No. 12-3583

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

PROMEDICA HEALTH SYSTEM, INC.,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

ON PETITION FOR REVIEW FROM THE FEDERAL TRADE COMMISSION

BRIEF OF *AMICUS CURIAE* AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONER

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RULE 26.1 DISCLOSURE

Pursuant to Federal Rule of Appellate Procedure 26.1 and Sixth Circuit Rule Rule 26.1, *amicus*, the American Hospital Association, makes the following disclosure:

1. Is *amicus* a subsidiary or affiliate of a publicly owned corporation? No.

2. Is there a publicly owned corporation, not a party to the appeal, that has a financial interest in the outcome? No publicly owned corporation or other publicly held entity has a direct financial interest in the outcome of this litigation due to the participation of the *amicus*.

/s/ Beth Heifetz
Beth Heifetz

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INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE*[1]

The American Hospital Association ("AHA"), as *amicus curiae*, respectfully submits this brief in support of Petitioner, ProMedica Health System, Inc. ("ProMedica"). The AHA represents nearly 5,000 hospitals, health care systems, and networks, as well as 40,000 individual members. AHA members are committed to a robust and competitive hospital provider market, and they are deeply affected by current market trends and changes in law and technology. The AHA has a substantial interest in the application of antitrust law to hospital mergers, which often foster, rather than diminish, competition, and in many cases are necessary for hospitals to deliver care effectively in a rapidly changing market.

[1] Pursuant to Federal Rule of Appellate Procedure 29, *amicus* certifies that all parties have consented to the filing of this brief. *Amicus* likewise certifies that no party's counsel in this matter authored this brief in whole or in part; no party or party's counsel contributed money intended to fund the brief's preparation or submission; and no person other than *amicus* and its members and counsel contributed money intended to fund the brief's preparation or submission.

SUMMARY OF ARGUMENT

"The healthcare industry is undergoing a period of fundamental transformation in which the very model of healthcare delivery is being questioned and changed." Moody's Investors Service, *U.S. Not-for-Profit Healthcare Outlook Remains Negative for 2012* 7 (Jan. 25, 2012) [hereinafter Moody's 2012 Outlook].[2] At a time when hospital revenues are already strained, hospitals must respond to rapidly changing market forces, including (1) reimbursement reductions and changes, (2) an increasing necessity to implement robust electronic health records systems, and (3) limited access to capital. These market forces are driving an urgent need for hospitals to make significant capital investments and achieve greater economies of scale, both of which are critical to hospitals' "future ability to compete." *United States v. Gen. Dynamics*, 415 U.S. 486, 510 (1974). These market facts go "directly to the question" at the heart of this case: whether, as a result of the present merger, "future lessening of competition [i]s probable." *Id.* at 506.

Mergers enable hospitals to improve their access to capital and to achieve economies of scale. For many hospitals—particularly stand-alone hospitals—merging with another hospital or system may be the only hope for remaining competitive in the future. That is important because effective delivery of high

[2] *Obtained from* http://www.carelogistics.com/media/52520/120125_moody_s_2012_nfp_healthcare_outlook.pdf.

quality care to a community depends on the hospital's ability to succeed in an increasingly competitive environment. Indeed, changes in the field are prompting a "national explosion of consolidation" in the health care industry. Moody's Investors Service, *New Forces Driving Rise in Not-for-Profit Hospital Consolidation* 1 (Mar. 8, 2012) [hereinafter Moody's Consolidation Report].[3] Without the ability to merge, many hospitals may become less competitive to the detriment of patients and communities. This Court should consider these realities when assessing the future competitive effects of the present merger.

ARGUMENT

I. THE CHANGING LANDSCAPE OF HEALTH CARE IS A CRITICAL FACTOR IN THIS COURT'S FORWARD-LOOKING ANALYSIS OF COMPETITIVE EFFECTS.

Section 7 of the Clayton Act is concerned with acquisitions in which "the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly." 15 U.S.C. § 18. "[T]he very wording of § 7 requires a prognosis of the probable *future* effect of the merger." *Brown Shoe Co. v. United States*, 370 U.S. 294, 332 (1962) (emphasis in original). Because "[m]ost merger analysis is necessarily predictive," courts undertake "an assessment of what will likely happen if a merger proceeds as compared to what will likely happen if it

[3] *Obtained from* http://www.hfma.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=31309.

does not." U.S. Dep't of Justice and Fed. Trade Comm'n, Horizontal Merger Guidelines 1.0 (Aug. 19, 2010).

Although Congress did not provide "definite quantitative or qualitative tests" to determine whether a merger may "'substantially' lessen competition," it "indicated plainly that a merger had to be functionally viewed, in the context of its particular industry." *Brown Shoe*, 370 U.S. at 321-22. As this Court has recognized, antitrust law focuses on "'actual market realities,'" not on formalistic rules. *Smith Wholesale Co. v. R.J. Reynolds Tobacco Co.*, 477 F.3d 854, 865 (6th Cir. 2007) (quoting *Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 466-67 (1992)); *see also Verizon Commc'ns Inc. v. Law Offices of Curtis V. Trinko, LLP*, 540 U.S. 398, 411 (2004) ("Antitrust analysis must always be attuned to the particular structure and circumstances of the industry at issue."); *NicSand, Inc. v. 3M Co.*, 507 F.3d 442, 453 (6th Cir. 2007) (en banc) (citing *Verizon Commc'ns*, 540 U.S. at 411, and *Eastman Kodak*, 504 U.S. at 466-67). "'[O]nly a further examination of the particular market—its structure, history and probable future—can provide the appropriate setting for judging the probable anticompetitive effect of the merger.'" *Gen. Dynamics*, 415 U.S. at 498 (quoting *Brown Shoe*, 370 U.S. at 322 n.38).

The analysis required by the courts seeks to identify "proper indicators of future ability to compete." *Id.* at 510. Market-share statistics and past

performance do not always paint "a proper picture of a company's future ability to compete." *Id.* at 501. "[S]tatistics concerning market share and concentration, while of great significance, [are] not conclusive indicators of anticompetitive effects." *Id.* at 498. Evidence may show "that other pertinent factors affecting the . . . industry and the business of the [defendant] mandate[] a conclusion that" the acquisition threatens "no substantial lessening of competition." *Id.*; *see also United States v. Citizens & S. Nat'l Bank*, 422 U.S. 86, 120 (1975) (holding that defendant had "show[n] that the market-share statistics gave an inaccurate account of the acquisitions' probable effects on competition").

In *General Dynamics*, for example, the Court discounted the usefulness of past performance in light of "fundamental changes in the structure of the market for coal," 415 U.S. at 501, and industry "trend[s]" that were "the product of inevitable pressures on the coal industry in all parts of the country," *id.* at 506. "Such evidence," the Court concluded, "went directly to the question of whether future lessening of competition was probable." *Id.*

Relying on *General Dynamics*, many courts have engaged in "'further examination of the particular market'" and determined that an acquisition threatens "'no substantial lessening of competition,'" particularly when one firm suffers from a "weakened financial condition." *United States v. Int'l Harvester Co.*, 564

F.2d 769, 773-74 (7th Cir. 1977) (quoting *Gen. Dynamics*, 415 U.S. at 498).[4] Although a company may not be "a failing firm in the technical sense," its "weak competitive status remains relevant to an examination of whether substantial anticompetitive effects are likely from the transactions." *FTC v. Arch Coal, Inc.*, 329 F. Supp. 2d 109, 157 (D.D.C. 2004) (denying preliminary injunction); *see also United States v. Baker Hughes Inc.*, 908 F.2d 981, 991 (D.C. Cir. 1990) ("A defendant can [rebut the Government's prima facie case] by affirmatively showing why a given transaction is unlikely to substantially lessen competition, or by discrediting the data underlying the initial presumption in the government's favor.").

Similarly, this Court should examine "the particular market" for the provision of health care services—"its structure, history and probable future"—to ascertain the "proper indicators" of hospitals' "future ability to compete." *Gen. Dynamics*, 415 U.S. at 498, 510. The "fundamental changes" sweeping through

[4] *See also Lektro-Vend Corp. v. Vendo Co.*, 660 F.2d 255, 276-77 (7th Cir. 1981) (holding that there was no § 7 violation where firm's "deteriorating market position prior to the acquisition" showed that firm "was not about to collapse," but "was anything but healthy"); *FTC v. Nat'l Tea Co.*, 603 F.2d 694, 699-701 (8th Cir. 1979) (holding that district court appropriately considered acquiring firm's status as a "weak competitor" when "scrutinizing the 'probable future' of the market"); *United States v. Consol. Foods Corp.*, 455 F. Supp. 108, 137 (E.D. Pa. 1978) (concluding that firm's "competitive position is one of weakness rather than strength," and "[t]he likely result of the merger, therefore, would be an increase, rather than a lessening of competition").

the field go "directly to the question of whether future lessening of competition [i]s probable." *Id.* at 501, 506. In light of these changes, traditional measures of hospitals' "market share and concentration . . . [are] not conclusive indicators of anticompetitive effects." *Id.* at 498.

II. CURRENT MARKET TRENDS ARE TRANSFORMING THE HEALTH CARE FIELD, DRIVING AN URGENT NEED FOR CAPITAL INVESTMENTS AND ECONOMIES OF SCALE.

In the health care field, "'actual market realities,'" *Smith Wholesale*, 477 F.3d at 865 (quoting *Eastman Kodak*, 504 U.S. at 466), demonstrate that hospitals' past performance often reveals little about their future ability to compete in this changing field. Many hospitals are already struggling to make ends meet, and three major trends have created further pressure: reimbursement reductions and changes, electronic health records requirements, and difficulties accessing capital. To remain competitive, hospitals must have the capability to adapt to these trends by making significant capital investments and achieving economies of scale. These constitute "proper indicators of [hospitals'] future ability to compete." *Gen. Dynamics*, 415 U.S. at 510.

A. Reimbursement Reductions And Changes Are Constraining Revenues And Will Require Hospitals To Alter Methods Of Delivering Care.

In light of the challenges facing hospitals and the uncertainty surrounding the future of health care, industry analysts have reported an "unequivocally

negative" outlook for hospitals "for at least the next several years." Moody's 2012 Outlook, *supra*, at 1. Hospital reimbursement rates have declined in recent years, and they are expected to suffer further cuts. Meanwhile, commercial and government payers have implemented dramatic reimbursement changes, which will fundamentally alter the manner in which hospitals provide care. Together, these changes will require hospitals to make significant investments in technology, as well as develop greater economies of scale.

1. Recent Reimbursement Pressures.

Hospital reimbursements are declining, resulting in an "unprecedented threat to revenues." *Id.* at 2. According to industry analysts, "the median hospital revenue growth rate is the lowest in two decades at 4.0%." Moody's Investors Service, *Hospital Revenues in Critical Condition; Downgrades May Follow* 2 (Aug. 10, 2011) [hereinafter Moody's Downgrades].[5] Revenue is expected to continue to decline in 2012 and "reach a low point in 2013." Moody's Investors Service, *U.S. Not-for-Profit Hospital Medians Show Resiliency Against Industry Headwinds But Challenges Still Support Negative Outlook* 2 (Aug. 30, 2011) [hereinafter Moody's Medians].[6]

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[5] *Obtained from* http://www.hhnmag.com/hhnmag/PDFs/2011PDFs/moodys.pdf.

[6] *Obtained from* http://nhhefa.com/documents/MoodysNot-for-ProfitHospitalMid-YearOutlookandFY2010Medians.pdf.

Hospital reimbursement rates under Medicare and Medicaid—which make up over half of hospital revenues—have been constrained, and these revenue sources are very likely to suffer deeper cuts. Moody's Downgrades, *supra*, at 3-4. Medicare payment rates increased every year from 1999 to 2010, but rates were effectively cut in federal fiscal year 2011. *Id.* at 3. Changes in reimbursement methods will not only transform the way in which hospitals deliver care, *see infra* at 11-16, but will also lead to cuts of $150 billion in Medicare payments over the next ten years. Karen Minich-Pourshadi, *5 Healthcare Uncertainties Made Clearer*, HealthLeaders Media 2 (Aug. 27, 2012).[7] Further Medicare cuts are likely as legislators struggle to reduce the federal deficit. Moody's Downgrades, *supra*, at 4.

Medicaid reimbursement rates are also under fire. Financially strapped states have cut Medicaid reimbursement rates in an effort to balance their budgets. Phil Galewitz, *Medicaid Payments Go Under the Knife*, USA TODAY (July 5, 2011).[8] Currently, average Medicaid rates are only 72% of Medicare rates. Moody's 2012 Outlook, *supra*, at 5. Deeper Medicaid cuts loom: Over the next five years, $14 billion dollars will be cut from Medicaid Disproportionate Share

[7] http://www.healthleadersmedia.com/page-2/FIN-283783/5-Healthcare-Uncertainties-Made-Clearer.

[8] http://www.usatoday.com/news/washington/2011-07-05-state-medicaid-reimbursements_n.htm.

Hospital Payments, which provide additional assistance to hospitals caring for a high number of Medicaid and uninsured patients. *See* 42 U.S.C. § 1396r-4(f)(7)(A)(ii). For hospitals in states that elect not to expand Medicaid coverage, these cuts will be particularly harsh because they will not be offset by revenues from newly eligible Medicaid patients. Cheryl Clark, *States May Drop Medicaid Expansion, CMS Says*, HealthLeaders Media 3 (Aug. 9, 2012)[9]; *see also Nat'l Fed'n of Indep. Businesses v. Sebelius*, 132 S.Ct. 2566, 2604-05 (2012) (concluding that States must have a "real option" to reject Medicaid expansion).

Meanwhile, these reimbursement pressures are compounded by a decrease in inpatient admissions and a shift toward outpatient treatment. Margaret E. Guerin-Calvert, *Assessment of Cost Trends and Price Differences for U.S. Hospitals* 4 (Mar. 2011).[10] This shift is significant because reimbursement for observation stays and same-day visits "is much lower than for a comparable inpatient day." Standard & Poors, *The U.S. Not-for-Profit Health Care Sector's Rating Stability is Vulnerable to Headwinds After 2012* 4 (Jan. 25, 2012) [hereinafter S&P Headwinds].[11]

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[9] http://www.healthleadersmedia.com/page-3/TEC-283237/States-May-Drop-Medicaid-Expansion-CMS-Says.

[10] *Available at* http://www.aha.org/content/11/11costtrendsprice diffreport.pdf.

[11] *Available at* http://www.standardandpoors.com/spf/upload/Events_ US/US_FI_Event_hc6512art7.pdf.

To weather the storms thus far, hospitals have implemented "aggressive cost reduction strategies across the board" to match decreased revenues with decreased costs, including by cutting salaries and benefits. Moody's Medians, *supra*, at 6. But these cost-cutting measures only go so far. "While managing costs is an effective near- to medium-term strategy, . . . its effectiveness is limited in the long term as it is hard to find new cost-cutting initiatives year after year, unless the broader business model also changes." S&P Headwinds, *supra*, at 6. "[A]s many providers are forced to hold down or lower costs year after year to maintain operating margins" in the face of reimbursement pressure, "it remains unclear how hospitals can come up with additional reductions." *Id.* at 7. As a result, "[a]dditional expense reductions will now involve deeper and more difficult strategies in order to both gain efficiencies and fundamentally change how hospitals deliver care." Moody's Medians, *supra*, at 6.

2. Changes In Reimbursement Methods Threaten Revenues And Alter The Metrics For Success, Requiring Hospitals To Reduce Costs As They Improve Quality.

As hospitals struggle to reduce costs in line with reimbursement reductions, they must also adapt to groundbreaking changes in reimbursement methods. To maximize reimbursements under these new methods, hospitals must improve their quality of care while finding new ways to gain efficiencies.

a. The Shift From Volume To Value.

"Of the many forces transforming our nation's healthcare system, none is more significant than the turn from payment based on volume to payment based on value." Healthcare Fin. Mgmt. Ass'n ("HFMA"), *Value in Health Care: Current State and Future Directions* 1 (June 2011) [hereinafter *Value in Health Care*].[12] Both government and private payers are moving away from the traditional fee-for-service model, which assigns a reimbursement amount for each particular service. Instead, payers are implementing "value-based" reimbursement, which keys payment to the quality and cost-effectiveness of care.

Value-based programs—sometimes called "pay-for-performance" programs—take on various forms. Some commercial insurers tie hospital payments to performance goals such as clinical outcomes and cost per case. Blue Cross Blue Shield of Michigan, *2012 Hospital Pay-for-Performance Program, Peer Groups 1-4* 3 (Nov. 2011).[13] Other programs incorporate additional measures of value, including adoption of information technology ("IT") and patient satisfaction. Integrated Health Association California Pay for Performance

[12] *Available at* http://www.hfma.org/HFMA-Initiatives/Value-Project/Value-in-Health-Care--Current-State-and-Future-Directions/.

[13] http://www.bcbsm.com/pdf/HPP_pg14_program_description_2012.pdf.

Program, *Measurement Year 2012 P4P Manual* 1-2 (Dec. 31, 2011).[14] Even Medicare has joined the trend toward value-based reimbursement; the Hospital Value-Based Purchasing Program marks "the beginning of an historic change in how Medicare pays health care providers." *Administration Implements New Health Reform Provision to Improve Care Quality, Lower Costs* (Apr. 29, 2011).[15] The program will withhold a portion of Medicare reimbursement each year and redistribute it as "incentive" payments based on hospitals' achievement of various quality outcomes. 42 U.S.C. § 1395ww(o); *see also Forbes Insights: Getting From Volume to Value in Health Care* 5 (2012).[16]

Payers are also measuring hospital "readmission" rates, *i.e.*, the rates at which patients are readmitted to a hospital after initial discharge. *E.g.*, Blue Cross Blue Shield Michigan, *supra*, at 11-12. For example, hospitals now face penalties for having disproportionately high readmission rates, which could cost a hospital up to three percent of its total Medicare reimbursements. *See* 42 U.S.C. § 1395ww(q).

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[14] http://www.iha.org/pdfs_documents/p4p_california/MY2012_P4P_Manual_December2011.pdf.

[15] http://www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011a.html.

[16] *Available at* http://images.forbes.com/forbesinsights/StudyPDFs/AllscriptsVolumetoValue.pdf.

Bundled payment systems also illustrate this shift. Under a new pilot program, the Government will make a flat ("bundled") payment for a package of services, which may include hospital, physician, and post-acute care costs. News Release, HHS, *Affordable Care Act Initiative to Lower Costs, Help Doctors and Hospitals Coordinate Care* (Aug. 23, 2011).[17] Bundled payment systems "are currently being more widely tested by commercial payers," Moody's 2012 Outlook, *supra*, at 5, and they "driv[e] the need for greater efficiencies," Moody's Consolidation Report, *supra*, at 2.

b. Adapting To Reimbursement Changes Requires Investments In IT And Economies Of Scale.

The focus on value is "driving a fundamental reorientation of the healthcare system" to maximize quality and cost-effectiveness. *Value in Health Care*, *supra*, at 1. As the health care field evolves, hospitals' relevant "success factors" "will change from what we know today." Frederick A. Hessler, *The Capital Challenge*, in *Managing the Transition*, H&HN Magazine 11 (2012).[18] In a value-based field, these "success" factors include making immediate capital investments in IT and achieving economies of scale. *Id.*; *see also Gen. Dynamics*, 415 U.S. at 510 (identifying "proper indicators of future ability to compete").

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[17] http://www.hhs.gov/news/press/2011pres/08/20110823a.html.

[18] *Available at* www.hhnmag.com/hhnmag/PDFs/2012PDFs/HHN05_12_HHN.pdf.

Investments in IT. Value-based reimbursement methods demand that hospitals make significant investments in IT to achieve a variety of performance-based goals. Enhanced IT is "essential if providers are to comply with new quality standards and pay-for-performance initiatives being imposed by Medicare and private insurers." David Dranove, Northwestern University Kellogg School of Management, *Perspective on the University of Louisville Hospital Merger* 1.[19] To qualify for value-based payments, providers must have IT that permits them to "[a]ccurately and consistently report data on appropriate metrics," share information throughout the organization, and measure quality results against benchmarks to monitor progress. *Value in Healthcare*, *supra*, at 16. Such systems enable providers to "link quality and financial metrics to quantify the value of care provided." *Id.*; *see also Forbes Insights*, *supra*, at 15. IT may also help hospitals improve quality of care by developing clinical protocols to promote consistent practices. Fitch Ratings, *Capital Expenditure Trends Among Nonprofit Hospitals* 3 (May 16, 2012) [hereinafter *Capital Expenditure Trends*]. Moreover, IT will enable providers to "improve processes and allocate resources in a highly efficient way, resulting in an efficient cost structure." Hessler, *supra*, at 11. These systems require large upfront investments, which may be particularly difficult for smaller

[19] http://www.louisvilleky.gov/NR/rdonlyres/82812527-B425-4407-BA21-6EBF66AEA17C/0/Dranovereport.pdf.

providers with limited resources. *Pay for Performance in Health Care: Models and Approaches* 62 (Jerry Cromwell et al., eds., Mar. 2011).[20]

Economies of Scale. Another "success factor" is the ability of hospitals to gain "sufficient size to achieve economies of scale in all their operations." Hessler, *supra*, at 11. Economies of scale allow providers to reduce costs, as well as provide comprehensive care for a community or population "by deploying the right resources in the appropriate setting." *Id.* More comprehensive care is likely to result in better clinical outcomes and fewer readmissions, which in turn lead to higher value-based payments.

B. To Remain Competitive In The Future, Hospitals Must Adopt Electronic Health Records.

Another trend transforming the health care field is the movement toward electronic health records. Not only are electronic health records necessary for hospitals to succeed in a value-based reimbursement model, *see supra* at 15-16, but a portion of Medicare and Medicaid reimbursements are now conditioned on hospitals' adoption of electronic health records that meet various objectives. The costs of electronic health records are staggering, however, making it difficult for already-struggling hospitals to keep up.

Electronic health records have the potential to improve efficiency and clinical outcomes—both of which are essential in value-based purchasing. Federal

[20] *Available at* http://www.rti.org/pubs/bk-0002-1103-mitchell.pdf.

"meaningful use" requirements encourage hospitals to reap these benefits by awarding Medicare and Medicaid "incentive payments" to hospitals that are "meaningful users" of electronic health records. 42 U.S.C. § 1395ww(n). A hospital is deemed a "meaningful user" if it implements certified technology that meets various standards—for example, the technology must have the ability to conduct drug-drug and drug-allergy interaction checks. 42 C.F.R. § 495.6(f)(2). Hospitals that have not achieved targeted "meaningful use" standards by 2013 or early 2014 will face penalties in the form of decreased Medicare reimbursements. 42 U.S.C. §§ 1395f(l)(4), 1395ww(b)(3)(B); Electronic Health Record Incentive Program—Stage 2, 77 Fed. Reg. 53968, 53970 (Sept. 4, 2012). To maintain revenues, it is imperative that hospitals implement certified electronic health records that pass muster under "meaningful use" requirements.

Despite this imperative, hospitals' overall rate of electronic health records adoption remains low, and they have a long way to go before they reach full implementation. Catherine M. DesRoches et al., *Small, Nonteaching, and Rural Hospitals Continue to be Slow in Adopting Electronic Health Record Systems*, Health Affairs 4 (May 2012) (relying on AHA data). Indeed, more than 80 percent of hospitals have not met the "meaningful use" criteria currently in effect. *Id.* at 5. In the meantime, the digital divide is widening. Large, urban, teaching hospitals are more likely to adopt electronic health records systems than their smaller, rural,

nonacademic counterparts. *See id.* at 4. Smaller hospitals may continue to fall further behind as other hospitals reap the eventual cost-saving benefits of electronic records.

Hospitals that have not adopted electronic health records cite financial concerns—including capital and maintenance costs—as the primary barrier to implementation. Ashish K. Jha et al., *Use of Electronic Health Records in U.S. Hospitals*, N. Eng. J. Med. 1628, 1632 (Apr. 16, 2009). Electronic health record systems require significant "upfront costs to initiate" the technology. Guerin-Calvert, *supra*, at 10. In addition to evaluating and purchasing the technology itself, the hospital may need to hire additional staff or outsource the conversion of paper charts to electronic charts; train its staff members on the systems; and adapt the hospital infrastructure to house the technology. AHA, *The Road to Meaningful Use: What it Takes to Implement Electronic Health Record Systems in Hospitals*, Trendwatch 8 (Apr. 2010) [hereinafter Road to Meaningful Use].[21] Electronic health records also require ongoing maintenance costs, such as implementing system updates. Guerin-Calvert, *supra*, at 10; *Road to Meaningful Use*, *supra*, at 8. One expert estimates that implementing electronic health records will cost between $20 and $200 million, depending on the size of the hospital. Michael

[21] *Available at* http://www.aha.org/research/reports/tw/10apr-tw-HITmeanuse.pdf.

Lasalandra, *Impact of Electronic Medical Records Discussed*, Harvard Public Health NOW (Oct. 30, 2009).[22] Even those hospitals that already have electronic health records may face high costs—$10 million, in one hospital's estimate—to upgrade their systems to meet federal requirements. *Road to Meaningful Use*, *supra*, at 11. Although hospitals eventually will receive "incentive payments," those payments are available only *after* hospitals have made significant investments. *Id.* at 12. Hospitals' ability to make these investments is an important measure of their future ability to compete.

C. The Capital Crisis: Despite Hospitals' Need For Significant Capital Investments, They Continue To Suffer From Limited Access To Capital.

Despite hospitals' strong need to invest in electronic health records and other technology, it is increasingly difficult for hospitals to access capital. A hospital's ability to access capital is a critical "indicator[] of future ability to compete" in the changing field of health care. *Gen. Dynamics*, 415 U.S. at 510.

1. The Need For Capital.

Hospitals' need for capital is greater now than ever. As discussed above, the trend toward value-based purchasing will require hospitals to adopt sophisticated IT, including electronic health records, to compete in the health care market.

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[22] http://www.hsph.harvard.edu/now/10302009/impact-of-electronic-medical-records.html (discussing estimates of Ashish K. Jha).

Meanwhile, hospitals must continue to update their plant, property and equipment to maintain quality care.

As the Administrative Law Judge ("ALJ") recognized in this case, "hospitals are very capital intensive. Hospitals must spend money on capital to maintain their equipment, to provide new systems, and to avoid decline." ALJ Op. at 184. Hospitals that do not consistently invest in buildings, equipment and IT cannot effectively compete in the future market of health care. "'Years of thin or deferred capital spending can place hospitals at a significant competitive disadvantage with patients, payers, physicians, and employees.'" HFMA, *Financing the Future II, Report 6: The Outlook for Capital Access and Spending* 8 (Aug. 2006) (internal quotation marks omitted) [hereinafter HFMA Capital Outlook].[23] Hospital quality—and, as a result, patients' clinical outcomes—could suffer. *Id.* at 6.

2. The Process Of Accessing Capital.

Hospitals rely on various sources of capital, including investment income, philanthropy, and tax-exempt bonds. HFMA, *How Are Hospitals Financing the Future?: Access to Capital in Health Care Today* 3 (2003) [hereinafter HFMA Access]. For not-for-profit hospitals, tax-exempt bonds are the traditional and primary means of financing future projects. *See id.* A hospital's ability to finance

[23] All reports in the HFMA *Financing the Future* series are available at http://www.hfma.org/HFMA-Initiatives/Financing-the-Future/Financing-the-Future/.

projects through tax-exempt bonds depends primarily on its credit rating, which is shorthand for its ability to access capital and the price at which it can borrow money. Ratings agencies, including Moody's and Standard and Poor's, evaluate and rate the creditworthiness of hospitals. A higher bond rating indicates a lower investment risk, which allows hospitals to pay a lower interest rate on the bonds. In other words, the higher the bond rating, the lower the cost of capital. *See* HFMA Capital Outlook, *supra*, at 5. Even the slightest drop in a bond rating—resulting in a slightly higher interest rate—may cost a hospital significantly more over the lifetime of a bond issue. *See id.* at 6.

3. Hospitals' Difficulties Accessing Capital.

The health care sector "is becoming increasingly bifurcated into 'haves' and 'have nots.'" HFMA, *How Are Hospitals Financing the Future?: The Future of Capital Access* 2 (May 2004). The "haves" are those hospitals with broad access to capital, while the "have-nots" suffer from limited access. *Id.* In 2009, 88% of hospitals reported that it was "more difficult or impossible to access capital from tax-exempt bonds" since the 2008 recession. *Road to Meaningful Use*, *supra*, at 12.

Difficulties obtaining access to tax-exempt bonds have led hospitals to "quickly scale[] back their capital projects." Daniel M. Grauman et al., *Access to Capital: Implications for Hospital Consolidation*, hfm Magazine 62, 63 (Apr.

2010). "In order to preserve liquidity, some healthcare systems delayed major projects that were not already started, halted projects already begun, postponed new equipment purchases and/or re-prioritized projects." Moody's 2012 Outlook, *supra*, at 14. The median growth rate of capital investment has declined for two consecutive years. Moody's Medians, *supra*, at 13. And the median average age of plant has increased for three straight years, *id.* at 22, indicating that hospitals are delaying capital spending, and that they will have an even greater need for capital spending in the future, HFMA, *How Are Hospitals Financing the Future?: Core Competencies in Capital Planning* 23 (July 2004).

Deferring capital projects naturally defers the benefits to patients from these projects. Many deferred projects were designed to improve efficiency, quality, and patient safety. AHA, *Report on the Capital Crisis* 10 (Jan. 2009).[24] Without capital expenditures, hospitals are unable to invest in new technology and equipment that benefit patients, and hospitals may find it more difficult to recruit top physicians. Continued deferment of capital expenditures is not sustainable. "[G]iven the pace of change in the industry . . . , hospitals may not be able to reign in capital expenditures and remain competitive." *Capital Expenditure Trends*, *supra*, at 5-6. As a result, consolidation activity has continued "as resource strapped hospitals seek partners to help them invest in these areas." *Id.* at 6.

[24] http://www.aha.org/content/00-10/090122capitalcrisisreport.pdf.

To the extent that hospitals have made capital expenditures, they are increasingly funding projects with cash holdings, as opposed to debt borrowings. "While this strategy protects current debt service coverage requirements, it reduces the balance sheet cushion and may reduce liquidity, weakening cash to debt measures." Moody's 2012 Outlook, *supra*, at 11.

4. The Downward Spiral.

Because a hospital's access to capital is closely tied to its financial health and ability to invest in the future, trends in capital spending reveal "the potential for a downward spiral." HFMA, *How Are Hospitals Financing the Future?: Capital Spending in Health Care Today* 2 (Jan. 2004). The spiral involves the following sequence:

- "Hospitals increasingly struggle with their financial health…
- [T]heir deteriorating financial health makes them less creditworthy…
- [T]heir ability to access capital becomes limited…
- [T]hey must devote a larger proportion of their capital to keeping up with the demands of today…
- [T]hey are decreasingly able to invest in the future…
- [A]s a result, their financial health drops significantly."

Id. As "[s]truggling hospitals" experience this "very slow downward spiral," they become "unable to meet consumer and competitive needs." HFMA Capital Outlook, *supra*, at 14 (internal quotation marks omitted). The outlook can be

particularly bleak for smaller hospitals that enter the spiral with lower credit ratings and less access to capital. *See* Moody's Medians, *supra*, at 14.

Unless hospitals short-circuit the downward spiral by improving their access to capital, they will continue to fall behind and may never regain their footing. HFMA, *How Are Hospitals Financing the Future?: Where the Industry Will Go from Here* 1-4 (Sept. 2004) [hereinafter HFMA Industry]. "[E]ventually, if they are not acquired, they wind down and close." HFMA Capital Outlook, *supra*, at 14 (internal quotation marks omitted). As a result, "more hospital closures are likely." HFMA Industry, *supra*, at 3.

The results could be devastating for both patients and the community. The financial unraveling of a hospital has the potential to impact the community more profoundly than the unplanned closure of nearly any other institution. Patients will suffer as hospitals struggle to survive and slowly deteriorate. Prices will rise, equipment will wear down without being replaced, and physicians will leave for greener pastures. Ultimately, the health of the community will suffer. Furthermore, closure may result in reduced specialty services and overcrowding in other hospital emergency departments, while patients may delay treatment due to confusion regarding where to obtain appropriate care. Kara Odom Walker et al., *Effect of Closure of a Local Safety-Net Hospital on Primary Care Physicians'*

Perceptions of Their Role in Patient Care, 9 Annals Fam. Med. 496, 500-01 (2011).

D. This Court Should Consider The Impact Of These Trends When Assessing Competitive Effects Of The Merger.

These three trends—reimbursement reductions and changes, electronic health records, and limited access to capital—are changing the landscape of health care, and they speak "directly to the question of whether future lessening of competition [i]s probable." *Gen. Dynamics*, 415 U.S. at 506. Hospitals' past performance is no longer a "conclusive indicator[] of anticompetitive effects." *Id.* at 498. Rather, hospitals' ability to compete turns on their ability to keep pace with these trends, which requires significant capital investments and economies of scale. This Court should consider these "proper indicators of future ability to compete" when determining whether, absent a merger, an acquired hospital can constitute a meaningful competitive force in this changing field. *Id.* at 510.

III. MERGERS ARE CRITICAL TO HOSPITALS' FUTURE ABILITY TO COMPETE IN THE CHANGING FIELD OF HEALTH CARE.

Current market forces "have ignited the national explosion of consolidation" in the health care field. Moody's Consolidation Report, *supra*, at 1. For a field that has a depressed ratings outlook, consolidation often offers a glimmer of hope. *See* Moody's 2012 Outlook, *supra*, at 2 (citing the "[o]ngoing trend toward mergers and acquisitions" as a positive development). Mergers arm hospitals with

two critical "success factors" that will enable them to adapt to recent health care trends: economies of scale and improved access to capital. Hessler, *supra*, at 11.

A. Mergers Enable Hospitals To Become More Competitive Through Economies Of Scale.

Even the most vigilant cost-cutting efforts cannot carry already-struggling hospitals through this period of transformation. Mergers present hospitals with a unique opportunity to achieve deeper cost reductions and greater economies of scale with the promise of becoming more competitive.

Now more than ever, "size and scale are . . . a more important means to gaining greater efficiencies and driving waste and costs out of the delivery systems." Moody's Consolidation Report, *supra*, at 1. Through consolidation, hospitals can gain the "size and scale" necessary to diversify their revenue sources, spread costs over a larger base, and "allocat[e] . . . resources to better withstand likely future reductions in funding." Fitch Ratings, *US Hospital M&A Generally Positive for Bondholders* (July 6, 2012) [hereinafter Fitch M&A].[25]

For example, mergers allow hospitals to reduce excess capacity, *i.e.*, the number of available hospital beds that go unoccupied. Kathleen Carey, *Stochastic Demand for Hospitals and Optimizing "Excess" Bed Capacity*, 14 J. Reg. Econ. 165, 181 (1998). Unused beds—as well as the staff and buildings necessary to

[25] http://www.fitchratings.com/web/en/dynamic/articles/US-Hospital-MA-Generally-Positive-for-Bondholders.jsp.

maintain those beds— "represent fixed costs that must still be paid and thus spread over a dwindling number of patients and . . . over all other services at that particular facility." Comm'n on Health Care Facilities, *Final Report: A Plan to Stabilize and Strengthen New York's Health Care System* 57 (Dec. 2006).[26] Reducing excess capacity results in significant cost savings, which can then be captured and reinvested to fill community needs, such as a pro-competitive expansion of services. *See* Carey, *supra*, at 181.

Mergers also allow hospitals to eliminate duplicative services and technology, *see* Fitch M&A, *supra*, which "could save money without compromising access to care," Comm'n on Health Care Facilities, *supra*, at 57. Eliminating these expenses may result in lower prices. *See* Guerin-Calvert, *supra*, at 19.

Consolidation efforts short of a merger do not typically result in the same degree of success in eliminating excess capacity and duplicative resources. By establishing common ownership of facilities and equipment, mergers allow hospitals a clearer path to achieve these critical improvements, which are relevant to the "probable anticompetitive effect of the merger." *Gen. Dynamics*, 415 U.S. at 498 (internal quotation marks omitted). They are precisely the sorts of benefits

[26] *Available at* http://www.nyhealthcarecommission.org/docs/final/commissionfinalreport.pdf.

that this Court has considered in a § 7 merger analysis. *E.g.*, *FTC v. Butterworth Health Corp.*, No. 96-2440, 121 F.3d 708 (table), 1997 WL 420543, at *2-3 (6th Cir. July 8, 1997) (per curiam) (considering factors such as a "direct examination of consumer welfare," including cost savings that will result from the merger).

B. Mergers Provide Hospitals With Greater Access To Capital, Allowing Them To Make Necessary Investments To Remain Competitive In The Future.

Access to capital is critical to hospitals' ability to make capital investments—and to effectively compete in the future. Mergers allow hospitals to improve their access to capital by increasing their size and, in many cases, by joining a hospital system.

Hospital size is closely tied to a hospital's bond rating; larger hospitals tend to have higher bond ratings, in part due to their greater "scope and acuity of services" and "ability to gain greater efficiencies." Moody's Medians, *supra*, at 14. Smaller providers, on the other hand, are subject to greater ratings pressure. *See id.* By increasing size, hospitals may improve their ability to access capital.

Through a merger, the acquired hospital frequently joins a larger hospital system, which provides even greater access to capital. HFMA Access, *supra*, at 16 ("In general, hospitals that are part of systems tend to have better access to capital. Rating agencies may allow systems to achieve higher credit ratings with some lower thresholds—such as days cash on hand—because they generally see less risk

in a system than a stand-alone hospital."). A hospital system disperses risk among a variety of facilities, services, and even geographic locations. *See* Grauman, *supra*, at 64. In addition, hospitals frequently obtain "[g]reater synergies as a larger system with critical mass, particularly if in same or adjacent markets." Moody's Consolidation Report, *supra*, at 5. Furthermore, hospitals that become part of a system may also join that system's obligated group, which is a group of organizations that act as a single entity for credit purposes and that are obligated on the collective debt of the group. *See* Kathleen Roney, *5 Critical Transaction Issues for Hospital CFOs*, Beckers Hospital Review (July 13, 2012).[27] Membership in an obligated group will increase the security of the acquired hospital's debt and likely lead to higher credit ratings. *Id.*

In light of the benefits of size and system membership, it is unsurprising that hospital mergers have a positive impact on a hospital's credit—and corresponding ability to access capital. *See* S&P Headwinds, *supra*, at 15 (discussing "two multinotch upgrades" that occurred as a result of mergers). "Access to capital . . . almost certainly will improve as a result of consolidation." Grauman, *supra*, at 64. Greater access to capital allows hospitals to make critical capital expenditures.

[27] http://www.beckershospitalreview.com/hospital-transactions-and-valuation/5-critical-transaction-issues-for-hospital-cfos.html.

C. Particularly For Stand-Alone Hospitals, Mergers May Be The Only Means Of Remaining Competitive In The Future.

In the rapidly changing field of health care, many stand-alone hospitals—*i.e.*, those hospitals that are not part of a system—are facing a crossroads: Will they merge with a partner hospital to ensure that they remain competitive, or will they remain independent and hope to find other means to weather the storms? As analysts have recognized, "[l]ong term structural change in the sector has favored a minority of larger, well managed hospitals and systems, while creating ever tighter competitive conditions for the majority of smaller, *especially freestanding*, hospitals." Moody's 2012 Outlook, *supra*, at 2 (emphasis added). Indeed, the ALJ in this case recognized that hospitals such as St. Luke's, which are "struggling financially prior to [a] Joinder," may "face[] significant financial challenges to remaining independent in the future." ALJ Op. at 190. "[W]hile St. Luke's was not in imminent danger of failure," the ALJ admitted that, "absent the Joinder, St. Luke's future viability beyond the next several years is uncertain." *Id.* at 189.

Stand-alone hospitals are particularly vulnerable to the threat of the downward spiral. *See supra* at 23-24. There is a "longstanding credit quality gap between . . . systems and stand-alone providers," and market changes threaten to widen the gap. S&P Headwinds, *supra*, at 13. Recent downgrades in hospital credit ratings "were disproportionately weighted toward stand-alone hospitals." *Id.* In the future, stand-alone hospitals "with weaker ratings will be greatly constrained

in obtaining the capital they need for facility improvements, product line development, IT improvements, or physician alignment strategies." Grauman, *supra*, at 63-64. "This pressure may push them over the edge to seek a merger partner or acquisition." *Id.* at 64.

Indeed, experts are advising the boards and management of stand-alone hospitals to consider consolidation. "[G]iven the ever-growing pressures [facing hospitals,] it is imperative that each hospital be willing to perform a candid, objective assessment of its ability to continue to go it alone." *Id.* Although many not-for-profit boards and CEOs "have a bias toward independence," *id.*, they are advised to carefully consider "whether independence continues to be in the hospital's best interest," *id.* at 66; *see also* Ryan S. Gish & Kit A. Kamholz, *To Stand Alone or to Seek a Partner: A Question . . . or an Imperative?* Trustee (Sep. 2009). Various indicators—"[a] weakening in key financial metrics, a softening market share, or an inability to keep pace with facility and technology upgrades"—"may point to the need for affiliation or merger." Grauman, *supra*, at 66. Many stand-alone hospitals have followed this advice; in 2009, 85% of hospital mergers and acquisitions involved stand-alone hospitals. Melanie Evans, *The Few, the Proud . . . the Stand-Alone Hospital*, ModernHealthcare.com (July 26, 2010).

Hospitals that are "left out of consolidations, especially smaller stand-alone hospitals . . . , will face greater negative rating pressure going forward." Moody's

Consolidation Report, *supra*, at 1. This pressure will make it harder for hospitals to access capital and to remain competitive. Those hospitals that do survive are likely to "evaluate their service offerings [and] may downsize their footprints," John Commins, *Pace of Hospital M&As Likely to Accelerate*, HealthLeaders Media 3 (Mar. 19, 2012),[28] which will further reduce competition. Therefore, many acquisitions of stand-alone hospitals will result in more competition, rather than less. *See* Horizontal Merger Guidelines 1.0 (requiring "an assessment of what will likely happen if a merger proceeds as compared to what will likely happen if it does not").

D. Antitrust Law Should Consider These Market Realities When Assessing The Probable Effect Of A Hospital Merger.

If antitrust law turns a blind eye to the "actual market realities" of health care and blocks mergers based on outdated measures of a hospital's ability to compete, many hospitals will fail. *Smith Wholesale*, 477 F.3d at 865 (internal quotation marks omitted). During this period of rapid market transformation, many smaller hospitals—especially stand-alone hospitals—will struggle to remain competitive unless they find a partner that can help improve their access to capital and provide greater economies of scale. This "market realit[y]," *id.*, is highly relevant to the Court's "assessment of what will likely happen if a merger proceeds

[28] http://www.healthleadersmedia.com/page-3/FIN-277847/Pace-of-Hospital-MAs-Likely-to-Accelerate.

as compared to what will likely happen if it does not," Horizontal Merger Guidelines 1.0; *see also Gen. Dynamics*, 415 U.S. at 501.

The law should not force hospitals to wait to merge until they are in imminent danger of closing their doors. *See* Gish & Kamholz, *supra*. If hospitals must tumble through the downward spiral, both patients and the community will suffer from disruptions in the quality and consistency of care as hospital services slowly deteriorate. A "direct examination of consumer welfare," *Butterworth*, 1997 WL 420543, at *3, counsels against this result. In many cases, "the public interest would best be served by allowing the hospitals to proceed with the merger." *Id.*

CONCLUSION

The health care field has reached a pivotal juncture in history. The competitive landscape, including the "proper indicators of [hospitals'] future ability to compete," has changed. *Gen. Dynamics*, 415 U.S. at 510. This Court should give serious consideration to whether "pertinent factors affecting the . . . industry . . . mandate[] a conclusion that" the present merger threatens "no substantial lessening of competition." *Id.* at 498. This Court's decision will have far-reaching effects as hospitals continue to explore mergers as a means of remaining competitive, and as the Federal Trade Commission continues its efforts against hospital mergers such as this one.

Dated: September 24, 2012

Respectfully Submitted,

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Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned certifies that this brief complies with the type-volume limitations of Federal Rule of Appellate Procedure 32(a)(7)(B)(i).

1. Exclusive of the exempted portions of this brief, as provided in Federal Rule of Appellate Procedure 32(a)(7)(B)(iii), this brief includes 6,992 words.

2. This brief has been prepared in proportionally spaced typeface using Microsoft Office Word 2007 in 14 point Times New Roman font. As permitted by Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned has relied upon the word count of this word-processing system in preparing this certificate.

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing Brief of *Amicus Curiae* with the Clerk of the Court using the CM/ECF system, which will send a notification of such filing to the appropriate counsel. If any parties or their counsel of record are not registered users, I have served them by placing a true and correct copy of the foregoing document in the United States mail, postage prepaid, to their address of record.

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