

The Heartland Specialty Hospital Case

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In *Heartland Surgical Specialty Hosp. v. Midwest Division, Inc.*,¹ an alleged group boycott of a physician-owned specialty hospital was addressed in a number of pretrial rulings. While the case was ultimately settled, a decision on summary judgment and rulings on *Daubert* motions relating to damages are of interest.

The plaintiff, Heartland Surgical Specialty Hospital LLC (Heartland), claimed that eleven managed care organizations (MCOs) and hospitals combined to boycott Heartland to keep it from obtaining any major managed care contracts. Heartland alleged that it was unable to obtain contracts with any of the six major MCOs in the Kansas City area because of this alleged boycott and that this deprived the public of Heartland's allegedly advanced care. Heartland claimed that the MCO defendants accounted for approximately 90% of managed care enrollment in the Kansas City metropolitan area and that the hospital defendants' combined share was 74%. Heartland's theory was that no MCO defendant could build a competitive network without the defendant hospitals, and therefore these hospitals were able to apply pressure to the MCOs to cause them to refuse to contract with Heartland, despite the high quality of service and care Heartland allegedly brought to the market. Heartland alleged that the MCOs agreed with each other to exclude Heartland so that none of them would suffer a competitive disadvantage from the exclusion. Heartland sought damages of approximately \$120 million before trebling.

¹ Case No. 05-2164-MLB-DJW (D. Kan.).

In its summary judgment decision, a 120-page opinion, the U.S. District Court for the District of Kansas found disputes of fact as to Heartland's boycott theory (i.e., that the hospital defendants agreed with each other to threaten the MCOs if they contracted with Heartland, and that the MCOs responded by agreeing with each other to not contract with Heartland). The decision was based upon a review of the specific evidence adduced as to each defendant.²

Many aspects of the court's summary judgment opinion are of interest:

- The court did not conclude (and the plaintiff did not contend) that "narrow network" clauses that restrict the hospitals in a MCO's network in exchange for lower prices from the hospitals with which it does contract are potentially anticompetitive or unlawful. The court specifically found that such clauses are common in the healthcare industry and can provide competitive benefits.³ The court did find, however, that in this case there were clauses in MCO contracts with the defendant hospitals that excluded new hospitals from networks but permitted the addition of new facilities that were majority-owned by hospitals already in the network. The court found that these clauses were arguably not justifiable on ordinary competitive grounds and provided some evidence of a conspiracy to boycott, since the effect of the clauses was to exclude specialty hospitals that were majority-owned by physicians. In particular, the court referred to alleged actions by defendant hospitals to permit majority-owned facilities to be added to MCO networks and to waive contractual provisions that would have prohibited such additions, and in one case, the alleged coordination of such efforts by an MCO with regard to multiple defendant hospitals.
- The court relied in particular on testimony from a former managed care employee that it interpreted as arguably providing that there was a "gentlemen's agreement" that the MCOs would include facilities that were majority-owned by existing hospitals in their contracts, and that there was an "understanding" among the MCOs that they would not extend contracts to specialty hospitals. The

² *Heartland Surgical Specialty Hosp. v. Midwest Div., Inc.*, 527 F. Supp. 2d 1257 (D. Kan. 2007).

³ See, e.g., *Stop & Shop Supermarket Co. v. Blue Cross & Blue Shield of Rhode Island*, 373 F.3d 57 (1st Cir. 2004).

court considered the latter testimony as “weak direct evidence” of a conspiracy to boycott.⁴

- Multiple defendant MCOs and/or defendant hospitals allegedly discussed issues relating to specialty hospitals at annual “Classic Cup dinners,” a public industry meeting chaired by a local magazine, and meetings of the local chapter of the Healthcare Financial Management Association (HFMA). These discussions included advocacy by some defendants that MCOs not contract with specialty hospitals, but there was no claim that specific agreements were reached at these meetings.
- Heartland claimed the MCO defendants initially gave Heartland positive feedback about contracting with it, but later all of them refused to do so, even without conducting a network-need analysis.

The court did grant summary judgment on the horizontal conspiracy claim as to one of the hospital defendants, Carondelet Health System. The court said that the only evidence adduced as to Carondelet involved its attendance at the HFMA meeting, its attempts to negotiate agreements with MCO defendants concerning network configuration language, and its request to one MCO concerning adding Carondelet’s own majority-owned facility to that MCO’s network. The court found that in the absence of evidence of Carondelet’s participation in efforts to coordinate hospital defendants’ positions on the inclusion of majority-owned specialty hospitals, or participation in any other meetings or actions arguably in furtherance of the alleged conspiracy, summary judgment should be granted as to Carondelet.

The court also addressed defendants’ *Daubert* motions relating to plaintiff’s damages estimates. Heartland offered two damages estimates. The first related to damages due to alleged lost volume because of Heartland’s inability to obtain contracts with the six MCO defendants. This estimate was provided by a healthcare consultant who had worked at a number of specialty hospitals and had served for a number of months as acting chief executive officer at Heartland.

⁴ 527 F. Supp. 2d at 1301.

The second estimate was based on the assumption that—but for the alleged conspiracy—Heartland would have developed and built a general acute care hospital that it projected to be highly profitable. Heartland had not developed a specific business plan for the operation of such a hospital. The second estimate was provided by a damages consultant who focused on litigation. After a *Daubert* hearing at which the speculative nature of this latter claim was vigorously attacked, Heartland withdrew this claim.

The court struck approximately half of Heartland’s claimed damages relating to its operations as a specialty hospital. It concluded that the claim for future damages was too speculative. However, the court declined to strike Heartland’s claim for past damages, despite arguments that, among other things, the damages were calculated based on a self-serving survey of Heartland’s physician owners.

The court’s *Daubert* decision was based, in significant part, on the following:

- The past damages estimate was based on judgments by the physician owners of Heartland as to how much additional volume they would have referred had Heartland obtained contracts with the MCO defendants. Defendants attacked those projections as biased and speculative. The court found that the methodology was appropriate because it had been previously used by Heartland’s damages expert in projecting the profitability of other healthcare ventures and that he had relied on “the best data available . . .”⁵
- Defendants attacked Heartland’s failure to make adjustments for the lower rate that hospitals were paid under contract, as compared with the higher out-of-network rates that Heartland had received in the absence of MCO contracts. The court found that the damages expert had a rationale for claiming that the adjustment was unnecessary because of other offsetting factors, and found that the rationale was sufficient based on the expert’s “experience generally in the healthcare industry and specifically at Heartland . . .”⁶

⁵ *Id.* at 10, n.8.

⁶ *Id.* at 15.

- The court also relied on the fact that the expert justified his estimates based on an increase in Heartland’s patient volumes in the three months after it obtained contracts with Blue Cross and United (who had earlier settled with Heartland) and based on a comparison with the profit margins of nine other specialty facilities. The court reached this conclusion even though it stated that the expert “did not use these facilities as benchmarks to calculate Heartland’s damages.”⁷
- The court found that the future damages estimate was unduly speculative because the expert “performed no analysis of future market conditions, future population trends, future reimbursement trends [or future competition] . . .”⁸

The remaining defendants settled before the case could go to trial.

The court’s rulings in *Heartland* are probably more notable for what they do not signify. They do not indicate a broad level of antitrust concern with regard to the exclusion of specialty hospitals from managed care networks. It appears that if the evidence here had been limited to the presence of individually negotiated “narrow network” clauses that excluded specialty hospitals, there would not have been a basis for a boycott claim. Indeed, throughout the case, selective contracting was generally acknowledged to be appropriate and pro-competitive in many contexts.

Moreover, the rulings do not involve any ultimate conclusions on either liability or damages. They simply indicate that these issues raised sufficient questions to go to the jury.

However, the decision does illustrate that contacts between multiple hospitals and multiple payors in a market can raise an appearance of a conspiracy that can make summary judgment difficult, even if, as defendants argued, all those contacts are innocent. Claims of conspiracy may be more easily rejected in single-payor cases.⁹ Even public meetings that involve discussions among competitors concerning public policy issues relating to specialty hospitals, in the wrong context, can be taken as some

⁷ *Id.*

⁸ *Id.* at 16.

⁹ See, e.g., *Abraham v. Intermountain Health Care, Inc.*, 461 F.3d 1249 (10th Cir. 2006); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980).

evidence of a conspiracy. Moreover, the involvement of multiple parties may at least raise questions about market power and competitive effect. When a specialty hospital is largely unable to obtain managed care contracts in a market, these kinds of actions may, rightly or wrongly, raise significant litigation issues.

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