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United States Court of Appeals
Tenth Circuit

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Christopher M. Wolpert
Clerk of Court

PUBLISH

UNITED STATES COURT OF APPEALS

FOR THE TENTH CIRCUIT

NEW MEXICO ONCOLOGY AND HEMATOLOGY CONSULTANTS, LTD.,

Plaintiff - Appellant/Cross-Appellee,

v.

PRESBYTERIAN HEALTHCARE SERVICES; PRESBYTERIAN NETWORK, INC.; PRESBYTERIAN HEALTH PLANS, INC.; PRESBYTERIAN INSURANCE, CO., INC.,

Defendants - Appellees/Cross-Appellants.

COMMUNITY ONCOLOGY ALLIANCE; AMERICAN MEDICAL ASSOCIATION; AMERICAN HOSPITAL ASSOCIATION,

Amici Curiae.

No. 19-2210 & 20-2024

Appeal from the United States District Court
for the District of New Mexico
(D.C. No. 1:12-CV-00526-MV-GBW)

George M. Sanders, Law Offices of George M. Sanders, Chicago, Illinois (Thomas Bacon, Law Offices of George M. Sanders, Chicago, Illinois, and Alice Lorenz, Lorenz

Law, Albuquerque, New Mexico, with him on the briefs), for Plaintiff - Appellant/Cross - Appellee.

Jeffrey A. LeVee, Jones Day, Los Angeles, California (Kelly M. Ozurovich, Jones Day, Los Angeles, California, Kate Wallace, Jones Day, Boston, Massachusetts, Edward Ricco, Charles K. Purcell and Bruce D. Hall, Rodey, Dickason, Sloan, Akin & Robb, P.A., Albuquerque, New Mexico, with him on the briefs), for Defendants - Appellees/Cross - Appellants.

Leonard A. Nelson and Kyle A. Palazzolo, American Medical Association, Chicago, Illinois, file an Amici Curiae brief for American Medical Association.

Jeremy A Rist, Blank Rome LLP, Philadelphia, Pennsylvania, filed an Amici Curiae brief for Community Oncology Alliance, Inc.

Douglas Ross and David Maas, Davis Wright Tremaine LLP, filed an Amici Curiae brief for American Hospital Association.

Before **MATHESON**, **KELLY**, and **EID**, Circuit Judges.

KELLY, Circuit Judge.

Plaintiff-Appellant New Mexico Oncology Hematology Consultants Ltd. (NMOHC) appeals from the district court's grant of summary judgment to Defendants-Appellees Presbyterian Healthcare Services (PHS), Presbyterian Network, Inc., Presbyterian Insurance Co., and Presbyterian Health Plans, Inc. (PHP) (collectively, Defendants) on NMOHC's Sherman Act, Section 2, monopolization and attempted monopolization claims. N.M. Oncology v. Presbyterian Healthcare Servs., 418 F. Supp. 3d 826 (D.N.M. 2019). Exercising jurisdiction under 28 U.S.C. § 1291, we affirm.

Background

NMOHC is a physician practice that owns and operates the New Mexico Cancer Center (NMCC) in Albuquerque. PHS is a not-for-profit integrated healthcare system that participates in multiple markets, including the private health insurance market, the oncology market, and the inpatient hospital services market. PHS employs many physicians, who are referred to collectively as the Presbyterian Medical Group (PMG). PHS also controls PHP which operates, on a for-profit basis, and sells health insurance products, including commercial health insurance to employers and individuals, Medicare Advantage plans to seniors, and Medicaid plans. NMOHC is an in-network provider for PHP.

The NMCC opened in 2002 and NMOHC and PHP entered into a five-year provider agreement. At the expiration of the five-year term, the agreement would move into evergreen status and renew on an annual basis if PHP and NMOHC did not enter into a new agreement. In 2007, PHS opened its own oncology program and began to compete with NMOHC. Around the same time, NMOHC and PHP began negotiating a new provider agreement, however, the negotiations stalled as PHP demanded a $3 million reduction in PHP's payments. NMOHC and PHP remain under the terms of the original provider agreement.

NMOHC's claims on appeal center around three alleged anticompetitive practices that PHS implemented: (1) the "Mandate;" (2) an alleged joint venture between PHP and Radiology Associates of Albuquerque (RAA); and (3) PHS's

policies concerning physician referrals.[1] The Mandate was a benefit change that PHP implemented on its Medicare Advantage plans. Pursuant to the Mandate, PHP would cover certain chemotherapy support drugs covered under Medicare Part B — drugs administered to address side effects from chemotherapy agents, such as nausea — only if they were purchased from the Presbyterian Specialty Care Pharmacy. To administer the drugs at the NMCC, NMOHC would have to accept shipments of the drugs from the Presbyterian Pharmacy at the NMCC, a process NMOHC calls "white bagging," which it refused to do. NMOHC refused to accept these drugs on the grounds that its doctors did not know the sources of the medication, did not know if the Presbyterian pharmacy was appropriately handling the drugs, and did not know the timing of when the Presbyterian pharmacy would make any shipment.

NMOHC also alleges that a joint venture between RAA and PHP existed in which PHP enrollees needing breast imaging services were forced to use RAA under their PHP plan. RAA shared office space with PHS-employed breast surgeons and nurse navigators. NMOHC alleges that once a PHP patient was diagnosed with breast cancer, RAA would refer the patient to a PHS breast surgeon and a nurse-navigator would then schedule an appointment for the patient with a PHS oncologist

[1] NMOHC also asserted below: (1) that in its negotiations for a new provider agreement with PHP, PHP attempted to lower reimbursement rates below competitive levels in an attempt to eliminate NMOHC from the oncology market; and (2) that PHP and United Healthcare colluded to constrain competition in the private health insurance market. N.M. Oncology, 418 F. Supp. 3d at 841. NMOHC briefly mentions this conduct in its facts section but does not sufficiently raise it on appeal as anticompetitive conduct, thereby waiving any argument on this ground. See Exum v. U.S. Olympic Comm., 389 F.3d 1130, 1133 n.4 (10th Cir. 2004).

without consulting the patient's physician. Separately, the enhanced referral management program was a PHS program to track PMG physician referrals and encourage internal referrals.

NMOHC filed suit against Defendants in 2012. In its Third Amended Complaint (TAC), it asserted claims under Section 2 of the Sherman Act for monopolization and attempted monopolization. NMOHC also asserted a parallel claim under New Mexico antitrust law,[2] a RICO claim, and other non-antitrust state law claims. Defendants moved to dismiss NMOHC's Second Amended Complaint at the time under Rule 12(b)(6), but the district court denied the motion. However, the district court has dismissed NMOHC's RICO claim and claim for monopolization of the inpatient hospital services market. See N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs., 169 F. Supp. 3d 1204 (D.N.M. 2016); N.M. Oncology & Hematology Consultants, Ltd. v. Presbyterian Healthcare Servs., 54 F. Supp. 3d 1189 (D.N.M. 2014). NMOHC has not appealed either ruling.

In March 2017, Defendants moved for summary judgment on the remaining claims, which the district court granted. N.M. Oncology, 418 F. Supp. 3d at 866. The district court examined whether Defendants possessed monopoly power as regards the monopolization claim or whether there was a dangerous probability of achieving monopoly power insofar as attempted monopolization. It concluded that

[2] In evaluating New Mexico Antitrust Act claims, the court generally follows authority interpreting claims under Section 2 of the Sherman Act. N.M. Stat. Ann. § 57-1-15.

genuine issues of fact might exist. Id. at 840, 859. But it determined that NMOHC had failed to establish that Defendants engaged in exclusionary conduct. Id. at 841, 860. NMOHC failed to establish that any of Defendants' unilateral conduct constituted anticompetitive conduct under the Sherman Act. Id. at 847–48. The district court considered the conduct alleged as a "refusal to deal" but none of that conduct demonstrated the requisite willingness to forgo short-term profits for an anticompetitive end. Id. at 850, 854–55, 866. After dismissing the Sherman Act claims, the district court declined to exercise jurisdiction over the remaining state law claims. Id. at 866.

On appeal, NMOHC argues the district court (1) disregarded the testimony of its experts, (2) failed to consider all of the evidence or draw inferences in favor of NMOHC as the non-movant, (3) made factual findings on disputed issues of fact, and (4) made its own market share calculations and ignored Defendants' monopoly power over Medicare Advantage plans, as well as the consumer harm caused by the Mandate and Defendants' referral practices. NMOHC argues that it "never framed its antitrust theories as predatory bidding, too low or too high prices, the termination of its provider contract (because the provider contract was not terminated), nor a refusal to deal," yet the district court analyzed the case as if it had. This is belied by NMOHC's presentation which urges the court to combine various antitrust concepts (many of which were not raised directly below) and find sufficient evidence of antitrust violations.

Discussion

We review the district court's grant of summary judgment *de novo*. Chasteen v. UNISIA JECS Corp., 216 F.3d 1212, 1216 (10th Cir. 2000). Summary judgment is appropriate when "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). A fact is material if it can "have an impact on the outcome of the lawsuit" and genuine if "a rational jury could find in favor of the non-moving party based on the evidence presented." Chasteen, 216 F.3d at 1216. To survive a motion for summary judgment, the nonmoving party must show more than "[t]he mere existence of a scintilla of evidence in support of the [nonmoving party's] position . . . there must be evidence on which the jury could reasonably find for the [nonmoving party]." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 252 (1986). We may also presume that businesses act rationally when we evaluate their conduct. See Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 595 (1986).

The district court did not err in holding that NMOHC had failed to establish a Sherman Act claim under Section 2 because NMOHC failed to establish that Defendants had engaged in exclusionary or anticompetitive conduct.

> The elements of a § 2 monopolization claim are (1) monopoly power in the relevant market; (2) willful acquisition or maintenance of this power through exclusionary conduct; and (3) harm to competition. And the elements of a § 2 attempted monopolization claim are (1) predatory or anticompetitive conduct, (2) a specific intent to monopolize, and (3) a dangerous probability of achieving monopoly power.

Lenox MacLaren Surgical Corp. v. Medtronic, Inc., 847 F.3d 1221, 1231 (10th Cir. 2017) (citation omitted). While monopolization and attempted monopolization claims are distinct, there is sufficient overlap that anticompetitive conduct under either claim can be evaluated together. See Four Corners Nephrology Assocs., P.C. v. Mercy Med. Ctr. of Durango, 582 F.3d 1216, 1222 (10th Cir. 2009).

Anticompetitive conduct comes in too many forms to permit a "comprehensive taxonomy," however, over time the inquiry of what is anticompetitive conduct has been defined into several common forms of conduct. Novell, Inc. v. Microsoft Corp., 731 F.3d 1064, 1072 (10th Cir. 2013). Generally, unilateral conduct cannot be considered anticompetitive, but "liability can sometimes be assigned" based on unilateral conduct. Id. at 1072–74. These exceptions include such conduct as a refusal to deal. Id. at 1074. To establish a refusal to deal claim, the plaintiff must establish: (1) that there was a "preexisting voluntary and presumably profitable course of dealing between the monopolist and rival;" and (2) that "the monopolist's discontinuation of the preexisting course of dealing must suggest[ ] a willingness to forsake short-term profits to achieve an anti-competitive end." Id. at 1074–75 (citation omitted).

None of the conduct that NMOHC asserts was anticompetitive constituted a refusal to deal. First and foremost, none of the conduct demonstrated a willingness to "forsake short-term profits to achieve an anti-competitive end." Id. at 1075 (citation omitted). PHP implemented the Mandate on the grounds that it could obtain the same drugs at a discounted rate under the federal 340B drug program through the

Presbyterian pharmacy. As we discuss below, NMOHC's claim lacks "significantly probative" evidence, Anderson, 477 U.S. at 249–50, tending to show otherwise. Further, NMOHC's allegations of anticompetitive referral practices, either by nurse navigators or by PMG physicians, would also not constitute a refusal to deal because referring patients internally would serve to increase revenues.

Second, none of the asserted conduct shows that Defendants ended a preexisting course of dealing with NMOHC. Defendants' practice of referring patients to NMOHC for treatment did not end, it only decreased. As for the Mandate, PHP did not have a course of dealing with NMOHC through its Medicare Advantage plans because those plans were sold by PHP to consumers.

NMOHC's allegation of a "joint venture" between RAA and PHS, that might bring NMOHC's conduct beyond unilateral conduct, also has no merit. Dr. Brian Potts, former President of RAA, testified that he was not aware of any agreements between RAA and Defendants concerning referrals. Dr. Potts also testified that any referrals that RAA made to surgeons were made based on a consultation with the referring physician. Indeed, NMOHC seemingly concedes this by referring to the joint venture as a "de facto joint venture." Further, the evidence that NMOHC relies upon for proof that there was a joint venture does not support its assertion. It first cites to its own response to Defendants' third set of interrogatories to assert that a joint venture existed and that there was a referral agreement between RAA and PHS. NMOHC also cites to the testimony of a nurse-navigator that it alleges shows that RAA would refer patients to PHS surgeons and oncologists. However, the nurse-

navigator never testified to any joint venture, only testifying that she interacted with patients after they had already been referred to a PHS surgeon through RAA.

NMOHC also claims that the Mandate, which it at times characterizes as an unlawful tying arrangement, but then denies it was relying on a tying claim, was implemented "as part of a leveraging strategy to drive NMOHC from the Outpatient Oncology Services market." However, NMOHC does not sufficiently define this argument in its opening brief nor does it address the district court's reasoning that such a leveraging claim cannot establish anticompetitive conduct under the Sherman Act. N.M. Oncology, 418 F. Supp. 3d at 850–51, 855. Such inadequately briefed arguments are waived. See Hernandez v. Starbuck, 69 F.3d 1089, 1093 (10th Cir. 1995).

Indeed, on the merits, such argument fails as well. NMOHC's argument regarding the Mandate could be interpreted as a "monopoly leveraging" claim, which is an effort to use "monopoly power in one market merely to achieve a competitive advantage in a second market" — here, the health insurance and outpatient oncology markets respectively. Four Corners, 582 F.3d at 1222. However, a monopoly leveraging claim does not demonstrate a violation of Sherman Act section 2, absent proof of some other anticompetitive conduct in the allegedly monopolized market. Id. Therefore, where a plaintiff has not established some other anticompetitive conduct, accusing the defendant of "'monopoly leveraging' won't do anything to save" the claim. Id. NMOHC has not established any other type of anticompetitive conduct so its argument of a "leveraging strategy" is unavailing.

NMOHC — and the American Medical Association (the AMA) as *amicus* — seemingly argues that that its claim should not be evaluated under defined categories of anticompetitive conduct, but instead through an *ad hoc* and fact-specific analysis. Indeed, as noted above, NMOHC asserts that its claims are not based on a theory of predatory bidding, a refusal to deal, or a tying claim. Rather, according to NMOHC, anticompetitive conduct can take a variety of forms and "[w]hether specific conduct is anticompetitive requires a fact-specific analysis."

However, while anticompetitive conduct does take many forms, courts have been able to adapt the general inquiry of what is anticompetitive conduct into particular circumstances, that has allowed the creation of specific rules for common forms of alleged misconduct. Novell, 731 F.3d at 1072. The difficulty with an *ad hoc* approach is that the line between anticompetitive conduct and aggressive competition "can be indistinguishable." Monsanto Co. v. Spray-Rite Serv. Corp., 465 U.S. 752, 762 (1984). Indeed, when it comes to enforcing unilateral anticompetitive conduct, there is a risk that over-enforcement could actually inhibit competition, "since it may lessen the incentive for the monopolist" to invest in their business. Verizon Commc'ns Inc. v. L. Offs. of Curtis V. Trinko, LLP, 540 U.S. 398, 407–08 (2004). Given this, the Supreme Court's narrowing of the type of unilateral conduct that can be anticompetitive strikes the appropriate balance between preventing anticompetitive behavior while also protecting competition itself by allowing firms to take actions to recoup their investments. See Four Corners, 582 F.3d at 1221–22.

Even looking at the substance of NMOHC's claims outside of the scope of a refusal to deal, Defendants' actions still do not appear to be anticompetitive. As to the claims concerning internal referrals, PHS was under no obligation to refer its patients to another practice or hospital. See id. at 1223. As for the Mandate, again, the Mandate affected a relationship that PHP had with its plan members, not NMOHC. Further, the Mandate was not anticompetitive because it was NMOHC's decision not to accept the drugs from Presbyterian's pharmacy that inflicted a hardship on its patients, not PHP's decision. While NMOHC may have had justifiable reasons for not accepting the drugs at its facility, other providers did accept the drugs, and NMOHC cannot frame its own decisions as another's anticompetitive conduct.

NMOHC also raises several other arguments, but all fail. NMOHC attempts to argue that Defendants' referral practices were similar to a "group boycott." However, NMOHC does not define this type of conduct and never made such a claim below, therefore waiving this argument on appeal. See United States v. Viera, 674 F.3d 1214, 1220 (10th Cir. 2012). NMOHC also argues that the referral practices were "akin to the coercive conduct against customers that the Supreme Court condemned in" Lorain Journal Co. v. United States, 342 U.S. 143 (1951). However, NMOHC does not sufficiently define this argument nor does it make any factual comparison of Lorain Journal to this case. Lorain Journal involved a newspaper that refused to sell advertising space to advertisers who advertised on a local radio station that the newspaper was intending to put out of business. 342 U.S. at 148. It is that

refusal to sell advertising space "*even if compensated at retail price*" that makes the conduct in Lorain Journal anticompetitive. See Verizon Commc'ns, 540 U.S. at 409. NMOHC does not make any equivalent allegations, let alone present such evidence, against Defendants.

NMOHC and the *amici* also argue that Defendants' referral programs were unethical and harmed patients. However, the Sherman Act does not incorporate professional ethical rules. See Nat'l Soc'y of Prof. Eng'rs v. United States, 435 U.S. 679, 696 (1978). Further, such a complaint would be better suited to professional regulatory bodies.

NMOHC argues that the district court erred because antitrust cases should generally not be resolved on summary judgment due to the fact intensive nature of the claims. However, while "summary judgment should be used sparingly in antitrust cases, the usual rules governing summary judgment still apply." Bell v. Fur Breeders Agric. Co-op., 348 F.3d 1224, 1229 (10th Cir. 2003) (citation omitted). Just as in any Rule 56 motion, NMOHC has the burden "to set forth specific facts showing that there is a genuine issue for trial." In re Rumsey Land Co., 944 F.3d 1259, 1270 (10th Cir. 2019) (citation omitted). NMOHC has not met this burden.

NMOHC also argues that the alleged cost for a referral to NMOHC is an internal transfer payment between PHS and PHP, which it asserts is not a real cost. However, NMOHC's own expert admitted that the amounts paid by PHP to NMOHC were a real cost and that PHS saved money by reducing outside referrals.

Finally, NMOHC argues that there was no evidence that PHS saved costs through the Mandate and that therefore there is a genuine dispute of material fact as to PHS' willingness to forsake short term profits that should have precluded summary judgment. It argues the Defendants could have lost money from the Mandate because the reimbursement rates PHP paid to NMOHC were lower than PHS' drug acquisition costs. However, even if NMOHC had significantly probative evidence on this issue — which, as discussed below, it did not — this dispute probably is immaterial. No evidence suggests that Defendants discontinued a preexisting course of dealing with NMOHC as regards the Mandate and therefore "the outcome of the suit" would not be affected. Stone v. Autoliv ASP, Inc., 210 F.3d 1132, 1136 (10th Cir. 2000) (citation omitted). As stated above, the Mandate affected a relationship between PHP and its members, not NMOHC.

NMOHC also lacks "significantly probative" evidence to support its assertion that Defendants did not save money because of the Mandate. Anderson, 477 U.S. at 249–50. According to PHP's Executive Director of Pharmacy Services, PHP paid lower costs for drugs through the Presbyterian pharmacy. NMOHC conceded that Presbyterian could "make additional profits from the sale of 340B drugs" than it would otherwise make selling drugs not purchased through the 340B program. NMOHC also asserts that the cost savings from the Mandate only represent "an internal transfer payment between PHS and PHP," but again, such transfer payments represent a real cost.

NMOHC cites to its Fifth Supplemental Response to Defendants' Third Set of Interrogatories to argue that the evidence on record suggests that PHS "actually could suffer losses as a result of the Mandate." NMOHC's assertion is that Defendants assumed that 70% of patients covered by the Mandate could receive 340B drugs, but that such assumption was overstated. NMOHC asserts that as a result, PHS lost money from the implementation of the Mandate because PHS' acquisition costs for the drugs exceeded the reimbursement it received from PHP for drugs PHS could not sell to patients under the 340B program. However, NMOHC must show that Defendants took actions that "suggest[ ] a willingness to forsake short-term profits," not merely that an implemented policy resulted in a loss after-the-fact. See Novell, 731 F.3d at 1074–75.

We conclude that NMOHC has failed to establish that Defendants had engaged in exclusionary or anticompetitive conduct, therefore, we do not address the question of monopoly power or antitrust injury. The district court did not abuse its discretion in declining to exercise jurisdiction over NMOHC's remaining state law claims after it dismissed the Sherman Act claims. See Brooks v. Gaenzle, 614 F.3d 1213, 1229 (10th Cir. 2010).

On appeal, the AMA, Community Oncology Alliance, Inc. (COA), and American Hospital Association (AHA) also move for leave to file briefs as *amicus curiae*. The parties oppose the respective motions on the grounds that the briefs rely on extra-record evidence and that they make arguments that are irrelevant to the issues on appeal. We provisionally granted leave for *amici* to file. Federal courts

have discretion in allowing participation as amicus curiae. See, e.g., Richardson v. Flores, 979 F.3d 1102, 1106 (5th Cir. 2020). Under Appellate Rule 29(b), a motion seeking leave to participate as *amicus* must, state the movant's interest, "why an amicus brief is desirable," and "why the matters asserted are relevant to the disposition of the case." See Fed. R. App. P. 29(b)(3). The *amici* have complied with this requirement and their briefing is relevant to the disposition of the case. The *amici* address whether this court should reconsider its antitrust jurisprudence in light of its impact on, *inter alia*, health care delivery systems and physician practices. They also provide more information about the Defendants' practices, including the implementation of the Mandate. Therefore, *amici* have an interest in this proceeding and brief matters relevant to the disposition of this case.

AFFIRMED. We also GRANT the American Medical Association, Community Oncology Alliance, Inc., and American Hospital Association leave to file as *amicus curiae*.