HLB
Hooper, Lundy & Bookman, PC
HEALTH CARE LAWYERS & ADVISORS

HEALTH LAW PERSPECTIVES

Newsletter | Volume 17 | No. 2

February 2015

Ninth Circuit Affirms Antitrust Challenge to Idaho Hospital's Acquisition of Medical Group

By David Henninger

In an important decision for ACOs and other hospital- physician integrated delivery systems, the U.S. Court of Appeals for the Ninth Circuit recently upheld a district court's judgment in favor of the Federal Trade Commission (FTC), which held that the acquisition in December 2012 by St. Luke's Health System in Idaho of Saltzer Medical Group, a multi- specialty physician group, violated federal antitrust law, specifically Section 7 of the Clayton Act. *St. Alphonsus Medical Center – Nampa, Inc. v. St. Luke's Health System, Ltd.,* No. 14-35 M3 (Ninth Cir. Feb. 10, 2015).

Significantly, the court rejected St. Luke's defense that the acquisition is not anti- competitive, but rather would create pro- competitive efficiencies in the market, in that the physicians in the acquired practice would have access to St. Luke's electronic medical records system which will improve patient care, and the acquisition would allow St. Luke's to move toward integrated care and risk- based reimbursement. The Ninth circuit also affirmed the District Court's remedy of divestiture, which requires that St. Luke's fully divest itself of Saltzer's assets.

Section 7 of the Clayton Act prohibits mergers or acquisitions where the effect may be to lessen competition, or to tend to create a monopoly. The first step in determining whether a merger or acquisition violates Section 7 is to define the relevant product and geographic markets affected by the transaction. While the parties in this case agreed that the relevant product market was adult primary care physicians (PCPs), they disagreed on the relevant geographic market. St. Luke's argued that the relevant geographic market for PCP services encompassed not just the city of Nampa, where Saltzer Medical Group was located, but also a broader area which included the city of Boise, which is twenty miles away, while the FTC argued that the relevant market was limited to Nampa alone.

The district court agreed with the FTC that the relevant market was Nampa, and the Ninth Circuit upheld that determination, based upon evidence presented at trial that although a significant number of Nampa residents currently leave the city for primary care they did so because they work outside of Nampa, and that insurers need Nampa PCPs in their networks to be competitive. The court concluded that patients in Nampa would not look elsewhere for care if there were a significant increase in price by Nampa PCPs.

The Ninth Circuit then reviewed the district court's finding that the acquisition will likely lead to anticompetitive effects in the relevant market. That finding was based upon St. Luke's high PCP market share, its ability to negotiate higher PCP reimbursement rates, and its ability

In This Issue

to charge ancillary services at higher hospital billing rates. The PCP market share of St. Luke's in the relevant market post- acquisition was extremely high, and included almost 80% of the PCPs in Nampa.

The court specifically noted that the results of the application of the Herfindahl-Hirschman Index (HHI), a metric for determining market share commonly used in antitrust analysis, "are well above the thresholds for a presumptively anticompetitive merger", and that the high HHI alone could establish a violation of Section 7. The Court also agreed with the district court's finding that St. Luke's would likely use its market power to negotiate higher PCP rates, based in part on pre- acquisition internal correspondence produced at trial. While the Ninth Circuit determined that the district court's finding regarding price increases for ancillary services was not supported by the record, it upheld its conclusion that the acquisition was anticompetitive and violated Section 7.

The Court then turned to St. Luke's argument that the acquisition can be justified because it will have procompetitive effects, in that it will create a more efficient combined entity. After questioning the validity of this "efficiencies defense" under any circumstances, the Ninth Circuit analyzed St. Luke's efficiency arguments. The Court first agreed with the district court that any efficiencies created by integrating the former Saltzer physicians into St. Luke's medical records system would not outweigh the anticompetitive effects of the acquisition.

The Court then turned to the argument that the acquisition would better align the interests of hospitals and physicians, and lead to a more integrated and efficient health care system, and again agreed with the district court's conclusion that the acquisition was not necessary to achieve those goals. The Ninth Circuit then further noted that even if the acquisition were necessary to achieve these efficiencies, the resulting improved patient care, while a laudable goal, would not excuse a transaction such as this that lessens competition.

Finally, the Ninth Circuit upheld the district court's finding that divestiture of the acquisition is the appropriate remedy, and rejected St. Luke's arguments that divestiture will not restore competition, since Saltzer would no longer be able to compete, and that another remedy short of divestiture should be imposed, such as establishing separate bargaining groups of PCPs to negotiate with insurers.

The case should serve as a warning to integrated health care delivery systems developed through acquisitions by hospitals of physician practices and other non-hospital providers, that anticipated enhanced efficiencies and improvements in quality of care may not provide protection from antitrust challenge where the transaction will result in significant market power in a physician specialty or other specific care provider sector. It also emphasizes the importance for ACOs and other integrated delivery systems of conducting a thorough market share analysis prior to going forward with any significant acquisition or merger.

For more information, please contact David Henninger in Los Angeles at 310.551.8111.

Responding to Subpoenas for Mental Health Records in California: Implications of the Applicability of the LPS Act versus the CMIA

By Amy Joseph & Stanton Stock
In Collaboration with Linda Kollar & Devin Senelick

Responding to a subpoena for a patient's health information can often seem like a Catch-22. On one hand, health care providers could face liability if they produce records without complying with complex federal and state privacy laws. On the other hand, they could be threatened with sanctions by courts and attorneys if they fail to produce records in a timely manner. Narrow is the path of proper compliance, particularly when the subpoena is for a patient's mental health information or records, and providers must engage in a comprehensive, fact-specific analysis when determining how to respond to such subpoenas.

In California, the threshold question providers must ask when presented with a subpoena duces tecum (subpoena for records) is whether the mental health information being sought is protected by California's general health information privacy law – the California Confidentiality of Medical Information Act, California Civil Code Section 56 et seq. (CMIA) – or the Lanterman-Petris-Short Act, California Welfare and Institutions Code, Section 5328 et seq. (LPS Act), which has special protections for mental health records. The answer to this question is key, because if the information is subject to protection under the LPS Act, nothing less than a court order will suffice to compel disclosure of the patient's records.

This article provides an overview of the key distinctions between the CMIA and the LPS Act with respect to which providers fall under each statutory scheme, the type of information protected, and the implication with respect to subpoenas in the absence of a patient's authorization to disclose his or her mental health information or records. This article also provides a brief summary of the analysis under federal law and the corresponding preemption issues, and certain other key considerations. [1]

I. LPS Act Versus CMIA: Applicability and Implications

The LPS Act applies to facilities where patients are involuntarily treated or evaluated[2] and some facilities where patients are voluntarily treated, including state mental hospitals, county psychiatric facilities, private institutions that include a department or ward for persons who are mentally disordered, psychiatric health facilities described in California Health & Safety Code Section 1250.2, community programs funded by the Bronzan-McCorquodale Act (Short-Doyle Act funding), and others.[3] In some cases it is immediately clear that a provider is subject to the LPS Act, such as in the case of a county psychiatric hospital. In other situations, a closer look may be required at the definitions of the enumerated categories and the provider's funding sources, such as whether the provider receives funds from the county to provide mental health services.

The LPS Act broadly applies to "[a]ll information and records obtained in the course of providing services" by covered facilities, and imposes strict restrictions on the disclosure of such information or records without a patient's authorization. The LPS Act expressly permits disclosure under certain circumstances, including "to the courts, as necessary to the administration of justice."[4] However, this provision has been interpreted narrowly to allow the release of information only directly to a court pursuant to a court order. See Riverside County v. Superior Court, 42 Cal.App.3d 478 (1974) (disclosure not permitted to State Board of Chiropractic Examiners, because the language of the exception applies to "courts"). Disclosure is not permitted to a requesting party merely in response to a subpoena. Rather, the LPS Act only permits production in response to a valid authorization from the patient or a court order (unless another exception permitting disclosure applies). Even if a court order is obtained, the records may only be produced directly to the court. The judge will determine what further disclosure, if any, is required for the administration of justice.

If a provider that maintains mental health information and records does not fall within the purview of the LPS Act, the CMIA likely applies. CMIA applies to "providers of health care", "health care service plans", and "contractors", as those terms are defined in California Civil Code Section 56.05. The CMIA protects "medical information," which is defined to include "any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental or physical condition, or treatment."[5]

Under the CMIA, disclosure is required when compelled (1) by a party to a judicial or administrative proceeding pursuant to a subpoena, subpoena duces tecum, notice to appear served pursuant to California Code of Civil Procedure Section 1987, or other provision authorizing discovery; (2) by a board, commission or administrative agency pursuant to an investigative subpoena issued pursuant to California Government Code Section 11180 et seq.; or (3) by an arbitrator or arbitration panel pursuant to a subpoena duces tecum issued under California Code of Civil Procedure Section 1282.6 or other provision authorizing discovery. In contrast to the LPS Act, the CMIA not only permits disclosure in response to a subpoena, it requires it if it is "compelled," meaning no other reason exists to object to disclosure under federal or state law. However, as noted further in Section II.B below, certain procedural protections must be implemented prior to disclosure pursuant to a subpoena, as required by California Code of Civil Procedure Section 1985.3 (Section 1985.3).

II. Other Considerations

A. Federal Law and Preemption Issues

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits disclosure of a patient's protected health information[6] as required by law, including in response to subpoenas in administrative and judicial proceedings.[7] However, at least one of two additional requirements must be met. First, the requesting party must provide satisfactory assurances to the custodian of records that it made reasonable efforts to ensure the patient has been given notice of the request and an opportunity to object. Satisfactory assurances require a written statement and accompanying documentation, evidencing efforts to provide notice. Or, second, the party seeking the information must provide satisfactory assurances to the custodian of records that the subpoenaing party made reasonable efforts to secure a qualified protective order. A qualified protective order means a court order or a stipulation that limits the use of the records to the instant litigation, and requires the return or destruction of the records after the proceedings have ended. California's notice requirements under Section 1985.3 are considered to meet the requirements for satisfactory assurance.

The provisions addressing disclosure in response to subpoenas therefore varies as between HIPAA and both the CMIA and the LPS Act, and a preemption analysis is required. Generally, a standard or requirement under HIPAA preempts contrary state law, unless an exception applies. One such exception is where a state law provision addressing patient privacy is "more stringent," meaning the state law is more protective of patient privacy.

1. LPS Act – Preemption Analysis

HIPAA permits disclosure in response to a subpoena as long as the requesting party gives the required satisfactory assurances that it made reasonable efforts to notify the patient or obtain a qualified protective order. The LPS Act is stricter – it does not permit disclosure of mental health information or records in response to a subpoena under any

circumstance, unless accompanied by a court order. Because the LPS Act is more protective of privacy rights, and is "more stringent" than HIPAA, it is not preempted. Therefore, where the records sought are subject to both HIPAA and the LPS Act, a provider may not disclose records in response to a subpoena without a court order.

2. CMIA – Preemption Analysis

In contrast, the CMIA is less protective of patient privacy than HIPAA with respect to responding to subpoenas. Although both HIPAA and the CMIA permit disclosure of a patient's information in response to a subpoena, the CMIA does not contain additional procedural steps, such as requiring notice to the patient or a qualified protective order. However, other provisions of California law impose additional requirements in certain circumstances. In particular, Section 1985.3, which applies to civil proceedings, requires notice to patients where personal records are sought (see form SUBP-025, "Notice To Consumer or Employee And Objection"). Because Section 1985.3 requires consumer notice, and HIPAA provides the option of either patient notice or a protective order, Section 1985.3 is more protective of patient privacy, and a provider that receives a subpoena without a court order in a civil action must ensure that the procedure set forth in Section 1985.3 is followed.

B. Other Considerations

Aside from determining the threshold question of the applicable privacy provisions, a number of other issues should be evaluated to determine how to respond to a subpoena for mental health records. Comprehensive analysis of these issues falls outside the purview of this article. However, some of the key issues that may require objection to disclosure pursuant to a subpoena are referenced below.

First, the psychotherapist-patient privilege, codified in California Evidence Code §§ 1010, et seq., protects confidential communications between a psychotherapist and a patient. Unless a statutory exception applies, the psychotherapist must assert the privilege on behalf of the patient, and production of records containing privileged information is not permitted.

Second, the recipient of a subpoena must determine if the subpoena is valid prior to disclosure. State and federal laws establish different requirements for executing and serving subpoenas, depending on whether they are issued in criminal or civil judicial proceedings. In particular, for California civil proceedings, Section 1985.3 requires notice to be provided to a patient that his or her records are being sought in a state civil proceeding.

In addition, the California Constitution establishes general privacy rights that may also apply. For example, Article I, section 28(b)(4) of the California Constitution permits the victim of an alleged crime to prevent the disclosure of all healthcare records to the defendant and anyone acting on the defendant's behalf. As another example, in *People v. Hammon*, 15 Cal. 4th 1117 (1997), the California Supreme Court held that even the constitutional rights of the accused does not permit an unnecessary invasion of the patient's rights of privacy with respect to pretrial disclosure of information protected by the psychotherapist-patient privilege.

Depending on the circumstances, other potential issues should be considered, particularly with respect to a minor's mental health information or records. For example, under certain situations a minor's health information may not be disclosed to the minor's parent or legal guardian, and objection to a subpoena on such grounds may be warranted.[9]

III. Conclusion

This summary provides guideposts to help assess whether a recipient of a subpoena for mental health information or records is subject to either the LPS Act or the CMIA, as the threshold question to address where a patient has not authorized disclosure. This question is key because if the LPS Act applies, the provider may not disclose any information or records in response to the subpoena without a court order. However, if the CMIA applies, more analysis is required, including whether other grounds exist to permit or require objection to disclosure, such as the need to assert privilege or challenge the validity of the subpoena. When in doubt, advocacy in favor of patient privacy is the best policy.

For more information, please contact Linda Kollar, Devin Senelick or Amy Joseph in Los Angeles at (310) 551-8111, or Stanton Stock in San Diego, at (619) 744-7300.

---

[1] Navigating the complex web of federal and state privacy laws includes a number of considerations that are outside the purview of this article, and a fact-specific analysis is required to make a determination as to how best to respond to a subpoena, including the available objections under various circumstances. Importantly, this summary does not provide a comprehensive analysis of privacy laws, and it does not cover all types of subpoenas, such as those issued for depositions or in the context of administrative or juvenile court proceedings. Moreover, this article does not discuss motion practice or the procedures for objecting to a subpoena. In some circumstances, providers of mental health services may also be subject to the federal substance abuse regulations, 42 C.F.R. Part 2, depending on the scope of services provided to clients. 42 C.F.R. Part 2 imposes a separate set of restrictions on disclosure which would also need to be considered.

[2] See Cal. Welf. & Inst. Code §§ 5150 et seq.

[3] See Cal. Welf. & Inst. Code § 5328 for a comprehensive list of the types of facilities subject to the LPS Act.

[4] Cal. Welf. & Inst. Code § 5328(f).

[5] Cal. Civ. Code § 56.05(j).

[6] See 45 C.F.R. § 160.103 (defining protected health information).

[7] 45 C.F.R. § 164.512(a), (e)(1)(ii).

[8] 45 C.F.R. §§ 160.202 & 160.203.

[9] See, e.g., Health & Safety Code § 123115(a) (therapist believes disclosure to a parent may be detrimental to the minor's physical safety or psychological well-being).

CALENDAR

February 11	**LACBA Presents A Conversation on 1206(l) Medical Foundations, Los Angeles, CA** Charles Oppenheim moderated and Jennifer Hansen participated on the panel.
February 19	**CHA Rural Hospital Symposium , Redondo Beach, CA** Steve Lipton presented ***Managing Challenging Patients in the ED***
February 25	**Quality of Care Foundation/CAHF Director of Nursing Conference, Newport Beach, CA** Mark Johnson participated on the Partners in Safety panel.
February 24-25	**AHLA LTC & The Law Conference, New Orleans** Mark Reagan co-presented ***Post-Acute Providers and Understanding The Focus on Quality from a Managed Care Plan Perspective.***
March 5	**LTC Risk Legal Forum Summit 2015, Las Vegas** ***James Segroves presents Alternative Dispute Resolution Best Practices.***
March 13	**Health Care Roundtable – Chief Compliance Officers, Scottsdale, AZ** Steve Lipton presents ***EMTALA Update.***
March 24	**The 6th Annual LACBA-LACMA, LACBA Healthcare Law and Medicine Educational Symposium, Los Angeles. Glenn Solomon co-presents *Out of Network Reimbursement.***
March 26-27	**AHLA Institute on Medicare and Medicaid Payment Issues, Baltimore** Robert Roth is Program Chair and co-presents ***Hot Topics in Overpayments and Stark Self-Disclosure;*** John Hellow co-presents ***Hospital Inpatient IPPS Update; Lloyd Bookman presents Medicaid Litigation Update.***
March 31	**Medtrade Spring Convention, Las Vegas** Felicia Sze presents ***Managed Care Contracting: Cutting Through the Legalese and Managing the Managed Care Relationship: Enforcing Your Contracts with Plans.***
March 25	**AHLA Webinar: ACO Credentialing and Peer Review: Essential Tools for Effective Clinical Integration** Jennifer Hansen Co-presents.
April 15	**HFMA San Diego Seminar on Improving the Payer & Provider Relationship, including Payer Panel. Jennifer Hansen and Peter Brachman co-present prior to a payor panel on *Working Collaboratively with Payors to Resolve Disputes.***
April 19	**CSHA Annual Meeting & Spring Seminar, Huntington Beach** **Charles Oppenheim and Ben Durie present *Recent Developments and Practical Tips or Stark Self Disclosure.***
April 28, 30	**Hooper, Lundy & Bookman, PC Presents 2015 Provider Managed Care Update: Post-ACA Changes to Government and Private Managed Care Markets, Oakland-4/28; Los Angeles-4/30** ***Details and Registration Information Coming Soon.***
May 8	**SCARHM 35th Annual Educational Conference, Rancho Mirage** Steve Lipton and Nina Adatia Marsden present ***Legislative/Regulatory Update.***
May 20, 21	**44th Annual CAMMS Educational Forum, Universal City, CA** Jennifer Hansen and Katherine Dru present ***Privileging for New or Novel Procedures or Treatments;*** Ross Campbell and Ruby Wood present ***Complying with Reporting Requirements, Responding to Subpoenas and Sharing Peer Review Information.***

CHA Announces New Edition of Hospital Compliance Manual

The California Hospital Association (CHA) has just released the 2015, 6th Edition of the California Hospital Compliance Manual.

New to the 2015 edition are detailed explanations of state law regarding hospital financial assistance policies required by SB 1276 and IRS regulations that impact not-for-profit hospitals released on Dec. 31, 2014.

CHA's compliance manual is the only publication written for hospital compliance officers that integrates California with federal law regarding high-risk compliance areas.

Written by Hooper, Lundy & Bookman, PC, attorneys and CHA, the manual focuses on key components of an effective compliance program. The manual features nearly 700 pages of content including 16 chapters, a model hospital compliance plan, numerous compliance forms and appendixes, and an index.

The Manual includes the following Chapters:

- Hospital Compliance Plans
- Governing Boards
- Federal and State False Claims Acts
- Submission of Accurate Claims Information
- Proper Cost Reporting Practices
- Physician Self-Referral Laws
- Federal and State Anti-Kickback Laws
- Financial Assistance Policies — NEW chapter includes federal regulations
- Issues for Tax-Exempt Hospitals
- Fundamentals of Hospital Licensing and Certification
- Screening for Excluded Providers and Suppliers
- Hospital Signage Requirements
- Patient Safety Organizations
- Other Laws
- Repayment and Self-Disclosure
- Responding to Government Audits and Investigations

To order the new manual or for more information, see www.calhospital.org/compliance.

HLB
HOOPER, LUNDY & BOOKMAN, PC
HEALTH CARE LAWYERS & ADVISORS
1875 Century Park East, Suite 1600
Los Angeles, California 90067-2799