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Baptist Health And Hospital-Physician Relations

Law360, New York (October 14, 2008) -- We continue to see a tension between the desire for increased competition and quality in the delivery of health care and efforts to limit hospital competitors. We see this tension between regulators and legislators.

For example, the U.S. Federal Trade Commission and Department of Justice have repeatedly stated their opposition to legislative attempts to stymie competition by opposing certificate of need law regimes. While some states continue limiting new entrants into the hospital market through CON laws, Congress tried repeatedly this past session to pass legislation to reinstate a prohibition against physician ownership of specialty hospitals.

We also continue to see a battle between traditional hospitals and new physician specialty hospitals. This battle and the tension between a desire for new ways of delivering healthcare and the traditional view of who are competitors in the delivery of hospital services was raised in Little Rock Cardiology Clinic PA v. Baptist Health, number 4:06VC01594, slip op. (Eastern District of Arkansas, Aug. 29, 2008).

This article examines the Baptist Health case, the Court's view of market definition and the impact the case may have on future physician-hospital relations.

Background

In 1997, Little Rock Cardiology Clinic opened a cardiac hospital, Arkansas Heart Hospital. That same year, Arkansas Blue Cross and Blue Shield, the state's largest health insurer, terminated its provider network participation agreement with the clinic and its physicians.

The Clinic alleged that Baptist Health and Blue Cross conspired, allowing Baptist Health, the state's largest hospital system, to monopolize the hospital services market and Blue Cross to obtain monopoly power in the health insurance industry. The cardiologists alleged that they were the only specialists in the state of Arkansas excluded from the network.

Further, in May 2003, Baptist Health adopted an "economic credentialing policy" to prohibit any doctor from having or maintaining staff privileges at any Baptist Health facility if that doctor directly or indirectly holds an interest in a competing hospital, which is defined as any hospital in the state of Arkansas.

The enforcement of that policy was preliminarily enjoined in February 2004 and has not been enforced since then. See Baptist Health v. Murphy, 226 S.W.3d 800 (Ark. 2006).

The cardiologists' complaint was initially filed against Baptist Health in November 2006. A year later, the Court allowed plaintiffs to amend the complaint to add Blue Cross as defendant. The defendants moved to dismiss the second amended complaint.

The Court granted defendants' motion, but gave plaintiffs leave to file a third amended complaint. On Aug. 29, 2008, the Court dismissed all of the cardiologists' claims.

The Court's Opinion

In dismissing the third amended complaint, the Court held that the Clinic's claims relating to the health-insurance market were barred by the statute of limitations because the terminations from Blue Cross's network occurred nearly ten years earlier.

In rejecting the Clinic's argument of a "continuing violation," the Court found that Blue Cross adhered to the policy adopted in 1997 in refusing to deal with the Clinic and its doctors. In such circumstances, the Court held, implementation is only a reaffirmation of the policy's adoption, and the statue begins to run as soon as the competitor suffers injury.

In addressing the remaining claims, the Court held that the Clinic failed to plead a plausible relevant market. The threshold question that the Clinic failed to answer was: what is the relevant market in which Baptist Health and the other defendants acted to monopolize or restrain trade through their actions?

The Clinic made three attempts at amending the Complaint to, among other things, further refine the market definition. Unfortunately for the Clinic, the third time was not the charm.

The Court ruled that the defect in the complaint was not due to "inadequate draftsmanship or the absence of discovery" but rather from an "incurable defect in the legal theory" that could not be cured through another amended complaint.

The Court held that if the product market is services offered by cardiologists to hospitalized patients, then the Clinic's claims fail because Baptist Health does not compete in the market for cardiology services.

The Court also held that the relevant product market cannot be defined by reference to whether the patients who receive services are privately insured because that is

irrelevant to the question of what the product is or whether the purchaser would consider that item or service interchangeable with another.

The Clinic's closest attempt at defining the relevant product market as the market for hospital services was to describe it as a market comprised of cardiology services provided to patients in hospitals.

The Clinic, however, failed to persuade the Court that cardiology services provided by physicians to patients in hospitals were a "clustered" product market. Rather, the Court stated that cardiology services and hospital services were two distinct, albeit complementary, services.

Some evidence that the alleged services were not clustered was the fact that the Clinic failed to allege that Baptist Health sold cardiology and hospital services in a single transaction or that consumers failed to differentiate between the two services.

The Clinic also failed at convincing the Court of the legitimacy of its geographic market allegation. On first blush, it may appear that the Clinic attempted to support its allegations of geographic market with more than "labels or conclusions." See Bell Atlantic Corp. v. Twombly, 127 S. Ct. 1955, 1965 (2007).

The Clinic referenced zip code data and identified that 85 to 95 percent of the cardiology patients in Little Rock and North Little Rock used hospitals in Little Rock. Yet, according to the Court, the Clinic oddly excluded certain communities within the referenced zip code data.

More importantly, the Court noted that the alleged Little Rock and North Little Rock patient preferences only identified the geographic area where those patients actually go for services as opposed to where they could practically go.

The Court noted, "[i]f the plaintiffs' method of defining the geographic market were valid, antitrust plaintiffs could define a market by identifying any small area around the defendant's location in which nearly all potential customers patronize the defendant," which would allow the geographic market to be "as small as one block, which is absurd."

In an apparent glimmer of hope for the Clinic, the Court noted that while the "geographic market alleged in the complaint appears implausible, more detailed pleading to justify the alleged geographic market may be required."

In spite of what seemed to be correctable problems associated with the definition of the relevant market, the Court dismissed the complaint with prejudice. In coming to this conclusion, the Court appeared somewhat exhausted with the Clinic's third attempt and "continued inability to plead a coherent relevant market."

It is also likely that the Court felt compelled by the Supreme Court's Twombly decision to more closely scrutinize the Clinic's pleading efforts with respect to definition of the

relevant market. In Twombly, the Supreme Court addressed the pleading requirements to establish an agreement for a Sherman Act Section 1 claim.

Even in this somewhat limited context, the Supreme Court emphasized that the pleading requirements of Rule 8 require antitrust plaintiffs to "assert facts that affirmatively and plausibly suggest the pleader has the right he claims ... rather than the facts that are merely consistent with such a right." Id. at 1964-66.

Whether Twombly was a clarification or a heightening of the pleading requirements for antitrust claims may be disputed, but it appears to have had an impact in Baptist Health. Although not specifically cited, the Baptist Health court must have been cognizant of the Supreme Court's admonition in Twombly: "when the allegations in a complaint, however true, could not raise a claim of entitlement to relief, 'this basic deficiency should ... be exposed at the point of minimum expenditure of time and money by the parties and the court.'" Id. at 1966.

It appears that, after the third amended complaint the Court believed that the Clinic's efforts had begun pushing the limits beyond that "point of minimum expenditure of time and money."

Baptist Health: Its Meaning And Impact

Baptist Health's real meaning for hospitals and "upstart" physician-owned specialty hospitals might not be decided until the Eighth Circuit weighs in on appeal. However, there are take-away points beneficial for both traditional community hospitals and for physician-owned specialty hospitals.

First, counsel must be increasingly diligent in drafting and examining the allegations of the relevant market in these types of cases, especially after Twombly.

In spite of the Clinic's efforts to characterize and redefine the relevant market, the Court demanded more. If the antitrust damages are truly with the physician-owners as physicians and not with the specialty hospitals, can physicians convince the courts that the integration of the industry, through exclusive co-management agreements between hospitals and physicians for example, or consumer expectations have changed to permit an allegation of a combined cardiology and hospital services market?

In addition, each plaintiff is unique. The Clinic admitted in its complaint that the "general hospital services market" was a source of Baptist Health's market power and a "subject of inquiry" but that the Clinic did not suffer distinct injury in that market. However, lack of injury in the hospital services market might not always be the case.

Further, the fact that Baptist Health was not a competitor in cardiology services does not mean that other hospitals would not be competitors in cardiology services. Depending upon the jurisdiction, a hospital could be a competitor in cardiology services if, for example, the hospital also employed cardiologists.

As the Court suggests, whether there exists a market of combined physician and hospital services might depend on whether hospitals and payers engage in bundled reimbursements or whether consumers perceive no distinction between the services.

Second, even if hospitals view Baptist Health as a shield against antitrust claims, they cannot presume it is impenetrable and deal with upstart competitors at will.

Baptist Health lost one round in state court regarding its economic privileging policy, a policy that its president acknowledged was intended to keep specialty hospitals at bay. The Clinic was successful in enjoining the enforcement of the economic credentialing policy by alleging that Baptist Health's actions tortiously interfered with the cardiologists' physician-patient relationships.

While Baptist Health may avoid the threat of treble damages in the federal antitrust suit, the cost of litigation and the threat of tort damages still exist. To the extent hospitals might use Baptist Health (if it is upheld) as a means to fend off specialty hospital antitrust claims, physicians might similarly use the state court decision to attack hospital economic credentialing policies.

Finally, Baptist Health may be less significant if the tension between traditional hospitals and physician competitors is resolved through other means.

With greater health care reimbursement pressures on providers and demands by consumers (patients and payers alike) to improve the quality of care, there has been a resurgence of integration efforts between hospitals and physicians.

Whether full integration by hospital employment or contractual integration efforts through joint ventures or co-management arrangements, hospitals and physicians are recognizing the potential financial and clinical benefit of collective behavior. If this integration trend continues, the issues raised by cases like Baptist Health will become fewer.

Of course, such integration may lead to different antitrust battles involving the same players — physicians, hospitals and payers — but on different teams.

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