No. 19-2210

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

NEW MEXICO ONCOLOGY AND HEMATOLOGY CONSULTANTS, LTD.,

Plaintiff/Appellant

v.

PRESBYTERIAN HEALTH CARE SERVICES, et al.,

Defendants/Appellees.

On Appeal from November 14, 2019 Order Granting Summary Judgment by
United States District Court for the District of New Mexico
in No. 1:12-CV-00526-MV-GBW,
Sat Below: Judge Martha Vazquez, U.S.D.J.

MOTION OF *AMICI CURIAE* AMERICAN HOSPITAL ASSOCIATION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF APPELLEES

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The American Hospital Association ("AHA") respectfully moves this Court, pursuant to Federal Rule of Appellate Procedure 29 for leave to file as *amicus curiae*, the brief attached hereto as Exhibit A in support of Appellees. In support of its motion, AHA states as follows:

1. AHA is a national organization that represents nearly 5,000 hospitals, health care systems, networks, and other providers of care, as well as 43,000 individual members. Some of AHA's members operate vertically-integrated health care delivery systems, caring for patients through affiliated hospitals, physicians, pharmacies, and insurance offerings.

2. The Plaintiff's claims in this case address common conduct of vertically-integrated health care systems, such as encouraging patients to see physicians affiliated with the system, using nurse navigators to coordinate patients' care within the system, and having patients use affiliated pharmacies.

3. AHA has an interest in the way courts address these common practices of vertically-integrated hospitals and health systems, and AHA has a unique perspective on these issues.

4. Neither Appellees nor their counsel authored this Brief. None of the parties to this case nor their counsel nor any third party paid for preparation of this Brief.

For the above reasons, AHA respectfully requests this Court grant this motion for leave to file the attached proposed amicus brief.

Dated: September 3, 2020

Respectfully Submitted,

/s/ Douglas Ross

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1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B), as this brief contains 211 words, excluding the parts exempted by the Federal Rules of Appellate Procedure and 10th Circuit Rules. This number was calculated using the "word count" application of Microsoft Word.

2. This brief complies with the type-face requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally-spaced type face using Times New Roman in 14-point font.

/s/ Douglas Ross
Douglas Ross

September 3, 2020

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I hereby certify that with respect to the foregoing:

(1) all required privacy redactions have been made per 10th Cir. R. 25.5;

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/s/ Douglas Ross
Douglas Ross

September 3, 2020

CERTIFICATE OF SERVICE

I hereby certify that on the date listed below, the foregoing Amicus Brief was electronically filed with the Clerk of Court using the CM/ECF system and served electronically via the Court's CM/ECF system to the attorneys of record in this matter who are registered with the Court's CM/ECF system.

/s/ Douglas Ross
Douglas Ross

September 3, 2020

EXHIBIT A

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Fed. R. App. P. 26.1, Amicus Curiae American Hospital Association (AHA) certifies as follows: (1) AHA is not a publicly held corporation or other publicly held entity; (2) AHA does not have any parent corporations; and (3) no publicly held entity owns 10% or more of AHA.

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

INTRODUCTION AND STATEMENT OF INTEREST

The American Hospital Association (AHA) is a national organization that represents nearly 5,000 hospitals, health care systems, networks, and other providers of care, as well as 43,000 individual members.[1] Hospitals and health systems operate in a health care market that is continually evolving. The passage of the Patient Protection and Affordable Care Act (ACA) in 2010, for example, accelerated structural changes that have produced an unprecedented realignment in the provision of health care. This realignment will continue regardless of any changes that continue to be effected in the ACA.

Hospitals and health care professionals work together to efficiently provide integrated, quality care to patients. One logical and time-tested way to accomplish this is through vertical integration, such as when a hospital employs physicians, or when an insurer offers comprehensive health care coverage to the public through its own delivery system of hospitals and physicians. Some of the nation's best known and most highly regarded health care organizations, such as the Mayo Clinic and Kaiser Permanente, were built decades ago on the belief that integrating a payer (providing prepaid health coverage to members), hospitals, physicians, and

[1] AHA notes that one of its former board chairs, Jim Hinton, was CEO of Presbyterian at the time of his tenure as AHA chairman of the board. Mr. Hinton is no longer CEO of Presbyterian, no longer chairman of AHA, and had no role in AHA's submission of this amicus brief.

other health care providers in one organization will provide patients with high quality, coordinated care, while at the same time controlling costs.

Different health care systems approach integration in different ways; there is no one-size-fits-all model. Presbyterian Healthcare Services has chosen to integrate vertically by providing (directly or through subsidiaries) health care coverage (insurance), hospitals, physicians, nurses, pharmacy services, and other services under one umbrella. Other health care systems choose looser forms of integration, such as contracting (rather than affiliating) with health plans and providers, while still other systems may prefer not to formally integrate at all.

Because Presbyterian operates a vertically integrated system, it encourages patients who have health care coverage from Presbyterian's insurance arm to remain within the Presbyterian delivery system. As the district court observed, Presbyterian encourages referrals to its own physicians and requires some patients to purchase chemotherapy drugs from Presbyterian's specialty pharmacy.[2] Plaintiff New Mexico Hematology and Oncology Services, an independent provider of oncology services, argues these decisions by Presbyterian supply the

[2] *New Mexico Oncology v. Presbyterian Healthcare Servs.*, 418 F. Supp. 3d 826, 831 (D.N.M. 2019). Plaintiff has not been excluded from Presbyterian's network. Plaintiff is in network and receives referrals from Presbyterian's physicians; Presbyterian merely encourages patients to visit its affiliated providers. *Id.* at 847-48.

element of anticompetitive conduct necessary for the success of Plaintiff's claims that Presbyterian monopolized certain health insurance markets and attempted to monopolize the market for comprehensive oncology services in violation of Section 2 of the Sherman Act. The district court disagreed: it held Presbyterian's conduct—far from being anticompetitive—is protected under the antitrust laws. Relying on well-established Tenth Circuit precedent, the district court found that allowing Presbyterian "to decide for [itself] what blend of vertical integration and third party competition will produce the highest return may well increase competition . . . and thus benefit consumers."[3]

AHA submits this brief in support of the district court's determination that Presbyterian's efforts to integrate vertically did not violate the antitrust laws. Court wisely have avoided using the antitrust laws to discourage efficiency-enhancing vertical integration among providers.

[3] *Id.* at 866 (quoting *Christy Sports, LLC v. Deer Valley Resort Co.*, 555 F.3d 1188, 1192 (10th Cir. 2009)).

ARGUMENT

I. Health Care Organizations Frequently Choose to Integrate Vertically to Better Provide Quality Care for their Patients while Controlling Costs

Health care delivery systems have been transitioning from traditional fee-for-service payment systems to reimbursement models that reward providers for improving the quality of care for patients and control the total cost of care provided. Although this transition preceded the ACA by decades, the ACA introduced new programs and incentives for health care delivery systems to experiment with "payment models that emphasize improved access to care and care management along the care continuum, furthering the incentives for integration among providers."[4] Some health care systems—like Presbyterian—experimented with different modes of delivering health well before passage of the ACA. ACAs reimbursement initiatives, including the Medicare Shared Savings Program and value-based payments to hospitals, are designed to further encourage high quality care while controlling cost.[5] Since passage of the ACA a decade ago,

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[4] Jessica Heeringa, et al., *Horizontal and Vertical Integration of Health Care Providers: A Framework for Understanding Various Provider Organizational Structures*, INT'L J. INTEGRATED CARE, Jan. 20, 2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6978994/.

[5] *See, e.g.*, Bruce Fried & David Sherer, *Value Based Reimbursement: The Rock Thrown into the Health Care Pond*, Health Aff. Blog (July 8, 2016), http://healthaffairs.org/blog/2016/07/08/value-based-reimbursement-the-rock-thrown-into-the-health-care-pond/.

"Congress doubled down on the value-based reimbursement bet," enacting changes to the Medicare program designed to increase the use of value-based reimbursement in the provision of services to Medicare beneficiaries.[6] These new payment models "are built on a foundation of primary care, shared accountability, and improved care management."[7]

To succeed at value-based care, health plans "have enthusiastically endorsed a variety of payment models to engage primary care providers, specialists, and health systems in taking accountability for the populations they serve and accepting financial risk for their performance."[8] The move to payment models based on the value of the heath care actually delivered to the patient has encouraged more health plans and hospitals to affiliate with physicians. Integrating physicians into a health system promotes coordination across the broad spectrum of care many patients need.[9] This care coordination is particularly

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[6] *Id*. (discussing the Medicare Access and CHIP Reauthorization Act of 2015, known as "MACRA", which introduced the Merit-Based Incentive Payment System for physicians).

[7] Heeringa, et al., *supra*.

[8] Bruce Broussard, Medicare Advantage And The Future Of Value-Based Care, HEALTH AFFAIRS, July 3, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190627.482360/full/

[9] *See, e.g.*, The Economic Case for Vertical Integration in Health Care, NEW ENGLAND J. MED., June 2020, https://catalyst.nejm.org/doi/abs/10.1056/CAT.20.0119.

important for patients—such as cancer patients—who undergo a complex course of treatment. Care coordination for these patients leads to better outcomes (higher survival rates and better quality of life) and lower costs. The Department of Justice Antitrust Division has long recognized the value of vertical integration in health care: "There does not seem to be serious dispute that more integration and coordination in delivery of health care services have the potential to decrease costs and improve quality."[10]

Unsurprisingly, health care providers and insurers have adopted varied approaches to vertically integrating their offerings. Many hospitals have integrated with physicians to take on risk that payers increasingly seek to share with providers. Some health plans have acquired physician clinics and ambulatory service providers to help better coordinate and manage their members' care. Both health plans and health systems have engaged in vertical integration strategies with pharmacies and pharmacy benefit managers.[11]

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[10] *See, e.g.*, Statement of DOJ Antitrust Division Chief of Staff, Antitrust Laws and Their Effects on Healthcare Providers, Insurers and Patients, Dec. 1, 2010, https://www.justice.gov/archive/atr/public/testimony/264672.pdf

[11] *See, e.g.*, Shelby Livingston, *Federal Judge Signs Off On CVS-Aetna Merger After Post-Deal Review*, MODERN HEALTHCARE. Sept. 4, 2019, https://www.modernhealthcare.com/mergers-acquisitions/federal-judge-signs-cvs-aetna-merger-after-post-deal-review; Alia Paavlola, Six Hospitals Investing In Retail, Specialty Or In-House Pharmacy, BECKERS HOSPITAL REV., July 10, 2019, https://www.beckershospitalreview.com/pharmacy/6-hospitals-investing-in-retail-specialty-or-in-house-pharmacy.html.

One example: the nation's largest insurer, UnitedHealth care, has acquired physician practices, surgery centers, and other providers. "Although best known as a provider of health insurance, over the last decade United has grown into one of the largest employers of physicians in the U.S."[12] United's provider arm, Optum, includes physicians, pharmacies, and outpatient care facilities. "This model—vertical integration, plus a horizontal approach that attempts to connect with consumers at multiple stops along the continuum of patient care—has become the target for other leading payers."[13]

Intermountain Health care, an integrated delivery system based in Utah and Idaho, which operates hospitals, physician clinics, and a health plan, is another example of how vertical integration works well. Intermountain long has used vertical integration to improve outcomes and reduce cost. According to the former chief quality officer at the organization, "Intermountain achieved such quality-based savings through measuring, understanding, and managing variation among

[12] Chasing the Leader: Healthcare Vertical Integration Follows Optum Model, BAILEY SOUTHWELL & CO., Oct. 3, 2018, https://www.baileysouthwell.com/chasing-the-leader-healthcare-vertical-integration-follows-optum-model/.

[13] *Id.*

clinicians in providing care."[14] Intermountain improved performance on both quality and cost by closely examining variations in physician conduct treating particular conditions so it could promote the treatments that led to the best outcomes at the lowest cost.[15]

The conduct Plaintiff attacks in this case—an effort by a vertically-integrated health plan to encourage patients to visit its affiliated physicians and to use its integrated pharmacy—is the natural outcome of procompetitive efforts to improve patient care and reduce costs. Some health plans and health systems vertically integrate through partnerships. Some health systems form clinically integrated networks and other accountable care organizations positioned to take on risk for broad populations.[16] This diversity of approaches is exactly what the antitrust laws are intended to promote: innovation and experimentation.[17]

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[14] Brent C. James, *How Intermountain Trimmed Health Care Costs Through Robust Quality Improvement Efforts*, HEALTH AFFAIRS, June 2011, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.0358.

[15] *Id.*

[16] *See, e.g.*, Mary Vanac, *Cleveland Clinic-Oscar Health Partnership Shows Success in Concierge Medicine*, MODERN HEALTHCARE, Mar. 9, 2020, https://www.modernhealthcare.com/payment/cleveland-clinic-oscar-health-partnership-shows-success-concierge-medicine.

[17] *See, e.g.*, FTC Report, *To Promote Innovation: The Proper Balance of. Competition and Patent Law and Policy*, Oct. 1, 2003, https://www.ftc.gov/reports/promote-innovation-proper-balance-competition-patent-law-policy ("Competition among firms can spur the invention of new or better products or more efficient processes.").

The antitrust laws do not require health plans and health systems to deal with their competitors on the same terms as they do with affiliated providers. That would defeat the purpose of vertical integration, and turn antitrust law on its head: an organization has "no antitrust duty to deal with its rivals."[18] If a vertically-integrated health plan or health system cannot achieve better quality and more efficient care through the use of its own providers, the market supplies the remedy: the firm risks losing customers to competing health plans or health systems.[19]

Vertically integrated systems have succeeded because they can provide high quality care at competitive prices. Yet amicus curiae Community Oncology Alliance, Inc. (COA) asserts that when a health plan or health system uses its own integrated pharmacy to deliver medications to physicians for administration to

[18] *Pac. Bell Tel. Co. v. Linkline Communications, Inc.,* 555 U.S. 438, 450 (2009); *Fed. Trade Comm'n v. Qualcomm Inc.*, ___ F.3d ___, No. 19-16122, 2020 WL 4591476, at *11 (9th Cir. Aug. 11, 2020) (there is "no duty to deal under the terms and conditions preferred by a competitor's rivals") (quotations omitted).

[19] Amicus curiae American Medical Association ("AMA") asserts that Presbyterian encouraging patients to visit its affiliated providers raises medical ethics concerns. AMA Amicus Br. at 4-6. Not so. There are good reasons for nurses and physicians to encourage patients to stay within an integrated delivery system. Among them, serving patients within an integrated system allows for better information exchange between providers, more team-based decision making, and better monitoring of patients' health over time. Moreover the ethical conduct of health care professionals is appropriately regulated by licensing bodies, not antitrust courts.

patients, it "present[s] serious quality of care issues for patients."[20] COA doesn't provide support for this assertion. And the claim is at odds with COA's admission elsewhere that "multiple studies have demonstrated health care consolidation has been **neutral** as to quality of care."[21] As the district court observed, internal Presbyterian documents show Presbyterian planned to require members to use to its own pharmacy so as to "lower the overall cost of care without harming quality."[22] As an antitrust matter, lowering cost without affecting quality should be encouraged, not discouraged.

II. Network Designs Featuring Certain Providers May Be Procompetitive

Health plans and their health care provider partners design provider networks to make health care more affordable and easier for patients to navigate. Integrated health plans and health systems may offer plans that include networks of some, but not all, providers in a community. With a narrower selection of in-network providers, health plans frequently can offer lower premiums and more benefits to consumers. The federal antitrust agencies long ago recognized that

[20] COA Amicus Br. at 14.

[21] COA Amicus Brief at 10 (emphasis in original).

[22] *NMOHC*, 418 F. Supp. 3d at 839. *See also id.* at 852 (noting an internal strategy memo in which Presbyterian said its plan to have members use Presbyterian's pharmacy "will not impact the clinical outcomes or quality of care").

"selective contracting may be a method through which networks limit their provider panels in an effort to achieve quality and cost-containment goals, and thus enhance their ability to compete against other networks."[23] Of course, selective networks invariably exclude some providers in the community. But this exclusion typically promotes, rather than diminishes, competition.[24] Excluded providers are incentivized to collaborate with other health plans and providers to form competing networks. This competition can benefit patients in the form of lower insurance prices and better quality of care.

Here, Presbyterian did not actually exclude Plaintiff, as Plaintiff remains an in-network provider for Presbyterian's health plans. Presbyterian simply encourages patients to visit its own affiliated providers, including by providing patients a guide of those providers. Presbyterian also has adopted a nurse navigator program to coordinate care within the Presbyterian system. Amici

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[23] DOJ/FTC Statements of Antitrust Enforcement Policy in Healthcare (1996), Statement 9 (at 122).

[24] *See, e.g.*, Statement of DOJ Antitrust Division Chief Robert Bloch before the Practicing Law Institute, Nov. 15, 1991; *Capital Imaging Associates, P.C. v. Mohawk Valley Medical Associates, Inc.*, 725 F. Supp. 669, 673 (N.D.N.Y. 1989), *aff'd*, 996 F.2d 537 (2nd Cir.) ("[o]ne of the essential features of an HMO is that it selects preferred physicians and excludes others thereby creating competition among the providers of health care services"); *Hassan v. Independent Practice Associates, P.C.*, 698 F. Supp. 679, 694 (E.D. Mich. 1988) (recognizing that it was pro-competitive for an IPA to terminate two allergists from its physician panel on grounds that they overutilized costly allergy tests and disagreed with the IPA's allergy testing policy).

supporting Plaintiff criticize these tactics and characterize nurse navigators as sources of increased costs.[25] On this last point, amici focus on the incremental cost of a nurse navigator and so miss how care coordination typically ***lowers*** the total cost of treating a patient, which is why navigators frequently are used in value-based care models.[26] Most importantly, as discussed above, better care coordination leads to better patient care. Especially for complex conditions like cancer, "care coordination programs can be an effective tool for maximizing the quality of care provided."[27]

CONCLUSION

Vertical coordination typically is procompetitive, or at worst competitively neutral. Vertically integrated health care delivery systems offer the promise of managing complex care for patients over large populations in a cost efficient manner. The district court recognized this when it granted summary judgment for

[25] Amicus Brief of AMA at 14-15; Amicus Brief of COA at 4.

[26] Agency for Healthcare Research and Quality, *Care Coordination Measures*, Ch. 2, June 2014 https://www.ahrq.gov/ncepcr/care/coordination/atlas/chapter2.html ("The goal of care coordination is to facilitate the appropriate and efficient delivery of health care services both within and across systems.").

[27] Sheryl Riley, et al., *The Role of Patient Navigation in Improving the Value of Oncology Care*, J. CLINICAL PATHWAYS, Jan./Feb. 2016, https://www.journalofclinicalpathways.com/article/role-patient-navigation-improving-value-oncology-care.

defendants and sent the parties out to compete in the market to determine what model of patient care best suits the needs of the population in New Mexico.

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