SUBMISSION OF ANTHEM HEALTH PLANS OF VIRGINIA, INC. (TRADES AS ANTHEM BLUE CROSS AND BLUE SHIELD IN VIRGINIA)

TO THE SOUTHWEST VIRGINIA HEALTH AUTHORITY

ON THE REVIEW OF THE COMMONWEALTH OF VIRGINIA APPLICATION FOR A LETTER AUTHORIZING COOPERATIVE AGREEMENT FROM WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE

September 30, 2016

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I. Introduction

This submission by Anthem Blue Cross and Blue Shield in Virginia ("Anthem") is to assist the Southwest Virginia Health Authority (the "SVHA") in its review of Mountain States Health Alliance ("Mountain States") and Wellmont Health System's ("Wellmont") Application for a Letter Authorizing Cooperative Agreement (the "Application").[1] If granted and actively supervised by the Virginia Commissioner of Health, this "Cooperative Agreement" would allow Mountain States and Wellmont to combine and effectively eliminate one another's sole source of competition in many locations and service lines in a way that would otherwise violate federal and state antitrust laws.

Anthem explained in its submission regarding the proposed regulations for the Cooperative Agreement Statute,[2] that there are numerous reasons why Cooperative Agreements are a poor substitute for competition. For these reasons, the SVHA should closely scrutinize such applications, including the one submitted by the Parties. Indeed, Federal Trade Commission (FTC) Chairwoman Edith Ramirez specifically highlighted the proposed merger of Wellmont and Mountain States in explaining that these types of arrangements run a high risk of "leading to increased healthcare costs and lower quality and decreased access to care."[3]

Chairwoman Ramirez identified at least five reasons why this is the case. She observed that these arrangements:

(1) **fail to replicate the benefits of competition**. Health care providers compete along a myriad of dimensions, including price, quality, access, the type of services offered, amenities, patient satisfaction and innovation. Regulation of a cooperative agreement -- no matter how extensive -- can never fully address all of these issues;

(2) **require "constant and active oversight**." Attempting to measure the many dimensions of competition in health care requires voluminous data and substantial expertise;

(3) **can be circumvented by the hospitals**. Even with sufficient resources, the regulations contemplated by the Cooperative Agreement often can be gamed;

(4) "**reduce incentives to lower costs or innovate**;" and

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[1] This Application is submitted pursuant to Section 15.2-5384.1 of the Code of Virginia (the "Cooperative Agreement Statute"), Virginia's Rules and Regulations Governing Cooperative Agreement (12VAC5-221-10 et seq.) (the "Cooperative Agreement Regulations").

[2] *See* Submission of Amerigroup Corporation to the Tennessee Department of Health on the Proposed Rules and Regulations Implementing Section 68-11-1301 – 68-11-1309 of the Code of Tennessee, Sep. 21, 2015, *available at* https://www.tn.gov/assets/entities/health/attachments/Amerigroup-COPA_Written_Comments.pdf.

[3] Edith Ramirez, Chairwoman, Fed. Trade Comm'n, Keynote Address at the Antitrust in Healthcare Conference, (May 12, 2016), https://www.ftc.gov/system/files/documents/public_statements/950143/160519antitrusthealthcarekeynote.pdf.

(5) **may not last, which can leave "payors and ultimately consumers vulnerable when they expire**." If the hospitals have merged operations under the arrangement, it can be especially difficult at some time later -- if not impossible -- to "unscramble the eggs" and return to the competitive environment which existed prior to the grant of antitrust immunity.

Another senior FTC official noted that the above risks and their potential to harm health care consumers exist in the context of cooperative agreements "no matter how rigorous or well-intentioned the regulatory scheme may be."[4]

While a number of states have laws similar to the Cooperative Agreement statute, very few health care combinations have been approved under such legislation, and the results of these arrangements so far have been mixed at best. Indeed, we are aware of only five states -- West Virginia, North Carolina, South Carolina, Montana, and Texas -- that have approved hospital mergers under state action immunity legislation and only three of those (West Virginia, South Carolina and North Carolina) have COPAs in effect to govern merged hospitals. We understand, however, that North Carolina has recently decided to repeal its certificate of public advantage statute.[5]

For these reasons, when considering whether to grant a Cooperative Agreement, state officials should rigorously assess whether the Parties have met their burden of demonstrating that the advantages of the Cooperative Agreement outweigh the disadvantages.[6] As these comments explain, Wellmont and MSHA have fallen far short of demonstrating that a Cooperative Agreement should be granted. Their application fails for several reasons:

- **Wellmont and Mountain States significantly understate the competitive risks from the combination by downplaying the extent to which they compete today.** Applying standard merger analysis accepted by the federal antitrust agencies and courts alike, it is clear that the combined system would be a "must-have" for health insurers purchasing provider services because insurers would not be able to put together a viable network without it. Mountain States and Wellmont are also each other's closest competitor -- estimates indicate that approximately three-quarters of Wellmont patients would go to a Mountain States facility if the Wellmont facility, which is their first choice, were no longer available, and nearly the same proportion of Mountain States patients would go to a Wellmont facility if the Mountain States facility, which is their first choice, were no longer available. Competition from other providers isn't nearly as extensive as the Application

[4] Letter from Marina Lao, Director, Office of Policy Planning, Fed. Trade Comm'n, to Susan Puglisi, Esq., Virginia Dep't of Health, Office of Licensure and Certification, (Sept. 17, 2015), at 3, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-virginia-department-health-regarding-virginias-rules-regulations-governing/151015virginiadoh.pdf.

[5] *See* 2015 N. C. Sess. Laws 288-SB-298 § 4 (repealing Article 1E of Chapter 90 of the General Statutes and Article 9A of Chapter 131E of the General Statute effective Jan. 1, 2018); *see also NC Dissolves Anti-Monopoly Rules on Mission Health*, CITIZEN TIMES, Sept. 30, 2015, *available at* http://www.citizen-times.com/story/news/2015/09/29/nc-dissolves-anti-monopoly-rules-mission-health/73042066/.

[6] *See* VA. ADMIN. CODE § 15.2-5384.1 E.1 (2015); TENN. CODE ANN. § 68-11-1303(e)(1) (2016) and TENN. COMP. R. & REGS. 1200-38-01-.05(1) (2015).

suggests. ***The bottom line is that, in 12 contiguous counties in southwest Virginia and northeast Tennessee, Wellmont and Mountain States are the only providers of general acute care inpatient hospital services*.**

- **The Parties have not demonstrated that their combination, along with all of its significant competitive risks, is the only option available to them.** There are clear alternatives available to Wellmont and Mountain States that would raise far fewer antitrust concerns, or none at all.

    - **Either system could partner with a health system from an adjacent region or elsewhere.** There are numerous examples of health systems from outside a region acquiring a local system and bolstering the competitiveness and investments in that local system while still allowing the local system and its leadership to retain important reserve powers. These examples demonstrate that while the Parties' emphasis on maintaining "local control" may make for a nice sound bite, it is misleading to suggest that the only way to retain "local control" is through the merging of closest competitors and, further, that local control is always the best way to ensure that community benefits from a combination of health systems.

    - **Wellmont and Mountain States can collaborate without merging and achieve many of the "efficiencies" they claim will be obtained by their combination.** The federal antitrust agencies have made clear that there are many ways that competing health systems can collaborate short of a merger that eliminates entirely the competition between them. The Parties have not adequately explained why activities short of a merger would be unable to achieve the same ends as the proposed merger.

- **The claimed benefits are illusory and unsubstantiated.** For many of the claimed benefits, the Parties provide only vague descriptions even after the Authority requested more specific answers. For some, the goal the Parties have set for themselves is no greater than what they are already achieving now, without a merger. For example, the Parties are committing to report performance on a variety of quality, access and service metrics. The Authority specifically asked the Parties what metrics they were committing to report on beyond those that they already report on.[7] The Parties do not commit to report on any additional metrics nor do the Parties propose what additional metrics should be used, other than agreeing to participate in the Commonwealth's effort to create a common system performance scorecard. Improving quality and access is a crucial claimed benefit of the Cooperative Agreement and should be addressed with specificity by the Parties. For other benefits, the parties do not explain why a collaboration without a merger could not have achieved the benefits. Absent such an explanation, the purported benefits should be discounted entirely.

[7] *See* Southwest Health Authority Supplemental Questions Submitted May 27, 2016 at Question 20c ("SWHA Supplemental Questions").

- **The Parties' "Commitments" will not assure that the Cooperative Agreement will result in the claimed benefits.**

  - **The "Overall Achievement Scoring" system proposed by the Parties is simply a commitment to report rather than to achieve outcomes; it fails to protect consumers because it would allow the Parties to pick and choose on which commitments they will actually follow-through**. Tables 15.8 – 15.11 in the Application describe quantitative measures to evaluate the Cooperative Agreement's continuing benefit. The Accountability mechanism for each commitment is an annual report -- a report and nothing more. Committing to report on undetermined accountability standards is wholly insufficient to prove that the proposed benefits from the Application outweigh the potential disadvantages.

    Moreover, the scoring system itself is flawed because weighting each category equally does not account for the vast differences in the impact on patients and the community from non-compliance. For example, the commitment to combine the "best of both organizations' career development programs" does not carry the same importance to patients and the community as the commitment to maintain three full-service tertiary hospitals. Mountain States and Wellmont could choose not to comply with a single commitment in two key categories, "Commitment to Improve Community Health" and "Expanding Access and Choice," and yet still receive a "passing" score. Certain commitments that are designed to address the greatest potential for competitive harm -- particularly with respect to rate increases and access – should, at a minimum, be mandatory in order to obtain a "passing" score.

  - **The proposed rate commitment actually could result in *higher* health care spending over time and fails to protect consumers from potential price increases.** The Parties propose that the New Health System will not increase hospital rates more than the hospital Consumer Price Index ("CPI") (notably, without proposing which CPI should be used) minus 0.25%, and physician and outpatient rates by more than the medical care CPI index minus 0.25%. This cap fails to account for the fact that payors' negotiated rate increases to hospitals in this region could be lower than the CPI index minus 0.25%. For example, using the 2015 CPI index for Medical Care in the South region for Class D and the Parties' proposed rate commitment, the New Health System would see a rate increase of 3.25%.[8] During the last negotiated contract with Anthem, Wellmont received a rate increase of 1.8% and MSHA received an overall increase of 2.5%. Both increases are *lower* than what the Parties are proposing. On the physician side, commercial rates may also increase less than the Medical Care CPI index minus 0.25%. For example, Medicare rates to physicians, who are used by many commercial health plans in establishing their payment rates to physicians, actually

[8] *See* Bureau of Labor Statistics, U.S. Department of Labor, Consumer Price Index, All Urban Consumers, South Class Size D, Medical Care, 2011-2016, [last visited Sept. 21, 2016] [www.bls.gov/oes/]. Based on this, a price adjustment escalation would be 3.5%.

declined from 2015-2016.[9] **As a result, the proposed rate cap could in effect function as a price floor rather than a ceiling and result in higher health care spend over time.** The Parties also fail to address how this rate cap will work with value-based payment models or risk-based contracts, which they simultaneously commit to participate in.

- **The proposed quality commitments are little more than commitments to report on undetermined metrics and fail to ensure sustainable and measurable improvements in health care quality for constituents of southwest Virginia.** Many of the purported "commitments" are little more than promises to make public more quickly data that the Parties are already required to track and report, in many cases publicly. Other commitments are too vague to assess their value at all. For example, the Parties commit to report quality measures for the top 10 DRGs aggregated across the system annually. The value of this exercise depends significantly on which DRGs are reflected in this reporting and what is meant by "quality measures" -- none of which is clear from the Application. Moreover, aggregating the data across the entire system will seriously reduce its usefulness to consumers who wish to determine the quality of a particular facility they may use.

- **The service commitments are incomplete and lack any details regarding specific plans, timelines or the costs to achieve them.** For Virginia in particular, the Parties fail to provide details regarding a number of important service level commitments such as reopening Lee Regional Medical Center.

- **The physician commitments fail to take into account that for a number of important specialties, such as cardiovascular, pulmonology and oncology, the Parties have a high combined market share.** The Parties should be required to provide more analysis and information with respect to the potential competitive harm involving this increased concentration across physician specialties.

The decision to grant the Parties' Application for a Cooperative Agreement is a "big decision for this region," as noted by the Tennessee Health Commissioner John Dreyzehner.[10] And it will be one that is difficult to reverse. Not only does the Commonwealth have to determine if the proposed benefits outweigh the potential disadvantages -- based upon vague and incomplete information -- but the Commonwealth must also ensure a robust oversight system is put in place to actively oversee the Cooperative Agreement during its entire existence. The Parties have not demonstrated how such a system that would provide the requisite supervision could be implemented.

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[9] *See* March 2016 MedPac Report to Congress: Medicare Payment Policy, at 95, *available at* http://www.medpac.gov/docs/default-source/reports/chapter-4-physician-and-other-health-professional-services-march-2016-report-.pdf?sfvrsn=0.

[10] Hank Hayes, *Public Hearing Speakers Tell THD: Get the Wellmont-MSHA Merger Done*. KINGSTON TIMES NEWS Sept. 1, 2016, *available at* http://www.timesnews.net/Business/2016/09/01/Public-hearing-speakers-tell-TDH-Get-the-Wellmont-MSHA-merger-done.

In summary, the Parties have failed to meet their burden of showing how the advantages of their Cooperative Agreement outweigh the disadvantages. The Application should be denied.

This submission is organized as follows. Section II describes how the Parties have significantly understated the risks to competition from the proposed Cooperative Agreement. Section III addresses the purported benefits identified by the Parties and explains that they are both illusory and unsubstantiated. Section IV illustrates why the so-called "commitments" offered by the Parties will not sufficiently protect against the competitive harm that will be caused as a result of the Cooperative Agreement.

II. The Parties Understate the Loss of Competition From the Merger

Despite the Parties' attempt to understate the potential risks to consumers posed by the proposed merger, their Application at its core asks the Commissioner to approve a ***merger to monopoly*** that poses obvious and grave disadvantages to consumers. As explained more fully below, this is clearly a merger to monopoly because:

- **The parties would be a must-have hospital system with a 90+% market share in the Parties' 75% and 90% service areas;**

- **In twelve counties in southwest Virginia and northeast Tennessee the Parties are the only providers of hospital inpatient services; and**

- **The hospital systems are clearly the closest substitutes for each other, offering -- in the Parties own words—"essentially equivalent levels of services."**[11]

Under the statute, the Commissioner must closely evaluate when considering the potential disadvantages of the merger several possible adverse competitive effects, including the following:

- adverse impact on the ability of payers to negotiate reasonable payment and service arrangements with providers;

- reduction in competition among providers;

- adverse impact on patients in the quality, availability, and price of health care services; and

- availability of alternative arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages.[12]

In the Application, the Parties wholly dismiss even the possibility of harm to competition from the merger, asserting that they "do not foresee ***any*** adverse impacts on population health, quality,

[11] VA Application at 23.
[12] VA. R. & Regs. Governing Cooperative Agreements, 12VAC5-221-80-G.2(a)-(d) (2016).

access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement."[13] *In fact, the potential disadvantages to health care consumers associated with the combination are both obvious and grave*.

As indicated by the Parties' own revised market share analysis, they account for 92.1% and 98.5% share of total hospital discharges in the New Health System's 90% and 75% service area respectively.[14] An economic analysis of the Parties' 90% draw areas (consisting of 127 zip codes) for Anthem VA and BlueCross BlueShield of Tennessee patients alone reveals that the combined firm would have a 77% market share and would be a "'must have' hospital system, in that it would be impossible for a payor to put together a marketable provider network in the draw area that did not include the merged hospital."[15] The combined share of the Parties under this analysis climbs to as high as 95.9% when analyzed by county.[16] Even without computing market shares, though, it is obvious that the Parties will essentially have a monopoly over inpatient hospital services because **in twelve counties the Parties are the <u>only</u> providers of hospital inpatient services**.

As explained by the FTC in its letter to the Virginia Department of Health, "[s]ettled antitrust jurisprudence establishes…that a proposed merger that would result in a monopoly or near-monopoly is likely to raise serious antitrust concerns."[17] Indeed, under the Horizontal Merger Guidelines issued by the U.S. Department of Justice ("DOJ") and the FTC, a merger resulting in such an increase in concentration in an already concentrated market like this one is presumed to enhance market power.[18]

This presumption of enhanced market power—as defined by the antitrust enforcement agencies—is determined based on a calculation of the Herfindahl-Hirschmann Index ("HHI") to determine both how concentrated the market is pre-transaction and how a proposed merger would impact the level of concentration in that market.[19] Markets with a HHI score of greater than 2500 are considered to be "highly concentrated" and "[m]ergers resulting in highly concentrated markets that involve an increase in the HHI of more than 200 points will be presumed to be likely to enhance market power."[20] In this case, one economic analysis estimates that the pre-merger and post-merger HHIs are 3,436 and 5,987 respectively.[21] This is well above the HHI threshold for "highly concentrated markets" and the change in HHIs is also well above the level indicating a presumption of enhanced market power.

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[13] VA Application at 10 (emphasis added).
[14] *See* VA Supplemental Response at Exhibit 12A and 12B.
[15] Michael Doane and Luke Froeb, Competition Economics LLC, *An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance* (Jan. 2015), at 10.
[16] *Id.* at Table 3 (see Unicoi County).
[17] Letter from Marina Lao, Director, Office of Policy Planning, Fed. Trade Comm'n to Susan Puglisi, Esq., Virginia Dep't of Health, Office of Licensure and Certification, (Sept. 17, 2015), at 2, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-virginia-department-health-regarding-virginias-rules-regulations-governing/151015virginiadoh.pdf.
[18] Horizontal Merger Guidelines at § 10.
[19] Horizontal Merger Guidelines at § 5.3
[20] *Id.*
[21] Doane and Froeb at 10 and Table 3.

No countervailing factors exist to resolve these concerns. The Parties' prior dealings demonstrate they are each other's **closest competitor** and are **close substitutes for each other**. The Parties state in their Application that they "offer essentially equivalent levels of services in their respective tertiary and secondary hospital facilities."[22] As the FTC recently noted in its comments opposing a Certificate of Public Advantage Application in West Virginia, historic activity between the Parties -- numerous competitive encounters -- is also "indicative of the close competition that exists between [the parties], and preview[s] the competitive harm that will occur if the proposed cooperative agreement is approved."[23] Here, for example, the Parties historically have challenged -- on multiple occasions -- each other's' certificate of need applications when attempting to open and/or acquire another hospital.[24] There is no question that this merger – if allowed to proceed -- will essentially eliminate hospital competition in a large portion of Virginia and Tennessee on both price and quality dimensions.

Standard antitrust merger analysis supports this. Diversion analysis -- an estimate of the share of inpatients that a hospital would lose to competing hospitals if a hospital were no longer available as an option to patients -- is a tool commonly used to assess the likely competitive effects of a proposed hospital merger. Despite the fact that the Parties point to 14 alternative acute care hospitals in their 90% draw areas, these facilities are generally small or more distant entities with little competitive significance. Thus, the diversion analysis of one economic study reveals that:

- If Wellmont hospitals were to be unavailable, the top five hospitals that patients would choose as alternatives are all Mountain States facilities. Combined, these diversion ratios account for 70% of the diversion from Wellmont. Overall, the diversion from Wellmont to Mountain States is 75%;[25] and

- Similarly, the overall diversion from Mountain States to Wellmont facilities is 72% and the two largest diversion ratios from Mountain States are Wellmont hospitals that account for 66% of the diversion from Mountain States.[26]

This significant combined competitive presence (and resulting market power) of the Parties is likely to have a very real impact on the price, quality, and availability of health care following the combination. One economic analysis predicts that under any scenario, this merger will result in a large price increase, reflecting the fact that it will "be difficult for payers to turn to a desirable alternative hospital network that excluded the two merging hospital systems."[27]

Moreover, competition from the entry of new hospitals into the market will not likely occur. The Parties concede that there is only one entity that is even considering entering the geographic

[22] VA Application at 23.
[23] Fed. Trade Comm'n Comments to Cabell-Huntington at 37.
[24] VA Application at 24.
[25] Doane and Froeb at 14.
[26] Doane and Froeb at 14-15.
[27] Doane and Froeb at 18. The analysis predicts a potential price increase in Virginia in the range of 20 – 130%. The wide range is based on the price elasticity used to calculate the potential increase. No matter what elasticity is used, however, this merger will result in a price increase.

service area. The Application states that Lee County Hospital Authority "has plans to open an acute care hospital" where the former Lee Regional Medical Center was once located.[28] The only other potential entrant is SBH-Kingsport, LLC, which is making efforts to operate an in-patient behavioral health center in Kingsport, Tennessee. Even if it is assumed that Lee County Hospital Authority is ultimately successful with its efforts to open an acute care facility (which is uncertain at best, and the Parties offer no details to suggest otherwise), this entry would be insufficient to resolve the significant competitive issues described above. With respect to SBH-Kingsport, LLC, a behavioral health center would not be a substitute for the general acute care hospital services provided by the Parties and therefore is irrelevant to the competitive analysis.

In short, this merger poses serious risks to competition and the healthcare community in southwest Virginia and northeast Tennessee. As discussed more fully in the next section, given the vague and unsubstantiated benefits identified by the Parties, notwithstanding their proposed "Commitments," it is clear that the disadvantages would outweigh the potential benefits.

III. The Benefits Identified By the Parties Are Illusory and Unsubstantiated

Under the Cooperative Agreement statute and implementing regulations, the potential disadvantages from the proposed merger are to be weighed against its potential benefits, which could include the following:

- enhancement in quality of care and population health status;
- preservation of hospital facilities to ensure access to care;
- gains in cost-efficiency of hospital services provided;
- improvements in utilization of hospital resources and equipment;
- avoidance of duplication of hospital resources;
- participation in the state Medicaid program; and
- reduction in total cost of care.[29]

"In order to [balance] procompetitive considerations like these against the likely substantial competitive harm from the proposed merger detailed above, the Commissioner should only take into account those benefits that are merger-specific."[30] This is because the Cooperative Agreement

[28] VA Application at 67.

[29] VA. R. & Regs. Governing Cooperative Agreements, 12VAC5-221-80-G.1.(a)-(h) (2016).

[30] VA. ADMIN. CODE § 15.2-5384.1E and F (2015). The Authority shall recommend approval and the Commissioner shall approve the COPA Application if "it determines that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement."

statute states that the Commissioner "must evaluate the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition."[31] Therefore, pursuant to the statute, to the extent any potential benefits could be achieved without the merger they should *not* be given weight.

This analysis is identical to the approach taken by the federal antitrust authorities when they review a merger under the Merger Guidelines.[32] It seeks to ensure that the efficiencies from a transaction are "of a character and magnitude such that the merger is not likely to be anticompetitive in any relevant market."[33] "The greater the likelihood of harm from a proposed merger, the more credible and substantial any claimed benefits must be to conclude that the benefits outweigh the harms."[34]

This analysis requires not only detailed information about what the Parties will be capable of doing and intend to do post-transaction, but also what they are capable of doing today, both on an independent basis and in collaborations with their merging partner that fall short of a full combination. Most of the purported benefits identified in the Application relate to additional investments the Parties say they will be able to make as a result of the savings they will achieve through the combination. However, while the Parties use soaring language to describe the investments they intend to make post-combination, they wholly fail to provide sufficient information regarding what they are already doing today that would allow the Commissioner to assess the extent to which the merger is *necessary* to enable these promised investments.

The Application states that the merger is motivated in large part by "[t]he important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with the continued downward pressure on reimbursement from government and commercial payers…"[35] The Application goes on to assert that "[t]he significant ongoing duplication of services and costs cannot be avoided without a consolidation" and that "[f]unding the population health, access to care, enhanced services, and commitments…would be impossible without the efficiencies and savings created by the merger."[36]

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[31] *Id*. at § 15.25384.1 E.3(d).

[32] *See* Letter from Marina Lao, Director, Office of Policy Planning, Fed. Trade Comm'n, to Susan Puglisi, Esq., Virginia Dep't of Health, Office of Licensure and Certification, (Sept. 17, 2015) at 2, https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-virginia-department-health-regarding-virginias-rules-regulations-governing/151015virginiadoh.pdf (citing the Horizontal Merger Guidelines § 10 and stating that only merger-specific benefits should be considered -- or those that are "only likely to be achieved as a result of the merger and unlikely to be achieved through another manner or relationship having less anticompetitive effects."; *see also* U.S. Dep't of Justice and the Fed. Trade Comm'n, Horizontal Merger Guidelines (Issued Aug. 19, 2010) at § 10, *available at* https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf

[33] Horizontal Merger Guidelines at § 10.

[34] *See* Fed. Trade Comm'n Comments on Cabell Huntington Application at 7 (*citing to* Merger Guidelines § 10).

[35] VA Application at 4.

[36] VA Application at 96-97.

Yet, the Parties offer no detailed information as to (1) what the Parties are investing in these areas today, (2) the scale of any financial pressures they are likely to face, or (3) their likely impact on the Parties in the years to come.[37]

A. The Parties proposed benefits do not reflect significant investments beyond what they are doing currently

Publicly available information suggests that one possible reason for these omissions is that the purported benefits identified by the Parties reflect little more than what the Parties are already able to do today on an independent basis. For example, many of the investment commitments asserted by the Parties do not reflect increases beyond the Parties' current level of spending, as shown below in Table A:

Table A. Comparison of Proposed Benefits vs. Current Activities

Merger Benefit Identified by the Parties	Parties' Activities Today
Invest not less than $75 million over ten years in population health improvements, committed through a regional ten-year plan.[38]	Each party is already spending approximately $5 million annually on community health improvement services, which would total approximately $100 million in combined spending over the same period if the Parties continue spending at the same pace.[39]

[37] Even had the Parties provided information sufficient to assess any financial pressures they may face in the years to come, these generic financial pressures do not begin to rise to the level at which they would be considered relevant from an antitrust perspective. Under traditional merger analysis, a firm's struggling financial situation is only a justification for an otherwise anticompetitive merger if the company qualifies as "failing" in that it is likely to exit the relevant market. *See* Horizontal Merger Guidelines at § 11. Antitrust case law reserves this designation for "extreme" instances. *Id.* ("This is an extreme instance of the more general circumstance in which the competitive significance of one of the merging firms is declining; the projected market share and significance of the exiting firm is zero") To be a failing firm, the company would need to demonstrate that it will be unable to meet its financial obligations in the near future -- something which the Parties do not even attempt to assert in the Application.

[38] VA Application at 6.

[39] Wellmont Health System, Report to Our Communities, Serving and caring beyond hospital walls, FY2014, at 4, http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Report-to-Our-Communities-fy14.pdf (stating that Wellmont spend $5,541.065 on Community Health Education and Outreach); Mountain States Health Alliance, Building Healthy Communities, 2014 Community Report, https://www.mountainstateshealth.com/sites/default/files/documents/MTN-150141_050815_2015%20Community%20Report_WEB.pdf (stating that in 2014 Mountain States spent $4,915,162 on Community Health Improvement Services).

Merger Benefit Identified by the Parties	Parties' Activities Today
Invest not less than $140 million over ten years to expand mental health, addiction recovery, and substance abuse prevention programs; develop both healthcare- and community-based resources for children's health across the region; meet regional physician needs and address service gaps and preserve and expand rural services and access points.[40]	In 2013 Mountain States *alone* invested $4.9 million in community health improvement services, including Respond hotline, a 24/7 help call line for individuals experiencing mental health crises and $12.8 million in subsidized health services, including mental health (provided at Woodbridge Hospital).[41] The amounts -- spent by only one of the health systems -- are more than the average, $14 million the New Health System is committing to each year.
Invest not less than $85 million over ten years to develop and grow academic and research opportunities and support post-graduate healthcare training.[42]	In 2014 alone, Wellmont spent over $6 million on training and education for health care professionals,[43] and Mountain States spent just under $12 million.[44] At this rate of combined spending, the Parties would hit $85 million in just under five years.

[40] VA Application at 6.

[41] *See* Community Benefit, Mountain States Health Alliance, https://www.mountainstateshealth.com/about-us/community-benefit.

[42] VA Application at 6.

[43] Wellmont Health System, REPORT TO OUR COMMUNITIES, SERVING AND CARING BEYOND HOSPITAL WALLS, FY2014, at 4, http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Report-to-Our-Communities-fy14.pdf (stating that Wellmont spent $6,077,250 on Training and Education for Health Care Professionals).

[44] Mountain States Health Alliance, Building Healthy Communities, 2014 Community Report, at 14, https://www.mountainstateshealth.com/sites/default/files/documents/MTN-150141_050815_2015%20Community%20Report_WEB.pdf (stating that Mountain States spent $11,959,474 on health profession education).

Merger Benefit Identified by the Parties	Parties' Activities Today
Invest approximately $150 million over ten years to facilitate the regional exchange of health information among participating providers and to establish an EHR system.[45]	Wellmont already agreed to participate in the OnePartner Health Information Exchange, a regional community initiative that enables the electronic exchange of health information across organizations to provide more timely, efficient and effective patient-centered care to the community.[46] Wellmont spent $59,505,490 in 2014 alone on Information Technology capital expenditures, and during the period FY2012-FY2014, it invested more than $113 million in IT systems.[47]
Make "major" investments in programs and partnerships to help address and ameliorate behavioral and addiction problems.[48]	In May 2016 Mountain States and East Tennessee State University announced plans for a joint venture to support the newly established Center for Prescription Drug Abuse Prevention and Treatment at ETSU. The Center is a medication-assisted addiction treatment facility, adding a needed service to the existing Mountain States-ETSU partnership on mental health. Mountain States will have operational control over the center, with ETSU physicians assisting with treatment.[49]

As demonstrated by this chart, either the Parties are not willing to commit to much more than they are already doing, or conversely, one must question the reliability of their statements regarding the extent of their claimed community benefits.

The analysis also suggests that the Parties are relatively financially strong today, as they are apparently capable of making substantial community investments. The Parties have been required to submit financial information in order to substantiate the purported benefits and rationale behind this Application. This has not been made publicly available so we cannot comment on the

[45] VA Application at 6.

[46] Wellmont Health System, REPORT TO OUR COMMUNITIES, SERVING AND CARING BEYOND HOSPITAL WALLS, FY2014, at 12, http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Report-to-Our-Communities-fy14.pdf

[47] Wellmont Health System, REPORT TO OUR COMMUNITIES, SERVING AND CARING BEYOND HOSPITAL WALLS, FY2014, at 4, http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Report-to-Our-Communities-fy14.pdf (stating that Wellmont spent $59,505,490 on information technology); Wellmont Health System, Fiscal 2013 Report to Our Communities, http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Health-System-FY13-Community-Benefit-Report.pdf (stating that Wellmont spent $34,930,620 on information technology); Wellmont Health System, Fiscal 2012 Report to Our Communities, at 30, https://www.wellmont.org/uploadedFiles/Content/Our_Mission/About_Us/Community_Benefit/1090772_FY%202012%20CBR_For%20WEB(1).pdf (stating that Wellmont spent $18,936,155 on information technology).

[48] VA Application at 9.

[49] *See Mountain States Partner in Expanded Effort*, Eastern Tennessee State University (May 11, 2016), http://www.etsu.edu/news/2016/05_may/etsumshajointventure.aspx.

financial viability of the Parties or whether their reasoning is sound. *We urge the Authority and Commissioner to closely evaluate this and other related non-publicly available information*.

B. The purported benefits could be achieved without merging with their closest competitors

This additional context also makes clear that these purported investment benefits are not merger-specific. Even setting aside the fact that the investments touted by the Parties reflect nothing more than the Parties' current activities, the Application does not provide any detailed information that would establish that these benefits would not be possible through other means that would not raise antitrust concerns, such as partnerships with other parties and/or more limited forms of collaboration by the Parties.

First and foremost, there is ample evidence that other health care organizations demonstrated an interest in partnering with Wellmont. The Application states that Wellmont received proposals from eight health systems aside from Mountain States, but offers no information regarding whether partnerships with these other health systems would have generated similar benefits while raising substantially fewer competitive concerns (if any at all).[50] As the statute explicitly says, the Commissioner must evaluate alternative arrangements. Therefore, the Parties should be required to provide more concrete detail on this point.

Indeed, the Parties attempt to justify their refusal to engage in partnerships with health systems from outside the area (which would raise far fewer competitive concerns, if any) by asserting the importance of local control. However, there are numerous examples of health systems from outside a region acquiring a local system and bolstering the competitiveness of that local system and allowing the local hospital system to retain local control. For example, Novant Health recently entered the Virginia market through its acquisition of Prince William hospital, and subsequently built a new facility -- Haymarket Medical Center, a four-story, 60-bed community hospital.[51] In January 2016, Novant entered a regional partnership agreement to collaborate with UVA Health System,[52] which has already proven effective in steering members to UVA and away from reportedly more expensive facilities.

Duke LifePoint is another example of a healthcare system that acquires or affiliates with community hospitals and bolsters the competitiveness of those local hospitals. Duke offers the

[50] At least one news report identifies five other health systems as potentially vying for a partnership with Wellmont: Covenant Health (Knoxville, TN), Carilion Clinic (Roanoke, VA), Novant Health (Winston-Salem, NC), Sentara Healthcare (Norfolk, VA), and Carolinas Healthcare System (Charlotte, NC). Helen Adamopoulos, *Who are Wellmont's 6 Possible Partners?*, BECKER'S HOSPITAL REVIEW (Aug. 19, 2014), http://www.beckershospitalreview.com/hospital-transactions-and-valuation/who-are-wellmont-s-6-possible-partners.html. Partnerships between Wellmont and any of the other health systems listed here would have raised far fewer, if any, antitrust concerns.

[51] *Novant Health Announces Opening of Haymarket Medical Center*, POTOMAC LOCAL (Mar. 28, 2014), http://potomaclocal.com/2014/03/28/novant-health-announces-opening-of-haymarket-medical-center/.

[52] Eric Swensen, *Novant Health and UVA Health System Close on Partnership*, UVATODAY (Jan. 6, 2016), https://news.virginia.edu/content/novant-health-and-uva-health-system-close-partnership.

community hospitals guidance on clinical service development and access to specialized medical services to meet the communities' needs, while LifePoint offers its expertise in operating community hospitals. Hospitals acquired by Duke LifePoint benefit from financial stability and large investments in local services and technology.[53]

Hospitals in the Duke LifePoint system have a track record of improving the quality of and access to care in their communities. For example, in 2014 Duke LifePoint acquired Harris Regional Hospital, located in rural western North Carolina. Within a year the hospital broke ground on a new emergency department facility, nearly doubling the number of beds that the previous space housed. By 2016, Harris Regional announced plans to expand cardiology services for the region. The partnership with Duke LifePoint enabled these improvements, as the acquisition agreement included a commitment to invest $43 million to help the hospital system grow and expand services for the region.[54]

There are other useful examples from other parts of the country as well. UC Health is another example. In Colorado Springs, Memorial Hospital voted to lease the hospital to University of Colorado in 2012, a decision that brought $1.8 billion to the city over time and promised to expand the hospitals' legacy of delivering health care in the region.[55] Through the transaction Memorial Hospital retained ownership of its buildings and local control, all while securing its financial future and obtaining access to a nearby academic medical center. University of Colorado had previously merged with Poudre Valley Health in a transaction where that community hospital continued to exist as a separate entity and had shared control of the board of directors.[56] The combined system is now called UC Health.

In another example, Marquette General Health System in Michigan's Upper Peninsula broke ground on a $290 million state-of-the-art medical facility this year, after Duke LifePoint pledged $350 million in capital investments upon acquiring the hospital in 2013. By equipping Marquette General with the expertise and capabilities to handle complex patients, Duke LifePoint aims to treat patients closer to home rather than several hours away at the nearest major hospitals.[57]

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[53] *Duke University Health System and LifePoint Hospitals Partner to Create Innovative Options for Community Hospitals, Duke Medicine* (Feb. 31, 2011), http://corporate.dukemedicine.org/news_and_publications/news_office/news/duke-university-health-system-and-lifepoint-hospitals-partner-to-create-innovative-options-for-community-hospitals.

[54] *WestCare Health System Acquired by Duke LifePoint, Duke Life Point Healthcare* (Aug. 1, 2014), http://www.dukelifepointhealthcare.com/Articles/westcare_health_system_acquired_by_duke_lifepoint.aspx

[55] *See University of Colorado Moving Forward With Memorial Health System*, CU Connections, University of Colorado (Aug. 30, 2012), *available at* https://connections.cu.edu/stories/university-colorado-moving-forward-memorial-health-system.

[56] *See* Rulon F. Stacey, PhD, FACHE, President, Presentation, University of Colorado Health: A Transformational Partnership at the Colorado General Assembly Joint Budget Committee (Sept. 20, 2012), http://www.tornado.state.co.us/gov_dir/leg_dir/jbc/CUHealth-09-20-12.pdf (noting that each hospital was to continue to exist as a separate entity and control operations with a shared bottom line and a shared board of directors).

[57] *UP Health System – Marquette Breaks Ground on $300+ Million Medical Campus,* UP Health System – Marquette, (May 26, 2016), http://www.mgh.org/hospital-news/up-health-system-marquette-breaks-ground-on-300-million-medical-campus.

Novant Health, Duke LifePoint, and UC Health System are just a few of many examples where acquisition or affiliation with an outside system still resulted in substantial benefit for the local community.

Second, the Applications do not offer any detailed explanation as to why the Parties could not achieve many of the same efficiencies and benefits through collaboration rather than a full combination. The Application states that "[t]he Parties have attempted to collaborate with respect to quality improvement methodologies and related projects" but that these efforts "have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system."[58] The Application does not, however, explain why the Parties have not attempted to collaborate in the myriad ways that would not raise competition concerns anywhere near the level of risk posed by the proposed merger -- other than citing the need to avoid duplication of services or costs.[59]

For example, the Application cites as an example of the types of collaboration possible with the merger that the Parties will be able to consolidate their air ambulance services with a single provider and also consolidate their competing Level I Trauma Centers.[60] The FTC and DOJ have issued guidance explaining that in most circumstances hospital joint ventures involving specialized clinical or other expensive health care services do not raise significant antitrust concerns.[61]

More specifically, under this guidance, the federal antitrust enforcers utilize a flexible analysis to take into consideration the nature and effect of the joint venture, the characteristics of the services involved and of the hospital industry generally, and the reasons for, and purposes of, the venture. It also allows for consideration of the efficiencies that will result from the venture.[62] Even though the parties argue that this merger is necessary to avoid duplication of services or costs -- duplicative services and costs can also be addressed through a joint venture. A joint venture amongst the providers of air ambulance services or Level I Trauma Centers likely could attain the desirable efficiencies with far fewer anticompetitive effects.

These types of non-merger collaborations have proven successful in other systems. For example, in Norfolk, VA, Sentara Norfolk General ("Sentara") collaborates with Children's Hospital of the King's Daughters ("CHKD") in the treatment of babies requiring neonatal intensive care treatment. Babies that are born at Sentara's high-risk obstetrics program that require this level of care are sent to CHKD's neonatal intensive care unit. The President and CEO of CHKD describes the arrangement as "a very collaborative working relationship that…results in the highest quality of

[58] VA Application at 24-25.
[59] *See* i*d.* at 96.
[60] VA Application at 23-24, 38-39. As an initial matter, it is not clear what the Parties' intentions are with respect to their Level I Trauma Centers by citing this as a form of collaboration possible only with merger. Do they intend to close one of these centers? If so, which one? Alternatively, do they intend to make one into a Level 2 trauma center rather than close it?
[61] See U.S. Dep't of Justice and the Fed. Trade Comm'n, Statements of Antitrust Enforcement Policy in Health Care (August 1996), Statement 3, *available at* https://www.justice.gov/atr/statements-antitrust-enforcement-policy-health-care.
[62] *Id.*

care for those very compromised babies."[63] Also for example, Silver Cross Hospital, located in New Lenox, Illinois, pursues strategic partnerships with major hospitals and specialty institutions in specific clinical service lines as an alternative to mergers. Silver Cross has had success in both providing high quality care to its community and maintaining financial stability during a time of contraction in inpatient care.[64]

IV. The Commitments Offered by the Parties Are Not a Replacement for Competition and Will Not Adequately Protect Patients Against Competitive Harm

As explained above and in our comments on the proposed Cooperative Agreement regulations, [65] commitments and state supervision are never able to fully replicate the benefits that result from actual competition. Nevertheless, if the Commissioner decides to approve the Application, it is essential that the Parties' commitments be designed and structured in such a way as to mirror the results of competition to the greatest extent possible. To this end, the Parties should be held to commitments that are both meaningful and enforceable.

Unfortunately, as proposed in the Application, many of the "commitments" made by the Parties are (i) little more than promises to continue doing what they are already doing; (ii) too vague to be meaningful or enforceable; (iii) commitments to merely report rather than to achieve outcomes; and/or (iv) structured in such a way that fails to provide an effective means of protecting against the negative effects of the merger.

Enforceability is especially critical as the Commissioner must actively supervise the Cooperative Agreement in order for federal antitrust immunity to apply. Moreover, as discussed further below, there may be no turning back once this Cooperative Agreement is enacted since a realistic plan of separation is nearly impossible to craft. Accordingly, protections built into the Cooperative Agreement must be both **specific** and **evolving** to reflect what is happing elsewhere in the competitive world -- something that is nearly impossible to do.

In this section we address many of the clear deficiencies in the commitments proposed by the Parties. However, it is important to note at the outset that the Application makes clear that the Parties have not actually proposed accountability measures, and so it is impossible to assess in any level of detail these commitments on the face of the Application alone. Instead, the Parties propose that the actual measures be developed by the Commissioner and the Parties in the course of the approval process.[66] If this approach is adopted by the Commissioner, this process should be done in a transparent fashion, including the opportunity for public comment and input. At a minimum the

[63] Tammie Smith, *Norfolk Children's Hospital Could Be Model for Richmond*, RICHMOND TIMES DISPATCH (Apr. 1, 2013), http://www.richmond.com/life/health/article_4be013fe-aebe-5375-bb25-148ca4d21dff.html.

[64] *See* Paul Pawlak and Ruth Colby, Why Our Independent Hospital Chose Partnerships Over a Merger, New England Journal of Medicine Catalyst (May 23, 2016), http://catalyst.nejm.org/when-to-choose-a-partnership-over-a-merger-2/.

[65] *See* Submission of Anthem Health Plans of Virginia, Inc. (Trades as Anthem Blue Cross and Blue Shield in Virginia) to the Regulatory Advisory Panel on the Review by the Commissioner of Health of Virginia of a Proposed Cooperative Agreement Under § 15.2-5384.1 of the Code of Virginia, July 23, 2015.

[66] VA Application at 133.

Parties should be required to provide projected levels for each measure in the absence of the Cooperative Agreement, as required, so as to allow evaluation of the impact of the Cooperative Agreement and the commitments.[67] The Parties and the Commissioners must also agree on the proposed accountability measures before the Application is approved.

A. Overall Achievement Scoring

A fatal flaw in the Parties' commitments is the system they propose for measuring compliance and the extent of a continuing benefit -- what they call the "Overall Achievement Score."[68] An Overall Achievement Score of 70% or greater will be "considered definitive evidence of Continuing Benefit, and the Virginia State Agreement shall remain in effect."[69] According to the Parties, the goal of this approach is to enable the Commissioner "to objectively track the progress of the Cooperative Agreement over time to ensure community health improvement" and whether "the Cooperative Agreement is in substantial compliance with the terms of the Letter Authorizing Cooperative Agreement and that the benefits of the Cooperative Agreement outweigh any disadvantages attributable to any reduction in competition resulting from the Cooperative Agreement.

But, the Overall Achievement Score does nothing of the sort because: (1) the Parties are not committing to achieve specific outcomes; they merely commit to report on a variety of undetermined metrics; (2) there is no basis for establishing that a score of 70% should be viewed as sufficient to outweigh the disadvantages arising from the loss in competition; and (3) the proposed system will not adequately ensure the Cooperative Agreement is in substantial compliance with the statutory requirements.

(1) Commitments to Report, But Not Necessarily Achieve Outcomes

In Table 17.1 of the Application the Parties outline 29 different commitments. Some of these, if met, conceivably could offer substantial value to southwest Virginia and northeast Tennessee. However, as discussed above, the commitments are vague and underdeveloped since the Parties defer identifying specific measures or outcomes until the Department of Health weighs in. The Authority identified this issue in its May 27 letter to the Parties asking for supplemental materials, noting that the proposed accountability metric on nearly all of the commitments is *simply to report and not actually to achieve any particular outcome*.[70] The Parties have in fact committed to very little of substance. In order to fully evaluate whether the proposed benefits from the Application (the commitments in this case) outweigh the potential disadvantages, the Parties must outline specific commitments in detail – including adequate benchmarks that would allow a measurement of what the Parties have achieved compared to what they likely would have achieved absent the merger.

[67] *Id.* at 97.
[68] *Id.* at 118.
[69] *Id.* at 124.
[70] SWHA Supplemental Questions at 20.

(2) A Fatally Flawed Scoring System

The Overall Achievement Score as proposed would weigh each of five categories of quantitative measures equally.[71] This approach does not reflect the vast differences in relative importance to patients and the community across the various commitments. For example, combining the "best of both organizations' career development programs" is given the same weight as the Parties' commitment to maintain three full-service tertiary hospitals.

Perhaps even more troubling is that this approach would effectively allow the Parties to unilaterally pick and choose from what is effectively a menu of commitments as to which they will comply with and which they will not. The representative example provided in the Application illustrates the flaws in this approach.[72] Table B below summarizes each of the commitments used in the example offered in the Application. In this example, when the equal weighting principal is combined with the proposed 70% threshold for a Continuing Benefit, as demonstrated in the table below, it becomes clear that the Parties could ***fail to comply with a single commitment in two entire categories*** ("Commitment to Improve Community Health" and "Expanding Access and Choice") and yet still receive a "passing" score. The same would be true if the Parties failed to comply with ***any*** of the commitments in Categories A ("Commitment to Improve Community Health") and B ("Enhanced Health Care Services") below.

[71] VA Application at 118. The five categories identified by the Parties are: (1) Commitment to Improve Community Health; (2) Enhanced Health Care Services Measures; (3) Expanding Access and Choice; (4) Improving Health Care Value: Managing Quality, Cost and Service; and (5) Investment in Health Education/Research and Commitment to Workforce. Id. at 118-124.

[72] *Id.* at 119, Table 15.12.

Table B. Demonstration of Overall Achievement Scoring

Category	Measures Satisfied	Overall Achievement Score
A. Commitment to Improve Community Health	0/3	
1. Invest $75 million over 10 years in population health	X	
2. Investment in Key Focus Areas	X	
3. Expanded quality reporting	X	
B. Enhanced Health Care Services	5/5	
1. Invest $140 million over 10 years pursuing specialty services	†	
2. New capacity for residential addiction recovery services	†	
3. Ensure recruitment and retention of pediatric subspecialists	†	
4. Develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, telemedicine and rotating specialty clinics in rural hospitals	†	
5. Develop comprehensive physician needs assessment and recruitment plan every three years in each community	†	
C. Expanding Access and Choice	0/6	
1. All hospitals in operation at the effective date of the merger will remain operational	X	
2. Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol	X	
3. Maintain open medical staffs at all facilities	X	
4. No exclusive contracting for physician services, with exceptions	X	
5. Independent physicians not required to practice exclusively at the combined system	X	
6. Combined system will not prohibit independent physicians from participating in health plans and networks of their choice	X	
D. Improving Health Care Value: Managing Quality, Cost and Service	10/10	
1. Reduce commercial contracted fixed rate increases by 50% in first year	†	
2. Increases in subsequent years capped at CPI minus 0.25%	†	
3. Include provisions for improved quality and value-based incentives	†	
4. Develop local, region-wide, clinical services network	†	
5. Common Clinical IT Platform	†	
6. Health information exchange open to community providers	†	
7. Establish annual priorities related to quality improvement	†	
8. Negotiate with principal payers in good faith on commercially reasonable terms	†	
9. No agreement to be exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer	†	
10. No “Most-Favored-Nation” pricing with health plans	†	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
1. Invest $85 million over 10 years in research, residency, and specialty fellowships	†	
2. Develop and implement 10-year plan for post-graduate training	†	
3. Develop and implement 10-year plan for research and growth	†	
4. Honor prior service credit for eligibility and vesting	†	
5. Efforts to address differences in salary and pay rates	†	
6. Combine best of both organizations’ career development programs	†	
Overall Achievement Score	***21/30***	***70%***

Of course, this approach allows the Parties to pick and choose any combination of commitments with which they could decide not to comply. Using again the example in the

Application, the Parties could fail to comply with ***all*** of the following commitments and yet still meet the Continuing Benefit threshold:

- Invest $75 million in community health (A.1);
- Invest $140 million in specialty services (B.1);
- All hospitals in operation at time of merger will remain operational (C.1);
- Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol (C.2);
- Maintain open medical staffs at all facilities (C.3);
- Reduce commercial contracted fixed rate increases by 50% in first year (D.1);
- Increases in subsequent years capped at CPI minus 0.25% (D.2); and
- Invest $85 million in research, residency, and specialty fellowships (E.1).

Overall Achievement Score: 73.3%

All of the above assumes, of course, that each of the commitments is actually meaningful and enforceable. This is not the case for many of the commitments offered by the Parties.

(3) An Arbitrary "Pass Grade"

The Parties propose that a score of 70% or higher will establish that there is a "Continuing Benefit" and the Cooperative Agreement should continue. There is absolutely no basis for concluding that a score of 70% should be viewed as sufficient to outweigh the disadvantages arising from the loss in competition. As discussed above, a score of 70% can occur even if the Parties' fail to deliver on a number of commitments. Moreover, merely establishing that there is some level of benefits from the Cooperative Agreement is not enough to determine that the Cooperative Agreement is in substantial compliance with the terms of the Letter Authorizing the Cooperative Agreement. That determination occurs only after weighing the benefits against "any disadvantages attributable to any reduction in competition resulting from the Cooperative Agreement."[73] The proposed scoring system, does not at all take into account any potential disadvantages attributable to any reduction in competition -- it simply tracks proposed benefits through the commitments. Accordingly it cannot be definitive evidence of substantial compliance -- the Commissioner will still need to weigh the benefits against potential disadvantages to competition in order to determine substantial compliance.

[73] VA Application at 118.

B. Rate Commitments

1. Rate Increases

Commitment: *For all Principal Payers, the New Health System will reduce existing commercial contracted fixed rate increases by 50% for the first contract year after formation of the New Health System.*[74] *For subsequent contract years, the New Health System will commit not to increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%.*[75]

(a) General problems with rate regulation

The Parties' have proposed rate commitments as a means of ensuring that the new Health System does not "potentially use any market or bargaining power achieved through the merger to increase rates for payers and consumers."[76] The Parties argue this rate cap will "bend the price curve, acting as a maximum cap on price growth always lower than the national average."[77] The Commonwealth is tasked with actively supervising the rate cap and ensuring the commitment is implemented.

Substituting price regulation for market-based competition among providers is rarely done because it is almost impossible to do. A competitive market generates many signals on prices, margins, quality, and costs, which create appropriate incentives for market participants. This is done automatically and replacing the signals with regulatory constraints and incentives is a significant challenge. In addition, since a competitive market changes over time, a well-designed Cooperative Agreement (and the associated regulatory supervision) needs to be dynamic, i.e., the regulation should be designed in a flexible manner that can adapt to changes in the competitive environment, such as the introduction of innovative forms of production or organization that might impact market structure or new contracting methods.

As noted previously, there are only a few examples of hospital mergers being granted an exemption from antitrust scrutiny under the state action doctrine. In these examples, the oversight typically has taken the form of caps on variables such as the overall amount of profit margins the relevant providers may earn, and/or on the amount of costs they might incur from providing inpatient and outpatient services, in comparison to relevant competitors.[78] Sometimes the regulatory focus

[74] *Id.* at 30.
[75] *Id.* at 30.
[76] VA Response at 43.
[77] *Id.*
[78] *See e.g.,* Original Mission Health COPA § 4.8 at 27-28 (margin cap) and 4.5 at 24 (cost cap) *available at* http://www.wncchoice.com/files/copa_docs/1995%20COPA.pdf; Mission Health Second Amended COPA § 4 at 14-17, *available at* http://www.wncchoice.com/files/copa_docs/2005%20COPA.pdf. These caps may be supplemented by other provisions such as reporting requirements (*See* Montana COPA § 14 at 66-67, *available at* https://dojmt.gov/wp-content/uploads/2011/05/decisionamended19961.pdf; Original Mission Health COPA § 11 at 34-

has been on an overall revenue cap or an average price cap for inpatient and outpatient services.[79] While these metrics are not overly burdensome for regulators to implement and periodically review, their broad nature can lead to distortions in the market and provide incentives and opportunities for the merging parties to game the regulation through various means.

(b) Problems with the Parties' proposed rate commitment

The Parties' proposed rate cap commitment suffers from a number of *serious* problems including the following:

- The Parties blatantly ignore the fact in a competitive market that providers may be held to contract increases well ***below*** the proposed CPI index minus 0.25%. For example, using the 2015 CPI index for Medical Care in the South region for Class D and the Parties' proposed rate commitment, the New Health System would see a rate increase of 3.25%.[80] During the last negotiated contract with Anthem, Wellmont received a rate increase of 1.8% and MSHA received an overall increase of 2.5%. Such increases are also increasingly only given when ***earned*** based on achieving minimum scares based on quality, health outcomes, and patient satisfaction. This proposed rate cap therefore will in effect create a price floor rather than a ceiling because it assumes a rate (cap) *above* market as a starting point, and is not even conditioned on meeting performance goals. This will most certainly result in higher health care costs over time that would result absent the Corporate Agreement.

- The Parties also ignore the fact that, on the physician side, commercial rates may also increase less than the Medical Care CPI index minus 0.25%. For example, Medicare rates to physicians, which are used by many commercial health plans in establishing their payment rates to physicians, actually declined from 2015-2016.[81] The Parties have based their proposed rate cap on previously negotiated rates and very wrongly assumed that over time under competition those rates always increase.

- The Parties do not specify what CPI index should be used. CPI data is published by the Bureau of Labor Statistics and there are a variety of potential indexes that could be used—national, regional, population size, etc.[82]

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37); fair dealing with insurers (*See* Original Mission Health COPA § 7 at 31); and physician employment restrictions (*See* Montana COPA § 7 at 31; Original Mission Health COPA § 8 at 32).

[79] *See e.g.,* Montana COPA § 1 at 43-51 (imposing a cost and revenue cap).

[80] *See* Bureau of Labor Statistics, U.S. Department of Labor, Consumer Price Index, All Urban Consumers, South Class Size D, Medical Care, 2011-2016, [last visited Sept. 21, 2016] [www.bls.gov/oes/]. Based on this, a price adjustment escalation would be 3.5%.

[81] *See* March 2016 MedPac Report to Congress: Medicare Payment Policy, at 95, *available at* http://www.medpac.gov/docs/default-source/reports/chapter-4-physician-and-other-health-professional-services-march-2016-report-.pdf?sfvrsn=0.

[82] *See* Guide to Available CPI Data, Bureau of Labor Statistics, *available at* http://www.bls.gov/cpi/cpifact8.htm.

- The Parties elsewhere in their Application commit to negotiating more risk-based payment models with Payors yet they wholly fail to address how the rate cap will work with risk-based payment models. In recent years most payers have tied contract rate increases of anywhere from 50 – 100% to improvements in quality and pay for performance. The proposed rate cap does not tie increases to any quality improvements.

- The proposed cap is limited to "Principal Payers" which are defined as "those commercial payers who provide more than two percent (2%) of the New Health System's' total net revenue." [83] The cap should apply to all commercial payers, regardless of how much they contribute to the New Health System's net revenue

- The proposed cap does not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.[84] However, Medicare and Medicaid Managed Care Organizations also negotiate rates in Virginia and Tennessee. A rate cap tied to the CPI index will not work for Medicaid and Medicaid Managed care contracts and the Parties need to propose something that will.

- The proposed cap is subject to abuse and manipulation by the New Health System overtime. The Parties do not commit to applying the cap across all services and across the entire chargemaster.

The rate commitments also do not take into account that price setting is not the only way the New Health System can engage in monopolistic behavior that harms health care in this region. The Parties also could dictate "terms" of contracting, meaning they can over-utilize, provide unnecessary services, increase lengths of stays, and dictate (through monopolistic contracting) that health plans must severely limit or even eliminate traditional medical management. The proposed commitments do not take any of this into account, and unless they do, health system will be able to increase healthcare costs even if their prices do not rise.

Even if these rate commitments keep prices from increasing for some period of time, the Cooperative Agreement will never remedy the lost quality and service competition between the Parties. Indeed, as the FTC noted in its Comments on the Cabell-Huntington Application proposing similar rate commitments, rate regulation through a cooperative agreement makes it more likely that quality and service competition will be harmed. "When prices are fixed, hospital competition takes on elevated importance in driving quality, because higher quality is the primary way hospitals can attract patients from rivals. . . To the extent that regulating price through the AVC [Cooperative Agreement] successfully caps their rates and margins, it may reduce the Applicant's ability and incentive to

[83] VA Application at 10, n.3 ("The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers."); *see also* Letter from Doug Gray, Executive Director, Virginia Association of Health Plans, to Cynthia B. Jones, Director, Department of Medical Assistance Services (Feb. 26, 2016) (explaining that MMCOs do negotiate rates in Virginia).
[84] *Id.*

invest in quality, services, facilities and equipment."[85] For this reason, the quality commitments -- addressed below -- must be exceedingly specific, rigorous and comprehensive.

2. Risk-based Models

> Commitment: *The Parties state that they "intend" to discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business. Those discussions would address both New Health System's and Principal Payer's willingness and ability to successfully implement risk-based models and over what time period.*[86]

As an initial matter, at best this commitment assures virtually nothing -- it simply asserts that the parties intend to engage in discussions. Nor is it at all clear how the Commissioner would go about evaluating compliance with a commitment to "intend" to do something. Even if this commitment were strengthened to require the Parties to actually engage in these discussions, the Commissioner would have limited visibility into the nature of these negotiations and whether the Parties would have engaged in the discussions in good faith.

The Parties attempt to justify this vagueness by stating that "[n]o payer has historically expressed an interest in a global spending cap for hospital services in this region."[87] Anthem is interested in exploring risk-based models with the Parties and has entered into risk-based arrangements in other nearby regions that have proven successful. For example, a number of hospitals in the Richmond area have risk-based contracts under Anthem's QHIP program and perform well. These health systems do not need a near monopoly over health care services to deliver high quality care under risk contracts and engage in population health management.

Moreover, the Parties argue that the merger is necessary for them to engage in population health management. Yet Mountain States already operates an Accountable Care Organization, AnewCare that, according to Mountain States, is able to generate substantial savings while improving quality scores.[88] Mountain States is able to do this today without this proposed merger and has offered no compelling reason why it couldn't use its ACO or other collaborative arrangements like this going forward to manage population health and enter into risk-based arrangements.

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[85] Fed. Trade Comm'n Comments to Cabell-Huntington Application at 43.
[86] VA Application at 42.
[87] VA Application at 42.
[88] *See* Press Release: "AnewCare Collaborative's Medicare Shared Savings Program Performance Year 2015 Quality and Financial Results," Mountain States Health Alliance, Aug. 29, 2016, *available at* https://www.mountainstateshealth.com/news/AnewCare-Collaborative%E2%80%99s-Medicare-Shared-Savings-Program-performance-year-2015-quality-and-financial-results ("For the third year in a row, our accountable care organization has achieved tremendous savings while improving quality scores. This year, we're excited to announce that we've generated more than $15 million dollars in savings and earned a quality score of 93 percent,"

3. Quality- & Value-Based Incentives

Commitment: *For all Principal Payers, "the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the system"*.[89]

Just as with the risk-based model discussion commitment above, this commitment is too vague to be meaningful. What constitutes "endeavoring" to include these provisions? How would the Commissioner have any visibility into the Parties' efforts in this respect or otherwise enforce such a commitment? How is the Commissioner to know what the agreed upon priorities are and shouldn't the Parties specify a baseline standard with respect to all payers?

4. MFN/Exclusive Contracting

Commitment: *The Parties commit not to engage in "most favored nation" pricing with any health plans, be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer, or to engage in exclusive contracting for physician services, except for hospital-based physicians.*[90] *In the event of repeal or material modification of the Virginia Certificate of Public Need law and/or the Tennessee Certificate of Need law, the Parties reserve the right "to enter into exclusive network and 'most favored nation' agreements with insurers, and to engage in any other competitive practices that comply with antitrust laws regarding the non-inpatient services, notwithstanding the commitments" stated in the Application*.[91]

This commitment is an important one but it is unclear why the Parties' have attempted to carve out the commitment in the event of repeal or material modification of the Certificate of Need laws. This commitment should not be conditioned on the existence of the Certificate of Need laws in Virginia and Tennessee. In fact, given that Virginia is currently considering a repeal of its Certificate of Public Need law, there is a good chance that the commitment, as drafted, will be nullified.

C. Service Availability Commitments

Commitment: *The Parties commit that "[a]ll hospitals in operation at the effective date of the merger will remain in operation as clinical and healthcare institutions for at least five* [*(5)*] *years."*[92]

This commitment is again too vague to be meaningful. The Parties do not explain what constitutes a "clinical and healthcare institution" and how it compares to a "hospital." We assume this distinction is meaningful as the Parties themselves go on to reserve the right to "adjust [the] scope of services or repurpose hospitals facilities."[93] Without additional detail as to the meaning of

[89] VA Application 43.
[90] VA Application at 65-66.
[91] *Id.* at 86.
[92] *Id.* at 81.
[93] *Id.* at 81.

this language, it is not possible to assess the minimum levels of service availability that the Parties are committing to post-combination for this five-year period, if indeed this language limits in any meaningful sense their ability to repurpose these facilities.

Commitment: *The Parties commit to maintaining three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol*.[94]

Similar to the commitment discussed above, this is too vague to be meaningfully enforced without additional information -- namely definitive access standards. Without these standards, the Parties could, for example, move all heart services from Bristol to Johnson City, or vice versa. The Parties also have not made any commitments with respect to maintaining a full-service tertiary referral hospital in Virginia.

Commitment: *The new Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System*.[95]

While the exchange of health information across a common IT platform is a benefit, this commitment is too vague. The Parties' response to the Authority's request for a more specific timetable for implementation of the new IT platform is still only marginally better than the initial response of "as soon as reasonably practical."[96] The Parties respond that only if the Cooperative Agreement is approved will the Parties undertake the assessment to determine a "roadmap to bring the New Health System onto a Common Clinical IT Platform." It is hard to assess the extent of a benefit this would be without understanding the time and cost necessary to achieve it.

In addition, the Parties note that this commitment is aimed at better coordinating population health efforts and related to their goal to "participate meaningfully in a health information exchange open to community providers."[97] As noted in the previous section, Wellmont already has agreed to participate in the OnePartner Health Information Exchange and both parties have spent a considerable amount of money investing in improved IT systems. Accordingly, this is not a merger-specific benefit.

D. Quality Reporting Commitments

Commitment: *The New Health System will commit to publicly reporting on its website the New Health System's CMS core measures for each facility within thirty days of reporting the data to CMS. The New Health System will also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available.*

[94] *Id.* at 82.
[95] VA Application at 74.
[96] Supplemental Submission at 22 in response to Question 22(a).
[97] VA Application at 93.

As an initial matter, it should be noted that while quality reporting can be a useful exercise, it is of little use to consumers if there are no alternatives to which they can turn if the level of quality reported is poor. Therefore, at a minimum, the Parties should be required to achieve certain percentiles in each of the quality reporting categories.

Many of these purported "commitments" are little more than promises to make public more quickly, data that the Parties are already required to track and, in many cases report publicly. For example, consumers can already access much of this information through CMS's Hospital Compare tool.[98] Quality information on the Parties is also available to consumers on a number of independent websites such as the LeapFrog Group.[99] The level of reporting promised in the Parties' Application will add little to enable the Commonwealth or consumers to effectively monitor or assess the quality of care offered to patients post-merger.

Moreover, many of those commitments that would entail "new" forms of reporting by the Parties are likely to be of little use to the Commissioner and consumers. For example, the Parties commit to reporting certain types of information, including severity-adjusted cost/case, length of stay, mortality rate, and 30-day readmission rate, by facility, aggregated by facility across the DRGs that comprise 80% of the discharges from the New Health System facilities.[100] Aggregating this type of information across such a significant number of DRGs and discharges is likely to offer little in the way of transparency into the quality of service offered by the Parties post-merger for specific conditions -- which is what consumers care the most about.

Other commitments are too vague to assess their value at all. For example, the Parties commit to reporting quality measures for the top 10 DRGs aggregated across the system annually.[101] The value of this exercise depends significantly on which DRGs are reflected in this reporting and what is meant by "quality measures -- none of which is clear from the Application. Moreover, aggregating such reports on the entire system will fail to give consumers the information they want regarding outcomes at specific hospitals.

The Parties state that this commitment will outweigh potential disadvantages because the New Health System will be "held accountable by the Commonwealth and the public for its quality performance".[102] For this commitment to actually be meaningful, the Parties should be required to do more than merely report quality metrics --they must achieve minimum scores on meaningful metrics, and show improvement over time.

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[98] *See* Medicare.gov Hospital Compare Tool, *available at* https://www.medicare.gov/hospitalcompare/search.html?. Consumers can determine how hospitals score on a variety of metrics including: patient experience; timely and effective care; complication rates; readmission and death measures; use of medical imaging; and information on certain measures of payment and patient outcomes.

[99] *See* http://www.leapfroggroup.org/. The Health Care Quality Working Group of the Authority has already used the Parties' scores on these reports to assess their current quality and request additional information for the Application.

[100] VA Application at 79.

[101] *Id.* at 79.

[102] VA Supplemental Response at 44.

E. Physician Commitments

The Parties make a number of commitments with respect to how they will treat the physician community. For example, the Parties commit to *maintain open medical staffs, not engage in exclusive contracting for physician services (other than hospital-based physicians), not require exclusivity by physicians practicing at their hospitals, and not inhibit independent physicians from participating in health plans and health networks of choice*. [103] The Parties assert these commitments will ensure availability to all qualified employed, contracted or independent physicians in the Geographic Service Area; benefit the physician community by reducing reliance on a hospital system employment model; and result in a more collaborative relationship.[104]

Although the Parties may claim that the transaction has limited impact on the physician community because there are a large number of independent physicians that does not erase the fact that this merger will result in only one hospital system operating in a 12-county area. This means that the Parties' employed physicians will no longer compete. It also means that the Parties will no longer have to compete for referrals from independent physicians and that independent physicians will not have a choice as to where to provide care or refer patients. This will negatively impact all independent physicians, especially in the future when physicians may wish to develop alternative payment models (such as bundled payments) and play hospitals off each other in negotiations in order to be able to offer the lowest costs alternatives.

The Application also does not take into account that there are significant overlaps in certain physician specialties between the two hospital systems. Even in the wide geographic area of the New Health System's 75% and 90% service areas, the combined system will have greater than 40% share in the following specialties.

Table C. Significant Physician Overlaps

Specialty	Wellmont	MSHA	New Health System Combined Share[105]
Hospitalist	17.1%	29.9%	**47%**
Cardiovascular	47.3%	18.5%	**65.8%**
Oncology & Hematology	27.6%	21%	**48%**
Pulmonology	38.6%	18.2%	**56.2%**
Urgent Care	6.7%	56.7%	**63.4%**

In these service lines -- which include some of the most critical service lines -- the Parties will control a substantial share of the physicians. The Parties have not provided market shares by physician specialty on a county or facility basis which could indicate an even higher combined share in more local geographical areas, which may be the more appropriate focus under the antitrust laws.

[103] VA Application at 66.
[104] VA Supplemental Response at 42; 45-46
[105] *See* VA Second Supplemental Response, Replacement Exhibit 14.1 (Section E). The combined share calculation includes the Mountain States Affiliated physicians.

With respect to other physician specialties, although the Parties may not have a dominant share and state they do not intend to materially increase the percentage of physicians in the community employed or affiliated with the new Health System, over time, it is inevitable that the Parties' will increase their employed physicians.[106] For example, the Parties already have stated that they intend to recruit new physicians for high-level specialties. As current independent physicians retire or leave the area, the number of independent physicians is likely to decrease while the number of New Health System employed physicians increases.[107] For a new physician coming to the area to work, it is likely that employment with the only health system in the area would be a more attractive option than joining a declining group of independent physicians. The Application does not propose a physician cap. Arguably physician caps do not always work, but the Commonwealth should consider the long term effect on the physician community of eliminating all hospital competition.

F. Plan of Separation

Although not specifically a commitment, as part of the Application, the Parties were required to provide an independent opinion from a qualified organization verifying a plan of separation that can be operationally implemented without undue disruption to essential health services provided by the Parties. We understand this plan has been submitted and verified by FTI Consulting, Inc. but it has not been made publicly available. As a result, we cannot comment specifically on what the Parties have proposed or whether their reasoning is sound. Crafting an operationally effective plan of separation seems nearly impossible to do once the "eggs are scrambled" and the Cooperative Agreement has been in effect. *We urge the Authority and Commissioner to closely evaluate and look critically at this.*.

V. Conclusion

The Authority and the Department of Health have a substantial and unchartered task ahead of them in evaluating this Application. The Parties are proposing a merger to monopoly that will dramatically change the delivery of healthcare in southwest Virginia. We urge the Authority to very closely evaluate this Application and consider both the immediate and long-term effects of eliminating health care competition in this region.

[106] VA Supplemental Response at 46
[107] *Id.*