, cases initiated by POFs have repeatedly failed to proceed to trial because they are generally difficult to prove and therefore cannot survive summary judgment. The first case that *was* able to survive summary judgment challenge was *Heartland Surgical Specialty Hospital v. Midwest Division, Inc.*, in which the plaintiff *surgical specialty hospital* (SSH) alleged horizontal conspiracies between multiple health plans and multiple hospitals, as well as vertical conspiracies between the hospitals and payors directly, resulting in pressure on payors, as well as direct agreements with them, to exclude the SSH from their networks.¹ This lawsuit is unique in that it alleges horizontal conspiracies in the POF context, since most lawsuits center around exclusive contracts or the denial or restriction of staff privileges for physicians with interests in POFs. Part of the reason that the *Heartland* case was the first of its kind to be allowed to continue to trial is because antitrust law enforcement has been “*pretty protective*” of hospitals that have taken measures to combat “*cream skimming*” by specialty hospitals.¹ However, antitrust laws still protect against entities with market power from using that market power to pressure others (here, other hospitals and payors) into agreeing to exclude a competitor from the market, and that is where the hospital defendants in this case ran into trouble.

The *Heartland* case eventually settled in Spring 2008 for an undisclosed amount.¹ What *Heartland* demonstrates, however, is how antitrust challenges by POFs will not always fall on the side of the general hospitals. While this precedent has now been established, there are still important and unresolved issues that the courts have yet

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to determine. One of the most important elements of any antitrust challenge is the requirement of an *agreement between competitors in the restraint of trade*. In a majority of these cases, the allegations of agreement are launched at hospital boards that are in supposed agreements with their medical staffs. The circuits are split on whether or not a hospital and members of its medical staff can be considered separate entities for the purposes of forming an agreement to restrain trade.¹ Some circuits argue that the medical staffs are simply a subpart of the larger hospital entity and therefore cannot be judged as making decisions as separate entities. Another important consideration courts are facing is the determination as to whether a hospital's staff privilege decision is merely a "*unilateral act*" rather than any form of conspiracy, as such unilateral decisions are legal (assuming the unilateral activity is not predatory). Finally, courts are also split on the question of whether certain actions taken by hospitals in response to POFs can be considered to have legitimate business justifications (the last step in any rule of reason in antitrust analysis), i.e., if a general hospital can show that its actions are in pursuit of a *legitimate business goal*, such as protecting its ability to cross-subsidize unprofitable services so that it may continue to provide those services to the community or to protect from "*cream-skimming*", then some courts may find the actions justified, even if detrimental to the POF.¹ These questions will be considered repeatedly in the coming year as multiple cases proceed to trial, and it will be critical for all healthcare provider enterprises to stay abreast of the legal developments in this ever-expanding area of antitrust law.

¹ "Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?" By William E. Berlin, Esq., The Health Lawyer, American Bar Association, Volume 20, No. 5 (June 2008), pg 6.

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¹ "Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?" By William E. Berlin, Esq., The Health Lawyer, American Bar Association, Volume 20, No. 5 (June 2008), pg 3-5.

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¹ Heartland Surgical Specialty Hospital, LLC v. Midwest Division, Inc. d/b/a HCA Midwest Division, et al., 527 F.Supp. 2d 1257 (D. Kan. 2007)

¹ "Physician-owned hospital can pursue antitrust lawsuit," By Amy Lynn Sorrel, AMNews, Nov. 12, 2007, <http://www.ama-assn.org/amednews/2007/11/12/gvsa1112.htm> (accessed 6.30.2008) (quoting Thomas L. Greaney, Professor of Antitrust Law at Saint Louis University in St. Louis, Missouri).

¹ "Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?" By William E. Berlin, Esq., The Health Lawyer, American Bar Association, Volume 20, No. 5 (June 2008), pg 5.

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¹ "Antitrust Implications of Competition Between Physician-Owned Facilities and General Hospitals: Competition or Exclusion?" By William E. Berlin, Esq., The Health Lawyer, American Bar Association, Volume 20, No. 5 (June 2008), pg 9; see e.g. *Williamson v. Sacred Heart Hospital of Pensacola*, 1993 WL 543002 (N.D. Fla. 1993).



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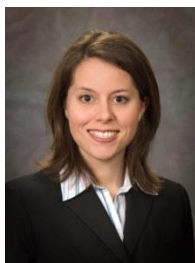
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