UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Bureau of Competition
Bureau of Economics
Office of Policy Planning

September 30, 2016

VIA ELECTRONIC MAIL

Southwest Virginia Health Authority
c/o The Honorable Terry Kilgore, Chairman
851 French Moore Jr. Boulevard, Suite 178
Abingdon, VA 24210
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Marissa J. Levine, M.D., MPH
State Health Commissioner
Virginia Department of Health
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Richmond, VA 23219
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Re: Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System

Dear Authority Members and Dr. Levine:

On behalf of the staffs of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning, and pursuant to Virginia Code § 15.2-5384.1, we are providing the attached written public comment that presents our views on the Application for a Letter Authorizing Cooperative Agreement submitted by Mountain States Health Alliance and Wellmont Health System. We can provide copies of any documents referenced in this comment upon request.

Please direct questions concerning this submission to Goldie V. Walker, Attorney, Bureau of Competition, 202-326-2919, gwalker@ftc.gov; and Stephanie A. Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

Respectfully submitted,

Markus H. Meier, Acting Deputy Director
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Tara Isa Koslov, Acting Director
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cc: Honorable Mark R. Herring, Attorney General, Commonwealth of Virginia (by mail)

Enclosures

Federal Trade Commission Staff Submission to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System

Pursuant to Virginia Code § 15.2-5384.1
and the regulations promulgated thereunder at 12VAC5-221

September 30, 2016

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FTC Staff Submission - September 30, 2016

I. Executive Summary

The staffs of the Federal Trade Commission's ("FTC") Bureau of Competition, Bureau of Economics, and Office of Policy Planning (collectively, "FTC staff")[1] respectfully submit this public comment regarding the cooperative agreement application submitted by Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont") (collectively, the "parties" or "applicants") in Virginia.[2] We appreciate the opportunity to present our views on the proposed merger of Mountain States and Wellmont (the "merger" or "cooperative agreement") in connection with the review of the cooperative agreement application by the Southwest Virginia Health Authority ("Authority") and the State Health Commissioner ("Commissioner") of the Virginia Department of Health ("VDH") pursuant to Section 15.2-5384.1 of the Code of Virginia ("Virginia Cooperative Agreement Act").[3]

FTC staff recognizes the challenges confronting many states regarding unmet needs in healthcare, particularly in rural areas with vulnerable patient populations, inadequate access to providers, and struggling local economies. We also understand that healthcare providers face regulatory and financial pressure to better coordinate the delivery of healthcare services. The FTC appreciates the Authority's efforts to establish goals for improving healthcare outcomes and access to quality healthcare for patients in Southwest Virginia, particularly the development of the Blueprint for Health Improvement & Health-Enabled Prosperity.[4] The FTC has a similar mission: to preserve competition that will benefit consumers and enhance innovation in healthcare markets. The antitrust laws, which the FTC enforces, are consistent with the "triple aim" of healthcare reform to improve quality, enhance patient experience and access to care, and reduce costs.[5]

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[1] These comments express the views of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

[2] Mountain States Health Alliance & Wellmont Health System, Application for a Letter Authorizing Cooperative Agreement for Commonwealth of Virginia (Feb. 16, 2016), https://swvahealthauthority.files.wordpress.com/2016/02/application-for-a-letter-authorizing-cooperative-agreement-application.pdf [hereinafter Virginia Cooperative Agreement Application].

[3] Virginia Cooperative Agreement Act, VA. CODE ANN. § 15.2-5384.1., http://law.lis.virginia.gov/vacode/title15.2/chapter53.1/section15.2-5384.1/. According to Virginia's Rules and Regulations Governing Cooperative Agreements, "[t]he Commissioner may consult with the Federal Trade Commission when reviewing an Application." 32 Va. Reg. Regs. 1897, 1903 (Feb. 8, 2016) (to be codified at 12 VA. ADMIN. CODE §5-221-80.B), http://register.dls.virginia.gov/details.aspx?id=5578 [hereinafter Virginia Cooperative Agreement Regulations]. *See also* Comment from FTC Staff to Susan Puglisi, Va. Dep't of Health 1 (Sept. 17, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-virginia-department-health-regarding-virginias-rules-regulations-governing/151015virginiadoh.pdf.

[4] *See* SOUTHWEST VIRGINIA HEALTH AUTHORITY, BLUEPRINT FOR HEALTH IMPROVEMENT & HEALTH-ENABLED PROSPERITY (Jan. 7, 2016), https://swvahealthauthority.files.wordpress.com/2016/04/approved1-7-15-_-blueprint-goals.pdf [hereinafter BLUEPRINT].

[5] *See, e.g.*, Edith Ramirez, *Antitrust Enforcement in Health Care – Controlling Costs, Improving Quality*, 371 NEW ENG. J. MED. 2245, 2247 (2014), http://www.nejm.org/doi/full/10.1056/NEJMp1408009 ("The FTC supports the key aims of health care reform, and we recognize that collaborative and innovative arrangements among providers can reduce costs, improve quality, and benefit consumers. But these goals are best achieved when there is healthy competition in provider markets fostering the sort of dynamic, high-quality, and innovative health care that

We are submitting this comment to express our concern that the proposed merger of Mountain States and Wellmont would undermine, rather than advance, the Authority's goals. The proposed merger presents substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, and reduced access to care. Evidence shows that this harm would not be outweighed by any potential benefits of the merger, nor would it be eliminated or effectively mitigated by regulating the combined entity's post-merger conduct. Competition is the most reliable and effective mechanism for controlling healthcare costs while preserving quality of care, including in rural areas facing economic challenges.

FTC staff's concerns detailed in this submission are based on a year-long assessment of the proposed merger. During this time, we applied the analytical framework described in the *Horizontal Merger Guidelines* ("*Merger Guidelines*"), which antitrust agencies, state courts, and federal courts use to evaluate mergers.[6] We have evaluated both the potential harm to consumers from the loss of competition as well as the potential benefits, including clinical quality benefits and cost savings, that Mountain States and Wellmont claim they will be able to achieve through the proposed merger. Under Virginia law, the Authority and the Commissioner must weigh these same factors when reviewing cooperative agreement applications. Thus, our analysis is closely aligned with the analysis that the Authority and the Commissioner will undertake.

Mountain States and Wellmont are the two largest hospital systems in the border area of Southwest Virginia and Northeast Tennessee. In fact, Mountain States and Wellmont own and operate the *only* hospitals in 12 of the counties in that area. As such, Mountain States and Wellmont are currently the only two full-service hospital systems serving the vast majority of patients living in this area.[7] Indeed, Mountain States and Wellmont are each other's closest, most-intense competitor and together they would hold a near-monopoly over inpatient services in the area and have significant shares in several outpatient services and physician specialty service lines.

Competition between Mountain States and Wellmont greatly benefits area employers and residents. It enables health insurers to negotiate lower hospital reimbursement rates (*i.e.*, prices) on behalf of their customers, which reduces the prices that area employers and residents must

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practitioners seek and patients deserve."); Deborah L. Feinstein, Director, Bureau of Competition, FTC, Remarks at the Fifth National Accountable Care Organization Summit: Antitrust Enforcement in Health Care: Proscription, not Prescription 16 (Jun. 19, 2014), https://www.ftc.gov/system/files/documents/public_statements/409481/140619_aco_speech.pdf ("We continue to hear claims that antitrust principles are at odds with the mandates of the Affordable Care Act. I believe these arguments misunderstand the focus and intent of federal antitrust enforcement. . . . In the final analysis, our actions make clear the important role of antitrust in health care policy. Ultimately, we believe that the imperatives of developing lower cost, higher quality health care can coexist with continued enforcement of the antitrust laws.").

[6] U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010), https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf [hereinafter *Merger Guidelines*].

[7] *See infra* note 49 and accompanying text for further discussion of the geographic area served by Mountain States and Wellmont.

pay in premiums, copayments, deductibles, and other out-of-pocket expenses. That competition also improves healthcare quality, availability of services and new healthcare technologies, and other non-price factors as the two compete to attract patients to their respective systems. As a result, area employers and residents – commercially insured, those covered by Medicare and Medicaid, and the uninsured – have benefited from this competition. The proposed merger would eliminate that competition to the detriment of the residents of Southwest Virginia and Northeast Tennessee. Many consumers, health insurers, and community stakeholders have expressed similar concerns.[8]

As described in greater detail in Section IV.A.1, FTC staff's quantitative economic analyses confirm that Mountain States and Wellmont are extremely close competitors, and that the merger will result in extraordinarily high market shares and concentration. To measure the degree of lost competition likely to result from the proposed merger, we calculated diversion ratios, which estimate the proportion of Mountain States patients that view Wellmont hospitals as their next-best choice, and vice-versa. The diversion ratios show that 85% of Mountain States patients view Wellmont hospitals as their next-best choice and that 90% of Wellmont patients view Mountain States hospitals as their next-best choice. Diversion ratios of this large magnitude indicate that Mountain States and Wellmont are extremely close substitutes and competitors, and that the merger would likely lead to significant price increases, as well as reduced incentives to maintain or improve quality.

Additionally, we calculated market shares and concentration levels, which can be very informative when evaluating the likely competitive impact of a proposed hospital merger. High market shares and concentration among healthcare providers often indicate that merging hospital systems will be able to raise prices, without offering corresponding improvements to care that would justify the higher prices. FTC staff estimates that the combined Mountain States-Wellmont hospital system would control approximately 71% of inpatient hospital services, as well as a significant share of several outpatient services and physician specialties, in the geographic area that it plans to serve.[9] Further, the proposed merger would increase market

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[8] *See, e.g.*, Comments from America's Health Insurance Plans to the Tenn. Dep't of Health-COPA Index Advisory Group (Apr. 19, 2016), https://www.tn.gov/assets/entities/health/attachments/AHIP_COPA_Comments_041819.pdf; Declaration of Colin Drozdowski, Vice President for National Provider Solutions, Anthem, Inc. (Attachment A) [hereinafter Drozdowski (Anthem) Decl. (Att. A)]; Comments from Virginia Association of Health Plans to Southwest Virginia Health Authority (May 25, 2016) (regarding proposed certificate of public advantage for Wellmont and Mountain States); Virginia Cooperative Agreement Application, Exhibit 2.1: Record of Community Stakeholder and Consumer Views, https://swvahealthauthority.files.wordpress.com/2016/02/2-1-record-of-community-stakeholder-and-consumer-views.pdf, at 12 ("Patients have confessed to me that they are scared about the potential merger."); *id.* at 44 ("I am concerned that the merger will bring a lack of competition and 'choice' for patients in their health care"); *id.* at 46 ("I do not believe that lack of competition is a good thing…."); *id.* ("What you are doing is called a MONOPOLY and, by definition, reduces the choices for the consumer."); Brian Krumm, *Time for a Conversation on Hospital Consolidation*, BRISTOL HERALD COURIER (June 21, 2015), http://www.heraldcourier.com/news/opinion_columns/time-for-a-conversation-on-hospital-consolidation/article_f47bce42-17c1-11e5-8a6d-c35f320b8ac2.html ("the result could be the same as so many other communities across America – less competition and higher prices").

[9] This is a conservative market share estimate, based on inpatient admissions from commercially insured patients in the 21-county area that the combined hospital systems plan to serve. This area may be broader than a properly

concentration to a level that far exceeds the legal threshold for a presumption of significant anticompetitive effects. The combined market share and increase in concentration would also exceed those of past hospital mergers that the FTC and federal courts have found to be anticompetitive.[10]

Although there is overwhelming evidence that the merger will likely lead to higher prices and reduced quality for healthcare services, Mountain States and Wellmont assert that their merger would also result in clinical quality benefits and cost savings, and is necessary to ensure continued access to healthcare facilities and services throughout the region. The Authority should carefully evaluate these claimed quality benefits and cost savings. Most studies have shown that competition among health systems – not consolidation – results in the greatest price constraint and quality benefits for consumers.[11] FTC staff has assessed the parties' claims, with a particular focus on potential clinical quality efficiencies. Importantly, Mountain States and Wellmont have not provided sufficient information to substantiate many of them, nor have they demonstrated that the claimed benefits and cost savings would offset the merger's substantial harm to competition.

Moreover, the proposed merger does not appear necessary to achieve many of these claimed benefits, which could be realized either independently or through another collaboration or merger that would not be as harmful to competition as the proposed merger. The Virginia Cooperative Agreement Act requires consideration of whether these benefits can be achieved through alternative arrangements that are less restrictive to competition. Despite the parties' claims to the contrary, an alternative merger with an out-of-market hospital system is unlikely to result in greater price increases, facility closures, job losses, and other negative economic consequences as compared to the proposed cooperative agreement.[12]

Mountain States and Wellmont recognize that the merger is likely to raise significant antitrust concerns.[13] They attempt to mitigate potential adverse effects on prices and quality by proposing several commitments that they assert would restrict their post-merger pricing and contracting behavior, and ensure quality improvements. However, their proposed commitments would prove difficult to implement, monitor, and enforce, and would not replicate the benefits of competition. The price commitments could even result in higher prices than might otherwise occur in a competitive market. Moreover, the merged hospitals would have strong financial incentives to circumvent regulatory commitments, which could further undermine the

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defined relevant geographic market under the *Merger Guidelines* and case law. *See infra* IV.A.1.b). In narrower geographic areas, the combined system's market share is likely to be substantially higher.

[10] *See* Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

[11] For surveys of the research literature, *see, e.g.*, MARTIN GAYNOR & ROBERT TOWN, THE IMPACT OF HOSPITAL CONSOLIDATION – UPDATE (Robert Wood Johnson Found., The Synthesis Project, Policy Brief No. 9, 2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261 (Attachment C); Martin Gaynor, Kate Ho & Robert Town, *The Industrial Organization of Health-Care Markets*, 53 J. ECON. LITERATURE 235 (2015), https://www.researchgate.net/profile/Martin_Gaynor/publication/278676719_The_Industrial_Organization_of_Health-Care_Markets/links/558303cd08ae89172b85d370.pdf.

[12] *See infra* Section IV.A.5 for further discussion.

[13] *See infra* note 205.

effectiveness of the proposed commitments in mitigating the likely competitive harm of the proposed merger. For these reasons, such commitments, commonly referred to as "conduct remedies," are generally disfavored by antitrust agencies and courts.[14] Finally, if Mountain States and Wellmont are allowed to merge, there should be no expectation that a subsequent antitrust enforcement action or any required plan of separation could effectively unwind the merger if either state decides that the benefits of the cooperative agreement no longer outweigh the harms and terminates the cooperative agreement. Experience shows that unwinding healthcare provider mergers and successfully restoring the lost competition is difficult, if not impossible.

Practical impediments also exist. The cooperative agreements implemented in other states illustrate the challenges with regulating a hospital monopoly in perpetuity. These challenges may be exacerbated under this proposed cooperative agreement, which would involve regulation by two different states. Moreover, if either the Virginia or Tennessee state legislature were to repeal or revise the underlying cooperative agreement statutes, the regulatory oversight intended to mitigate the anticompetitive effects of the merger could be eliminated entirely, leaving the combined system free to exercise its significant market power with no regulatory oversight or antitrust enforcement.

If the cooperative agreement is approved, the harm resulting from the reduction in competition is likely to far outweigh any potential benefits. Consequently, we urge the Authority and the Commissioner not to approve the cooperative agreement.

II. The FTC's Interest and Experience

The FTC is an independent, bipartisan agency with a unique dual mission of promoting competition and protecting consumers. To carry out this mission, Congress has charged the FTC with enforcing the Clayton Act, which prohibits mergers and acquisitions that may substantially lessen competition or tend to create a monopoly. In addition, the FTC enforces the Federal Trade Commission Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[15] Competition is at the core of the American economy, particularly in the healthcare sector.[16] Vigorous competition among healthcare providers in an open marketplace provides consumers with the benefits of lower prices, higher quality goods and services, greater access to goods and services, and innovation.[17] Pursuant to its statutory

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[14] In merger challenges, the FTC prefers "structural remedies" (*i.e.*, an injunction preventing consummation of a merger or a divestiture of assets) rather than "conduct remedies" (*i.e.*, restrictions intended to regulate the conduct of a merged firm).

[15] *See* Clayton Act, 15 U.S.C. § 18; Federal Trade Commission Act, 15 U.S.C. § 45.

[16] *See, e.g.*, Standard Oil Co. v. Fed Trade Comm'n, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition."); N.C. State Bd. of Dental Examiners v. Fed. Trade Comm'n, 135 S. Ct. 1101, 1109 (2015) ("Federal antitrust law is a central safeguard for the Nation's free market structures. In this regard, it is 'as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms.'").

[17] *See* Nat'l Soc. of Prof. Eng'rs v. United States, 435 U.S. 679, 695 (1978) (The antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements

mandate, the FTC seeks to identify mergers and acquisitions, business practices, laws, and regulations that may impede competition without providing countervailing benefits to consumers.

Anticompetitive mergers and conduct in healthcare markets has long been a focus of FTC law enforcement, research, and advocacy.[18] A critical part of the FTC's role in protecting consumers is reviewing proposed mergers and acquisitions in the healthcare industry. The FTC has considerable experience in evaluating proposed hospital, outpatient facility, and physician group mergers, including those in rural areas, to determine whether they are, on balance, likely to benefit or harm consumers.[19]

III. The FTC Evaluates Healthcare Mergers Similarly to the Approach Outlined in the Virginia Cooperative Agreement Act

The FTC's mission to protect competition and consumers in healthcare markets is similar to the Authority's and Commissioner's mandate to help improve the health and lives of the residents of Southwest Virginia. When reviewing a proposed hospital merger, FTC staff devotes significant resources to understand the transaction's likely efficiencies and benefits (*e.g.*, lower costs and improved quality), as well as its likely competitive harm (*e.g.*, higher prices, reduced quality and access to care). Most hospital mergers do not raise competitive concerns and are allowed to proceed without any challenge from the FTC.

The FTC and U.S. Department of Justice ("DOJ") have jointly issued *Merger Guidelines* that outline the analytical framework used by the antitrust agencies to evaluate the competitive

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of a bargain – quality, service, safety, and durability – and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[18] *See, e.g.*, *Competition in the Health Care Marketplace*, FED. TRADE COMM'N, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care; FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2016), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev3.pdf; Joseph Farrell, Paul A. Pautler & Michael G. Vita, Fed. Trade Comm'n, *Economics at the FTC: Retrospective Merger Analysis with a Focus on Hospitals*, 35 REV. INDUS. ORG. 369 (2009), http://link.springer.com/content/pdf/10.1007%2Fs11151-009-9231-2.pdf; *Examining Health Care Competition*, FED. TRADE COMM'N (Mar. 20-21, 2014), https://www.ftc.gov/news-events/events-calendar/2014/03/examining-health-care-competition [hereinafter FTC Healthcare Workshop 2014]; *Examining Health Care Competition*, FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE (Feb. 24-25, 2015), https://www.ftc.gov/news-events/events-calendar/2015/02/examining-health-care-competition [hereinafter FTC-DOJ Healthcare Workshop 2015]. These workshops focused on the competition implications of various issues that are central to healthcare reform, including the challenges of measuring healthcare quality, as well as evolving healthcare provider and payment models. The workshop record suggests that neither a transition to value-based payment models nor improved population health management require anticompetitive levels of provider consolidation. *See also* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [hereinafter DOSE OF COMPETITION REPORT]. The report was based on, among other things, 27 days of formal hearings on competitive issues in healthcare, an FTC-sponsored workshop, independent research, and the Agencies' enforcement experience.

[19] *See* FED. TRADE COMM'N, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS, *supra* note 18, at Section III.

impact of a proposed merger. These guidelines reflect experience in analyzing a wide variety of mergers – including many hospital and other healthcare-related mergers, both proposed and consummated – as well as economic and other relevant research. Federal and state courts routinely rely on the *Merger Guidelines* framework to analyze the likely competitive effects of a proposed hospital merger. Ultimately, as stated in the *Merger Guidelines*, the "Agencies seek to identify and challenge competitively harmful mergers while avoiding unnecessary interference with mergers that are either competitively beneficial or neutral."[20]

This approach is similar to that which the Authority and the Commissioner will take when reviewing cooperative agreement applications. The Virginia Cooperative Agreement Act directs the Authority to review applications for a cooperative agreement between merging hospitals and to recommend approval of the cooperative agreement to the Commissioner if the Authority "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."[21] The Commissioner is then authorized to approve the cooperative agreement if she determines by a preponderance of the evidence that the likely benefits outweigh the likely disadvantages, after which she would be responsible for actively supervising the parties to ensure compliance with the approved provisions.[22] Notably, the types of benefits and disadvantages that the Authority and the Commissioner must consider, as discussed in greater detail below, are similar to those that FTC staff considers when reviewing hospital mergers.

Some hospital mergers, including those that raise competitive concerns, may yield meaningful clinical quality improvements and cost savings that might not be possible without the merger. Taking this into account, our analysis of a proposed merger includes a thorough assessment of the potential benefits and efficiencies, as well as the disadvantages and harms resulting from a reduction in competition. Those benefits are then weighed against the likely adverse effects. The FTC declines to challenge transactions that might raise competitive concerns when there is compelling evidence that the likely benefits of the transaction would be of sufficient magnitude to offset the potential harm from lost competition. It should be noted, however, that the greater the likelihood of harm from a proposed merger, the more substantial any claimed benefits must be to conclude that the benefits outweigh the harms. Indeed, "[e]fficiencies almost never justify a merger to monopoly or near-monopoly."[23]

FTC staff has conducted a thorough investigation of the proposed merger between Mountain States and Wellmont. As is customary in our investigations of hospital mergers, a team of attorneys and economists interviewed many market participants, including hospitals, health insurers, and employers. We examined a significant amount of public and non-public information, including business documents and data obtained from Mountain States, Wellmont, and other market participants. We also performed an economic analysis of hospital discharge data collected by Virginia and Tennessee, as well as a financial analysis of the merging parties'

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[20] *Merger Guidelines* § 1.
[21] Virginia Cooperative Agreement Act, § 15.2-5384.1 (E.1.).
[22] Virginia Cooperative Agreement Regulations, 12VAC5-221-10.
[23] *Merger Guidelines* § 10.

hospitals. Although the FTC is typically prohibited from disclosing confidential information obtained during an investigation, we are nonetheless able to provide an extensive assessment of the proposed merger based on public sources. Our analysis is also supported by the non-public data and information that we have reviewed. We carefully considered the potential clinical quality benefits and cost savings that Mountain States and Wellmont claim they will be able to achieve through the proposed merger. To assist in our evaluation of quality of care and health improvement claims, we retained an outside quality of care expert, Dr. Kenneth Kizer, Director of the Institute for Population Health Improvement at the University of California Davis Health System and a Distinguished Professor in the UC Davis School of Medicine (Department of Emergency Medicine) and the Betty Irene Moore School of Nursing.[24]

IV. Statutory Factor Analysis: Benefits of the Cooperative Agreement Are Unlikely to Outweigh the Disadvantages Resulting from a Reduction in Competition

In conjunction with our standard analysis under the *Merger Guidelines*, FTC staff evaluated the proposed merger applying the statutory factors that the Authority and the Commissioner must consider when reviewing the cooperative agreement application. As set forth below, we present our assessment of the disadvantages and benefits that must be considered under the Virginia Cooperative Agreement Act. In Section IV.A.1, we describe the evidence and economic analyses supporting our conclusion that Mountain States and Wellmont are each other's closest competitor and that the post-merger market structure indicates a high likelihood of significant harm to consumers resulting from the elimination of vigorous competition between the two systems. We include this foundation because it is relevant to assessing the disadvantages listed in the statute. In Section IV.A.2 through A.5, we provide our assessment of each statutory disadvantage factor. In Section IV.B.1 through B.7, we provide our assessment of each statutory benefit factor. Ultimately, we conclude that the claimed benefits of the cooperative agreement are unlikely to outweigh the significant disadvantages that would result from a reduction in competition between Mountain States and Wellmont.

A. The Cooperative Agreement Is Likely to Result in Significant Disadvantages Due to a Reduction in Competition Between Mountain States and Wellmont

Today, Mountain States and Wellmont compete vigorously to be included in health plan networks and to attract patients. The proposed merger would eliminate this competition and would likely lead to increased prices and reduced quality and availability of healthcare services in Southwest Virginia and Northeast Tennessee.

The FTC and healthcare economists use the following framework for analyzing competition in hospital markets. Hospital systems generally compete in two interrelated stages: first, they compete for inclusion in a health insurer's network; and, second, they compete to attract patients and physician referrals to their respective systems. In the first stage, health

[24] *See* Kenneth W. Kizer Biography, UC DAVIS HEALTH SYS., http://www.ucdmc.ucdavis.edu/iphi/Staff/kizer_bio_03302011.html.

insurers – on behalf of their customers (employer and individual) – use competition between hospitals as leverage to negotiate better reimbursement rates (*i.e.*, prices). This, in turn, results in lower premiums, copayments, deductibles, and other out-of-pocket expenses for employers who purchase health insurance for their employees, consumers who receive health insurance as an employee benefit, and consumers who purchase their own health insurance.[25] In the second stage, competition between hospitals to attract patients typically leads to increased quality and availability of healthcare services. Thus, hospital systems compete on both price and quality, and mergers between close rivals eliminate that beneficial competition. Therefore, when competing hospitals merge, two different kinds of adverse effects may occur: higher prices charged to insurance companies (which are then passed on to employers and consumers) and non-price effects such as reduced quality and availability of services.[26] These anticompetitive effects are larger when the merging hospitals are closer (*i.e.*, more intense) competitors, and when non-merging hospitals are less significant competitors.

This framework is consistent with a large and growing body of empirical research finding that mergers between close competitors in concentrated healthcare provider markets are likely to result in substantial consumer harm, without offsetting improvements in quality.[27] For example, one article discussing several recent studies of hospital mergers concludes that "the magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent."[28] Notably, this empirical finding is true regardless of whether the merging hospitals have for-profit or not-for-profit status.[29] In other words, non-profit hospitals have the propensity to exercise market power and raise prices, similar to for-profit hospitals.[30] Thus, as most courts generally recognize, the non-profit status of merging hospitals does not mitigate the potential for anticompetitive harm.[31]

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[25] *See* Drozdowski (Anthem) Decl. (Att. A) ¶ 20, 26.

[26] *Merger Guidelines* §§ 1, 6. *See* Drozdowski (Anthem) Decl. (Att. A) ¶ 55 ("In health care, . . . competition plays a key role in driving quality and performance improvement."), ¶ 32 ("If a provider perceives that it has few or no alternatives, it often will seek to extract rates from insurers that are above competitive levels.").

[27] *See, e.g.*, GAYNOR & TOWN (Att. C), *supra* note 11; Gaynor, Ho & Town, *supra* note 11.

[28] GAYNOR & TOWN (Att. C), *supra* note 11, at 2.

[29] *See, e.g.*, Robert Town, *The Economists' Supreme Court Amicus Brief in the Phoebe Putney Hospital Acquisition Case*, 1 HEALTH MGMT. POL'Y & INNOVATION 60 (2012), http://www.hmpi.org/pdf/HMPI-%20Town,%20Phoebe%20Putney.pdf; Gaynor, Ho & Town, *supra* note 11.

[30] *See, e.g.*, Michael G. Vita & Seth Sacher, *The Competitive Effects of Not-For-Profit Hospital Mergers: A Case Study*, 49 J. INDUS. ECON. 63 (2001), http://onlinelibrary.wiley.com/doi/10.1111/1467-6451.00138/epdf (finding substantial price increases resulting from a merger of non-profit, community-based hospitals, and determining that mergers involving non-profit hospitals are a legitimate focus of antitrust concern); Steven Tenn, *The Price Effects of Hospital Mergers: A Case Study of the Sutter–Summit Transaction*, 18 INT'L J. ECON. BUS. 65, 79 (2011), http://www.tandfonline.com/doi/full/10.1080/13571516.2011.542956 (finding evidence of post-merger price increases ranging from 28%-44%, and concluding that "[o]ur results demonstrate that nonprofit hospitals may still raise price quite substantially after they merge. This suggests that mergers involving nonprofit hospitals should perhaps attract as much antitrust scrutiny as other hospital mergers.").

[31] *See, e.g.*, Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1081 (N.D. Ill. 2012) ("[T]he evidence in this case reflects that nonprofit hospitals do seek to maximize the reimbursement rates they receive."); Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *22 (N.D. Ohio Mar. 29, 2011) (finding that a nonprofit hospital entity "exercises its bargaining leverage to obtain the most favorable reimbursement rates possible from commercial health plans."); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1284-87 (7th Cir.

As discussed more fully below, Mountain States and Wellmont are unquestionably each other's closest competitor, and no realistic alternatives exist for the vast majority of patients in Southwest Virginia and Northeast Tennessee.[32] This indicates that the anticompetitive effects of this merger are likely to be significant. The two systems routinely compete for inclusion in health insurer networks and to attract patients to their respective systems. By eliminating this competition, the proposed merger would substantially increase the combined system's ability to exercise its market power, enabling it to extract higher prices in negotiations with health insurers,[33] which in turn would likely lead to higher healthcare costs for employers and consumers. The proposed merger also would reduce the combined system's incentives to maintain or improve the quality or availability of healthcare services.[34]

In their cooperative agreement application and other public statements, Mountain States and Wellmont emphasize the challenges that they face in providing healthcare services in Southwest Virginia and Northeast Tennessee.[35] In doing so, however, they undervalue the critical importance of competition in addressing these challenges. Competition is no less important in rural and economically-stressed communities than it is in urban and more prosperous ones. Competition between Mountain States and Wellmont has long benefitted area patients and employers in the form of lower prices and enhanced quality and availability of healthcare services. Contrary to assertions by the parties, we have seen no evidence that would suggest that this region cannot support competition between Mountain States and Wellmont, or that such competition inhibits their ability to serve the region effectively. Both of these hospital systems are financially sound and have the resources to continue operating independently,[36] and

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1990) (rejecting the contention that nonprofit hospitals would not seek to maximize profits by exercising their market power); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1213-14 (11th Cir. 1991) ("[T]he district court's assumption that University Health, as a nonprofit entity, would not act anticompetitively was improper."); Hospital Corp. of America v. Fed. Trade Comm'n, 807 F.2d 1381, 1390-91 (7th Cir. 1986) (rejecting the contention that nonprofit hospitals would not engage in anticompetitive behavior). *See also* DOSE OF COMPETITION REPORT, *supra* note 18, ch. 4, at 29-33 (discussing the significance of nonprofit status in hospital merger cases, and concluding that the best available empirical evidence indicates that nonprofit hospitals exploit market power when given the opportunity and that "the profit/nonprofit status of the merging hospitals should not be considered a factor in predicting whether a hospital merger is likely to be anticompetitive.").

[32] *See* Drozdowski (Anthem) Decl. (Att. A) ¶¶ 9, 35, 48.

[33] *See* Drozdowski (Anthem) Decl. (Att. A) ¶¶ 20, 32.

[34] *See* Drozdowski (Anthem) Decl. (Att. A) ¶¶ 11, 52.

[35] *See* Virginia Cooperative Agreement Application at 4-5 ("The challenges are intensified in the Parties' service area of Southwest Virginia and Northeast Tennessee, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.").

[36] *See id.* at 4 (acknowledging Wellmont's current "position of clinical strength and relative financial stability"); Tammy Childress, *Mountain States Health Alliance Posts Audited Year-End Results*, BRISTOL HERALD COURIER (Nov. 5, 2015), http://www.heraldcourier.com/workittricities/business_news/mountain-states-health-alliance-posts-audited-year-end-results/article_e1a9b05c-8316-11e5-a8d4-5f3b2b601935.html (reporting that for fiscal year 2015, Mountain States substantially reduced its debt as a result of strong volume growth and cost discipline); Nate Morobito, *Wellmont Health System, Executives Benefit from Good Financial Year*, WJHL (May 18, 2016), http://wjhl.com/2016/05/18/wellmont-health-system-executives-benefit-from-good-financial-year/ ("Overall, Wellmont Health System is coming off a solid year financially."); Hank Hayes, *Wellmont's Filing Discloses Compensation, Shows Better Operating Margins*, KINGSPORT TIMES-NEWS (May 17, 2016),

there is no indication that either system operates at a loss or is at risk of failing and ceasing operations.

1. The Merger Will Eliminate the Close and Vigorous Competition Between Mountain States and Wellmont and Will Result in Extraordinarily High Market Shares and Concentration

Mountain States and Wellmont are each other's closest competitor due to their similar facility locations, service offerings, and quality of care.[37] Each system operates large acute care hospitals that provide advanced inpatient services, as well as several smaller community hospitals, in Southwest Virginia and Northeast Tennessee. Mountain States and Wellmont also operate outpatient facilities and employ physicians across a number of specialties. As shown on the attached map of general acute care hospitals located in the 21-county area identified by the parties (Attachment D), there is significant geographic overlap between Mountain States's and Wellmont's facilities. Notably, Mountain States and Wellmont operate the only two acute care hospitals in Norton, Virginia (located 2 miles apart), as well as the only two hospitals in Kingsport, Tennessee (located roughly 3 miles apart). Consistent with our economic analyses, empirical research indicates that mergers among hospitals in close proximity are likely to result in particularly significant price increases.[38]

Mountain States and Wellmont compete on price, quality, innovation, and patient experience in order to be included in health insurers' networks and to attract patients to their respective hospital system for inpatient, outpatient, and physician services. Mountain States and Wellmont themselves acknowledge publicly that they have a history of vigorous competition.[39] Barbara Allen, the Chairwoman of Mountain States's board, said, "for years [MSHA and Wellmont have] been very ***fierce competitors***."[40] Similarly, Dale Sargent, the Medical Director of Hospitalist Programs for Wellmont, wrote that "MSHA and [Wellmont] have been battling one another since the two health systems formed."[41]

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http://www.timesnews.net/Business/2016/05/17/Wellmont-s-filing-discloses-old-salaries-and-shows-better-operating-margins.

[37] *See, e.g.*, Virginia Cooperative Agreement Application at 23-25 (describing the similarity of services offered by Mountain States and Wellmont).

[38] *See, e.g.*, WILLIAM B. VOGT & ROBERT TOWN, ROBERT WOOD JOHNSON FOUND., RESEARCH SYNTHESIS REPORT NO. 9: HOW HAS HOSPITAL CONSOLIDATION AFFECTED THE PRICE AND QUALITY OF HOSPITAL CARE? 7 (2006), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2006/rwjf12056/subassets/rwjf12056_1 ("Mergers among hospitals that are close together geographically generate greater price increases than do mergers among distant hospitals.").

[39] *See* Virginia Cooperative Agreement Application at 5 ("Wellmont and Mountain States have a history of competition dating back to the formation of the two health systems in the late 1990s . . . .").

[40] David McGee, *Wellmont, Mountain States Health Alliance Officials Make Deal Public*, BRISTOL HERALD COURIER (Apr. 2, 2015), http://www.heraldcourier.com/news/wellmont-mountain-states-health-alliance-officials-make-deal-public/article_3a4f3bee-d9af-11e4-9516-974cd93d1907.html (emphasis added).

[41] Dale Sargent, *It's Up to Us: We Alone Can Seize Opportunities for Region's Health Care*, BRISTOL HERALD COURIER (Nov. 8, 2015), http://www.heraldcourier.com/opinion/editorials/we-alone-can-seize-opportunities-for-region-s-health-care/article_c8679895-b573-55c8-a998-882c4267413c.html.

a) Diversion Ratio Analysis Confirms That Mountain States and Wellmont Are Each Other's Closest Competitor and That the Merger Is Likely to Result in Significant Disadvantages

To measure the degree of competition between the merging hospitals, FTC staff performed a diversion ratio analysis. This analysis calculates what would happen if, hypothetically, one of the merging systems were removed from an insurer's network and was no longer an option for that insurer's patient members. The patients who would have used their preferred hospital must now use a hospital outside of that system. If a significant fraction of those "diverted" patients would choose a hospital in the other merging system, then that system can be said to be a close competitor to the first system. This fraction of diverted patients is known as the diversion ratio, and it is a standard economic metric often used to measure closeness of competition in hospital merger cases.[42]

In this matter, FTC staff's diversion ratio analysis confirms what already makes sense intuitively: that Mountain States and Wellmont are each other's closest competitor and next-best alternative to the other for inpatient services.[43] FTC staff calculates that if Mountain States's hospitals were no longer an option for area residents, 85% of the patients who currently use a Mountain States hospital would seek care at a Wellmont hospital. Conversely, if Wellmont's hospitals were no longer an option for area residents, 90% of the patients who currently use a Wellmont hospital would seek care at a Mountain States hospital.[44] Diversion ratios of this magnitude indicate that Mountain States and Wellmont are extremely close substitutes and that a merger between them would likely lead to significant price increases, as well as reduced incentives to maintain or improve quality. Indeed, Competition Economics LLC, an economic

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[42] *See Merger Guidelines* § 6.1 ("Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects."). Unilateral price effects refers to the ability of a merged firm to raise prices on its own, without colluding with other competitors.

[43] To calculate diversion ratios, we estimate a patient choice model using the Virginia and Tennessee state hospital discharge data for commercially insured patients. *See* Tenn. Dep't of Health, Hospital Discharge Data System (HDDS) Inpatient Data (2014); Va. Health Info., Patient Level Data (2014), http://www.vhi.org/pld.asp. For a discussion of the underlying methodology, see Joseph Farrell, David J. Balan, Keith Brand & Brett W. Wendling, *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets*, 39 REV. INDUS. ORG. 271 (2011), http://link.springer.com/content/pdf/10.1007%2Fs11151-011-9320-x.pdf.

[44] America's Health Insurance Plans hired Competition Economics LLC to perform an independent analysis of the proposed merger between Mountain States and Wellmont, based on data for patients insured by Anthem Virginia and BCBS Tennessee. That analysis also estimated very high diversion ratios between Mountain States and Wellmont. The specific estimates (approximately 70% at the system level) differ from our estimates because the FTC analyses are based on all commercially insured patients while Competition Economics LLC analyses are limited to data for patients covered by Anthem Virginia and BCBS Tennessee. *See* Michael Doane & Luke Froeb, Competition Economics LLC, *An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance*, Tables 10, 12 & 13 (Oct. 29, 2015) (economic analysis funded by America's Health Insurance Plans), https://ahip.org//wp-content/uploads/2015/11/Wellmont-Mountain-States-Merger-Report.pdf [hereinafter Competition Economics Report]. *See also* Press Release, America's Health Insurance Plans, New Report: Wellmont/Mountain States Merger Predicted to Increase Health Care Costs, Limit Choices for Consumers (Nov. 13, 2015), https://www.ahip.org/new-report-wellmontmountain-states-merger-predicted-to-increase-health-care-costs-limit-choices-for-consumers/.

consultant hired by America's Health Insurance Plans to analyze the proposed merger, estimated that the price increase could be as high as 130%.[45] Moreover, these diversion ratios are higher than those in recent hospital mergers that the FTC has litigated, indicating that the competition between Mountain States and Wellmont that would be eliminated by the proposed merger is stronger than in other hospital mergers determined to be anticompetitive.

b) High Market Shares and Concentration Levels in the Proposed Geographic Service Area Confirm That the Cooperative Agreement Is Likely to Result in Significant Disadvantages

General principles of antitrust law and economics indicate that mergers between close competitors in highly concentrated hospital markets are likely to result in significant consumer harm because the merged hospital system will be able to raise prices without offering sufficient quality improvements to justify the higher price.[46] For this reason, market shares and concentration are important tools for assessing the potential for adverse competitive effects resulting from a merger. The proposed merger between Mountain States and Wellmont would create a system with high market shares in Southwest Virginia and Northeast Tennessee, lead to a highly concentrated provider market, and result in substantial harm to consumers due to lost competition.

Courts and antitrust agencies use a standard measure of market concentration, the Herfindahl-Hirschman Index ("HHI"), to gauge a merger's effect on concentration in the area.[47] Under the *Merger Guideline*s and relevant case law, mergers resulting in a post-merger HHI above 2,500 and an increase in HHI of more than 200 points are presumed likely to enhance the merged firm's market power and to be anticompetitive.[48]

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[45] Competition Economics Report, *supra* note 44, at 18, Table 14.

[46] *See, e.g.*, *Merger Guidelines* §§ 5-6; United States v. Phil. Nat'l Bank, 374 U.S. 321, 363-66 (1963) ("Specifically, we think that a merger which produces a firm controlling an undue percentage share of the relevant market, and results in a significant increase in the concentration of firms in that market, is so inherently likely to lessen competition substantially that it must be enjoined in the absence of evidence clearly showing that the merger is not likely to have such anticompetitive effects.").

[47] HHI measures are calculated by summing the squares of the individual firms' market shares. For hospital mergers, they are based on the market shares of all hospitals (or systems) deemed to be in the market.

[48] *Merger Guidelines* § 5.3. Courts accept this presumption of illegality when evaluating hospital mergers. *See, e.g.*, ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 570 (6th Cir. 2014) ("[T]he Commission is entitled to take seriously the alarm sounded by a merger's HHI data."); *id.* ("These two aspects of this case – the strong correlation between market share and price, and the degree to which this merger would further concentrate markets that are already highly concentrated – converge in a manner that fully supports the Commission's application of a presumption of illegality."); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1079 (N.D. Ill. 2012) ("High levels of concentration raise anticompetitive concerns, and the HHI calculation provides one way to identify mergers that are likely to invoke these concerns."); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991) ("The most prominent method of measuring market concentration is the Herfindahl-Hirschman Index (HHI)."); *id*. at 1218 n.24 ("Significant market concentration makes it easier for firms in the market to collude, expressly or tacitly, and thereby force price above or farther above the competitive level.") (quotation marks omitted); United States v. Rockford Mem'l Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) ("The defendants' immense shares in a reasonably defined market create a presumption of illegality.").

Using state hospital discharge data, FTC staff calculated market shares and HHI measures for the proposed merger between Mountain States and Wellmont using the 21-county area that the combined hospital system defines as the area it plans to serve.[49] Based on that analysis, the combined hospital system would have a market share of approximately 71% for inpatient hospital services (based on discharges of commercially insured patients) and the post-merger HHI would be 5,161, reflecting an HHI increase of 2,441 points.[50] These market share and concentration numbers approach monopoly levels and far exceed those that would create a presumption of illegality under the *Merger Guidelines* and the relevant case law.[51] The combined market share and HHI calculations also exceed the levels in past hospital mergers that courts have found to be anticompetitive and blocked.[52] As shown in Table 1 below, no other hospital system's market share even remotely comes close to that of Mountain States and Wellmont. Notably, Mountain States and Wellmont do not dispute that they would have a dominant post-merger market share.

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[49] *See* Tenn. Dep't of Health, *supra* note 43; Va. Health Info., supra note 43. The market shares and HHI calculations are based on inpatient admissions of commercially insured patients residing in the 21 counties that the combined hospital system plans to serve, as identified by Mountain States and Wellmont in their cooperative agreement application. *See* Virginia Cooperative Agreement Application at 14. The 21-county area includes 11 counties in Virginia (Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe), as well as the independent cities of Norton and Bristol, Virginia, and 10 counties in Tennessee (Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington). The shares are "patient-based shares" calculated based on where patients who reside in the 21-county area received inpatient hospital services, regardless of whether the hospital is located inside or outside the 21-county area, as opposed to "supplier-based shares," which are calculated based on the inpatient admissions for only the hospitals located within the 21-county area, regardless of where the patients reside. For consistency of presentation, we followed the parties' patient-based formulation of market shares. *See* Virginia Cooperative Agreement Application, Exhibit 5.2: Shares for New Health System, https://swvahealthauthority.files.wordpress.com/2016/02/5-2-shares-for-new-health-system.pdf, at 2. However, neither the *Merger Guidelines* nor relevant case law dictate the use of patient-based shares in an antitrust context.

[50] *See also* Competition Economics Report, *supra* note 44, at 10, Table 3. That analysis estimated a similarly large post-merger market share for the combined hospital system of 77%, a post-merger HHI of 5,987, and an HHI increase of 2,551.

[51] *See supra* note 48.

[52] *See* Market Shares and HHIs in Prior Healthcare Merger Cases (Attachment B).

Table 1: Inpatient Market Shares for 21-County Area
(Based on 2014 Commercial Discharges)

Hospital Systems	Pre-Merger Market Share	Post-Merger Market Share
Mountain States Health Alliance (TN, VA)	**42.23%**	**71.13%**
Wellmont Health System (TN, VA)	**28.90%**	
LifePoint Health • Clinch Valley Medical Center (VA) • Wythe County Community Hospital (VA)	5.42%	5.42%
Covenant Health • Morristown-Hamblen Healthcare System (TN) • Claiborne Medical Center (TN) • Fort Sanders Regional Medical Center (TN) • Parkwest Medical Center (TN) • LeConte Medical Center (TN) • Methodist Medical Center of Oak Ridge (TN)	4.68%	4.68%
Laughlin Memorial Hospital (TN)	4.19%	4.19%
Community Health Systems • Tennova – Newport Medical Center (TN) • Tennova – Lakeway Regional Hospital (TN) • Tennova – Jefferson Memorial Hospital (TN) • Tennova Healthcare – Clarksville (TN) • Tennova Healthcare – Lebanon (TN) • Southern Virginia Regional Medical Center (VA)	1.86%	1.86%
Carilion Clinic • Carilion Tazewell Community Hospital (VA) • Carilion Giles Community Hospital (VA) • Carilion New River Valley Medical Center (VA) • Carilion Clinic Saint Albans Hospital (VA)	1.74%	1.74%
University of Tennessee Medical Center (TN)	1.73%	1.73%
Adventist Health System • Takoma Regional Hospital (TN)	1.55%	1.55%
Duke LifePoint Healthcare • Twin County Regional Hospital (VA)	1.30%	1.30%
Vanderbilt University Medical Center (TN)	1.22%	1.22%
Buchanan General Hospital (VA)	1.20%	1.20%
Other Hospitals (less than 1% share each)	3.97%	3.97%
HHI	**Pre-Merger**	**Post-Merger**
	2,720	**5,161**
	Change in HHI = 2,441	

FTC staff has assessed market conditions using the 21-county area that the merging hospitals have identified as their service area, to be consistent with the information submitted by Mountain States and Wellmont. However, we do not concede that it necessarily represents a "relevant geographic market" under the *Merger Guidelines* or antitrust case law. This 21-county area is potentially broader than a market defined for antitrust purposes, meaning the shares listed above are conservative and likely to understate the competitive impact. But adjusting the area in which to assess market shares does not change the conclusion that the merger results in a high combined share. In fact, Mountain States and Wellmont admit that they would have an 88.4% share of total discharges in their 90% service area (*i.e.*, the zip codes that comprise the area where 90% of their patients reside) and a 93.6% share of total discharges in their 75% service area (*i.e.*, the zip codes that comprise the area where 75% of their patients reside).[53] Neither of these areas necessarily represent a relevant market for antitrust purposes, but they illustrate the overwhelming share of inpatient services controlled by Mountain States and Wellmont in Southwest Virginia and Northeast Tennessee. As demonstrated in the attached maps showing inpatient admission market shares in each county (Attachment E), Mountain States and Wellmont are by far the two largest providers of general acute care services in most of the counties in the region.

The proposed cooperative agreement also would result in high market shares for several outpatient and physician specialty services in Southwest Virginia and Northeast Tennessee, based on facility or physician counts. For example, shares calculated by Mountain States and Wellmont indicate that they would control a high share of outpatient facilities for imaging services (60% of CT scans and 53% of MRI), hospital-based surgeries (58%), surgeries at ambulatory surgery centers ("ASCs") (68%), and cancer treatment services (60% or more).[54] With respect to physician services, according to information contained in the cooperative agreement application, post-merger Mountain States and Wellmont would control 86% of cardiology services, 85% of hematology and oncology services, 80% of occupational medicine services, and 62% of pulmonary services.[55] Mountain States and Wellmont have since submitted a revised table showing lower combined shares in these and other physician specialties, but they did not provide any underlying data that might explain the discrepancy between the two sets of shares.[56] The revised table may understate the applicants' combined physician shares by

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[53] Mountain States & Wellmont, Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Letter Authorizing Cooperative Agreement, at 000096 (July 13, 2016), https://swvahealthauthority.files.wordpress.com/2016/07/msha-responses-to-questions-bates.pdf [hereinafter Responses to Authority Questions] (Exhibit 12A: Inpatient Shares Based on New Health System 75% Service Area); *id.* at 000097 (Exhibit 12B: Inpatient Shares Based on New Health System 90% Service Area).

[54] *Id.* at 000101 (Exhibit 12D: Outpatient Shares Based on New Health System's Geographic Service Area).

[55] *See* Virginia Cooperative Agreement Application at 56. The above market shares include physicians employed by Mountain States and Wellmont, as well as physicians affiliated with Mountain States. Even under a conservative approach that limits the hospital systems' share to employed physicians, they would still command a dominant share of these physician specialty services post-merger: 85% for cardiology, 79% for hematology/oncology, 80% for occupational medicine, and 57% for pulmonology.

[56] Mountain States & Wellmont, Supplement to Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Application for Letter Authorizing Cooperative Agreement, at 000132 (July 25, 2016), https://swvahealthauthority.files.wordpress.com/2016/08/supplement_to_msha-

including mid-level healthcare practitioners, such as physician assistants and nurse practitioners, as well as by consolidating physician specialty categories that were reported separately in the initial application. Nevertheless, even according to the revised table, Mountain States and Wellmont will employ or have an affiliation with more than 60% of physicians and mid-level practitioners who perform cardiovascular services and urgent care services, roughly 60% of those who perform pulmonology services, and roughly 50% of those who perform oncology and hematology services.[57]

Furthermore, shares based on the broad 21-county area likely understate the competitive implications of the cooperative agreement for physician services. Because patients likely stay relatively close to home when seeking care for most physician services, the relevant geographic markets for these services are likely to be much narrower than the 21-county area. Shares based on 21 counties may mask concentration in more local markets. For example, FTC staff analysis of Centers for Medicare & Medicaid Services ("CMS") data indicates that county-level shares for Mountain States and Wellmont physicians exceed 50% in a number of specialties, including primary care and family medicine physicians, and exceed 70% in cardiology, pulmonology, oncology/hematology, and occupational medicine in some counties.

Below, we present FTC staff's assessment of each potential disadvantage that the Authority and Commissioner must consider under the Virginia Cooperative Agreement Act.

2. The Cooperative Agreement Would Make It More Difficult for Health Insurers to Negotiate Reasonable Payment and Service Arrangements with Mountain States and Wellmont, Which Likely Would Result in Higher Prices for Employers and Patients

> ***COOPERATIVE AGREEMENT DISADVANTAGE FACTOR A:*** *The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers*[58]

ASSESSMENT: The Virginia Cooperative Agreement Act requires the Authority and the Commissioner to consider whether the proposed merger would have an adverse impact on the ability of health insurers "to negotiate reasonable payment and service arrangements" with healthcare providers. Ultimately, this is an important indicator of how the merger is likely to impact consumers because health insurers negotiate on behalf of their customers – area residents

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wellmont_swvha_responses.pdf (Replacement Application Exhibit 14.1 (Section E): Physician Status by Specialty/Employment); *id.* at 000128-29.

[57] *Id.*

[58] Virginia Cooperative Agreement Act, § 15.2-5384.1, E.3.a.

and employers.[59] When hospitals obtain greater bargaining leverage, they are able to negotiate higher reimbursement rates (*i.e.*, prices) with insurers. Insurers typically pass on these higher prices to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses. This affects fully insured employers who offer coverage to their employees, self-insured employers who pay their employees' healthcare claims, employees who pay some portion of their health insurance benefits, and individuals who purchase health insurance directly.[60] Furthermore, employers facing higher costs may reduce insurance coverage for their employees or eliminate insurance coverage altogether. Higher healthcare costs can also be passed through to employees in the form of lower wages and total compensation.[61] Because the FTC is concerned about the impact that healthcare mergers will have on consumers, we take seriously the impact that a hospital merger will have on the ability of insurers to negotiate competitive prices and other contractual terms on consumers' behalf.

Currently, prices for inpatient, outpatient, and physician services provided by Mountain States and Wellmont are set via separate negotiations between each hospital system and insurers. We focus our discussion below on inpatient hospital services, but the same analysis applies to outpatient and physician services. Each side in these negotiations has some bargaining power. The insurer's bargaining power stems from the fact that the hospital wants access to the insurer's patient members, and the hospital's bargaining power stems from the fact that its inclusion in the insurer's network will make that network more attractive to potential patient members. The prices that result from these negotiations are a function of the *relative* bargaining leverage of the two sides in the negotiations, which will depend on how each side would fare if no agreement were reached. Generally, the less one side has to lose from failure to reach an agreement, relative to the other side, the more favorable prices and other contractual terms it will be able to

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[59] *See* Drozdowski (Anthem) Decl. (Att. A) ¶ 26 ("To offer lower premium rates to existing and potential customers, Anthem Virginia and Amerigroup attempt to negotiate competitive rates for hospital and other medical services.").

[60] *See* Erin E. Trish & Bradley J. Herring, *How Do Health Insurer Market Concentration and Bargaining Power With Hospitals Affect Health Insurance Premiums?*, 42 J. HEALTH ECON. 104 (2015), http://www.sciencedirect.com/science/article/pii/S0167629615000375/pdfft?md5=66ce04855991acee37bcb9017c243ec6&pid=1-s2.0-S0167629615000375-main.pdf.

[61] *See, e.g.*, Gaynor, Ho & Town, *supra* note 11, at 236 (stating that employers pass through higher health care costs dollar for dollar to workers, either by reducing wages or fringe benefits, or even dropping health insurance coverage entirely); GAYNOR & TOWN (Att. C), *supra* note 11, at 1 ("Ultimately, increases in health care costs (which are generally paid directly by insurers or self-insured employers) are passed on to health care consumers in the form of higher premiums, lower benefits and lower wages[.]"); Jonathan Gruber, *The Incidence of Mandated Maternity Benefits*, 84 AM. ECON. REV. 622 (1994), http://economics.mit.edu/files/6484 (finding that increased health insurance costs can be passed to employees in the form of lower wages); Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity*, 28 J. HEALTH ECON. 649 (2009), http://www.sciencedirect.com/science/article/pii/S0167629609000113/pdfft?md5=df7052c7c702b150f9ebb693090e6fef&pid=1-s2.0-S0167629609000113-main.pdf (finding that increased health insurance costs can be passed to employees in the form of lower wages); Katherine Baicker & Amitabh Chandra, *The Labor Market Effects of Rising Health Insurance Premiums*, 24 J. LAB. ECON. 609 (2006), https://www.hks.harvard.edu/fs/achandr/JLE_LaborMktEffects RisingHealthInsurancePremiums_2006.pdf (finding that increased health insurance costs lead to reduced wages and employment); Priyanka Anand, *The Effect of Rising Health Insurance Costs on Compensation and Employment*, (Mar. 25, 2013) (unpublished manuscript), http://docplayer.net/1978184-The-effect-of-rising-health-insurance-costs-on-compensation-and-employment.html (finding that as health insurance costs increase employers that offer health insurance reduce total employee compensation).

negotiate. Mergers of competing hospitals give hospitals more relative bargaining leverage because, after the merger, insurers now have more to lose from failing to reach agreement with the merged system.

Today, Mountain States and Wellmont each *already* has substantial bargaining leverage in negotiations with health insurers. An insurer network that lacks the hospitals of either system is less attractive to employers and consumers than a network that includes the hospitals of both systems, and this gives each system significant bargaining power today relative to insurers. However, the bargaining leverage of each hospital system is limited by the availability of the *other* system as an alternative. That is, an insurer could still offer a fairly attractive network if it included only one of the two hospital systems, especially because that more limited network would likely be offered at a discount.[62] Indeed, this has happened before in Southwest Virginia and Northeast Tennessee. For example, in 2012, one health insurer dropped Mountain States from its network and relied on Wellmont to meet its patient members' healthcare needs after Mountain States demanded higher prices than the insurer was willing to pay and that insurer could not reach an agreement with Mountain States during contract negotiations.[63]

The proposed merger of Mountain States and Wellmont would give the merged hospital system even greater bargaining leverage over insurers and eliminate the leverage for insurers that competition between Mountain States and Wellmont provides. Failure to reach an agreement with the merged hospital system would now mean the loss of *both* hospital systems from the insurer's network, making it *very* unattractive to consumers. It would be virtually impossible for an insurer to assemble a viable local provider network without contracting with the merged hospital system.[64] This would give the merged hospital system the ability to extract substantially higher reimbursement rates from health insurers during contract negotiations.[65] Competition from other hospitals would not prevent this, as the other hospitals are either too far away from most of the patients who currently use Mountain States and Wellmont, or their service offerings are too limited to constitute a provider network that would be attractive.[66] Thus, the proposed merger between Mountain States and Wellmont would greatly enhance the hospitals' bargaining power, which would lead to substantially higher prices for consumers.[67]

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[62] *See* Drozdowski (Anthem) Decl. (Att. A) ¶ 26. It is important to note that, even in this case, both the hospital system and the insurer still benefit from reaching an agreement, and so agreement is usually reached. But the *terms* on which agreement is reached depend on the relative bargaining power of the hospital system and the insurer, which in turn will depend on the degree of hospital competition.

[63] *See* George Jackson, *MSHA Splits with CIGNA, Commits to New Health Care Model*, BRISTOL HERALD COURIER (Nov. 23, 2011), http://www.heraldcourier.com/news/msha-splits-with-cigna-commits-to-new-health-care-model/article_b18fc80e-0198-57da-8134-c9c8e7320b9b.html. *See also* Drozdowski (Anthem) Decl. (Att. A) ¶ 38 (indicating that in 2002 Anthem dropped Mountain States from its provider network).

[64] Drozdowski (Anthem) Decl. (Att. A) ¶ 77.

[65] *Id.* ¶ 32; Comment from Virginia Association of Health Plans to the Southwest Virginia Health Authority (May 25, 2016).

[66] Drozdowski (Anthem) Decl. (Att. A) ¶ 48.

[67] The above analysis assumes that the merged hospital system will bargain with insurers on an all-or-nothing basis (*i.e.*, contract with all hospitals in the system or none). If instead each hospital continued to negotiate separately, the merger would still lead to a price increase, though the mechanism would be slightly different.

Mountain States and Wellmont have suggested that consolidation occurring at all levels of the healthcare industry necessitates the proposed merger. In particular, they have highlighted consolidation among health insurers as a motivating factor for the proposed merger.[68] FTC staff routinely hears concerns from healthcare providers about insurer consolidation and leverage, along with claims that providers must counter this insurer consolidation and leverage by enhancing their own in response. However, as discussed above, mergers that increase healthcare providers' bargaining power are likely to result in higher prices for hospital services, regardless of the degree of competition between insurers. A merger between close hospital competitors increases the bargaining leverage of the hospitals, and leaves the bargaining leverage of the insurer unchanged, which means that the hospitals' *relative* bargaining leverage has increased, even if the insurer's leverage is already high.[69]

Hence, the proposed merger between Mountain States and Wellmont is likely to increase the prices of healthcare services for residents in Southwest Virginia and Northeast Tennessee. As discussed in Section VI.A, the price commitments proposed by Mountain States and Wellmont are unlikely to mitigate this harm.

3. The Cooperative Agreement Is Likely to Substantially Reduce Competition for Physician Services and Ancillary Healthcare Services

> ***COOPERATIVE AGREEMENT DISADVANTAGE FACTOR B:*** *The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement*[70]

ASSESSMENT: The framework to evaluate mergers that combine outpatient providers and physician services is essentially the same as that described above for inpatient hospitals. Like hospitals, providers of outpatient services and physician services compete for inclusion in health plan networks and to attract patients. These providers negotiate reimbursement rates with insurers, and the rates negotiated depend on their relative bargaining leverage. When there are adequate alternatives to a particular provider, an insurer has a greater ability to resist demands for higher rates by a particular outpatient provider and physician-services provider.

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[68] *See* Wellmont & Mountain States, Better Together: Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report, https://swvahealthauthority.files.wordpress.com/2016/02/1-1-pre-submission-report.pdf, at 7 [hereinafter Pre-Submission Report]; David McGee, *Health Systems' Proposed Merger 'Relatively' On Schedule, Leaders Say*, BRISTOL HERALD COURIER (Oct. 19, 2015), http://www.heraldcourier.com/news/local/health-systems-proposed-merger-relatively-on-schedule-leaders-say/article_eefd6803-0568-55ed-b237-d5dc262c6025.html.

[69] We also note that the Department of Justice has sued to block the Aetna-Humana and Anthem-Cigna mergers. *See* Press Release, U.S. Dep't of Justice, Justice Department and State Attorneys General Sue to Block Anthem's Acquisition of Cigna, Aetna's Acquisition of Humana (July 21, 2016), https://www.justice.gov/opa/pr/justice-department-and-state-attorneys-general-sue-block-anthem-s-acquisition-cigna-aetna-s.

[70] Virginia Cooperative Agreement Act, § 15.2-5384.1., E.3.b.

Mountain States and Wellmont are close competitors for outpatient and physician services. The systems operate competing outpatient centers that serve Southwest Virginia and Northeast Tennessee, and each system employs physicians in the area across numerous specialties. Mountain States and Wellmont compete for inclusion in insurer networks and negotiate with insurers to establish rates for outpatient and physician services. The merger will eliminate the competition between Mountain States and Wellmont for outpatient and physician services and will further consolidate those markets.

As previously stated, the proposed merger would result in the merged system commanding high, even dominant, market shares for several physician specialty services, including cardiology, hematology and oncology, occupational medicine, and pulmonology – ranging from 57% to 85%.[71] In addition, the merged system would have shares greater than 50% for several outpatient services. Market shares of this magnitude indicate that the cooperative agreement is likely to enhance Mountain States's and Wellmont's market power. Post-merger, the combined system's negotiating leverage is likely to increase substantially, which is likely to lead to higher prices and reduced quality and availability of physician and outpatient services to the serious detriment of employers and area residents. Notably, this is inconsistent with the Authority's Blueprint goals regarding access to specialty physician services.[72] As discussed in Section VI.A, the price commitments proposed by Mountain States and Wellmont will be unlikely to mitigate this harm.

4. The Cooperative Agreement Is Likely to a Have a Substantial Adverse Impact on the Quality, Availability, and Price of Healthcare Services for Patients in Southwest Virginia

COOPERATIVE AGREEMENT DISADVANTAGE FACTOR C: *The extent of any likely adverse impact on patients in the quality, availability, and price of health care services*[73]

ASSESSMENT: As described above, the cooperative agreement would give Mountain States and Wellmont tremendous bargaining leverage with insurers to negotiate significantly higher reimbursement rates, which are passed through to consumers in the form of higher premiums, copayments, deductibles, and other out-of-pocket expenses.[74] This would have a substantial adverse impact on patients with respect to the price of healthcare services.

Additionally, Mountain States and Wellmont compete on quality and service, including patient experience, access to healthcare services and innovative technology, and other quality and service metrics.[75] These non-price dimensions of competition greatly benefit patients and are

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[71] *See supra* note 55 and accompanying text.
[72] *See* BLUEPRINT, *supra* note 4, Goal 5.1 ("Increase access to certified specialty care providers, with a focus on endocrinology, cardiology, pulmonary, and oncology[.]").
[73] Virginia Cooperative Agreement Act, § 15.2-5384.1., E.3.c.
[74] *See supra* Section IV.A.2.
[75] *See* Drozdowski (Anthem) Decl. (Att. A) ¶¶ 11, 52, 55-61.

among the factors by which employers and consumers evaluate the desirability of a provider network. Today, Mountain States and Wellmont know that patients can choose to seek care at, and physicians can send their referrals to, the other system if they are not satisfied with the quality, patient experience, or services offered by either hospital system. That threat of losing patients and physician referrals to a rival system incentivizes each system to provide the best possible quality and patient experience, to add new services and technology, and to enhance the availability and convenience of care.[76] Not surprisingly, Mountain States and Wellmont compare themselves to each other on a number of quality and patient experience dimensions, to attract patients in the local area.[77]

The competition between Mountain States and Wellmont for patients also incentivizes each system to provide innovative medical technology and to enhance their service lines.[78] For example, competition between Wellmont and Mountain States spurred the adoption and expansion of upgrades to robotic surgery technology at both hospital systems.[79] Similarly, competition between the systems has led to increased rehabilitation services for patients recovering from stroke, brain and spinal cord injury, cardiac and pulmonary conditions, and

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[76] Alan Levine, President and CEO of Mountain States, emphasized this point to the Mountain States community in a 2014 newsletter article:

> So when we talk about growth, the most important word I want you to keep in mind is **CHOICE**. Let me explain what I mean by that. Our patients do not have to use our services. They have a choice. They can choose a different doctor, a different hospital, a different outpatient clinic. And if we don't deliver the quality they deserve or the patient experience they want, they **will** choose someone else. Our goal, and the way we will achieve success in the Growth pillar, is by giving our patients such outstanding care and such a positive patient experience that they will **want** to choose us. If we do our jobs well, they'll not only choose us, but they'll tell their family and friends that **they** ought to choose us too, if they want the very best that health care has to offer. . . . **That** is how we grow -- by earning our patients' trust and loyalty and respecting the fact that they always have a choice.

Alan Levine, Mountain States, *A Look at Our New Growth Pillar: Earning Our Patients' Trust*, MOUNTAIN STAR (Aug. 19, 2014), http://www.mshanews.org/news/article.aspx?id=1958 (emphasis in original).

[77] *See id.*; Mountain States, *Survey Shows MSHA Is No. 1 Health Care Provider in the Region*, MOUNTAIN STAR (Aug. 20, 2012), http://www.mshanews.org/news/article.aspx?id=368 (discussing results of the National Research Corporation survey that compared Mountain States to Wellmont along a number of quality and patient experience dimensions).

[78] Nathan Baker, *The Battle Must End: Health Care Officials Say Merger Is Best Route to Serve Community*, JOHNSON CITY PRESS (Apr. 26, 2015), http://www.johnsoncitypress.com/Local/2015/04/25/The-battle-must-end-Health-care-officials-say-merger-is-best-route-to-serve-community.html ("When one [system] purchased a new piece of equipment, the other [system], by competitive necessity, bought one too."). *See infra* Section IV.B.5.

[79] *See, e.g.*, Press Release, Wellmont, Holston Valley Begins Using da Vinci Surgical System Reinforcing Wellmont's Leadership in Robotics (May 8, 2012), http://wellmont.newsroom.meltwaterpress.com/news/holston-valley-begins-using-da-vinci-surgical-system-reinforcing-wellmont-s-leadership-in-robotics; Mountain States, *JCMC Upgraded to Newest da Vinci Robotic Surgical System*, MOUNTAIN STAR (July 11, 2012), http://www.mshanews.org/news/article.aspx?id=190. Robotic surgery allows for minimally invasive surgery, by translating surgeon hand movements into smaller, more precise movements of tiny instruments inside a patient's body. *See* DA VINCI SURGERY, http://www.davincisurgery.com/.

orthopedic conditions.[80] In addition, in response to community demand, Wellmont expanded urgent care services into Johnson City, Tennessee, and Abingdon, Virginia, two areas that at the time were predominantly served by Mountain States's hospitals.[81]

The elimination of competition between Mountain States and Wellmont will significantly diminish the hospitals' incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because the combined hospital system would no longer risk losing patients to its pre-merger rival. Importantly, a reduction in quality of care can have an adverse effect on patient outcomes such as mortality, readmissions, and length of stay. Reduced availability of services may result in decreased patient access, increased travel time to receive services, increased emergency room wait times, and other negative consequences. Indeed, the empirical economic evidence indicates that increased competition is associated with better quality.[82]

Notably, the benefits of competition among healthcare providers are not confined to those patients covered by commercial insurance plans. Competition benefits *all* patients, including those who are covered by government insurance programs (*i.e.*, Medicare and Medicaid) or are uninsured. By far, the most important such benefit is improved quality of care. As noted above, competition-reducing mergers often reduce quality. Those quality reductions will harm all of the hospitals' patients, not just those with commercial insurance. Competition may also indirectly restrain the prices or premiums paid by patients covered by a government insurance program or who are uninsured.[83]

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[80] *See, e.g.*, Press Release, HealthSouth Corp., Wellmont, HealthSouth Form Joint Venture to Open a New Rehabilitation Hospital in Southwest Virginia (Sept. 8, 2009), http://s2.q4cdn.com/500379385/files/doc_news/2009/HLS_News_2009_9_8_General_Releases.pdf;
Press Release, HealthSouth Corp., HealthSouth and Mountain States Health Alliance Finalize Joint Venture to Operate Quillen Rehabilitation Hospital in Johnson City, Tennessee (Nov. 5, 2014), http://s2.q4cdn.com/500379385/files/doc_news/HealthSouth-And-Mountain-States-Health-Alliance-Finalize-Joint-Venture-To-Operate-Quillen-Rehabilitation-Hospital-In-Johnson-City-Tennessee.pdf.

[81] WELLMONT, WELLMONT DEFINED: FISCAL 2011 REPORT TO OUR COMMUNITIES 28 (2011), http://www.wellmont.org/uploadedFiles/About_Us/Wellmont-Defined-Fiscal-2011-Report.pdf ("Not so long ago, area yards displayed signs reading 'We Need Wellmont,' as residents expressed their desire for Wellmont services in their communities.").

[82] *See* Gaynor, Ho & Town, *supra* note 11, at 249 ("[T]he evidence indicates that increases in competition improve hospital quality."); GAYNOR & TOWN (Att. C), *supra* note 11, at 3 ("While it is not possible to draw direct conclusions about the United States based on evidence from the United Kingdom, these studies add to the growing evidence base that competition leads to enhanced quality under administered prices.").

[83] Many Medicare patients are covered by Medicare Advantage (MA) plans rather than by traditional Medicare. MA hospital prices are negotiated rather than fixed and, as such, vary from traditional Medicare hospital prices. *See* Robert A. Berenson, Jonathan H. Sunshine, David Helms & Emily Lawton, *Why Medicare Advantage Plans Pay Hospitals Traditional Medicare Prices*, 34 HEALTH AFFAIRS 1289 (Aug. 2015), http://content.healthaffairs.org/content/34/8/1289.abstract; Laurence Baker, M. Kate Bundorf, Aileen Devlin & Daniel Kessler, *Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays*, 35 HEALTH AFFAIRS 1444 (Aug. 2016), http://content.healthaffairs.org/content/35/8/1444.abstract. A competition-reducing merger may to some extent increase MA prices, and those increases will be passed through to Medicare beneficiaries in the form of higher MA premiums or reduced benefits. In addition, under the Patient Protection and Affordable Care Act, prices that non-profit hospitals charge to uninsured, self-pay patients eligible for financial assistance can be no more than "amounts

Therefore, the proposed cooperative agreement is likely to have a substantial negative impact on patients with respect to the quality, availability, and price of healthcare services. As discussed in Section VI, the commitments proposed by Mountain States and Wellmont are unlikely to mitigate this harm.

5. The Cooperative Agreement Is Unnecessary Because Less Restrictive Arrangements Are Available That Would Achieve Similar Benefits While Posing Fewer Competitive Disadvantages Than the Merger

> ***COOPERATIVE AGREEMENT DISADVANTAGE FACTOR D:*** *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 likely to result from the proposed cooperative agreement*[84]

ASSESSMENT: The Authority and the Commissioner must consider whether there are alternative arrangements that would be less restrictive to competition and would achieve the same benefits, or a more favorable balance of benefits over disadvantages. This statutory factor is similar to the *Merger Guidelines* requirement that any cost saving or quality benefit must be "merger-specific" to be recognized as an efficiency – meaning the cost saving or quality benefit likely would *only* be achieved through the proposed merger rather than through practical alternatives that would raise fewer competitive concerns. Practical alternatives may include actions undertaken by the hospital systems independently, joint ventures and other forms of collaboration between the merging parties, or a merger or affiliation with a different partner.[85] In this section, we explain generally why most of the benefits from the merger could be achieved through alternatives that are less restrictive to competition and achieve comparable benefits or a more favorable balance of benefits over disadvantages.[86] Throughout the next section, in which we assess the claimed benefits of the merger, we identify specific instances where practical alternatives that are less restrictive to competition may be available.

Both Mountain States and Wellmont are integrated health systems with sufficient scale, capability, and resources to achieve the claimed benefits independently. For example, both

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generally billed to insured patients." *See* Sara Rosenblum, *Additional Requirements For Charitable Hospitals: Final Rules On Community Health Needs Assessments And Financial Assistance*, HEALTH AFFAIRS BLOG (Jan. 23, 2015), http://healthaffairs.org/blog/2015/01/23/additional-requirements-for-charitable-hospitals-final-rules-on-community-health-needs-assessments-and-financial-assistance/. The calculation of these "amounts generally billed" includes commercial insurance prices, which means that increases in commercial prices also increase the prices that hospitals are permitted to charge to uninsured patients.

[84] Virginia Cooperative Agreement Act, § 15.2-5384.1, E.3.d.

[85] *Merger Guidelines* § 10.

[86] This assumes that benefits would be achieved as a result of the merger. FTC staff believes that any benefits resulting from the merger that are substantiated and merger-specific are likely to be modest.

hospital systems already have fully-functioning electronic health records systems and engage in population health management initiatives and value-based payment models.[87]

There are also many ways that Mountain States and Wellmont could collaborate with each other to achieve the benefits they claim will result from the merger without actually having to merge, including, but not limited to, joint ventures and other contractual agreements to coordinate and standardize clinical healthcare services. Indeed, they already engage in many such collaborative efforts to improve healthcare services in this region, as identified in their cooperative agreement application.[88]

The merging parties contend that the cooperative agreement will allow them to provide new and enhanced services that they cannot otherwise provide due to antitrust concerns.[89] However, as the antitrust agencies have consistently made clear, the antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers. Indeed, the FTC has issued extensive guidance to healthcare providers about ways that they can collaborate without running afoul of the antitrust laws.[90]

Another option the parties could consider if they believe they could not independently achieve these benefits would be to merge or affiliate with alternative hospital systems that raise fewer antitrust concerns. Wellmont received eight alternative proposals from other hospital systems, suggesting there may well be viable, less competitively harmful alternatives to the proposed merger to near-monopoly.[91]

Mountain States and Wellmont counter that alternative mergers with out-of-market health systems would result in greater price increases, facility closures, job losses, and other negative economic consequences as compared to a local merger.[92] However, FTC staff is unaware of evidence supporting this broad statement. Indeed, the only evidence that Mountain States and Wellmont offer in support of their claim is inapplicable to the circumstances presented here. They cite an economic study showing that average price increases of 17% may occur when out-of-market health systems acquire *independent* hospitals, even though they do not compete in the

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[87] *See infra* Sections IV.B.1.c), IV.B.2, and IV.B.7.
[88] Virginia Cooperative Agreement Application at 24-25. *See infra* note 145.
[89] *See* Virginia Cooperative Agreement Application at 86 (suggesting that collaborative efforts between independent hospital systems cannot be undertaken due to antitrust concerns).
[90] *See, e.g.*, U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996), https://www.ftc.gov/sites/default/files/documents/reports/revised-federal-trade-commission-justice-department-policy-statements-health-care-antritrust/hlth3s.pdf (see specifically Statement 6 regarding provider participation in exchanges of price and cost information, Statement 7 regarding joint purchasing arrangements among providers of health care services, and Statement 8 regarding physician network joint ventures); Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, 76 Fed. Reg. 67026 (Fed. Trade Comm'n & U.S. Dep't of Justice Oct. 28, 2011), http://www.gpo.gov/fdsys/pkg/FR-2011-10-28/pdf/2011-27944.pdf.
[91] *See* Virginia Cooperative Agreement Application at 5 (discussing Wellmont's strategic alignment options).
[92] Pre-Submission Report, *supra* note 68, at 7-8; Virginia Cooperative Agreement Application at 36 (stating that an out-of-market merger "would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities" as the cooperative agreement between Mountain States and Wellmont).

same local healthcare market.[93] However, both Mountain States and Wellmont are already large, integrated hospital systems, not independent hospitals. Moreover, this study does *not* show that acquisitions by out-of-market health systems result in the same or greater price effects than a merger to near-monopoly in a local healthcare market. To the contrary, this study suggests that the price effects of mergers between hospitals located within close proximity of one another are likely to be far more significant than those involving distant ones.[94]

Moreover, the merging parties' claims that an acquisition by an out-of-market system would result in facility closures, job losses, and other negative economic consequences must be considered in light of the parties' limited commitment to maintain their existing facilities post-merger. For example, they have only committed to continue operating existing facilities for five years and to maintain three tertiary hospitals and Johnston Memorial for an unspecified period of time; for most hospitals, they have made no commitment to continue operating hospitals at current service levels or even as hospitals at all.[95] The parties also admit that there will be job losses and facility consolidation as a result of the merger.[96] Mountain States and Wellmont have not shown that alternative arrangements having less of an anticompetitive effect would result in more facility closures, job losses, and negative economic consequences.

In sum, the proposed merger eliminates substantial competition and will likely lead to significantly higher prices and a reduced incentive to maintain or improve quality and access to care. Moreover, there are likely to be several alternatives to the merger – remaining independent, joint ventures and other collaborations, or alternative mergers – that are likely to achieve

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[93] *See* Responses to Authority Questions, *supra* note 53, at 000005 (citing Lewis & Pflum 2016, *infra* note 94) ("At least one study has shown this type of merger 'allowed hospitals to increase average prices by around 17 percent, with some specifications suggesting even larger increases.'").

[94] *See, e.g.*, Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, RAND J. ECON. at 18 (Aug. 2016 - forthcoming), http://www.clemson.edu/economics/faculty/lewis/Research/Lewis_Pflum_hosp_bp.pdf ("When hospitals within two miles of each other merge, prices increase by roughly 50% more on average than for mergers involving hospitals more than five miles away."). There are a few other empirical studies suggesting that large hospital systems may be able to command higher prices simply by virtue of their size or breadth, regardless of the impact to competition in local healthcare markets. *See* Matthew S. Lewis & Kevin E. Pflum, *Diagnosing Hospital System Bargaining Power in Managed Care Networks*, 7 AM. ECON. J.: ECON. POL'Y 243 (2015), https://www.aeaweb.org/articles?id=10.1257/pol.20130009; Leemore Dafny, Kate Ho & Robin S. Lee, *The Price Effects of Cross-Market Hospital Mergers* (Nat'l Bureau of Econ. Research, Working Paper No. 22106, 2016), http://www.nber.org/papers/w22106.pdf. *See also* FTC-DOJ Healthcare Workshop 2015, *supra* note 18 (panel on "Trends in Provider Consolidation"). However, these studies do not suggest that the Mountain States-Wellmont merger would not result in a significant price increase, nor do they suggest that a merger between Wellmont (or Mountain States) and another hospital system would result in as large of a price increase as the proposed merger between Mountain States and Wellmont. There are two reasons for this. First, to the extent that large systems may be able to obtain higher prices, a combined Mountain States-Wellmont hospital system would be large enough to obtain higher prices. Second, and more important, in contrast to the Mountain States-Wellmont merger, none of the alternative mergers would result in the elimination of such extensive head-to-head competition between hospitals. As discussed throughout this comment, the loss of this competition is likely to have highly negative effects.

[95] *See infra* Section IV.B.3.

[96] *See infra* note 180 and accompanying text.

comparable benefits identified in the cooperative agreement, but without the substantial lessening of competition.

B. The Claimed Benefits of the Cooperative Agreement Are Largely Speculative, Achievable Without the Merger, and Unlikely to Outweigh the Merger's Likely Disadvantages

Under Virginia law, the Authority and the Commissioner must consider whether the proposed cooperative agreement is likely to generate sufficient public benefits to offset the likely harm to consumers.[97] This is similar to the analysis that courts and antitrust agencies perform when assessing the competitive impact of mergers.[98] As noted above, the *Merger Guidelines* reflect the combined experience of the antitrust agencies when assessing mergers. In addition to considering competitive harm, that assessment includes consideration of the potential benefits resulting from the transaction.

Mountain States and Wellmont claim that the proposed merger is necessary to generate cost savings and improve the quality and availability of healthcare services in Southwest Virginia and Northeast Tennessee. They estimate that the merger will eventually generate approximately $121 million in annual cost savings after the first five years.[99] They have also committed to invest $450 million over a ten-year period in various initiatives that they claim will improve healthcare in the region.[100] Based on FTC staff's assessment, the claimed benefits of this merger – even assuming they were realized – would be unlikely to outweigh the transaction's substantial adverse impact on competition and consumers.

For cost savings and quality benefits to be recognized as cognizable efficiencies under the *Merger Guidelines*, they must be sufficiently substantiated by the merging hospitals so that courts and antitrust agencies "can verify by reasonable means the likelihood and magnitude of each asserted efficiency, how and when each would be achieved (and any costs of doing so), how each would enhance the merged firm's ability and incentive to compete, and why each would be merger-specific."[101] Rigorous substantiation of efficiency claims is critical because efficiencies are difficult to verify and quantify, in part because much of the information is in the hands of the merging parties, and because efficiencies may not be realized. Indeed, legal cases indicate that efficiency claims based on "speculation and promises about post-merger behavior" are not

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[97] *See* Virginia Cooperative Agreement Act, § 15.2-5384.1., E.1.
[98] *See Merger Guidelines* § 10; Fed. Trade Comm'n v. ProMedica, No. 3:11 CV 47, 2011 WL 1219281, at *57 (N.D. Ohio Mar. 29, 2011) (finding that the defendant's efficiencies claims did not rebut a presumption of anticompetitive effects); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1088-89 (N.D. Ill. 2012) (recognizing the *Merger Guidelines* approach for evaluating efficiencies); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1222 (11th Cir. 1991) (recognizing that efficiencies are an important consideration in predicting whether a transaction would substantially lessen competition).
[99] Virginia Cooperative Agreement Application at 44-47.
[100] *Id.* at 6.
[101] *Merger Guidelines* § 10.

sufficient.[102] Efficiency claims also must be "merger-specific" – meaning they can only be achieved by this particular merger and not through other means having the same or lesser anticompetitive effects – a similar requirement to the Virginia cooperative agreement statutory factor discussed in Section IV.A.5.

Any cost savings and quality benefits that are substantiated and merger-specific must then be balanced against the likely competitive harm. Under the *Merger Guidelines*, the greater the potential anticompetitive effects from a merger, the greater the efficiencies need to be to outweigh the harm from the merger, and the more they must be passed through to consumers. Where the proposed merger is likely to result in substantial harm to competition, the *Merger Guidelines* require a showing of extraordinary efficiencies to overcome that harm.[103] Experience has shown that "[e]fficiencies almost never justify a merger to monopoly or near-monopoly."[104] Mountain States and Wellmont have failed to meet that standard.

First, many of Mountain States and Wellmont's claimed benefits are not adequately substantiated, and therefore cannot be verified. The parties present little more than speculative and aspirational goals and promises about their post-merger behavior, without offering clear commitments regarding specific benefits to be achieved, how those benefits will be achieved, and how much it will cost to achieve those benefits.

Second, the merging parties have not shown that all of their claimed benefits are both merger-specific and incremental to the benefits the parties would have achieved without the merger. Mountain States and Wellmont pledge to use cost savings derived from the merger to invest $450 million over a 10-year period on quality and healthcare initiatives, including population health management initiatives, behavioral health services, and academic and research opportunities.[105] However, it is unclear what portion of the $450 million is truly incremental compared to the current or future investments that Mountain States and Wellmont would have made independently, absent the merger. Mountain States and Wellmont already make significant investments in quality and healthcare initiatives,[106] and likely would continue to do so even without the merger. Moreover, as discussed below, many of the claimed cost savings, quality benefits, and healthcare initiatives are not merger-specific because they could be achieved without incurring the substantial harm to consumers likely to result from the proposed merger.

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[102] United States v. H&R Block, Inc., 833 F. Supp. 2d 36, 89 (D.D.C. 2011) (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 720-721 (D.C. Cir. 2001)).
[103] *Merger Guidelines* § 10. *See also ProMedica*, 2011 WL 1219281, at *57 ("Efficiencies must be 'extraordinary' to overcome high concentration levels") (quoting Fed. Trade Comm'n v. H.J. Heinz, 246 F.3d 708, 721 (D.C. Cir. 2001)); *OSF Healthcare Sys*., 852 F. Supp. 2d at 1089 ("'[h]igh market concentration levels require proof of extraordinary efficiencies'") (quoting *H&R Block*, 833 F. Supp. 2d at 89).
[104] *Merger Guidelines* § 10.
[105] Virginia Cooperative Agreement Application at 6.
[106] *See, e.g.*, MOUNTAIN STATES, BUILDING HEALTHY COMMUNITIES: 2014 COMMUNITY REPORT (2014), https://www.mountainstateshealth.com/sites/default/files/documents/MTN-150141_050815_2015%20Community%20Report_WEB.pdf; WELLMONT, REPORT TO OUR COMMUNITIES (FY 2014), http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Report-to-Our-Communities-fy14.pdf.

Third, to the extent that there are efficiencies and benefits that are verifiable and merger-specific, they appear to be modest in magnitude and unlikely to offset the significant disadvantages of the merger. Furthermore, *even assuming* they could achieve all of the claimed cost savings, Mountain States and Wellmont have not specified how much of these anticipated efficiencies would be passed through to customers in the form of lower prices. The hospital systems estimate $121 million in annual cost savings (accruing over five years), yet their cooperative agreement application only commits them to reinvesting an average of $45 million annually in quality and healthcare initiatives in the community. Thus, it is unclear how much of the remaining $76 million in purported annual cost savings would be passed through to customers and how much would be retained by the hospital systems.

Below, we present FTC staff's assessment of each potential benefit that the Authority and Commissioner must consider under the Virginia Cooperative Agreement Act.

1. The Cooperative Agreement Is Unlikely to Significantly Enhance Quality of Hospital and Hospital-Related Care

COOPERATIVE AGREEMENT BENEFIT FACTOR A: *Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction*[107]

ASSESSMENT: In their cooperative agreement application, Mountain States and Wellmont argue that the merger generally would lead to improved quality of care and enhanced clinical coordination throughout the merged entity.[108] Assessing potential quality improvements has long been a central element of FTC hospital merger investigations because we recognize that a hospital merger could improve patient health outcomes under certain circumstances. We often analyze the clinical quality effects likely to occur as a result of consolidation with guidance from leading academic and policy experts in healthcare quality. We also evaluate how the merger affects the hospitals' incentives to deliver higher quality care, and whether changes brought about by the merger would enable the combined hospitals to provide higher quality care more cheaply or efficiently than they could achieve individually.

The elimination of substantial competition between merging hospitals tends to weaken a hospital's incentives to deliver higher quality care. There exists a substantial empirical literature that has evaluated the relationship between competition and various measures of hospital quality of care. The literature does not support the conclusion that hospital consolidation generally improves clinical quality of healthcare services.[109] To the contrary, the literature demonstrates

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[107] Virginia Cooperative Agreement Act, § 15.2-5384.1., E.2.a.
[108] Virginia Cooperative Agreement Application at 31.
[109] *See* Patrick Romano & David Balan, *A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Hospital*, 18 INT'L J. ECON. BUS. 45 (2011),

that the net effect of mergers of competing hospitals on quality is often negative. Thus, the available evidence provides no reason to presume that any given hospital merger is likely to improve quality or reduce costs by enough to offset a price increase.

We have evaluated the specific quality claims asserted by Mountain States and Wellmont. As detailed below, many of the claims Mountain States and Wellmont make about the likely quality benefits from the merger are unsubstantiated or the benefits are modest in scope. Most of the remaining claimed quality enhancements can be achieved through less restrictive alternatives – either by the parties independently, through another form of collaboration between the parties, or through an alternative merger or affiliation with a different partner that would not meaningfully reduce competition. In sum, we believe that the information and data in this case indicate that the net effect on quality from this cooperative agreement is likely to be negative.

a) Consolidation of Clinical Services Is Uncertain and Could Reduce Patient Access

Mountain States and Wellmont claim that the merger will improve patient outcomes through the consolidation of certain clinical services, including consolidation of the area's two Level I Trauma Centers, consolidation of unidentified specialty pediatric services, repurposing of acute care beds, and consolidation of "certain co-located facilities."[110] Notably, the parties concede that there may be limited opportunities to eliminate duplicative services in Southwest Virginia, so any benefits are likely to be modest.[111] In any case, the consolidation of clinical services likely would require considerable effort, money, and time. Mountain States and Wellmont have not provided this information in their cooperative agreement application, so it remains unclear whether they could successfully consolidate clinical services in such a way as to improve patient outcomes, or when the merging hospitals expect to realize any purported quality benefits. Moreover, consolidation could also reduce the availability of, and patient access to, healthcare services, for example, due to the closure of hospital facilities or a reduction in hospital staff. If this occurs, then the consolidation of clinical services may be more harmful to patients than beneficial.

Mountain States and Wellmont have suggested that a post-merger consolidation of clinical services would increase the volume of trauma procedures performed within a single hospital system, leading to improved quality outcomes because the higher volumes would allow hospital staff to better develop their skills.[112] The research literature shows that a "volume/outcome" relationship only exists for certain procedures and services, including trauma

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http://www.tandfonline.com/doi/abs/10.1080/13571516.2011.542955; Gaynor, Ho & Town, *supra* note 11; GAYNOR & TOWN (Att. C), *supra* note 11.

[110] Virginia Cooperative Agreement Application at 38-9.

[111] Responses to Authority Questions, *supra* note 53, at 000011 ("there is limited duplication or overlap of the Applicants' services in the Virginia portion of the Geographic Service Area").

[112] *See* Virginia Cooperative Agreement Application at 38.

and certain other complex procedures.[113] Any benefits from clinical consolidation would be confined to those services for which there is a demonstrated volume/outcome relationship. Moreover, for such procedures, consolidation may improve clinical quality outcomes only if it enables the combined hospital system to surpass certain volume thresholds that Mountain States and Wellmont could not meet independently. In their cooperative agreement application, Mountain States and Wellmont rely on an article indicating that the general trauma volume/outcome threshold is about 650 trauma admissions per facility per year.[114] Although our quality expert believes the volume/outcome threshold is closer to 500 trauma admissions per year, even using the hospital systems' higher thresholds of 650 trauma admissions, it appears that both Mountain States and Wellmont have independently met this 650-admission volume/outcome threshold for trauma services. [115] Thus, the planned consolidation of the Level I trauma centers is unlikely to result in meaningful improvements to clinical outcomes.

Further, even if the merging hospital systems were able to obtain volume/outcome related improvements in clinical outcomes by consolidating their trauma services, those benefits must be weighed against any potential disadvantages that could result from the consolidation. If closing some trauma centers is necessary to consolidate volume at a more limited number of facilities, the increased travel time to these facilities could have an adverse impact on some patients. For example, if the merging hospitals were to consolidate their trauma centers into Johnson City Medical Center, some patients in Virginia would have to travel as much as 25 additional miles to reach the nearest trauma center, thereby delaying care and potentially increasing the risk of mortality or other complications.[116]

Because the merging hospital systems have failed to identify in their cooperative agreement application the specific pediatric service lines they are likely to consolidate, we cannot comment on whether they will likely have a volume/outcome relationship. Other consolidations, such as repurposing acute care beds and consolidating co-located facilities, are unlikely to have a volume/outcome relationship. As a result, although this consolidation could result in some cost savings, it is unlikely to significantly improve quality.

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[113] Romano & Balan, *supra* note 109. There is a distinction between volume/outcome relationships for physicians and volume/outcome relationships for facilities. Because the parties claim the volume/outcome benefit will occur from consolidating trauma facilities, the correct focus is on the facilities' volume/outcome relationship.

[114] Virginia Cooperative Agreement Application at 38 (citing Avery B. Nathans et. al., *Relationship Between Trauma Center Volume and Outcomes*, 285 J. AM. MED. ASS'N 1164 (2001), http://jama.jamanetwork.com/article.aspx?articleid=193615).

[115] *See* TRAUMA CARE ADVISORY COUNCIL, TENN. DEP'T OF HEALTH, TRAUMA CARE IN TENNESSEE: A REPORT TO THE 2010 107TH GENERAL ASSEMBLY 16 (2010), https://www.tn.gov/assets/entities/health/attachments/2010_Trauma_Care_in_TN_Report.pdf. We included trauma admissions from the two facilities with Level I trauma centers, Mountain States's Johnson City Medical Center and Wellmont's Holston Valley Medical Center. We excluded 1090 patient admissions to Wellmont's Bristol Regional Medical Center, the location of Wellmont's level II trauma center.

[116] *See generally* Nathan Baker, *Health System Merger: Trauma Center Consolidation Hinges On Need*, JOHNSON CITY PRESS (Feb. 20, 2016), http://www.johnsoncitypress.com/Health-Care/2016/02/19/Trauma-center-consolidation-hinges-on-need (describing the parties' potential plans to consolidate trauma centers).

Finally, to consolidate clinical services, the parties must be able to integrate successfully and this involves achieving sufficient cultural compatibility. But in describing the long-time competition that exists between Mountain States and Wellmont, Dale Sargent, the Medical Director of Hospitalist Programs for Wellmont, wrote that "Our cultures are incompatible. We could never bury the hatchet."[117] This raises doubts about whether Mountain States and Wellmont can adequately reconcile their different cultures and achieve the efficiencies and benefits that they have projected.

b) The Cooperative Agreement Is Unnecessary to Expand Behavioral Health Services in the Region

In their cooperative agreement application, Mountain States and Wellmont indicate that behavioral health problems and substance abuse are prevalent in the region and that "[t]he largest diagnosis related to regional inpatient admissions is psychoses. . . ."[118] Although the parties state that they will invest in programs and partnerships to help address behavioral health and substance abuse issues in the region, they do not substantiate their plans. Moreover, the parties' cooperative agreement plans should be viewed skeptically for two reasons.

First, their cooperative agreement plans regarding behavioral health services should be viewed skeptically in light of their efforts to prevent other providers from offering such services. For example, Mountain States opposed the Certificate of Need ("CON") application by Strategic Behavioral Health ("SBH") to open a new psychiatric facility in Kingsport, Tennessee.[119] Its proposed facility in Kingsport would add 72 inpatient beds to the region, including ten adult chemical dependency beds.[120] SBH expects the facility to attract additional specialists to the area, who likely would provide additional outpatient treatment capacity.[121] SBH initially filed its CON application in 2013.[122] Despite opposition from Mountain States,[123] an administrative law

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[117] Sargent, *supra* note 41.
[118] Virginia Cooperative Agreement Application at 9. *See also id.* at 7, 49, 53, 88, 91-94, 101.
[119] *See* Hank Hayes, *Proposed Kingsport Hospital Gets State Approval*, KINGSPORT TIMES-NEWS (June 23, 2016), http://www.timesnews.net/Business/2016/06/23/Proposed-new-hospital-gets-state-approval ("Mountain States Health Alliance (MSHA) opposed the CON and indicated the planned SBH facility would undermine its behavioral facility, Woodridge Hospital, based in Johnson City."). SBH operates ten facilities dedicated to behavioral health, including three facilities in neighboring North Carolina. *See Facilities*, STRATEGIC BEHAVIORAL HEALTH, LLC, http://www.strategicbh.com/facilities/.
[120] SBH-Kingsport, LLC, No. 25.00-126908J, SBH-KINGSPORT 000458, at 000459, ¶¶ 1, 4 (Tenn. Health Servs. & Dev. Agency, Feb. 8, 2016), https://www.tn.gov/assets/entities/hsda/attachments/SBH-KINGSPORT_000001.pdf (initial order). The facility planned to become "an integral part of the healthcare delivery system within its service area by reaching out to community based organizations" and providers of outpatient services. *Id.* at 000476-77, ¶ 53.
[121] *Id.* at 000477, ¶ 54 ("[SBH] feels that the project will attract additional healthcare professionals, specialized psychiatrists and other staff to the area."); *id.* at 000481, ¶ 64 ("SBH asks its physicians to participate in outpatient therapy and shares its therapists with the community.").
[122] *See* Hayes, *supra* note 119.
[123] *See* Nathan Baker, *Kingsport Psychiatric Hospital Headed for State Review; Officials Expect Appeal*, JOHNSON CITY PRESS (June 19, 2016), http://www.johnsoncitypress.com/Business/2016/06/19/Kingsport-psychiatric-hospital-headed-for-state-review-officials-expect-appeal.

judge granted the certificate of need on February 8, 2016.[124] Mountain States continues to contest this grant of the CON to SBH through the appeals process.[125] Thus, the merging parties should not be rewarded for proposed plans in their cooperative agreement application to fill a need for services when either (1) Mountain States's statements in the CON proceeding cast doubt about the public need for additional inpatient behavioral health capacity or (2) assuming there is a need, Mountain States actively opposes other providers from offering services to fill the public's health needs.

Second, the merging parties' plans regarding behavioral health services should be viewed skeptically because Mountain States and other organizations are already willing to develop new facilities and provide new services in the area. For example, Mountain States and Frontier Health are jointly developing a 12-bed adolescent crisis stabilization unit to be located in Gray, Tennessee.[126] Mountain States also has entered into a partnership with East Tennessee State University to bring a methadone clinic into the region, which will add substance abuse treatment to the region.[127] Thus, it is not clear that the cooperative agreement is necessary to provide additional mental healthcare services in the region.

c) Mountain States and Wellmont Have Not Shown That Consolidating Electronic Health Records Systems and Creating a New Health Information Exchange Are Necessary for Sharing Patient Data to Achieve Quality Improvements

In their cooperative agreement application, Mountain States and Wellmont commit to invest approximately $150 million over ten years to establish an electronic health record ("EHR") system that ensures a common platform and interoperability among its 19 hospitals, employed physicians, and related services.[128] They claim that these efforts "will allow providers

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[124] *SBH-Kingsport, LLC*, *supra* note 120, SBH-KINGSPORT 000458 (initial order).

[125] Despite Mountain States's appeal, the initial order granting the CON became a final agency decision in June 2016. *See* Hank Hayes, *Proposed Kingsport Hospital Gets State Approval*, KINGSPORT TIMES-NEWS (June 23, 2016), http://www.timesnews.net/Business/2016/06/23/Proposed-new-hospital-gets-state-approval (stating that SBH has received "final approval from the Tennessee Health Services and Development Agency (HSDA) to build a 72-bed hospital facility . . . in Kingsport"); Baker, *supra* note 123 (indicating that Mountain States had appealed the judge's February 2016 decision to grant the CON). Mountain States has appealed the agency decision to the Tennessee chancery court. *See* Case Summary, Mountain States Health Alliance v. Tennessee Health Services & Development Agency, No. 16-950-IV (Tenn. Chancery Court, 20th Judicial District, Davidson County, Aug. 26, 2016), http://www.nashvillechanceryinfo.org/CaseDetail.aspx?CaseID=70555.

[126] *SBH-Kingsport, LLC*, *supra* note 120, SBH-KINGSPORT 000239 at 000241, ¶ 8 (Jul. 7, 2015) (affidavit of Teresa M. Kidd, Ph.D).

[127] *See, e.g.*, News Channel 11 Staff, *MSHA, ETSU Postpone Methadone Clinic Vote "Out of Deference"*, WJHL (July 12, 2016) http://wjhl.com/2016/07/12/msha-and-etsu-postpone-methadone-clinic-vote-out-of-deference ("If we cannot agree on the location [of the methadone clinic], or if we do not have their public support for their proposed new location, we plan to move forward with the Gray Commons location.").

[128] *See* Virginia Cooperative Agreement Application at 72-74. Mountain States and Wellmont have proposed building a comprehensive Epic platform or using a completely new platform for supporting connectivity at the New Health System. Virginia Cooperative Agreement Application, Exhibit 4.1: Signed Copy of the Cooperative Agreement, https://swvahealthauthority.files.wordpress.com/2016/02/4-1-signed-copy-of-the-cooperative-agreement.pdf, at 63; Southwest Virginia Health Authority, Minutes of Meeting, Exhibit A, at 20, 22, 27, 52 (Apr.

in the New Health System the ability to quickly obtain full access to patient records at the point of care,"[129] and that these efforts will "facilitate the increased adoption of best practices and evidence based medicine," "provide immediate, system-wide alerts and new protocols to improve quality of care," and "reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services."[130] These claimed benefits do not justify approving the cooperative agreement, for several reasons.

With regard to the first category – full access to patient records at the point of care – both Mountain States and Wellmont already have well-functioning EHR systems that are fully integrated across their respective hospitals.[131] These systems allow complete sharing of patient records. This is true today, and will remain the case even if the cooperative agreement is not approved. The potential benefit from the cooperative agreement is therefore only the *incremental* benefit of allowing both Mountain States and Wellmont hospitals to share patient records within a single EHR system.

Mountain States and Wellmont have not demonstrated that this incremental benefit would be of sufficient magnitude to significantly improve patient health outcomes. Patients who will only use facilities in one of the current hospital systems (*i.e.*, Mountain States *or* Wellmont) are not likely to benefit from the combination of the EHR. Mountain States and Wellmont already have effective means of sharing information with each other, even with their separate EHR systems, further limiting the benefits of a common system. Moreover, it is possible that recent federal legislation regarding EHR interoperability may reduce or obviate the need for a common EHR platform between the parties.[132]

13, 2016), https://swvahealthauthority.files.wordpress.com/2016/05/final-draft-southwest-virginia-health-authority-minutes-4-13-16-3.pdf (Mountain States & Wellmont presentation).

[129] Virginia Cooperative Agreement Application at 74.

[130] *Id.*

[131] Wellmont launched its Epic system in 2014. *See* Hank Hayes, *Wellmont Launches Epic Electronic Health Record System*, KINGSPORT TIMES-NEWS (Mar. 20, 2014), http://e-edition.timesnews.net/article/9074700/wellmont-launches-epic-electronic-health-record-system. Mountain States uses Siemens Soarian in its hospitals and Allscripts for its practitioners, and these systems are interoperable. *See, e.g.*, Press Release, Allscripts, Mountain States Health Alliance Selects Allscripts Electronic Health Record and Practice Management for Physicians Across Four-State Area (Jan. 6, 2010), http://investor.allscripts.com/phoenix.zhtml?c=112727&p=irol-newsArticle_print&ID=1371346. Mountain States has met federal requirements for at least one year of Stage 1 Meaningful Use of its EHR system. *See* Alan Levine, Mountain States, *A Message from Our CEO: Let's Talk 'Meaningful Use'*, MOUNTAIN STAR (May 26, 2014), http://www.mshanews.org/news/article.aspx?id=1858. Additionally, Mountain States has been named a "Most Wired" healthcare system by Hospitals and Health Networks Magazine for several years in a row. "The honor acknowledges a high level of sophistication throughout the system in creating and using electronic medical records." Press Release, Mountain States, Mountain States Health Alliance Again Named a 'Most Wired' Health System (July 30, 2014), https://www.mountainstateshealth.com/news/msha-again-named-most-wired-health-system. *See also* Press Release, OnePartner, Mountain States Health Alliance Announces Participation in the OnePartner Health Information Exchange (Aug. 26, 2014), http://www.onepartner.com/news/mountain-states-health-alliance-announces-participation-with-onepartner-hie; Press Release, Mountain States, MSHA Named 2012 Most Wired Health System (Aug. 10, 2012), https://www.mountainstateshealth.com/news/MSHA-named-2012%20Most%20Wired%20Health%20System.

[132] *See* Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Our understanding is that MACRA, as it currently stands, would require widespread exchange of health information through interoperable certified EHR

With regard to the second category – system-level improvements and cost-savings – the proposed merger is not necessary to achieve these benefits. Once again, the relevant question is the size of the increment by which this specific merger will generate these benefits beyond what would happen without it. Mountain States and Wellmont are already large and sophisticated hospital systems that are capable of realizing many of these benefits on their own. Moreover, to the extent that they would be better able to realize these benefits in cooperation with a partner, each could do so through a merger or affiliation with a partner other than its primary competitor.

Finally, any benefit of a common EHR system would have to be compared to its costs. Converting to a common EHR system can be extremely expensive and time consuming,[133] and the conversion process can delay access to critical patient information. All told, the time, difficulties, and expense of converting to a common EHR system may outweigh the potential benefit.

Mountain States and Wellmont also "commit to participate meaningfully in a health information exchange [("HIE") that is] open to community providers."[134] In addition, they indicate that their support will enable an HIE to achieve a higher level of function.[135] A well-functioning regional HIE already exists, operated by OnePartner.[136] This HIE is able to "harmonize and normalize the [patient] data to deliver it in a meaningful format, easily viewable within the provider's existing workflow."[137] This enables secure access to patient information across the continuum of care, thereby improving patient health outcomes.[138]

Local physicians developed the OnePartner HIE,[139] demonstrating that the merger is unnecessary to have a successful regional HIE system. In fact, Mountain States and Wellmont

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technology among healthcare providers by the end of 2018. Thus, absent the merger, the parties may already be required to achieve EHR interoperability by 2018. Although we recognize that the MACRA provisions regarding interoperability may be subject to future modifications, the current provisions would seem to undermine the parties' argument that a merger is necessary to achieve a common EHR platform, so that they can exchange health information.

[133] *See* Akanksha Jayanthi & Ayla Ellison, *8 Hospitals' Finances Hurt by EHR Costs*, BECKER'S HOSPITAL CFO (May 23, 2016), http://www.beckershospitalreview.com/finance/8-hospitals-finances-hurt-by-ehr-costs.html; Akanksha Jayanthi, *8 Epic EHR Implementations with the Biggest Price Tags in 2015*, BECKER'S HEALTH IT & CIO REVIEW (July 1, 2015), http://www.beckershospitalreview.com/healthcare-information-technology/8-epic-ehr-implementations-with-the-biggest-price-tags-in-2015.html.

[134] Virginia Cooperative Agreement Application at 93.

[135] *Id.* at 74.

[136] *See About OnePartner*, ONEPARTNER, http://www.onepartner.com/about; *OnePartner HIE*, ONEPARTNER, http://www.onepartner.com/hie; Responses to Authority Questions, *supra* note 53, at 000116 (Exhibit 22C: Description of Parties' Use of Health Information Exchange).

[137] *OnePartner HIE*, ONEPARTNER, http://www.onepartner.com/hie.

[138] *See id.*; *About OnePartner*, ONEPARTNER, http://www.onepartner.com/about.

[139] *See About OnePartner*, ONEPARTNER, http://www.onepartner.com/about; Press Release, Performance Clinical Sys., Holston Medical Group Partners with Performance Clinical Systems for Care Coordination and Workflow Solutions (Oct. 24, 2012), http://www.businesswire.com/news/home/20121024006580/en/Holston-Medical-Group-Partners-Performance-Clinical-Systems.

already participate by providing clinical patient information to OnePartner,[140] and executives at Mountain States and Wellmont recently touted the value of the OnePartner HIE.[141] Today, providers, including Mountain States and Wellmont, have the option of utilizing the OnePartner HIE to access a significant amount of clinical patient information available on the existing HIE.[142]

More importantly, MSHA and Wellmont have not sufficiently articulated any mechanism by which the cooperative agreement would improve the OnePartner HIE, nor have they sufficiently described the incremental benefit that any new HIE system they might create would have over the current OnePartner product. Furthermore, the parties have not adequately explained the incremental benefit of the information accessible on a combined EHR system versus that available on the current HIE.

d) Mountain States and Wellmont Have Not Shown Why They Cannot Pursue Clinical Standardization Without the Cooperative Agreement

Mountain States and Wellmont claim that they are committed to standardizing management and clinical practice policies and procedures to promote efficiency and higher standards of care.[143] Although standardizing clinical policies and procedures may lead to quality improvements, the parties can achieve these either on their own, through some collaboration short of a merger, or through mergers or affiliations with alternative partners that raise fewer competitive concerns.

A hospital merger may generate overall quality improvements when the merging hospitals have very different clinical quality levels, and the merger will allow the clinically inferior hospital to come under the management, and adopt the practices, of the clinically superior hospital, thereby improving quality at the inferior hospital. Because Mountain States and Wellmont have similar levels of quality, this potential source of quality improvement is limited in this case.[144] Moreover, if Mountain States and Wellmont want to engage in greater

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[140] *See OnePartner News*, ONEPARTNER, http://www.onepartner.com/news (MSHA and Wellmont agreed to participate in OnePartner HIE in 2014); Press Release, OnePartner, Mountain States Health Alliance and Wellmont Health System Go Live with OnePartner Health Information Exchange (Aug. 1, 2016), http://www.onepartner.com/news/go-live-with-onepartner-hie (MSHA and Wellmont began sharing data through OnePartner HIE in August 2016).

[141] *See* Press Release, OnePartner, *supra* note 140 (quoting Alan Levine, President and CEO of MSHA, "Ensuring physicians have all the information they need is very important, and we are pleased OnePartner provides a vehicle for this effort. We congratulate the OnePartner team for their hard work and diligence in building this model.") (quoting Bart Hove, President and CEO of Wellmont, "Wellmont has experienced the benefits of having a common platform for electronic medical records in our facilities, so we appreciate the value of participating in OnePartner.").

[142] *See* Responses to Authority Questions, *supra* note 53, at 000117-18 (Exhibit 22C: Description of Parties' Use of Health Information Exchange).

[143] Virginia Cooperative Agreement Application at 36.

[144] For example, Mountain States and Wellmont's three flagship hospitals have similar Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") scores. *See Medicare Hospital Comparison*, MEDICARE.GOV,

efforts to coordinate care with one another and improve health outcomes for patients, there are numerous ways that they could do this. Indeed, despite their claims, Mountain States and Wellmont already successfully collaborate with each other to improve healthcare services in this region.[145]

Mountain States's and Wellmont's post-merger plan is to establish a physician-led clinical council to identify best practices and develop standardized clinical protocols and models of care. Yet, they provide no compelling reason why they could not convene this council absent the merger. Providers serving on the council need not be integrated into a single organization, as evidenced by the fact that the parties plan to include independent, privately practicing physicians.[146] Additionally, the parties already have opportunities to participate in alliances that allow them to share best practices with other hospitals, including each other, that do not require the loss of either competition or local control. For example, in 2013, Mountain States joined the Vanderbilt University Medical Center network, which allows its members to share best practices and collaborate clinically with a large number of other hospital systems.[147]

Finally, according to Dr. Kizer, both Mountain States and Wellmont are integrated delivery systems in their own right; each is well-positioned to standardize clinical practices among its facilities and providers even if it chose not to cooperate with the other system or independent providers.

e) Mountain States and Wellmont Already Pursue Significant Academic and Research Opportunities Independently

Mountain States and Wellmont claim that they will invest at least $85 million over the next ten years to "develop and grow academic and research opportunities, support post-graduate healthcare training, and strengthen the pipeline and preparation of nurses and allied health professionals."[148] They plan to invest funds derived from merger efficiencies towards this effort. Mountain States and Wellmont claim that this investment in research and training infrastructure will "enable research-based and academic approaches to the provision of the services the New

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https://www.medicare.gov/hospitalcompare/compare.html#cmprTab=1&cmprID=440017%2C440012%2C440063&cmprDist=0.7%2C21.4%2C24.2&dist=50&loc=KINGSPORT%2C%20TN&lat=36.548434&lng=-82.5618186.

[145] *See* Virginia Cooperative Agreement Application at 25 (In cooperation with East Tennessee State University, "the parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date."); *id.* at 24-25 (listing several other examples of collaboration between Mountain States and Wellmont to improve population health in this region).

[146] *Id.* at 36.

[147] *See* Kevin Castle, *Mountain States Health Alliance Announces Affiliation with Vanderbilt University Medical Center*, BRISTOL HERALD COURIER (May 3, 2013), http://www.heraldcourier.com/news/local/article_b4c48e72-b3ed-11e2-a6f1-0019bb30f31a.html ("In putting this affiliation together, we have gained all of the advantages of a large health system but we have not given up any local control."); Patricia Kirk, *Vanderbilt University Medical Center Forms Nation's Largest Clinically Integrated Network That Includes Its Own Health Insurance Offering*, DARK DAILY (June 8, 2013), http://www.darkdaily.com/vanderbilt-university-medical-center-forms-nations-largest-clinically-integrated-network-that-includes-its-own-health-insurance-offering#axzz43dyuOI1e (describing collaboration and sharing of best practices).

[148] Virginia Cooperative Agreement Application at 6.

Health System intends to invest to improve overall population health"[149] and will attract additional outside investment by the state and federal government, as well as grant-making organizations.[150] Other than general statements, however, the hospitals have not explained how or when they expect to achieve these benefits.

Furthermore, it is unclear whether the committed amount is higher than current spending levels or why the merger is necessary to invest in medical education that benefits the community. Currently, Mountain States and Wellmont both invest significantly in healthcare education in the region and already partner with East Tennessee State University ("ETSU") and most area colleges and universities to provide residencies, internships, and clinical education for medical, nursing, and pharmacy programs. In fiscal year 2013, Mountain States and Wellmont reported spending more than $18 million combined on health professions education, which covers spending on residencies, internships, and continuing education programs for practicing professionals.[151] Thus, the average $8.5 million that Mountain States and Wellmont have committed to spend annually through the cooperative agreement may not be an incremental investment and, in fact, may be less than what the hospital systems already spend independently.

In addition, Mountain States and Wellmont claim that the merger will allow them to develop an enhanced academic medical center with their academic partners, but they have not demonstrated how this will be achieved. The merging hospitals already serve as teaching hospitals in partnership with regional medical and nursing schools, offering residency and internship programs.[152] Mountain States and Wellmont assert that cost savings from the merger will allow them to fund additional residency slots and attract additional funding, but they have not provided a clear plan addressing how they will allocate these funds or how many additional positions they expect to fund.

2. Mountain States and Wellmont Have Not Shown That the Cooperative Agreement is Necessary to Enhance Population Health Status Consistent with Regional Health Goals Established by the Authority

COOPERATIVE AGREEMENT BENEFIT FACTOR B: *Enhancement of population health status consistent with the regional health goals established by the Authority*[153]

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[149] *Id.* at 52.
[150] *Id.* at 41.
[151] *See* MOUNTAIN STATES, *supra* note 106, at 14 ($12 million); WELLMONT, ONE: FISCAL 2013 REPORT TO OUR COMMUNITIES 52 (2013), http://www.wellmont.org/uploadedFiles/Content/Our_Mission/Community_Benefit/Wellmont-Health-System-FY13-Community-Benefit-Report.pdf ($6.8 million). Reported benefits are net of Medicare reimbursement.
[152] *See, e.g.*, *Affiliates/Clincs*, E. TENN. STATE UNIV.: QUILLEN COLL. OF MED., http://www.etsu.edu/com/aboutus/affiliates.aspx (affiliations with East Tennessee State University's Quillen College of Medicine).
[153] Virginia Cooperative Agreement Act, § 15.2-5384.1, E.2.b.

ASSESSMENT: In their cooperative agreement application, Mountain States and Wellmont claim that they will create an integrated delivery system designed to enhance community health through population health improvement initiatives.[154] However, it is unclear why this consolidation is necessary to achieve these goals. Mountain States and Wellmont already independently invest in population health initiatives. Additionally, both parties note that the causes of poor health in the region are varied and that no single organization can reverse these trends.[155] Moreover, the parties admit that the "commitments made by the New Health System alone will not solve the complex problems contributing to the poor health of the region."[156] Thus, the relevant question is whether they will be more likely to participate in such initiatives, or participate more effectively, with this merger than they would without it. There is no evidence that this is the case.

Mountain States and Wellmont commit to developing a population health improvement process and community health improvement plan in conjunction with the public health resources at ETSU. They state that they would invest at least $75 million over ten years towards various initiatives as determined by this action plan.[157] However, the parties have provided limited information about the specifics of their plans and state they will not identify the specifics of this plan until after they consummate the merger. As a result, these claims cannot be verified with the limited information Mountain States and Wellmont have provided. Moreover, where the parties provide information about how they will improve population health in the region,[158] many of the initiatives (such as increasing third grade reading level) cannot be fully assessed or credited as much more than aspiration.

Additionally, as identified in the cooperative agreement application, Mountain States and Wellmont have already engaged in numerous population health initiatives that benefit the region without the need for a merger. For example, Mountain States already operates drop-by health resource centers that support chronic disease management, and Wellmont operates mobile health buses that offer immunizations, cardiovascular screenings, cancer screenings, and physical examinations.[159] Both organizations also independently operate nurse call centers that enable wellness, coaching, and disease management programs,[160] partner with physicians and educational institutions, and have identified regional healthcare gaps, including diabetes, heart disease, and addiction.[161] Mountain States, Wellmont, and ETSU have already organized four Community Health Work Groups to identify area needs, and those groups started work in the fall of 2015.[162] ETSU already spearheads this effort with a goal of creating a ten-year action plan for

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[154] Virginia Cooperative Agreement Application at 6. *See also* Pre-Submission Report, *supra* note 68, at 9-14.
[155] Responses to Authority Questions, *supra* note 53, at 000072.
[156] *Id.* at 000074.
[157] *See* Virginia Cooperative Agreement Application at 6-7; Pre-Submission Report, *supra* note 68, at 13; *see generally Better Together*, WELLMONT & MOUNTAIN STATES, http://becomingbettertogether.org.
[158] *See* Responses to Authority Questions, *supra* note 53, at 000103-08 (Exhibit 18: Community Health Improvement Plan).
[159] Virginia Cooperative Agreement Application at 50.
[160] *Id.* at 50-51.
[161] *Id.*
[162] *Id.* at 88-90.

the region.[163] Thus, it appears that the region can continue to benefit from these initiatives without incurring the disadvantages associated with a merger to near-monopoly. Furthermore, Mountain States and Wellmont overstate the extent to which antitrust laws prevent them from pursuing population health initiatives in the absence of the merger.

Mountain States and Wellmont also assert that the merger would allow them to improve access to high quality healthcare in underserved rural areas through enhanced telemedicine capabilities, which they claim would help them achieve their population health goals. However, it does not appear that the merger is necessary to accomplish this goal, as both hospital systems have independently pursued telemedicine initiatives in recent years.[164] Furthermore, the technology needed for these initiatives is relatively inexpensive and commonly used by many providers; therefore, Mountain States and Wellmont should be capable of implementing them independently.

In another effort to improve population health, the merging hospitals indicate they will commit $27 million over ten years to develop pediatric specialty centers and pediatric emergency rooms in Kingsport and Bristol, and will add rotating pediatric specialty clinics in rural hospitals.[165] However, Mountain States and Wellmont already offer pediatric programs. Wellmont provides extensive pediatric services, including a partnership with East Tennessee Children's Hospital in Knoxville that brings regional sub-specialists directly into the Tri-Cities.[166] It is unclear whether this partnership will continue if the proposed merger is allowed to proceed. Both Holston Valley Regional Medical Center in Kingsport and Bristol Regional Medical Center also currently offer pediatric emergency services, along with a Level III neonatology center.[167] Wellmont also offers pediatric services at two of its rural hospitals in Virginia – Mountain View Regional Medical Center in Norton and Lonesome Pine Hospital in

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[163] *Id.* at 90.

[164] *See, e.g.*, Press Release, Mountain States, Collaboration with Vanderbilt Bringing Teleneurology Services to Two Mountain States Hospitals (Apr. 13, 2015), https://www.mountainstateshealth.com/news/teleneurology-collaboration (Mountain States already employs telemedicine in rural areas to give patients access to specialty care and to connect with Vanderbilt University neurologists.); Mountain States, *Mountain States Looks to the Future with Use of Telehealth*, MOUNTAIN STAR (June 9, 2015), http://www.mshanews.org/news/article.aspx?id=2245 ("Mountain States is very committed to implementing telehealth solutions whenever and wherever it makes sense."); *Stroke Care*, WELLMONT, http://www.wellmont.org/Medical-Services/Stroke-Care/Stroke-Care/ (Wellmont utilizes neurology telemedicine tools for stroke diagnosis and evaluation.); Mac McLean, *Governor Signs Bill Requiring Insurance Companies to Cover Long Distance Doctor Visits*, NEWS & ADVANCE (Feb. 18, 2013), http://www.newsadvance.com/lifestyles/governor-signs-bill-requiring-insurance-companies-to-cover-long-distance/article_e592cf04-b504-50e9-9069-0653cf142fd1.html (Wellmont is expanding its use of telemedicine to improve patient outcomes at Bristol Regional Medical Center's stroke clinic and Holston Valley Medical Center's cardiology program.); Mac Maclean, *Wellmont Launches New Telemedicine Program*, BRISTOL HERALD COURIER (Mar. 4, 2011), http://www.heraldcourier.com/news/wellmont-launches-new-telemedicine-program/article_f2b91ddb-8d2b-51ad-9d9d-4ca8b1208414.html (In 2011, Wellmont received a nearly $500,000 grant to launch a telemedicine program for patients in rural areas with chronic diseases.).

[165] Responses to Authority Questions, *supra* note 53, at 000023, 000066, 000068.

[166] *See Children*, WELLMONT, http://www.wellmont.org/Our-Services/Children/.

[167] *See id.*

Big Stone Gap.[168] Mountain States provides pediatric sub-specialty services at its Niswonger Children's Hospital in Johnson City, Tennessee, and all Mountain States facilities, including its rural hospitals, have access to pediatric specialists through its telemedicine program.[169] Given that Mountain States and Wellmont already offer these pediatric services and are capable of enhancing them independently, the merger may not be necessary to achieve these purported quality improvements to population health.

3. Mountain States and Wellmont Offer Only a Limited Commitment to Preserve Hospital Facilities to Ensure Access to Care

COOPERATIVE AGREEMENT BENEFIT FACTOR C: *Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care*[170]

ASSESSMENT: In their cooperative agreement application, Mountain States and Wellmont offer only a limited commitment to preserve hospital facilities to ensure access to care. They commit to maintain their three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol, Tennessee, and commit to keep Johnston Memorial as an acute care hospital, for unspecified periods of time.[171] There is no indication that this commitment would be a meaningful change from the *status quo*, however, because there is no evidence that Mountain States and Wellmont planned to close any of these hospitals absent the cooperative agreement.

Beyond these commitments, Mountain States and Wellmont commit that all other hospitals "will remain operational as clinical and health care institutions for at least five years," but reserve the flexibility to "adjust scope of services or repurpose hospital facilities" during that time.[172] Thus, there is no guarantee that all, or even most, of the parties' other hospitals, including those located in Virginia, will be maintained in their current form. Notably, Mountain States and Wellmont do not provide details about which facilities would be altered or closed. Instead, they defer such decisions until after the merger receives approval, referencing an Alignment Policy that gives no assurances of keeping facilities open and services accessible.[173]

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[168] *See Mountain View Regional Medical Center*, WELLMONT, http://www.wellmont.org/Our-Facilities/Hospitals-And-Medical-Centers/Mountain-View-Regional-Medical-Center/; *Lonesome Pine Hospital*, WELLMONT, http://www.wellmont.org/Our-Facilities/Hospitals-And-Medical-Centers/Lonesome-Pine-Hospital/.

[169] *See* Mountain States, *Mountain States Looks to the Future with Use of Telehealth*, *supra* note 164.

[170] Virginia Cooperative Agreement Act, § 15.2-5384.1., E.2.c.

[171] Virginia Cooperative Agreement Application at 82; Responses to Authority Questions, *supra* note 53, at 000040-41.

[172] *Id.* at 81. *See also* Responses to Authority Questions, *supra* note 53, at 000012 ("Over the long term (which the Authority has defined as 6-10 years), the New Health System may determine the need to repurpose beds" in currently operating Virginia hospitals.).

[173] *Id.* at 35 ("The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community."); Virginia Cooperative Agreement Application, Exhibit 12.1: Alignment Policy, https://swvahealthauthority.files.wordpress.com/2016/02/12-1-new-health-system-alignment-policy.pdf, at 3 (providing a mechanism for hospital management to "establish an

Mountain States and Wellmont claim that their rural hospitals operate at low or negative margins, and that without the merger, it would become increasingly difficult to maintain these facilities and preserve access to healthcare services in rural communities.[174] However, there is no evidence that Mountain States and Wellmont planned to close any of these facilities absent the merger. One factor to consider is whether the health systems independently derive any benefits from having a network of rural hospitals in the outlying communities that surround their tertiary hospitals, such as increased referrals or efficiencies that may contribute to the profitability of the overall health system. Thus, while *an individual hospital* could appear unprofitable – which itself could be a function of how the healthcare system allocates costs to each system hospital for accounting purposes – the hospital may, on balance, still be profitable to the *system as a whole* and therefore, likely to remain operational even in the absence of the cooperative agreement.

Mountain States and Wellmont also cite concerns about low reimbursement rates and future reductions in reimbursement that may occur as a result of declining admissions and healthcare reform efforts, and have suggested that they cannot continue to operate independently in this changing environment.[175] However, both of these hospital systems have the financial resources to continue operating independently,[176] and there is no indication that either system operates at a corporate loss or would qualify as a failing firm. Moreover, any challenges that Mountain States and Wellmont face in response to the changing delivery and payment landscape can be addressed in less restrictive ways than the proposed merger, without substantially reducing competition in this region.

4. Purported Gains in the Cost-Efficiency of Services Provided by Mountain States and Wellmont Are Unsubstantiated, Not Merger-Specific, and Insufficient to Overcome the Likely Competitive Harm

COOPERATIVE AGREEMENT BENEFIT FACTOR D: *Gains in the cost-efficiency of services provided by the hospitals involved*[177]

ASSESSMENT: Mountain States and Wellmont claim that the merger will generate approximately $121 million in annual cost savings through consolidation of clinical services, reductions in labor expenses, and reductions in purchasing and other non-labor expenses, but they provide little detail about these claims in their cooperative agreement application.[178] For example, they do not adequately explain how they plan to achieve these savings, the steps they plan to take, and the costs to achieve them. Without this information, the likelihood and

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inventory of current facilities and services and request recommendations for where potential overlap exists and/or synergies could be realized.").

[174] Virginia Cooperative Agreement Application at 53, 80-81.

[175] *See id.* at 4, 42, 72; Responses to Authority Questions, *supra* note 53, at 000002-03 (letter from Alan Levine and Bart Hove to Southwest Virginia Health Authority).

[176] *See supra* note 36.

[177] Virginia Cooperative Agreement Act, § 15.2-5384.1, E.2.d.

[178] *See* Virginia Cooperative Agreement Application at 44-47.

magnitude of their cost-savings claims cannot be verified. In addition, many of their claimed savings appear to be achievable without the merger. Thus, the purported gains in cost-savings are likely overstated and would not outweigh the substantial loss in competition.

a) The Benefits of Clinical Consolidation Are Speculative and Must Be Weighed Against Reduced Patient Access

Mountain States and Wellmont claim that they will be able to achieve approximately $26 million in annual cost savings through the consolidation of certain clinical services, such as trauma and specialty pediatric services.[179] Importantly, Mountain States and Wellmont have not provided sufficient details on these consolidation plans, and they have not provided the analysis necessary to determine whether they could successfully consolidate these clinical services or the magnitude of the investments that may be required to achieve them. Even if Mountain States and Wellmont were able to reduce their costs by eliminating competing clinical services, that is not an unqualified benefit. Those cost savings may be derived from a reduction in staff or closure of facilities, thereby reducing patient access to healthcare services and forcing some patients to travel further to receive care or wait longer for appointments, which may reduce quality of care and patient satisfaction. Indeed, contrary to statements of Mountain States and Wellmont that the merger is the best way to preserve local jobs and hospital facilities, they acknowledge that some jobs, facilities, and services will have to be eliminated or consolidated in order to achieve their projected cost savings.[180] Any detrimental impact that this consolidation would have on the quality of patient care should receive appropriate consideration.

b) Other Claimed Savings Are Unsubstantiated and May Be Achievable Without the Merger

Mountain States and Wellmont estimate that the merger will enable them to save approximately $70 million annually on purchasing and other non-labor expenses and approximately $25 million annually on labor expenses. We recognize that mergers have the potential to achieve cost savings by eliminating duplicative corporate and administrative staff or through purchasing synergies, and we consider this as part of our analysis. Here, however, the merging hospitals have not provided sufficient detail to evaluate the credibility, magnitude, and merger-specificity of their claims. For example, Mountain States and Wellmont have not identified the specific steps necessary to achieve these savings, the expenditures involved, and how any potential cost savings will be passed through to consumers, and they have not provided a sufficient breakdown of the estimated annual cost savings for each subcategory of labor and non-labor efficiencies in their cooperative agreement application.

Furthermore, some portion of these claimed cost savings may be achievable by the systems independently or through an alternative merger. Purchasing synergies and reductions in

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[179] *Id.* at 46-47.

[180] *See id.* at 11 ("As a result of the Cooperative Agreement, some positions will be eliminated."); *id.* at 38-39 ("Other cost-saving and efficiency opportunities include consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities.").

corporate overhead from eliminating duplicative administrative services often do not require geographic proximity and are categories of efficiencies that could be achieved through a merger or affiliation with an out-of-market health system. Indeed, Mountain States and Wellmont have indicated that they would seek a deal with an out-of-market health system if the proposed merger does not proceed as planned.[181] Many hospital systems have also achieved synergies through the use of group purchasing agreements.

Finally, it is possible that some of the claimed savings may not even be achievable. For example, the hospital systems list "physician clinical preference items" as an area where their purchasing needs are similar,[182] yet they have not provided information to evaluate the extent to which the physicians at each system are currently standardized or purchasing the same items. This savings claim may require physicians to change their preferences for the type of equipment or supplies they use, and Mountain States and Wellmont have not explained how they plan to ensure uniformity. Such standardization can be difficult to achieve because physicians have strong preferences and often resist change. Moreover, such standardization may incur training costs and could result in a shift to higher cost or lower quality equipment.

5. The Merger is Unlikely to Significantly Improve Utilization of Hospital Resources and Equipment or Avoid Duplicative Hospital Resources in a Manner That Benefits Patients

COOPERATIVE AGREEMENT BENEFIT FACTORS E and F: *Improvements in the utilization of hospital resources and equipment; Avoidance of duplication of hospital resources*[183]

ASSESSMENT: Mountain States and Wellmont characterize the competition that exists between them as leading to "expensive, unnecessary duplicative healthcare resources that are allocated inefficiently" and assert that the proposed merger will allow them to eliminate this duplication "to capture large cost savings and realign resources to improve access and quality."[184] At the outset, we note that Virginia is a certificate of public need state, meaning that Mountain States and Wellmont have made various investments only after demonstrating to the Virginia Department of Health that there was a "public need" for those investments. Moreover, as large, sophisticated healthcare systems, Mountain States and Wellmont presumably have made careful medical and business judgments about how to utilize precious tax-exempt resources to best serve the community's needs, and have not made unnecessary expenditures. In any case, Mountain States and Wellmont have yet to identify the specific expenditures that they believe to

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[181] *See* Luanne Rife, *Insurers Say Hospital Merger in Far Southwest Virginia Would Drive Up Costs*, ROANOKE TIMES (Nov. 13, 2015), http://www.roanoke.com/...nd_blogs/blogs/med_beat/insurers-say-hospital-merger-in-far-southwest-virginia-would-drive/article_e0a94a73-72ad-5995-9be3-7c2a4d54ae51.html ("Executives of both health systems have said they would seek out-of-market partners if the merger fails.").
[182] Virginia Cooperative Agreement Application at 44.
[183] Virginia Cooperative Agreement Act, § 15.2-5384.1, E.2.e.-f.
[184] Pre-Submission Report, *supra* note 68, at 7; Virginia Cooperative Agreement Application at 8.

have been wasteful or duplicative. Mountain States and Wellmont also fail to articulate any significant capital avoidance claims in their cooperative agreement application.

In addition, economic research indicates that hospital competition leads to lower costs, more effective resource utilization, and improved patient health outcomes, as compared to highly concentrated markets with less competition.[185] As previously discussed, competition between Mountain States and Wellmont has led to investments that have improved patient care and access to healthcare services. Indeed, the Chairman of Wellmont's Board of Directors denied the premise that competition between Mountain States and Wellmont has been counterproductive, and instead stated that it has produced high-quality healthcare in the region.[186] Thus, to the extent that competition between Mountain States and Wellmont results in facility expansions and new equipment purchases that improve access and quality, competition is good for consumers, not wasteful. Eliminating this competition could lead to a less productive allocation of resources and thereby deny consumers these benefits. For example, although new equipment can be costly, the quality benefits associated with technology advances may justify these expenditures.[187] Investments in facilities, technology, and equipment can result in shorter wait times, more convenient service options for physicians and patients, and the continued availability of services when a piece of equipment fails, all of which are far from wasteful, but quite beneficial. In contrast, to the extent that the combined system's future plans include the consolidation of clinical services, including reduced facility and equipment investments, this could result in reduced patient choice and access to healthcare services.

6. The Cooperative Agreement Is Unnecessary to Enhance Participation in the State Medicaid Program

COOPERATIVE AGREEMENT BENEFIT FACTOR G: *Participation in the state Medicaid program*[188]

ASSESSMENT: The Virginia Cooperative Agreement Act requires the Authority and the Commissioner to consider whether the proposed merger would impact participation in the state Medicaid program. The parties have not adequately explained why the merger is necessary

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[185] *See* Dan P. Kessler & Mark B. McClellan, *Is Hospital Competition Socially Wasteful?*, 115 Q. J. ECON. 577 (2000), http://qje.oxfordjournals.org/content/115/2/577.full.pdf+html (finding that hospital competition unambiguously improves social welfare: competition leads to substantially lower costs and lower levels of resource use, as well as lower rates of adverse patient health outcomes); Martin Gaynor, Rodrigo Moreno-Serra & Carol Propper, *Death by Market Power: Reform, Competition and Patient Outcomes in the National Health Service*, 5 AM. ECON. J.: ECON. POL'Y 134 (2013), https://www.aeaweb.org/atypon.php?doi=10.1257/pol.5.4.134 (finding that hospital competition leads to improved quality and resource utilization).

[186] Nathan Baker, *Wellmont Leaders Look to Leave Limelight to Mull Merger Options*, JOHNSON CITY PRESS (Oct. 17, 2014), http://www.johnsoncitypress.com/frontpage/2014/10/17/Wellmont-leaders-look-to-leave-limelight-to-mull-merger-options.html (describing Chairman Roger Leonard's reaction to statements suggesting that competition between Mountain States and Wellmont has been unhealthy).

[187] *See* David M. Cutler & Mark McClellan, *Is Technological Change in Medicine Worth It?*, 20 HEALTH AFFAIRS 11 (Sept. 2001), http://content.healthaffairs.org/content/20/5/11.full.pdf+html ("When costs and benefits are weighed together, technological advances have proved to be worth far more than their costs.").

[188] Virginia Cooperative Agreement Act, § 15.2-5384.1., E.2.g.

to continue or expand their participation in the state Medicaid program or why alternatives to the cooperative agreement would not suffice to continue or expand their participation. Mountain States and Wellmont have made unsubstantiated claims that the merged system's scale will allow the applicants to optimize access for the Medicaid population.[189] As we mentioned previously, however, Mountain States and Wellmont are already integrated health systems with sufficient scale to achieve their claimed benefits independently.

7. The Cooperative Agreement Is Unlikely to Meaningfully Improve Total Cost of Care

COOPERATIVE AGREEMENT BENEFIT FACTOR H: *Total cost of care*[190]

ASSESSMENT: The Virginia Cooperative Agreement Act requires the Authority and the Commissioner to consider whether the proposed merger would impact total cost of care. Although there is no standard definition for total cost of care, in 2012, the National Quality Forum ("NQF") endorsed a "Total Cost of Care" model intended to measure the total cost of all healthcare services provided to a patient during a given time period, including professional, inpatient, outpatient, pharmacy, and ancillary services. Such models may offer useful information for providers, payers, government entities, employers, researchers, and consumers when comparing costs, resources, and utilization metrics to achieve the triple aim objectives of reduced costs, improved quality, and enhanced patient experience and access to care. These models may facilitate the transition to value-based payment models, which are also intended to achieve the triple aim objectives.[191]

Mountain States and Wellmont have not specifically addressed the concept of total cost of care in their cooperative agreement application. Rather, they address the related issue of reducing prices borne by insurers and consumers. Controlling healthcare costs and prices are among the goals of the Virginia Cooperative Agreement Act and Virginia Cooperative Agreement Regulations.[192] Whether the cooperative agreement proposed by Mountain States and Wellmont will improve the total cost of care and reduce the prices borne by insurers and consumers are some of the key factors that should be considered when evaluating their application. As discussed in Section VI.A., Mountain States and Wellmont have proposed a price commitment "[t]o ensure that savings and benefits are passed on from the merged system to patients, employers and insurers, while also investing in improving quality and patient

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[189] Virginia Cooperative Agreement Application at 32-33.
[190] Virginia Cooperative Agreement Act, § 15.2-5384.1., E.2.h.
[191] *See Total Cost of Care*, HEALTHPARTNERS, https://www.healthpartners.com/hp/about/tcoc/index.html; *Balancing Cost and Quality for Value*, NAT'L QUALITY FORUM, http://www.qualityforum.org/Story/Balancing_Cost_and_Quality_for_Value.aspx; ICSI – MNCM Webinar, Total Cost of Care Measurement and Affordability Within the Triple Aim, May 22, 2013, https://www.icsi.org/_asset/pxpqpy/measurementaffordability-may2013-.pdf, at 30 (indicating Total Cost of Care model can facilitate aligned incentive contracting).
[192] Virginia Cooperative Agreement Act § 15.2-5368.C., § 15.2-5384.1.E.2.h. (stating that cooperative agreements may moderate increases in healthcare costs); Virginia Cooperative Agreement Regulations, 12VAC5-221-10, -221-70.B.1.c., -221-70.B.13.a., -221-70.B.16., -221-80.G.1.h., -221-80.G.2.a.-c. (requesting COPA applicants provide information about the transaction's effect on healthcare costs and plans for cost savings).

service."[193] For the reasons discussed in Section VI.A., it is unlikely that the price commitment will actually reduce prices borne by customers.

Although Mountain States and Wellmont do not address how the cooperative agreement would impact the total cost of care, they do discuss their intention to adopt a more value-based approach to delivering healthcare services.[194] The relevant question is whether they will be more likely to participate in such initiatives, or participate more effectively, with this merger than they would without it. There is no evidence that this is the case.

The applicants assert that the merger will give them sufficient scale to enter into value-based arrangements and risk-based contracts with health insurers. They claim this would enable them to enhance quality of care and reduce costs within the merged hospital system, as well as better manage the care for high-cost, high-utilization patients.[195] But the applicants present no support for their assertion that increased scale will make the New Health System more likely to engage in or be more successful at value-based contracting.[196] In fact, Mountain States and Wellmont already independently engage in various forms of value-based contracting today, suggesting their current scale and sophistication likely is sufficient for them to participate in these types of arrangements.[197] Furthermore, as Mountain States and Wellmont have

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[193] Virginia Cooperative Agreement Application at 47-48.

[194] *Id.* at 42-43 (stating that they will endeavor to include value-based provisions in contracts with commercial payers).

[195] *Id.* at 31, 42 ("The scale created by the merger will foster opportunities for cost-savings and quality-enhancement through risk contracting to a degree neither system could come close to achieving independently.").

[196] *See* Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PwC STRATEGY& (2016), http://www.strategyand.pwc.com/reports/size-should-matter (finding that greater size does not lead to lower costs or better quality outcomes for consolidated health systems); David Muhlstein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Results for 2015: The Journey To Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/ ("Also consistent with last year, large, consolidated ACOs did not necessarily achieve the best performance. In fact, we found that the opposite was often true, as smaller, physician-led ACOs were more likely to improve quality and lower cost enough to earn shared savings. **This result is a cautionary note given the trend toward mergers and consolidations among health systems; consolidation and larger size do not necessarily lead to the functional integration and efficiency needed to succeed under alternative payment models.**") (emphasis added). *See also* Fed. Trade Comm'n v. Penn State Hershey Med. Ctr., No. 16-2365, 2016 WL 5389289, at *16 (3d Cir. Sept. 27, 2016) (suggesting that the ability to engage in risk-based contracting cannot be considered a cognizable, merger-specific benefit when both of the merging hospitals are already capable of doing this independently).

[197] Responses to Authority Questions, *supra* note 53, at 000020; Drozdowski (Anthem) Decl. (Att. A) ¶¶ 42-44 and 57-59 (Anthem included pay-for-performance measures in both Wellmont and Mountain States contracts); Press Release, Wellmont, Wellmont, UnitedHealthCare Issue Joint Statement About New Three Year Agreement, Effective June 18 (undated) http://www.wellmont.org/Patients-And-Visitors/Billing-And-Insurance/Attention-UnitedHealthcare-Insurance-Customers/ (United included pay-for-performance initiatives in contract with Wellmont); Press Release, Wellmont, Wellmont Medical Associates Collaborates with Cigna in Initiative That Advances Quality of Patient Care (undated) https://www.wellmont.org/News/Our-Providers/Wellmont-Physicians/Wellmont-Medical-Associates/2014/Wellmont-Medical-Associates-Collaborates-With-Cigna-In-Initiative-That-Advances-Quality-Of-Patient-Care.aspx (Cigna's contract with Wellmont's physician practice group includes pay-for-performance measures); *Climbing the Mountain: Implementing Innovative Leadership, Population Health and*

acknowledged, the shift to value-based initiatives is already occurring among many hospital systems and insurers nationwide, and is mandated by CMS in some circumstances.[198] In keeping with this trend, Mountain States and Wellmont likely would continue to transition to value-based initiatives independently. To the extent Mountain States and Wellmont have already transitioned to value-based initiatives and would have continued to engage in value-based initiatives independently, this cannot be considered a merger-specific benefit.

In addition, the parties claim that "[m]any of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers."[199] It remains unclear exactly how the merger would affect incentives to enter into value-based and risk-based contracting models. However, it is possible that the cooperative agreement, by increasing the parties' bargaining leverage, could diminish the New Health System's willingness to cooperate with payers' attempts to lower costs through value-based and risk-based contracting models, if adopting such an approach would prove less profitable than traditional fee-for-service models. Thus, a New Health System with substantial market power may be able to resist certain efforts to negotiate beneficial value-based or risk-based contracts that make them worse off than fee-for-service contracts because insurers will have no viable alternatives than to contract with the New Health System.

In sum, assessing the cooperative agreement under the Virginia Cooperative Agreement Act factors, we conclude that the cooperate agreement is likely to result in serious disadvantages resulting from the loss of competition, while any benefits are likely to be modest and largely achievable by other means that are less restrictive to competition. In the next two sections, we assess whether entry by a new competitor or the applicants' proposed commitments could mitigate the significant disadvantages of the cooperative agreement.

V. Entry Would Not Be Timely, Likely, or Sufficient to Overcome the Likelihood of Substantial Harm to Competition

The Commissioner must identify any potential entrants and evaluate the likelihood that entry would occur within the two calendar years following the grant of a cooperative agreement.[200] Likewise, under the *Merger Guidelines* framework, the FTC considers whether

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Disease Management, GROUP PRACTICE J., July/August 2015, at 11, http://www.amga.org/wcm/PI/Acclaim/2014/wellmont.pdf (indicating that Wellmont "obtained and succeeded with risk-based contracting.").

[198] *See* Virginia Cooperative Agreement Application at 42 ("The Affordable Care Act is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. CMS has stated that its goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service."). *See also* Press Release, U.S. Dep't of Health & Human Servs., Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements From Volume To Value (Jan. 26, 2015), http://www.hhs.gov/news/press/2015pres/01/20150126a.html.

[199] Virginia Cooperative Agreement Application at 36.

[200] *See* Virginia Cooperative Agreement Regulations, 12VAC5-221-70.B.14.e.

entry by a new competitor would be timely, likely, and sufficient to alleviate the harm to competition caused by a merger.[201]

The evidence shows that new entry would not be timely, likely, or sufficient to offset the competitive harm of the proposed merger. Construction and operation of new acute care hospitals involves significant capital investment and takes many years from the initial planning stage to opening. The Southwest Virginia and Northeast Tennessee region is unlikely to attract investment in new hospitals because there are already 19 Mountain States and Wellmont hospitals in the 21-county area with sufficient capacity to handle existing health needs. Moreover, because the merger combines two large hospital systems, entry by a single hospital – or even a few hospitals – would not be sufficient to replicate the current scope and strength of competition between Mountain States and Wellmont. Of course, the time, cost, and challenges of building multiple new hospitals would be significantly greater than building a single hospital.

Furthermore, both Virginia and Tennessee have certificate of public need ("COPN") regulations that pose an additional barrier to entry.[202] Both the Virginia and Tennessee COPN statutes regulate hospital entry, the addition of acute care hospital beds or expansion of services at existing hospitals, and the purchase of medical equipment above a certain capital threshold.[203] In fact, two of Wellmont's recent COPN applications to expand its presence in Johnson City, Tennessee, were denied following opposition by Mountain States,[204] demonstrating how COPN regulations can be a barrier to expansion. Going forward, a combined Mountain States-Wellmont

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[201] *Merger Guidelines* § 9.

[202] *See* Virginia Medical Care Facilities Certificate of Public Need Rules and Regulations, 12VAC5-220, http://www.vdh.virginia.gov/OLC/Laws/documents/2011/pdfs/COPN%20regs%202011.pdf; Tennessee Health Services and Planning Act of 2002, Tenn. Code Ann. § 68-11-1607, http://www.lexisnexis.com/hottopics/tncode/. FTC staff is aware that Virginia is considering repealing its COPN laws, which have been in place since 1993, and have submitted public comments on this issue. *See* Comment from Fed. Trade Comm'n & Antitrust Div. of the U.S. Dep't of Justice to the Virginia Certificate of Public Need Work Group (Oct. 26, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-u.s.department-justice-virginia-certificate-public-need-work-group/151026ftc-dojstmtva_copn-1.pdf. Even if these laws encouraged future entry or expansion by other firms in this geographic region, any such entry is unlikely to occur within a two-year timeframe or be on a sufficient scale to replace the competition eliminated by the cooperative agreement.

[203] Virginia Medical Care Facilities Certificate of Public Need Law, VA. CODE ANN. §32.1-102.1 et seq.; Tennessee Health Services and Planning Act of 2002, TENN. CODE ANN. § 68-11-1607.

[204] *See* Virginia Cooperative Agreement Application at 24; Wellmont Health Sys. v. Tenn. Health Facilities Comm'n, No. M2002-03074-COA-R3-CV, 2004 WL 193074 (Tenn. Ct. App. Jan. 29, 2004), http://www.ecases.us/case/tennctapp/1056005/wellmont-health-system-v-tennessee-health-faciliti (denying Wellmont's application to build a new hospital in Johnson City, Tennessee); Mac McLean, *Wellmont Denied Certificate to Build Boones Creek, Tenn. Facility*, BRISTOL HERALD COURIER (Mar. 26, 2008), http://www.heraldcourier.com/news/welmont-denied-certificate-to-build-boones-creek-tenn-facility/article_99316bb6-9e46-59bf-8e3c-6be08930bbb5.html ("The Tennessee Health Services and Development Agency rejected an application for a certificate of need Wellmont required to built[sic] the proposed $43 million Boones Creek emergency facility."); Preston Ayres, *Long Road to MSHA-Wellmont Merger*, WCYB (Apr. 1, 2015), http://www.wcyb.com/news/long-road-to-msha-wellmont-merger/32138724. *See also supra* note 125 and accompanying text (describing Mountain States's opposition to a CON application submitted by SBH-Kingsport for a new behavioral health facility).

system would have every incentive to oppose potential entrants' COPN applications, making entry even less likely.

In short, it is unlikely that any firm could overcome the entry barriers necessary to build a new acute care hospital in the area, much less a new hospital system, especially within the two-year timeframe that the Commissioner must consider. Indeed, our investigation reveals no such plans for new entry by acute care hospitals.

VI. Proposed Commitments Will Not Mitigate the Harm Resulting From Loss of Competition

In an effort to address the significant antitrust concerns with the merger, Mountain States and Wellmont have proposed commitments that they claim would limit the prices the combined hospital system could charge, as well as control other aspects of the combined hospital system's contracting behavior and delivery of services.[205] Such commitments are often referred to as "conduct remedies" because they attempt to ameliorate the harm to competition and consumers resulting from a merger by imposing restrictions on the merged entity's conduct.[206] Among the commitments being considered are rate regulation, mechanisms for sharing cost savings and efficiencies with local residents, public reporting of quality metrics, and commitments regarding certain contractual provisions between the hospitals and commercial health insurers.[207] Mountain States and Wellmont assert that these restrictions on their post-merger conduct would shield consumers from the anticompetitive effects of the merger.[208] However, these conduct remedies are not adequate substitutes for actual competition and are unlikely to be successful in protecting consumers from higher prices and reduced quality.

It is doubtful that the cooperative agreement commitments can drive meaningful cost savings and quality improvements with as much force as the current competitive environment.

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[205] *See* Virginia Cooperative Agreement Application at 5 ("Without the State Agreements, the proposed consolidation of Wellmont and Mountain States would likely be challenged under state and federal antitrust laws."). *See also* Comment from Wellmont & Mountain States to Tenn. Dep't of Health 7 (Sept. 23, 2015), https://www.tn.gov/assets/entities/health/attachments/WHS_MSHA-COPA_Written_Comments.pdf (acknowledging the "significant antitrust concerns that exist in this particular merger").

[206] In contrast to conduct remedies, "structural remedies," which include divestitures and injunctions preventing mergers, restore or maintain competition at the pre-merger level, thereby remedying the source of the anticompetitive harm – the elimination of competition between the merging hospitals. Under a conduct remedy, competition at the pre-merger level is not maintained. Designing a conduct remedy that would counteract the effects of an anticompetitive merger is nearly impossible because the source of the harm is not prevented.

[207] The Virginia Cooperative Agreement Regulations contemplate similar types of commitments to mitigate potential harms. *See* 12VAC5-221-90.C., -221-70.B.18. (requiring COPA applicants to describe any commitments they are willing to make to address potential adverse impacts). The regulations also include an assurance by the hospitals not to leverage market power, although it is unclear how this would be detected and enforced. *See* 12VAC5-221-70.B.17.

[208] Virginia Cooperative Agreement Application at 128 ("The Parties do not foresee any adverse impact on population health, or quality, access availability, cost or price of health care services to patients or payers as a result of the Cooperative Agreement. The projects and commitments identified in this Application will result in significant benefits and clearly improve health care in the region.").

Conduct remedies that purport to restrain price increases, like those proposed by Mountain States and Wellmont, are unlikely to replicate the pricing that would have prevailed absent the merger because such a remedy cannot replace the competitive conditions that otherwise would have existed. A price cap or price growth cap cannot simulate the nuanced, iterative responses that competitors make in response to each other during the negotiation process.[209] In addition, a conduct remedy designed to mitigate one type of harm may inadvertently create another type of harm as an unintended consequence. For example, a conduct remedy limiting price increases may result in the unintended reduction in quality of care.

Conduct remedies designed to prevent price increases have several serious deficiencies. First, they are typically temporary. After the conduct remedy expires, the less competitive market structure remains, but any constraint imposed by the remedy will be eliminated, and prices are likely to increase as a result.[210] Second, designing and enforcing price restrictions is a complicated and highly resource-intensive endeavor, in part because such restrictions would need to constrain prices for all current and future services provided by the merged entity during the relevant timeframe, and account for different (or changes in) reimbursement methodologies.[211] In the healthcare industry, in particular, where prices, quality, and costs are difficult to measure, these kinds of regulatory mechanisms often do not achieve their intended purpose, no matter how well-intentioned.[212]

Even assuming that price restrictions could effectively replicate pricing that would prevail were the parties to continue to compete, the proposed merger between Mountain States

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[209] *See* Commonwealth v. Partners Healthcare Sys., No. SUCV2014–02033–BLS2, at 42 (Sup. Ct. of Mass. Jan. 30, 2015), http://www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf ("A conduct remedy, which typically involves regulation of specific conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring.").

[210] *See id.*, at 3 (stating that the temporary conduct remedies would be "like putting a band-aid on a gaping wound that will only continue to bleed (perhaps even more profusely) once the band-aid is taken off.").

[211] The purpose of imposing a conduct remedy is to constrain the exercise of market power following the merger. The constraint would not be effective if market power could be exercised by increasing the price of bundles of services containing a mix of constrained and unconstrained services.

[212] *See* Letter from 21 Health Care Economists to The Honorable Janet L. Sanders in the Matter of Commonwealth of Massachusetts v. Partners Healthcare Sys. (July 21, 2014) (Attachment F) [hereinafter Partners Economist Letter (Att. F)]; Gregory S. Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health* 11 (Feb. 10, 2011), http://www.mountainx.com/files/copareport.pdf [hereinafter Vistnes COPA Analysis] ("Economists have long recognized the difficulties of regulating monopolists and how regulation, no matter how carefully crafted and implemented, can inadvertently create undesirable incentive problems."); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* 32 (May 2, 2011), http://www.wncchoice.com/files/copa_docs/Vistnes%20Report.pdf [hereinafter Capps COPA Analysis] ("Economists generally agree that, with rare exceptions, competition produces better outcomes than regulation."); Comment from Amerigroup Corp. to the Tenn. Dep't of Health 4 (Sept. 21, 2015), https://www.tn.gov/assets/entities/health/attachments/Amerigroup-COPA_Written_Comments.pdf ("regardless of the obligations and restrictions placed on recipients of a COPA, regulations are never an effective substitute for competition").

Even assuming that price restrictions could effectively replicate pricing that would prevail were the parties to continue to compete, the proposed merger between Mountain States and Wellmont would still likely cause a reduction in the incentives to improve or maintain quality. Economic theory and empirical evidence indicate that adverse quality effects of mergers are particularly likely in markets where prices are regulated.[213] For example, studies of the United Kingdom healthcare market, where rate regulation has long been the norm, demonstrate that highly concentrated provider markets have worse patient health outcomes than competitive provider markets.[214] This evidence is relevant because the proposed price commitments are tantamount to price regulation. Thus, if the cooperative agreement is approved and rates become regulated in the highly concentrated provider market in the 21-county area, there will be a serious risk of reduced quality of healthcare services.

Designing a conduct remedy to mitigate the harms of lost quality competition would be extremely difficult and resource intensive. Any meaningful remedy would need to both establish an explicit quantitative measure of the level of quality that competition would have produced and require the merged entity to produce at least that level of quality. This is nearly impossible, for several reasons. While objective quality measures exist for specific inpatient hospital services (and may be incorporated into commercial insurance contracts), these measures are not comprehensive and are difficult to establish; moreover, it would be even more difficult to establish those measures for non-inpatient services (*e.g.*, outpatient services) because those quality measures are generally much less developed.

It would be equally challenging to design a compliance mechanism to ensure that the combined hospital system achieved defined quality targets. Due to the complexities of assessing quality, no mechanism exists to impose a conduct remedy sufficient to offset a loss of quality competition. It is difficult to envision how a supervisor of a cooperative agreement would actually go about forcing the combined system to achieve a particular quality metric as a practical matter. Indeed, the parties' application specifies no penalty for failure to meet quality objectives, short of terminating the entire cooperative agreement. Even if it were possible to establish a lesser penalty for failure to perform, the combined hospital system still may be less likely to reach the quality levels that Mountain States and Wellmont would have achieved independently in a competitive environment.

The federal antitrust agencies have long contended that conduct remedies are inadequate for addressing competitive harms that result from horizontal mergers. Instead, we strongly prefer "structural remedies," which seek to restore pre-merger competitive conditions through an injunction preventing consummation of a merger or a divestiture of assets.[215] Courts generally

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[213] *See, e.g.*, Gaynor, Ho & Town, *supra* note 11.
[214] *See, e.g.*, Gaynor, Moreno-Serra & Propper, *supra* note 185.
[215] *See* ANTITRUST DIV., U.S. DEP'T OF JUSTICE, ANTITRUST DIVISION POLICY GUIDE TO MERGER REMEDIES (2011), http://www.justice.gov/atr/public/guidelines/272350.pdf; Feinstein, *supra* note 5. *See also* Fed. Trade Comm'n, Analysis of Proposed Agreement Containing Consent Order to Aid Public Comment: In the Matter of Phoebe Putney Health System, Inc., et al., Docket No. 9348, at 1 (Aug. 22, 2013), https://www.ftc.gov/sites/default/files/documents/cases/2013/08/130822phoebeputneyanal.pdf ("The Commission has declined to seek price cap or other

agree with this position.[216] For example, a Massachusetts court recently rejected a consent agreement that would have allowed multiple hospital systems to merge, provided they agreed to certain conduct remedies. The court found that the proposed conduct remedies – which included price caps, component contracting, a prohibition on joint contracting, and physician and network growth restrictions – would have done little to restore the lost competition or to address the anticompetitive harms.[217] Furthermore, the court expressed serious concerns about its ability to enforce the conduct remedies, which would have required substantial technical expertise and resources to resolve complicated issues relating to healthcare pricing during a time in which healthcare contracting practices were changing enormously.[218] While every geographic area has unique aspects, these challenges would apply equally in Southwest Virginia and Northeast Tennessee.

In addition to being unable to replicate the lost competition resulting from the merger, rate regulation and other conduct remedies are challenging and costly to implement, and require constant supervision to ensure compliance. Adding to this complexity, hospitals subject to conduct remedies often have strong financial incentives to circumvent the required regulatory commitments.[219] All of these factors would strain the state's ability to determine whether the public policy goals of a cooperative agreement are being met and to hold hospital systems accountable.

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nonstructural relief, as such remedies are typically insufficient to replicate pre-merger competition, often involve monitoring costs, are unlikely to address significant harms from lost quality competition, and may even dampen incentives to maintain and improve healthcare quality.").

[216] *See, e.g.*, United States v. E.I. du Pont de Nemours & Co., 366 U.S. 316, 330-31 (1961) (Supreme Court held that structural remedies to preserve competition are the preferred form of relief for mergers that violate Section 7 of the Clayton Act because they are "simple, relatively easy to administer, and sure.").

[217] *See Partners Healthcare Sys.*, *supra* note 209, at 2. Indeed, several prominent health economists urged the Massachusetts court not to accept the consent agreement, arguing that it would not offset the consumer harm likely to result from the acquisitions. Responding to arguments offered by Partners that the mergers would yield economic and operational efficiencies, as well as quality improvements, that would help to slow the growth rate of healthcare expenditures and benefit consumers, the economists stated that "systematic evidence from hundreds of hospital mergers around the nation provides little empirical support for these assertions." Partners Economist Letter (Att. F), *supra* note 212, at 2.

[218] *See Partners Healthcare Sys.*, *supra* note 209, at 19 (stating that the methodology for regulating prices "remains a mystery" to the court, and expressing concerns that any monitor would be able to handle the complex task of administering the price caps) ("Even with some expertise in the field, the monitor will have to take into account complex contractual arrangements between Partners and the major payers, each of which have their own unique features and tradeoffs. The prices at issue are not for a homogenous good or a single product but for a complex set of services which can be bundled and redefined from one year to the next.").

[219] *See id.*, at 42 ("A conduct remedy, which typically involves regulation of specific conduct over a limited period of time, is more difficult to craft and easier to circumvent. It also does not directly address the problem, which is a loss of competition: indeed, it permits consolidation and then attempts to limit the consequences that flow from that by imposing certain restrictions on the defendant's behavior. . . . [C]onduct remedies 'seek to thwart the natural incentives of the merged entity to behave as a single firm' and thus require constant and costly monitoring."); *id.* at 32 ("Particularly where the product or transaction is complex and enforcement of the remedies is over a long period of time, there are many opportunities for the entity, in pursuit of its own self-interest, to 'crowd' the border of stated rules and create ways to evade them.").

A. Price Commitments Proposed by Mountain States and Wellmont Will Be Difficult to Administer and Unlikely to Address Consumer Harms

In their cooperative agreement application, Mountain States and Wellmont commit to reduce the negotiated rate increases to major commercial payers by 50% in "the first contract year following the first contract year after the formation of the New Health System."[220] For subsequent contract years, they agree not to increase negotiated hospital rates by more than the hospital Consumer Price Index ("CPI") minus 0.25%, or negotiated rates for physician and non-hospital outpatient services by more than the medical care CPI minus 0.25%.[221] Mountain States and Wellmont claim that this reduction in price increases will benefit insurers in the form of a lower cost trend, and that the associated cost savings will be passed through to consumers.[222] Despite these claims, the proposed price commitments are unlikely to protect consumers from the anticompetitive price increases that are likely to result from the lost competition between Mountain States and Wellmont.

The price commitment language included in the parties' cooperative agreement application is ambiguous and subject to interpretation. Consequently, the scope of the commitment remains unclear, which would give the combined hospital system wide discretion when calculating complex price and benchmark metrics. It also appears that the combined hospital system would have wide discretion to renegotiate the price growth cap formula or use alternative methods for calculating rate increases after the cooperative agreement has been approved.[223] All of this leaves open the potential for these metrics and formulas to be manipulated, especially because the combined hospital system would control the underlying data, such that the intent of the price commitment may appear to be achieved when, in fact, it is not.[224]

Several practical issues arise from the price commitments proposed by Mountain States and Wellmont, including:

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[220] Virginia Cooperative Agreement Application at 30.

[221] *Id.* In addition, the Virginia Cooperative Agreement Regulations allow the Commissioner to impose "[a] cap on the negotiated case-mix adjusted revenue per discharge by payer by product," but the methods for determining the cap, as well as for monitoring compliance, remain unspecified. Virginia Cooperative Agreement Regulations, 12VAC5-221-90.C.1.

[222] Virginia Cooperative Agreement Application at 29-30.

[223] *Id.* at 30 ("For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes.").

[224] This concern has been raised in other cases involving price commitments proposed by hospitals. *See Partners Healthcare Sys.*, *supra* note 209, at 2 ("Significantly, the monitor must rely on [the hospital system] for the critical information to make these calculations – so that the fox is literally guarding the proverbial chicken coop."). *See also supra* note 218; RANDALL R. BOVBJERG & ROBERT A. BERENSON, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? 22 (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf, [hereinafter URBAN INSTITUTE COPA REPORT] (describing the challenges of obtaining "objective information not controlled by the supplier of data" and how "[c]ontrol over data could allow a regulatee to cherry pick its public documentation and possibly even metrics of oversight").

- Inappropriate to Use Consumer Price Index as Benchmark for Future Price Increases: The use of the hospital and medical care CPIs as benchmarks is intended to allow prices to increase commensurate with costs, where the benchmarks serve as proxies for costs. However, these benchmarks do not take into account differences in cost structures, case mix, or service offerings between the merging hospitals and the other hospitals that make up the benchmark. Thus, CPI benchmarks could overstate cost changes in Virginia and Tennessee if, for example, costs in these states were to grow slower than the national or regional average. In addition, the medical care CPI is calculated based on a basket of goods and services that includes expenditures for medical devices and drugs as well as provider services.[225] Thus, using the medical care CPI could overstate price (and cost) growth of physician services if the rate of growth in drug prices, for example, exceeds that of physician prices. If either of these scenarios were to occur, relying on the proposed price growth cap in combination with the hospital and medical care CPIs as benchmarks may allow the combined hospital's prices to rise by more than its costs.

- Baseline Rates for the Combined Hospital System May Be Artificially High: FTC staff interprets the price commitment language in the cooperative agreement application to mean that the combined hospital system would be allowed to negotiate contracts with payers during the first full year after the merger is consummated,[226] and the reimbursement rates included in these payer contracts as they expire would be used to determine the baseline for comparing the combined hospital system to the CPI.[227] Thus, if the parties are not required to reduce rate increases until the first contract year after the first full year that the New Health System is formed, then the initial baseline rates could be set quite high, because they would be based on the rates that the combined hospital system would be able to negotiate as a result of its increased bargaining leverage.

- Price Growth Cap Unlikely To Reduce Prices Borne By Insurers and Consumers: As discussed previously, Mountain States and Wellmont suggest that the price growth cap commitment will reduce the prices borne by patients, employers, and insurers.[228] However, the price-capping formula proposed by Mountain States and Wellmont may actually function as a price floor, guaranteeing price levels that would be higher than they might otherwise be in a competitive market. Absent the merger, prices could have decreased in the future, or increased at a slower rate, due to vigorous competition between Mountain States and Wellmont. Under the cooperative agreement, the two

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[225] *Measuring Price Change for Medical Care in the CPI*, BUREAU OF LABOR STATISTICS, http://www.bls.gov/cpi/cpifact4.htm (last updated Apr. 12, 2010).

[226] Virginia Cooperative Agreement Application at 30 (". . . the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) **for the first contract year following the first contract year after the formation of the New Health System.**") (emphasis added).

[227] *Id.* at 30 ("For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract.").

[228] *Id.* at 47-48. *See supra* notes 192-193 and accompanying text.

systems will no longer serve as competitive constraints to each other, and there will be nothing to prevent Mountain States and Wellmont from negotiating for the maximum rate increases allowable per the pricing commitments. Because insurers will have few alternative providers to contract with to serve local residents, insurers will be forced to pay that maximum rate. Although this commitment may guarantee the insurers a rate no higher than the cap, it also guarantees a rate no lower than the cap. For these reasons, FTC staff believes it is unlikely that the price growth cap will reduce prices borne by insurers and consumers.

- Price Commitments Leave Many Patients Unprotected: The price commitments only apply to patients enrolled in health plans operated by commercial payers who provide more than 2% of the New Health System's total net revenue. Also, according to the parties' cooperative agreement application, the price commitments do not apply to Medicaid managed care, TRICARE, Medicare Advantage, or any other governmental plans offered by payers where prices are negotiated.[229] Thus, the price commitments leave a significant volume of patients in the region unprotected against potentially significant price increases.

B. Proposed Accountability and Enforcement Mechanisms for Quality Benefits Are Insufficient

The mechanisms proposed by Mountain States and Wellmont for evaluating the quality benefits of the cooperative agreement do not appear sufficient or meaningful. The parties claim to offer a set of "quantitative measures" as an accountability mechanism to track compliance with their commitments under the cooperative agreement.[230] Yet, most of the proposed mechanisms appear to be qualitative and vague, consisting of little more than some yet to be identified tracking measures and an annual report to the Commissioner in which the parties will attest to any progress they are making towards compliance.[231]

Measuring healthcare quality can be quite difficult and the method proposed by the parties does not address those challenges. The parties' proposed assessment does not constitute objective, quantitative data by which the claimed benefits can be evaluated, much less weighed against the disadvantages likely to result from the cooperative agreement.[232] Moreover, in the event that there is a problem with the information submitted in the annual report, adjustments could only be made every five years while the cooperative agreement remains in effect.[233] It is unclear how the Virginia Department of Health could objectively determine whether the hospital attestations regarding quality benefits are accurate, and thus whether the combined hospital system is complying with the requirements of the cooperative agreement.

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[229] *Id.* at 30. *See also* Comments from Virginia Association of Health Plans, *supra* note 8.
[230] *Id*. at 98.
[231] *Id.* at 133-34.
[232] *Id.* at 102, 112-18 (describing the proposed measures contained in the annual report).
[233] *Id.* at 111.

Likewise, the "Overall Achievement Scoring" parameters described in the cooperative agreement application appear insufficient to facilitate an assessment of compliance, and the formula proposed for evaluating evidence of "Continuing Benefit" does not appear to require a sufficient magnitude of benefits to offset the significant disadvantages likely to occur as a result of this merger.[234] Indeed, this formula appears to allow almost *any* outcome to be considered evidence of continuing benefit (*i.e.*, that the benefits of the cooperative agreement outweigh any disadvantages attributable to any reduction in competition).[235] Moreover, there does not appear to be any enforcement mechanism for failing to meet the quality commitments other than revoking the cooperative agreement and unwinding the transaction,[236] which, as explained below, may be extremely difficult if not impossible.

C. Proposal to Enhance Transparency for Quality Measures Will Be of Limited Value to Consumers in the Absence of Provider Competition

In their cooperative agreement application, Mountain States and Wellmont affirm the importance of transparency for healthcare quality measures to provide consumers with the information they need to make better healthcare decisions.[237] Generally, if consumers have access to meaningful price and quality information regarding the various healthcare providers in their local area, they can make better choices when selecting providers.[238] To achieve greater transparency, Mountain States and Wellmont have committed to publicly report CMS core quality measures on the combined hospital system's website within 30 days of reporting the data to CMS.[239] They have also agreed to provide benchmarking data against the most recently available CMS data in a faster manner than they currently do to allow the public to compare the merging hospitals to other hospitals.[240] However, nothing prevents either hospital system from taking these steps now while they remain independent. More importantly, while this greater transparency might be useful to patients, it does not address the root of the problem with the cooperative agreement, which is the loss of competition between Mountain States and Wellmont.

Finally, whatever benefit might be realized from increased transparency would offer limited value to consumers after the merger because they will have no meaningful alternatives to the combined hospital system. The proposed merger will eliminate the only real choice that patients in this area currently have. Thus, improving transparency for quality measures after the

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[234] *Id.* at 118, 124-25 (describing the "Overall Achievement Scoring" parameters and the formula for determining "Continuing Benefits").
[235] According to the formula in the cooperative agreement application, an Overall Achievement Score of 70% or higher would be definitive evidence of Continuing Benefit, but an Overall Achievement Score that is below 50% may still be considered definitive evidence of a Continuing Benefit, depending on the circumstances. Furthermore, the VDH Commissioner would have discretion to determine that there is Continuing Benefit, even if the Overall Achievement Score falls anywhere below these thresholds. *See id.* at 124-25.
[236] *Id.*
[237] *Id.* at 75.
[238] *See* FTC Healthcare Workshop 2014, *supra* note 18 (panels on "Measuring and Assessing Quality of Health Care," "Price Transparency of Health Care Services," and "Interplay Between Quality and Price Transparency").
[239] Virginia Cooperative Agreement Application at 76.
[240] *Id.*

merger to near-monopoly will not enable consumers to evaluate competing hospital systems and select the most suitable providers for their needs.

D. Commitments Regarding Contractual Provisions Do Not Mitigate Merger Harms

In their cooperative agreement application, Mountain States and Wellmont have committed not to engage in "most favored nation" pricing with any health plans, and they have agreed not to become the exclusive network provider to any commercial, Medicare Advantage, or managed Medicaid insurer.[241] Furthermore, they have committed not to engage in exclusive contracting for physician services (except for certain hospital-based physicians) and not to prohibit independent physicians from participating in health plans and networks of their choice.[242]

The antitrust agencies have noted that, depending on the circumstances, some of these contracting practices can be anticompetitive when imposed by a dominant hospital system.[243] However, these practices are not the primary source of harm from this merger – lost competition is the source of the harm – and prohibiting these practices will therefore not solve the problem. In addition, prohibiting most of these practices would not be meaningful in a market where competition among the most significant healthcare providers has been eliminated.[244]

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[241] *Id.* at 65.

[242] *See id.* at 65-66. In addition, the Virginia Cooperative Agreement Regulations allow the Commissioner to impose prohibitions on the inclusion of certain contractual provisions in agreements between providers and commercial health insurers, including anti-steering provisions, tying arrangements, and gag clauses. *See* Virginia Cooperative Agreement Regulations, 12VAC5-221-90.C.3.-5.

[243] *See, e.g.*, Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program, *supra* note 90, at 67029-30, Section IV.B.1.b. (identifying several contracting practices that may raise competitive concerns if imposed by a provider with high market shares or other possible indicia of market power, including: "[p]reventing or discouraging private payers from directing or incentivizing patients to choose certain providers . . . through 'anti-steering,' 'anti-tiering,' 'guaranteed inclusion,' 'most-favored-nation,' or similar contractual clauses or provisions"; "[t]ying sales (either explicitly or implicitly through pricing policies) of [some of the provider's] services to the private payer's purchase of other services from [other] providers"; "contracting on an exclusive basis"; and "[r]estricting a private payer's ability to make available to its health plan enrollees cost, quality, efficiency, and performance information to aid enrollees in evaluating and selecting providers in the health plan").

[244] For example, payers may attempt to control costs by steering patients to high-quality, low-cost providers or making price and quality information more transparent to patients. However, such strategies are unlikely to be successful in markets that lack sufficient competition among providers. Thus, if a cooperative agreement results in substantial provider consolidation, imposing prohibitions on contractual provisions that would undermine these strategies would be meaningless. Indeed, Mountain States and Wellmont imply as much in their cooperative agreement application, when they reserve the right to enter into exclusive network and most-favored nation agreements for non-inpatient services in the event of repeal or material modification to the COPN law in Virginia or the Certificate of Need law in Tennessee, which could ease entry barriers for potential competitors. *See* Virginia Cooperative Agreement Application at 86.

VII. Proposed Plan of Separation Would Not Be An Effective Remedy

The Virginia Cooperative Agreement Regulations require that the merging hospitals submit a Plan of Separation describing how they would unwind the merger if deemed necessary by the VDH.[245] In other words, if the VDH determines that the underlying public policy goals of the cooperative agreement are not being achieved, the Plan of Separation is intended to be a mechanism for the VDH to terminate the cooperative agreement and restore pre-merger competition. Hence, it is important to seriously consider how the termination provisions might play out in practice and what options the VDH would have if the cooperative agreement is approved and Mountain States and Wellmont systems are integrated.

As discussed below, even with an aspirational Plan of Separation in place, it would be unrealistic to expect that terminating a cooperative agreement following a merger's consummation would return the hospital systems to their pre-merger status and, therefore, fully restore the lost competition. A transaction of this scale and scope, as evidenced by Mountain States and Wellmont's stated plans, would involve a significant degree of integration. For example, the combined entity would be likely to: consolidate or close hospitals; consolidate and transfer service lines; reorganize physician and other staffing at hospitals (with some physicians potentially leaving the area); negotiate new, consolidated contracts with health insurers; integrate EHR and other IT systems; integrate accounting and other financial systems; eliminate management and other staff; consolidate administrative services and vendors; and change many aspects of daily operations at these hospitals. These changes likely would alter patient travel patterns and facility preferences, as well. Reversing all of these changes through a Plan of Separation would be highly disruptive at best, and quite likely impossible.

Recognizing this, antitrust agencies typically seek to prevent or remedy problematic mergers *before* they are consummated because it is inherently challenging, and rarely feasible, to "unscramble the eggs" and unwind the assets of companies after they have been integrated.[246] Historically, the FTC has faced difficulties in obtaining effective remedial relief after assets have been combined through a merger, including hospital and other healthcare provider mergers. Indeed, even in certain cases where the FTC has proven that such a merger was anticompetitive and resulted in higher prices without offsetting quality improvements or enhanced patient experience, the FTC has been unable to obtain a viable divestiture remedy for these harms.[247]

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[245] Virginia Cooperative Agreement Regulations, 12VAC5-221-70.19. ("The parties shall provide an independent opinion from a qualified organization verifying the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the Parties."). *See also* 12VAC5-221-20 (Definition of "Plan of Separation"); 12VAC5-221-110.B. (requiring that the parties update the Plan of Separation annually).

[246] *See* Feinstein, *supra* note 5. *See generally* Comment from FTC Staff to John J. Dreyzehner, Tenn. Dep't of Health 3-4 (Dec. 22, 2015), https://www.ftc.gov/system/files/documents/public_statements/903943/151222ftcltrtennesseedoh.pdf (describing how the FTC typically seeks to remedy problematic mergers before they are consummated, as it becomes difficult to obtain effective remedial relief after assets have been integrated).

[247] *See, e.g.*, Evanston Northwestern Healthcare Corp., No. 9315, at 89-91 (Fed. Trade Comm'n Apr. 28, 2008) , https://www.ftc.gov/sites/default/files/documents/cases/2008/04/080428commopinionon remedy.pdf (Opinion of the Commission on Remedy); Phoebe Putney Health Sys., Inc., 159 F.T.C. 1246, 1246-1247 (Mar. 31, 2015), https://www.ftc.gov/system/files/documents/public_statements/634181/150331phoebeputneycommstmt.pdf

Similarly, if the proposed cooperative agreement between Mountain States and Wellmont is approved, and they merge their operations, the remedies available if the merger does not yield its promised benefits would be severely limited, despite having a Plan of Separation. Indeed, given the scale of the merged system, separating Mountain States and Wellmont would likely be vastly more difficult than any consummated healthcare provider merger that the FTC has ever sought to unwind.

Notably, Mountain States and Wellmont opposed efforts by the VDH and Tennessee Department of Health to include a Plan of Separation provision in their respective regulations.[248] They stated that the feasibility of any Plan of Separation would depend on the circumstances at the time of implementation and "that a plan as implemented may differ significantly from the proposed plan."[249] This raises serious concerns about the effectiveness of such a remedy. In addition, and contrary to assertions made by hospital executives that they would be subject to antitrust scrutiny if a Plan of Separation were ever put into effect,[250] there can be no guarantee that the merger would be unwound by any federal or state antitrust enforcement.

The Plan of Separation, as described in the cooperative agreement application, is not an actual plan, but rather a process by which a plan may be developed and implemented after the merger is allowed to proceed. It contains numerous caveats and limitations that could undermine the effectiveness of any such plan in restoring pre-consolidation market competition, including:

- Plan of Separation Does Not Guarantee a Structural Remedy: Mountain States and Wellmont appear to focus on a potential divestiture of assets and operations to address harms, but acknowledge that any plan developed post-merger would have to be viewed through the lens of "then-current market circumstances" and could only restore competitive conditions to the pre-consolidated state "to the extent reasonably practicable." It appears as though specified plan components could also be avoided if changed circumstances in the market "would likely negate the effectiveness of said components in restoring competition to its pre-consolidated state."[251] Thus, Mountain States and Wellmont basically admit that the consolidated assets may no longer be separable, or even exist, in the event that a Plan of Separation must be implemented. We

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(Statement of the Federal Trade Commission) (Commission unable to unwind merger of two hospitals merging to a monopoly because of state certificate of need laws and regulations).

[248] *See* Va. State Bd. of Health, Minutes 19 (Sept. 17, 2015), http://www.vdh.virginia.gov/Administration/Meetings/documents/pdf/Minutes%20September%2017%202015%20final.pdf (stating that the parties "requested that provisions requiring a Plan of Separation to be included with the application for a cooperative agreement . . . be stricken" from the Virginia Cooperative Agreement Regulations); Comment from Wellmont & Mountain States to Tenn. Dep't of Health, *supra* note 205.

[249] *See* Comment from Wellmont & Mountain States to Tenn. Dep't of Health, *supra* note 205, at 2.

[250] *See* Hank Hayes, *Will the Feds Stand in the Way?*, KINGSPORT TIMES-NEWS (Jan. 11, 2016), http://www.timesnews.net/Business/2016/01/11/Will-the-feds-stand-in-the-way (quoting Alan Levine, President and CEO of Mountain States, "If the COPA is violated, we would have to submit a plan for separation, and that would also subject us to FTC scrutiny at that point.").

[251] Virginia Cooperative Agreement Application, Exhibit 18.1: Plan of Separation between Wellmont and Mountain States, https://swvahealthauthority.files.wordpress.com/2016/02/18-1-plan-of-separation.pdf, at 2.

further note that the establishment of "a separate and independent apparatus for payer contracting by the new competitive entity" is unlikely to be an effective remedy.[252]

- Plan of Separation Does Not Guarantee Restoration of Pre-Consolidation Market Competition: Based on the language in the cooperative agreement application, it is possible that the geographic areas subject to any termination order may be smaller than the entire service area of the combined hospital system.[253] If that were the case and the hospital system were only required to divest certain facilities and assets, the level of competition that currently exists between two large hospital systems may not be fully restored. Similarly, the Plan of Separation states that the "administrative, operational and clinical quality of all assets and operations" would only have to be maintained at the level that exists at the time of the termination order, which does not guarantee that competition would be restored to its pre-consolidated state.[254]

- Plan of Separation Does Not Guarantee Timeline for Restoring Pre-Consolidation Market Competition: The 240-day timeline for executing a plan could be waived if "the Parties and the Commissioner agree it is not feasible" to meet it.[255] This raises doubts about when such a plan would have to be executed. Based on recent FTC experience, it can take a year or more to effect divestitures, even when there has not been significant facility, clinical, and other integration between the parties.[256]

- Independent Review of Plan of Separation Contains Significant Caveat: Although F.T.I. Consulting has endorsed the Plan of Separation, it offers the limitation that "[a]mong other matters, later changes in market conditions may affect the views expressed in this letter."[257] Thus, F.T.I. Consulting's endorsement contains a caveat that effectively can be used to disavow the feasibility of any plan that may be offered at a later date.

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[252] *Id.* at 3. For a discussion of why this is not likely to be an effective remedy, *see* Brief Amicus Curiae of Economics Professors, Evanston Northwestern Healthcare Corp., No. 9315 (Fed. Trade Comm'n 2007), https://www.ftc.gov/sites/default/files/documents/cases/2007/10/071017econprofsamicusbrief.pdf.

[253] Virginia Cooperative Agreement Application, Exhibit 18.1, *supra* note 251, at 1 ("The Consultant shall assist the Parties in complying with the termination order to analyze competitive conditions *in the markets subject to the Commissioner's termination order* and identifying the specific steps necessary to return the markets to their pre-consolidation competitive state.") (emphasis added).

[254] *Id.* at 3.

[255] *Id.* at 2.

[256] *See, e.g.*, Press Release, Fed. Trade Comm'n, FTC Approves ProMedica Health System's Divestiture of former Rival St. Luke's Hospital (Jun. 24, 2016), https://www.ftc.gov/news-events/press-releases/2016/06/ftc-approves-promedica-health-systems-divestiture-former-rival-st (Divestiture of hospital approved in June 2016, four years after Commission ruled that the proposed transaction violated Clayton Act); Order to Maintain Assets at 1-2, Saint Alphonsus Med. Center-Nampa, Inc. v. St. Luke's Health System, Ltd., No. 1:12-cv-00560-BLW (9th Cir. Dec. 10, 2015) (Order appointing trustee to oversee divestiture of hospital 22 months after district court enjoined the transaction and over two and a half years after Commission filed complaint for permanent injunction).

[257] Virginia Cooperative Agreement Application, Exhibit 18.2: Opinion on Plan of Separation, https://swvahealthauthority.files.wordpress.com/2016/02/18-2-opinion-on-plan-of-separation.pdf, at 4-5.

VIII. Practical Problems Encountered with Certificates of Public Advantage in Other States

Although several states have enacted legislation similar to the Virginia Cooperative Agreement Act, very few hospital mergers have been approved pursuant to such legislation. We are aware of only five states that purported to grant antitrust immunity to merging hospitals under a cooperative agreement/certificate of public advantage ("COPA") regulatory scheme – North Carolina, South Carolina, Montana, Minnesota, and most recently, West Virginia.[258] Of these states, North Carolina, Montana, and Minnesota have repealed or modified the underlying legislation, which has allowed the merged healthcare systems to exercise their monopoly market power unconstrained by state regulatory oversight or, in all likelihood, antitrust enforcement. FTC staff has some concerns about these cooperative agreements, based on publicly available information, and we provide this information to the Authority and the Commissioner in case it is useful in evaluating the proposed cooperative agreement application.

Mountain States and Wellmont have touted the COPA that Mission Health System ("Mission Health") operated under for 20 years in North Carolina as an example of a successful COPA and a potential model for how to implement an effective cooperative agreement regulatory scheme.[259] Given the difficulty of assessing whether the public policy goals of the Mission Health COPA have actually been met, we view this example with skepticism and we hope the Authority and the Commissioner will as well. Independent health policy experts have studied the Mission Health COPA, but have not been able to determine whether the COPA successfully constrained prices, reduced healthcare costs, or improved quality, due to the lack of objective data, particularly for commercially insured patients.[260] More concerning, however, is

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[258] Under the state action doctrine, antitrust immunity was purportedly granted to the following hospital systems: HealthSpan Hospital System (Minnesota, 1994); Mission Health System (North Carolina, 1995); Benefis Health System (Montana, 1996); Palmetto Health System (South Carolina, 1998); and Cabell Huntington Hospital (West Virginia, 2016). In 1997, United Regional Health Care System was formed when the only two general acute-care hospitals in Wichita Falls, Texas – Wichita General Hospital and Bethania Regional Health Care Center – sought and obtained a purported antitrust exemption from the Texas state legislature. However, this does not appear to have involved a cooperative agreement regulatory scheme.

[259] *See* Jeff Keeling, *Rules Governing Hospital Merger Published*, BUS. J. TRI-CITIES TENN./VA. (Sept. 16, 2015), http://bjournal.com/rules-governing-hospital-merger-published/ ("Levine has pointed to a COPA that has governed hospital care in the Asheville, N.C. market since the 1996 merger of Memorial Mission and St. Joseph's hospitals as a model for this proposed merger. The Mission system's cost containment, health results and quality measures all suggest it can be done, he said. Whether that can be successfully emulated, with appropriate variations, in a larger, two-state system is a question that probably won't be answered until the merger, if approved, has been in place for several years if not longer.").

[260] *See* URBAN INSTITUTE COPA REPORT, *supra* note 224, at 16-17 (noting the limited public information available to assess the impact of the COPA on prices, costs, or quality, and the seemingly limited access that consultants had to data that might have allowed for an independent empirical analysis of the COPA's effects); *id.* at 16 ("This case study found no definitive evidence about whether the COPA's state oversight has successfully replaced the former competition that was lost by permitting the collaboration and combination of the only two general hospitals in the population center of WNC.") *id.* at 22 ("We did observe that the paucity of relevant objective data accessible to parties and public alike made any outside assessment a challenge."). *See also* Vistnes COPA Analysis, *supra* note 212, at 6-8, 11 n.14 (describing the scope of his analysis and acknowledging that he was unable to determine whether the merger actually resulted in a substantial increase in market power or whether Mission Health acted on

that the North Carolina legislature recently repealed the state's COPA statute, leaving no effective constraint on Mission Health's monopoly market power.[261] Although we are pleased that the North Carolina legislature no longer believes a COPA statute is necessary or beneficial, and that problematic hospital mergers will no longer be allowed to proceed under such a statute, we remain concerned about the current and future state of competition in western North Carolina.

In addition to the Mission Health example, we are aware of another hospital merger to monopoly that was allowed to proceed under a COPA regulatory scheme that imposed conduct remedies intended to mitigate the competitive disadvantages of the merger. For ten years, Benefis Health System ("Benefis Health") was subject to revenue caps and other cost-saving efficiency commitments agreed to as part of the COPA.[262] During this time, the Montana Department of Justice routinely concluded that Benefis Health complied with the terms of the COPA regulations, despite indications that Benefis Health sometimes exceeded its total revenue cap and suffered from quality of care deficiencies.[263] Indeed, Benefis Health requested amendments to the COPA commitments when it was unable to achieve the cost savings and

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incentives to evade regulations intended to curtail its market power); Capps COPA Analysis, *supra* note 212, at 14 (stating that "under the current regulatory framework, MHS has the ability to charge high prices . . . in direct contradiction to the clear intent of the COPA" but acknowledging that he was unable to assess whether MHS has in fact done so).

[261] *See* S.B. 698, Gen. Assemb., 2015-2016 Session, Session Law 2015-288 (N.C. 2015), http://www.ncleg.net/Sessions/2015/Bills/Senate/PDF/S698v5.pdf (ratified by General Assembly Sept. 29, 2015; signed into law by Governor Oct. 29, 2015) (repealing Article 9A of Chapter 131E of the NC General Statutes, relating to Certificate of Public Advantage, effective Jan. 1, 2018). The North Carolina state legislature recently accelerated the effective date of the repeal of the COPA statute to September 30, 2016. *See* H.B. 1030, Gen. Assemb., 2015-2016 Session, Session Law 2016-94, at 93 (N.C. 2016), http://www.ncga.state.nc.us/Sessions/2015/Bills/House/PDF/H1030v8.pdf (revising the effective date of repeal from January 1, 2018 to September 30, 2016). For further discussion of the bill's possible implications, *see* Mark Barrett, *NC Senate Considers Repeal of Law Governing Mission*, Citizen-Times (Jun. 16, 2015), *available at* http://www.citizen-times.com/story/news/local/2015/06/16/nc-senate-considers-repeal-law-governing-mission/28811673/. *See also* URBAN INSTITUTE COPA REPORT, *supra* note 224, at VII ("It would be shortsighted to simply cease COPA oversight and return to antitrust review alone once consolidated providers have built market power, because the window for antitrust review to address a merger is time-limited . . ."); *id.* at 21-22.

[262] *See* Amended Findings of Fact, Conclusions of Law, and Certificate of Public Advantage at 43-51, In the Matter of the Application for a Certificate of Public Advantage By the Columbus Hospital and Montana Deaconess Medical Center, Great Falls, Montana (Mont. Dep't of Justice 1996), https://dojmt.gov/wp-content/uploads/2011/05/decisionamended19961.pdf.

[263] *See, e.g.*, Preliminary Findings Concerning Compliance with Terms and Conditions, In the Matter of the Certificate of Public Advantage Issued to Benefis Healthcare, Great Falls, Montana (Mont. Dep't of Justice Dec. 31, 1998), https://dojmt.gov/wp-content/uploads/2011/05/progressreport19981.pdf (finding that Benefis Health exceeded the total revenue cap by approximately $3.4 million in the first year of operation, and citing several quality of care deficiencies and concerns); Letter from State of Mont. Department of Justice to Wayne Dunn, CFO, Benefis Healthcare: Findings of the Department of Justice Regarding Compliance of Benefis Healthcare with the Terms and Conditions of the Certificate of Public Advantage for the Years 2003 through 2005, at 2-3 (Aug. 15, 2007), https://dojmt.gov/wp-content/uploads/2011/05/findings20071.pdf (finding that Benefis Health exceeded the patient revenue cap by $3.7 million in 2004, and by $1.8 million in 2005); *id.* at 5 (finding that "surveys continued to reflect poor comparative responses from patients and families to the care and service received at Benefis" for 2005).

efficiencies that it had offered as justifications for approving the COPA.[264] In 2007, at Benefis Health's urging, the Montana state legislature passed a bill that effectively terminated the COPA agreement while allowing the health system to remain merged, despite the objections of the Montana attorney general.[265] As a result, Benefis Health has been able to freely exercise its monopoly market power with no regulatory or antitrust oversight since 2009, when the legislation took effect. Since that time, there have been concerns regarding significant price increases by Benefis Health.[266]

In sum, the COPA regimes implemented in other states illustrate the challenges with regulating a hospital monopoly in perpetuity. If either the Virginia or Tennessee state legislature were to repeal or revise the underlying cooperative agreement statutes, the regulatory oversight intended to mitigate the anticompetitive effects of the merger could be eliminated, allowing the combined hospital system to exercise unchecked market power.[267]

These challenges may be exacerbated under the proposed cooperative agreement because it involves regulation by two different states. Potential challenges include the possibility for

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[264] *See* Findings of Fact, In the Matter of the Application by Benefis Healthcare for Modification to the Certificate of Public Advantage (Mont. Dep't of Justice Mar. 22, 1999), https://dojmt.gov/wp-content/uploads/2011/05/requestedmodifications19992.pdf. The Montana Department of Justice denied most of the amendments to the revenue cap and cost savings targets proposed by Benefis Health, but did allow a downward adjustment to the annual expense reduction target and a change to the inflation index used in the revenue cap model. Thus, it appears that the COPA may have resulted in higher revenues and lower cost savings than originally projected at the time the COPA received approval. *See also* Findings of Fact at 7-11, In the Matter of the Application by Benefis Healthcare for Modification to the Certificate of Public Advantage (Mont. Dep't of Justice Apr. 4, 2003), https://dojmt.gov/wp-content/uploads/2011/05/benefisfindingsoffact20031.pdf (describing how the Montana Department of Justice approved several requests from Benefis Health to modify the COPA, including removing investment income from the revenue cap, granting increases in the inflationary factor used in the revenue cap model, eliminating restrictions on exclusive contracts with anesthesiologists, and allowing changes regarding quality of care reporting requirements); Preliminary Findings Concerning Compliance with Terms and Conditions at 5, In the Matter of the Certificate of Public Advantage Issued to Benefis Healthcare, Great Falls, Montana (Mont. Dep't of Justice Jan. 18, 2004), https://dojmt.gov/wp-content/uploads/2011/05/preliminaryprogressreport3.pdf (describing how Benefis Health would have exceeded the revenue cap without such relief).

[265] *See* MONT. CODE ANN. § 50-4-603.(5). (amended 2007), http://leg.mt.gov/bills/mca/50/4/50-4-603.htm (limiting the duration of a COPA to no more than 10 years from the date of issuance); Findings of Fact at 12, In the Matter of the Application by Benefis Healthcare for Repeal of the Certificate of Public Advantage (Mont. Dep't of Justice Oct. 2006), https://dojmt.gov/wp-content/uploads/2011/05/decision20061.pdf ("The Department finds that there is not sufficient evidence to conclude that increases in competition have eliminated the need for regulation over inpatient hospital services.").

[266] *See* Jimmy Tobias, *Costly Care: Great Falls Hospital Merger Holds Lessons For Missoula*, MISSOULA INDEP.: INDY BLOG (Mar. 26, 2014), http://missoulanews.bigskypress.com/IndyBlog/archives/2014/03/26/great-falls-hospital-merger-holds-lessons-for-missoula (citing the Benefis Health COPA as an example of the potential problems associated with hospital mergers that create substantial market power, including complaints of significant prices increases – up to 38% over three years for some health plans – after the COPA was rescinded; also reporting that the annual Montana attorney general reports on non-profit state hospitals "show prices rapidly rising at Benefis" from 2008 to 2010, including average prices at Benefis for esophagitis treatments increasing from $6,564 to $9,230, for simple pneumonia procedures increasing from $7,722 to $13,076, and for vaginal births increasing from $3,475 to $4,832).

[267] *See* URBAN INSTITUTE COPA REPORT, *supra* note 224, at 21-22, 24.

differing levels of supervision or disparate determinations regarding whether the benefits of the cooperative agreement outweigh the disadvantages. For example, if one state later decides to terminate the cooperative agreement and put the Plan of Separation into effect, while the other state does not, it is unclear how this conflict would be resolved.

Moreover, the cooperative agreement proposed by Mountain States and Wellmont involves many more hospitals, outpatient facilities, and physicians than any prior cooperative agreement or COPA. As such, the competition that would be eliminated and the resulting potential for consumer harm, as well as the complexity of implementing and monitoring adequate conduct remedies, are exponentially greater here than in any prior case.

IX. Conclusion

Existing competition between Mountain States and Wellmont benefits employers and consumers in Southwest Virginia and Northeast Tennessee in a myriad of ways. Competition constrains prices for inpatient, outpatient, and physician services, which ultimately benefits community members by keeping their out-of-pocket healthcare expenses down. The competition between Mountain States and Wellmont also has spurred both hospital systems to offer a wide breadth of services in the local community and to strive to be high-quality providers of those services in order to attract physician referrals and patient admissions.

The merger would eliminate this beneficial competition. Based on the record in this proceeding and the FTC's extensive experience evaluating healthcare mergers – as informed by antitrust law, economic research, and healthcare policy – it is clear that the combined hospital system would have a dominant share of the market, making it a near-monopoly and allowing it to exercise significant market power. This would likely result in higher prices and reduced quality for healthcare services in Southwest Virginia and Northeast Tennessee. Any cost-savings or quality benefits of the merger would need to be extraordinary in order to outweigh the significant competitive harm that is likely to result from the merger, and there is no indication that this is the case. Moreover, Mountain States and Wellmont have failed to show why many of the claimed benefits could not be achieved through an alternative arrangement – either independently, through a merger or affiliation with a different partner, or through another form of collaboration with each other – that would be less harmful to competition. Additionally, it is unlikely that the price or quality commitments offered by the merging parties will mitigate the harms of the proposed merger, and could exacerbate pricing or cause unintended reductions in the quality of care or access to care for consumers in Southwest Virginia and Northeast Tennessee.

In summary, FTC staff respectfully encourages the Authority and the Commissioner to consider the following factors and questions when reviewing the cooperative agreement application submitted by Mountain States and Wellmont:

1. Will the proposed merger substantially reduce competition, allowing the combined hospital system to negotiate higher prices for healthcare services, and reducing its incentives to maintain or improve quality of care?

2. Are the claimed benefits (a) credible and verifiable, (b) likely to be achieved and passed through to consumers, (c) achievable only through *this* merger, and (d) of sufficient magnitude to outweigh the proposed merger's significant disadvantages?

3. Have Mountain States and Wellmont substantiated their plans sufficiently to ascertain the steps, timeframe, and costs necessary to (a) consolidate clinical services, (b) surpass volume thresholds that they are not already capable of achieving independently to improve patient health outcomes, and (c) achieve projected synergies and cost reductions?

4. Will the proposed regulatory commitments effectively mitigate the competitive harms of the merger, and are they capable of being successfully implemented and objectively monitored, to determine whether the cooperative agreement is meeting the stated public policy goals?

5. Does the cooperative agreement offer any meaningful mechanism to discipline the combined hospital system if it fails to meet its regulatory commitments, and can the Plan of Separation offered by Mountain States and Wellmont realistically be achieved?

6. How long do the Authority and Commissioner intend to provide regulatory oversight of the cooperative agreement, and what will happen in the event that the underlying legislation is repealed or revised to allow the cooperative agreement to expire?

In our assessment, the likely benefits of the cooperative agreement do not outweigh the likely disadvantages of the elimination of competition between Mountain States and Wellmont, and the proposed commitments do not change this conclusion.

We thank you for the opportunity to present our views and hope they will be helpful as you evaluate the cooperative agreement application of Mountain States and Wellmont and the potential effects of their proposed merger. We would be happy to provide any additional expertise and information that we are authorized to share in connection with your review of the cooperative agreement application.

Please direct all questions regarding this submission to Goldie V. Walker, Attorney, Bureau of Competition, 202-326-2919, gwalker@ftc.gov; and Stephanie A. Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, swilkinson@ftc.gov.

FTC Public Comment
Attachment A

DECLARATION OF COLIN DROZDOWSKI

I, Colin Drozdowski, declare:

I. Introduction

1. I am presently employed by Anthem, Inc. ("Anthem") as the Vice President for National Provider Solutions. Anthem is a health benefits company based in Indianapolis, Indiana with many subsidiaries that conduct the business of insurance, one of which is Anthem Health Plans of Virginia, Inc. ("Anthem Virginia"). Anthem is a primary licensee and Anthem Virginia is a controlled affiliate licensee of the Blue Cross and Blue Shield Association. In Virginia, Anthem Virginia operates under the trade name "Anthem Blue Cross and Blue Shield." Amerigroup Corporation ("Amerigroup") is a wholly-owned subsidiary of Anthem that offers Medicare and Medicaid insurance products in several states, including Tennessee.

2. I have earned a Bachelor's of Arts and Masters of Economics. I have been employed in the health care industry for over 20 years, all of them within various health plans. Prior to joining Blue Cross and Blue Shield of Ohio in 1992, I worked for the Federal Reserve Bank in Cleveland, OH in the Economic Research Department. Since entering the health insurance industry, I have assumed a variety of positions, with increasing responsibilities. Throughout my career, I have always had a focus and an interest in provider contracting, network management, provider relations, payment innovation and creative provider collaborations. I have led both Medical Management and Medical Informatics teams. Within the Anthem family (under National Provider Solutions) I oversee, either directly or indirectly, all of the provider contracting and network management functions in our core (14 States) for commercial business and segments of our government business. These states include ME, NH, CT, NY, VA, GA, OH, IN, KY, MO, WI, CO, NV and CA. In addition, I also oversee provider

contracting in counties outside of but contiguous to our core 14 states, such as Tennessee. In total, our provider contracting efforts account for approximately $75 billion in annual medical spend. I reside in Virginia and have lived in the Richmond area since August of 2000. I serve my communities in a number of ways, and have been on the Boards of a number of health care-related entities, including the Virginia Association of Free and Charitable Clinics (Board Chair), Rx Partnership, and Physicians Immediate Care (urgent care provider).

3. I am familiar with many of the providers, hospitals and health systems in Virginia and Tennessee.

4. I have been asked, based on my knowledge and experience, to address Anthem Virginia's and Amerigroup's concerns about the proposed merger between Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("MSHA") or the "Parties."

5. Wellmont and MSHA each provide health care services across the continuum of care, including:

a. inpatient and outpatient hospital services;

b. physician services across a range of specialties; and

c. other ancillary services—including imaging, rehabilitation and physical therapy, hospice, and sleep evaluation.

6. Generally speaking, inpatient procedures can only be performed at a hospital and require the patient to remain at the hospital for more than 24 hours or overnight. Outpatient procedures can be performed at a hospital or a non-hospital facility, such as an ambulatory surgery center, and do not require an overnight or 24-hour stay. Whether a procedure is performed on an inpatient or outpatient basis is a clinical decision made by a patient's physician; Anthem does not make that determination.

7. Wellmont and MSHA serve Anthem Virginia and Amerigroup members through hospitals, physician offices, and ancillary facilities centering around a 14-county area in Virginia and Tennessee where they are the only providers of hospital services. In Virginia, these counties are: Dickenson, Russell, Smyth, Washington, Wise, Lee and Scott.[1] Although Wellmont and MSHA do not have inpatient facilities in two of these counties (Lee and Scott), they have the nearest hospitals to residents in these two counties. In Tennessee, these counties are: Hancock, Hawkins, Unicoi, Washington, Sullivan, Carter and Johnson.

8. The hospitals that are part of the Wellmont and MSHA systems are:

Wellmont and MSHA Virginia Hospitals				
County	**Owner**	**Facility**	**City, State**	**Staffed Beds**
Dickenson	MSHA	Dickenson Comm. Hosp. (Critical Access)	Clintwood, VA	1
Norton	MSHA	Norton Comm. Hosp.	Norton, VA	129
Norton	Wellmont	Mountain View Regional Med. Ctr.	Norton, VA	28
Russell	MSHA	Russell County Med. Ctr.	Lebanon, VA	78
Smyth	MSHA	Smyth County Comm. Hosp.	Marion, VA	44
Washington	MSHA	Johnston Mem. Hosp.	Abingdon, VA	116
Wise	Wellmont	Lonesome Pine Hosp.	Big Stone Gap, VA	30
Wellmont and MSHA Tennessee Hospitals				
County	**Owner**	**Facility**	**City, State**	**Staffed Beds**
Carter	MSHA	Sycamore Shoals Hosp.	Elizabethton, TN	74
Hancock	Wellmont	Hancock County Hosp.	Sneedville, TN	10
Hawkins	Wellmont	Hawkins County Mem. Hosp.	Rogersville, TN	16
Johnson	MSHA	Johnson County Comm. Hosp. (Critical Access)	Mountain City, TN	2
Sullivan	Wellmont	Bristol Regional Med. Ctr.	Bristol, TN	312
Sullivan	Wellmont	Holston Valley Med. Ctr.	Kingsport, TN	318

[1] References to counties in Virginia include those cities surrounded by a single county. For example, "Washington County" includes the city of Bristol, Virginia.

Sullivan	MSHA	Indian Path Med. Ctr.	Kingsport, TN	239
Unicoi	MSHA	Unicoi County Mem. Hosp.	Erwin, TN	25
Washington	MSHA	Franklin Woods Comm. Hosp.	Johnson City, TN	80
Washington	MSHA	Johnson City Med. Ctr.	Johnson City, TN	497

9. Other than Wellmont and MSHA, there are no other hospitals in this 14-county area. In counties where there are two hospitals, MSHA and Wellmont are clearly alternatives to one another. Even in counties with only a single hospital (i.e., either a Wellmont or MSHA hospital), the next closest alternative hospital in an adjacent county is frequently owned by the other system. The best example of the close proximity of MSHA and Wellmont hospitals is on the border between Virginia and Tennessee, in and around Kingsport and Bristol, Tennessee and Bristol, Virginia. There are three relatively large hospitals in this area: Wellmont owns Holston Valley Medical Center and Bristol Regional Medical Center, and MSHA owns Indian Path Medical Center. All three of these facilities are located in Sullivan County, Tennessee.

10. In addition to hospitals owned by Wellmont and MSHA, each system employs physicians and owns outpatient facilities throughout this 14-county area, including in cities and towns where it does not own hospital facilities. For example, MSHA owns Johnston Memorial Hospital in Abingdon, Virginia, but Wellmont employs a group of physicians and nurse practitioners (Wellmont Medical Associates Abingdon) to serve this same community with primary care, internal medicine, diabetic care and physical therapy services. To the best of my knowledge, the parties both have physician practices in the Virginia counties of Lee, Russell, Smyth, Washington, Wise and Wythe and in the Tennessee counties of Carter, Sullivan and Washington. They both offer ancillary services in the Virginia counties of Russell, Washington and Wise and in Sullivan County, Tennessee, to the best of my knowledge.

11. Historically, Wellmont and MSHA have provided services at competitive rates, expanded service offerings to meet demand, and worked to deliver quality care to the communities they serve. This has all occurred in a competitive environment where each system continually faced both actual competition and the threat of competition from the other. This competition and threat of expansion drove these systems to offer high quality services at competitive rates. Anthem Virginia and Amerigroup's concern is that if Wellmont and MSHA are permitted to form a single system, there will be no further competitive pressure to drive them to improve quality, innovate or provide services at competitive rates.

12. We are also concerned about what a combined MSHA and Wellmont might do to reduce competition from rival health plans. For example, MSHA has used its position as an essential provider in certain areas to prevent competition with its Medicare Advantage product. This has had a direct impact on Amerigroup's ability to offer a competing Medicare Advantage product throughout northeastern Tennessee. I discuss this in greater detail in paragraphs 50-51.

II. Background on Anthem's Business in Virginia

A. Anthem's Products and Membership in Virginia

13. Anthem Virginia offers several different health insurance products, including, for example, health maintenance organization ("HMO"), preferred provider organization ("PPO"), point-of-service ("POS") and Medicare Advantage plans. Some of these products can either be fully-insured or self-insured (i.e., administrative services only ("ASO") products).

14. As of October 2015, in Virginia, Anthem had a total of 2,042,004 members.

B. Anthem Virginia's Products and Membership in Southwest Virginia

15. For administrative convenience, Anthem Virginia divides its operations into five regions: "Western," "Central," "Eastern," "Northern," and "Out of State." Each region is further

subdivided into sectors. When negotiating with a provider, Anthem Virginia staff will compare a provider to other comparable providers in the same region or sector with respect to rates, case mix, utilization, and profitability. We may also look at similarly situated providers in other sectors and regions of the state.

16. The Western region of Virginia is divided into five sectors. Sector 1 includes Bedford, Campbell, Amherst, and Appomattox Counties. Sector 2 extends northeast from Rockbridge County to include Augusta, Highland, Rockingham, and Page Counties. Sector 3 comprises the area between Patrick and Halifax Counties along the North Carolina border. Sector 4 begins along the West Virginia border at Bath County and runs south to Franklin County and southwest to Bland and Wythe Counties. Sector 5 covers the extreme southwestern corner of the state and extends eastward to Tazewell, Smyth, Grayson, and Carroll Counties. Sector 5 contains all of the MSHA and Wellmont hospital facilities in Virginia and is hereafter also referred to as "southwest Virginia."

17. In Sector 5, Anthem Virginia offers the following products: HMO, PPO, POS, and Traditional. Its HMO product is the newest offering in this area—Anthem Virginia began offering HMO products throughout this area in 2012.

18. As of June 2015, in Sector 5, Anthem Virginia had a total of 86,211 members.

III. Amerigroup's Products and Membership in Tennessee

A. Products and Membership in Tennessee

19. In Tennessee, Amerigroup offers Medicare Advantage and Managed Medicaid under the state's TennCare program. Neither Anthem nor Amerigroup offers commercial insurance products in Tennessee.

20. Amerigroup contracts with health care providers in Tennessee to provide services

to its members. Amerigroup's goal in negotiating contracts with providers is to (1) improve quality and (2) bend the cost trend for the state by keeping rate increases to a minimum. The rates Amerigroup negotiates with providers directly impact the state's costs. Providers who can demand aggressive rate increases because they are essential to meeting network adequacy standards can inhibit Amerigroup from keeping costs low and as a result drive up Medicaid costs for the State.

21. As of April 2015, in Tennessee, Amerigroup had a total of 411,115 members.

B. Products and Membership in Northeast Tennessee

22. For administrative convenience, Amerigroup divides its business in Tennessee into three regions: the "East Grand Region," the "West Grand Region" and the "Middle Grand Region." The East Grand Region (or the East Region) includes the following counties: Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Claiborne, Cocke, Franklin, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hawkins, Jefferson, Johnson, Knox, Loudon, Marion, McMinn, Meigs, Monroe, Morgan, Polk, Rhea, Roane, Scott, Sequatchie, Sevier, Sullivan, Unicoi, Union and Washington.

23. Less formally—and based on the definition provided by the state of Tennessee[2]—Amerigroup refers to the far northeast counties within the East Grand Region as "northeast Tennessee." These counties are: Carter, Greene, Hancock, Hawkins, Johnson, Sullivan, Washington and Unicoi.

24. Amerigroup has offered products in the East Grand Region, including northeast Tennessee, only since January 1, 2015. Prior to this, Amerigroup's contract with the state was

[2] *See* http://hit.state.tn.us/tnmap/print_tnmap.htm.

limited to the Middle Region of Tennessee. In 2013, the state expanded its contracts to include statewide coverage. In December 2013, Amerigroup was awarded a statewide contract to begin in 2015 and as a result expanded into the Eastern and Western regions of Tennessee.

25. As of April 2015, in northeast Tennessee, Amerigroup had a total of 122,720 members.

IV. Anthem Provider Contracting

A. Provider Contracting in Virginia and Tennessee Generally

26. To offer lower premium rates to existing and potential customers, Anthem Virginia and Amerigroup attempt to negotiate competitive rates for hospital and other medical services. Our ability to negotiate such rates depends in large part on the existence of alternative providers in the same geographic area that are efficient, have a good reputation for quality in the community, and are attractive alternatives for our members. In an area where there are few or no alternative providers, it is much more difficult for Anthem Virginia and Amerigroup to negotiate competitive, favorable rates on behalf of our members. Although failing to reach an agreement with a provider is always disruptive, the level of disruption is magnified where there are few or no credible, alternative providers. When multiple providers can compete for inclusion in our network, Anthem Virginia and Amerigroup generally have a greater ability to walk away from, or credibly threaten to walk away from, negotiations if the provider demands unreasonable rates or contract terms. Competition among providers gives us with the ability to temper demands for rate increases.

27. Anthem Virginia's contracts with hospital providers (otherwise known as facility contracts) generally include both inpatient and outpatient services and the typical term for these are 2-3 years. The facility contracts also cover reimbursement for hospital providers that are

employed by the hospital (for example hospitalists or nurse anesthetists). Anthem Virginia also endeavors to have all of its hospital providers participate in its quality program which is described in further detail later in this declaration. By incorporating quality incentive payments into the facility contracts, Anthem Virginia's goal has been to increase quality incentives to providers rather than giving the facility a fixed rate of increase each year.

28. Anthem Virginia or Amerigroup refer to "in-network" providers as providers with whom they have a contract for services. Anthem Virginia or Amerigroup refer to "out-of-network" providers as providers with whom they do not have a contract for services. If an Anthem VA or Amerigroup member receives care from an out-of-network provider, the cost of that care is higher than if that member were to receive care from an in-network provider. This cost is born by Anthem VA or Amerigroup and the member. For this reason, members have an incentive to seek care from in-network providers. The attractiveness of Anthem Virginia and Amerigroup's networks, therefore, depends in large part on whether members have in-network access to a sufficient range of preferred providers. If Anthem or Amerigroup is unable to offer an adequate network of providers, this directly impacts the attractiveness of the network and could cause members to switch health plans, thereby impacting Anthem and Amerigroup's business.

29. Anthem Virginia's preferred methodology for contracting for Virginia and participating Tennessee hospitals is to pay rates based on the relative DRG weight multiplied by a conversion factor. We also contract using case rates and per diems. Most of our facilities include a stop loss threshold that pays a percent of charges once the threshold is met. The percent of charges is only paid on the excess amount over the threshold and not on the total charges on the claim. Except for that provision, none of our contracts are paid based on a

percent of charges.

30. All of the above is true irrespective of whether the hospital or health system is a for-profit hospital or a not-for-profit hospital. In my experience, I have not seen differences in negotiations with a for-profit hospital versus a not-for-profit hospital. Both for-profit and not-for-profit hospitals generally attempt to use their bargaining leverage to secure the highest reimbursement rates available.

31. Historically, Anthem Virginia and Amerigroup have tried to offer broad networks of providers through their health insurance products. To do so, they have offered reasonable terms to providers in contract negotiations. Nevertheless, in some cases a provider may seek to obtain rates higher than those offered, and it may decide to no longer participate in the plan's network. In my experience, a provider is much more willing to walk away from negotiations, and risk going out of network, if it perceives that there are few or no competitive alternatives to it in the same area for the same services.

32. If a provider perceives that it has few or no alternatives, it often will seek to extract rates from insurers that are above competitive levels. I believe this would likely be the case throughout the combined service area if the proposed merger were approved.

33. Anthem Virginia has recently started offering narrow network products and tiered networks in certain parts of Virginia—although not yet in southwest Virginia. The opportunity to offer narrow or tiered network products is important because it compels providers to compete both on price and quality to be selected to participate in the narrow network or to be included in the first tier of providers. If MSHA and Wellmont merge Anthem Virginia would lose the ability to have MSHA and Wellmont compete against each other for future narrow network products.

B. Provider Contracting in Sector 5 or Southwest Virginia

34. Anthem Virginia currently has provider contracts with all 10 of the general acute care hospitals located in Sector 5 or southwest Virginia. These hospitals are:

Anthem Virginia West Region - Sector 5 Hospitals				
County	**Owner**	**Facility**	**City, State**	**Staffed Beds**
Buchanan	Independent	Buchanan General Hosp.	Grundy, VA	49
Dickenson	**MSHA**	**Dickenson Comm. Hosp.**	**Clintwood, VA**	**1**
Norton	**MSHA**	**Norton Comm. Hosp.**	**Norton, VA**	**50**
Norton	**Wellmont**	**Mountain View Regional Med. Ctr.**	**Norton, VA**	**28**
Russell	**MSHA**	**Russell County Med. Ctr.**	**Lebanon, VA**	**78**
Smyth	**MSHA**	**Smyth County Comm. Hosp.**	**Marion, VA**	**44**
Tazewell	Carilion	Tazewell Comm. Hosp.	Tazewell, VA	7
Tazewell	Life Point Hospitals	Clinch Valley Med. Ctr.	Richlands, VA	97
Washington	**MSHA**	**Johnston Mem. Hosp.**	**Abingdon, VA**	**116**
Wise	**Wellmont**	**Lonesome Pine Hosp.**	**Big Stone Gap, VA**	**30**

Wellmont and MSHA (indicated in bold in the above table) are, by every measure, the largest inpatient providers in the area and account for 7 of the 10 hospitals. Anthem Virginia also directly contracts with certain hospitals in the contiguous border counties in Tennessee, including Indian Path Medical Center (MSHA), Holston Valley Medical Center (Wellmont) and Bristol Regional Medical Center (Wellmont).

35. The 3 hospitals not owned by Wellmont or MSHA in this area are generally not competitive alternatives to the Wellmont and MSHA hospitals for one or more reasons: they are limited in capacity, they offer limited services, and/or they are too distant from most

patients in the Wellmont and MSHA combined service area to be an attractive alternative. The most densely populated area of southwester Virginia is near the city of Bristol. A patient travelling from there would need to drive over an hour to reach the nearest non-MSHA/Wellmont hospital in Virginia at Clinch Valley Medical Center,[3] or substantially further to Buchanan General Hospital or Carilion Tazewell Community Hospital. That same patient would also require about an hour to reach the nearest independent hospital in Tennessee, Laughlin Memorial Hospital. Anthem's internal studies reach a similar conclusion: without MSHA or Wellmont facilities, we would not be able to provide adequate coverage for patients in parts of southwest Virginia.

36. As discussed previously, Wellmont and MSHA are by far the largest hospital systems in southwest Virginia. These systems are the only inpatient providers in a seven-county area in Virginia that includes Dickenson, Russell, Smyth, Washington, Wise, Scott and Lee counties.

37. Anthem Virginia has contracted with Wellmont on a continuous basis at least since July 2002. Anthem Virginia also has contracted with MSHA since March 2001, but not on a continuous basis.

38. In 2002, Anthem Virginia's hospital contract negotiations with MSHA were difficult and protracted. MSHA demanded double-digit rate increases. Anthem Virginia was unwilling to acquiesce to the demands of MSHA and allowed MSHA to terminate its contract and exit the Anthem Virginia network in May 2002. At that time, Anthem Virginia relied on hospital facilities that are now owned by Wellmont in order to provide services to its members in

[3] A patient in Bristol, Virginia might also seek treatment at Laughlin Memorial Hospital in Tennessee, but even that facility is also roughly an hour away by car.

this area—at that time, MSHA facilities were only located in Tennessee.

39. In 2003, Anthem Virginia and MSHA reached a new agreement at rates that were acceptable to Anthem Virginia and all of the MSHA facilities became in-network as of October 1, 2003. In order to bring all the MSHA facilities back in network, Anthem agreed to a 6.5% increase on the overall contract. This was substantially lower than the initial double-digit increases sought by MSHA before they went out of network. I believe the ability of Anthem to sell a network without MSHA helped us to avoid the initially proposed double-digit increases and ultimately arrive at a more moderate increase.

40. Since 2003, Anthem and MSHA have renegotiated hospital contract rates 4 times; the average term of these contracts has been 2-3 years. Negotiations with MSHA have typically been long, drawn-out and subject to multiple layers of review at MSHA.

41. Starting in 2007, MSHA acquired several hospitals in southwest Virginia, including Smyth County Hospital (2007), Dickenson Community Hospital (2009) and Johnston Memorial Hospital (2009). After these facilities were acquired, MSHA demanded rate increases for these facilities that were greater than Anthem Virginia had previously paid these facilities as stand-alone entities. For example MSHA demanded a nearly 45% price increase for inpatient services when it acquired Smyth County Hospital. Ultimately, Anthem agreed to a 8.47% overall increase (18.1% on inpatient and 4.3% on outpatient). The facilities acquired in 2009 were brought in-network under the 2010 negotiations and Anthem Virginia agreed to an average 6% increase for these facilities, with higher rate increases in the early years of the contract term. MSHA's negotiation history with these acquisitions suggests that MSHA will seek the highest rates that it can when its rates are not subject to review or oversight.

42. Anthem Virginia just completed its most recent negotiation with MSHA for a new

five-year contract effective November 1, 2015. The contract included an overall increase including QHIP® incentive payments. MSHA did not seek to renegotiate contract language related to the acquisition of new facilities.

43. Anthem Virginia has consistently contracted with Wellmont for its hospitals and other health care services. Since 2008, Anthem Virginia and Wellmont have renegotiated their contract twice—in 2008 and 2012.

44. Anthem Virginia also recently concluded negotiations with Wellmont resulting in a three-year contract with an overall increase inclusive of QHIP®. The parties have not yet executed this agreement.

C. Provider Contracting in Northeast Tennessee

45. Amerigroup has contracts with the following hospitals in northeast Tennessee:

Amerigroup - Northeast Tennessee Contracted Hospitals				
County	**Owner**	**Facility**	**City, State**	**Staffed Beds**
Carter	**MSHA**	**Sycamore Shoals Hosp.**	**Elizabethton, TN**	**74**
Greene	Independent	Takoma Regional Hosp.	Greeneville, TN	31
Greene	Independent[4]	Laughlin Memorial Hosp.	Greeneville, TN	140
Hamblen	Community Health Systems, Inc.	Lakeview Regional Hosp.	Morristown, TN	135
Hamblen	Covenant Health	Morristown-Hamblen Health Care System	Morristown, TN	159
Hancock	**Wellmont**	**Hancock County Hosp.**	**Sneedville, TN**	**10**
Hawkins	**Wellmont**	**Hawkins County Mem. Hosp.**	**Rogersville, TN**	**16**
Johnson	**MSHA**	**Johnson County Comm. Hosp.**	**Mountain City, TN**	**2**
Sullivan	**Wellmont**	**Bristol Regional Med. Ctr.**	**Bristol, TN**	**312**
Sullivan	**Wellmont**	**Holston Valley Med. Ctr.**	**Kingsport, TN**	**318**
Sullivan	**MSHA**	**Indian Path Med. Ctr.**	**Kingsport, TN**	**239**

[4] As discussed further below and in footnote 5, ISHN, the entity that handles contracting for MSHA in Tennessee also negotiates contracts for Laughlin Memorial Hospital.

Unicoi	**MSHA**	**Unicoi County Mem. Hosp.**	**Erwin, TN**	**25**
Washington	**MSHA**	**Franklin Woods Comm. Hosp.**	**Johnson City, TN**	**80**
Washington	**MSHA**	**Johnson City Med. Ctr.**	**Johnson City, TN**	**497**

46. As noted previously, Anthem Virginia also directly contracts with certain hospitals in the contiguous border counties in Tennessee, including Indian Path Medical Center (MSHA), Holston Valley Medical Center (Wellmont) and Bristol Regional Medical Center (Wellmont).

47. Wellmont and MSHA are, by every measure, the largest inpatient providers in northeast Tennessee and account for 10 of the fourteen 14 hospitals in the area (indicated in bold in the above table). These systems are the only inpatient providers in a seven-county area in Tennessee that includes: Carter, Hancock, Hawkins, Johnson, Sullivan, Washington and Unicoi counties.

48. The 4 other hospitals in northeast Tennessee that are not affiliated with Wellmont or MSHA are not competitive alternatives to the Wellmont and MSHA hospitals for one or more reasons: they are limited in capacity, they do not offer many tertiary services and/or they are too distant from patients in the Wellmont and MSHA combined service area to be an attractive alternative for patients. For example, a patient in Johnson City, Tennessee—the largest of the Tri-Cities and the largest city in the region—would need to drive roughly 45 minutes to reach the nearest non-MSHA or Wellmont hospital, Laughlin Memorial Hospital. Patients in other parts of the Tri-Cities area would require more time to reach that hospital. If Wellmont and MSHA were not in Amerigroup's network, patients would have to travel to Knoxville or Chattanooga to access essential tertiary services and as a result, Amerigroup would be unable to meet many of

its network adequacy requirements. While there may be some non-MSHA/Wellmont hospitals in East Tennessee, they are all small regional hospitals that offer more limited services.

1. Contracting with Wellmont and MSHA in Northeast Tennessee

49. Amerigroup has only contracted in the East Grand Region of Tennessee since January 1, 2015. In order to develop products in the East Grand Region, Amerigroup attempted to negotiate contracts with all of the available providers and for all of the products that Amerigroup was licensed to offer in Tennessee, including (1) Medicare Advantage (or Medicare Classic); (2) Dual Eligible Special Needs Plans ("D-SNP"); and (3) Managed Medicaid.

50. When Amerigroup approached MSHA's provider contracting entity in Tennessee, Integrated Solutions Health Network ("ISHN")[5] about a contract for MSHA's facilities and providers in Tennessee, ISHN refused to contract for Amerigroup's Medicare Advantage product in MSHA's eight-county primary service area (based on the location of their acute care facilities and physician practices). MSHA was only willing to contract with Amerigroup for its D-SNP and Medicaid products in this service area. MSHA offers a Medicare Advantage product in these counties and did not want to compete with Amerigroup for Medicare Advantage health plan enrollees. Because it does not have access to certain of MSHA's facilities for its Medicare Advantage network, Amerigroup is unable to offer Medicare Advantage products in the following counties: Carter, Greene,[6] Hancock, Hawkins, Johnson, Sullivan and Unicoi.

51. ISHN has closely monitored Amerigroup's activity with respect to sales of its

[5] ISHN describes itself as a "regional health solutions company" headquartered in Johnson City, Tennessee. It consists of approximately 2,000 physicians in northeast Tennessee, Southwest Virginia and Western North Carolina and over 275 provider groups. ISHN (through AnewCare) handles all of the contracting for MSHA hospitals and physicians in northeast Tennessee. It also handles contracting for a non-MSHA hospital: Laughlin Memorial Hospital in Greene County, Tennessee.

[6] Although MSHA does not have a hospital in Greene County, Laughlin Memorial is located in Greene County and ISHN handles contracting for that facility as well.

Medicare Advantage product in northeast Tennessee to ensure it is not marketing or selling a Medicare Advantage product in the eight counties. For example on November 18, 2014, a representative from ISHN emailed Amerigroup requesting that certain billboards in the Sullivan and Washington county area promoting Amerigroups' Medicare Advantage plan be removed. ISHN felt that the billboards appeared to be marketing a Medicare Advantage product in violation of the agreement. Amerigroup had to assure ISHN that it did not have an adequate network to sell a Medicare Advantage product in that area.

D. Proposed Merger's Impact on Provider Contracting in Southwest Virginia and Northeast Tennessee

52. While the growth of Wellmont and MSHA through prior acquisitions have posed certain challenges for Anthem Virginia's and Amerigroup's ability to serve this region, we have been able to control cost increases through having the two systems actively competing with each other. But I am concerned that if Wellmont and MSHA are no longer two independent systems, there will be no competitive alternative providers to constrain their prices or spur them to improve their quality and innovation in the delivery of health care in southwest Virginia and northeast Tennessee. Furthermore, I am concerned that neither Virginia nor Tennessee has the resources, funding or expertise, to monitor (in perpetuity) this entity to prevent abusive or monopolistic behaviors, including but not limited inefficient operations, lower quality, less focus on patients/consumers, unwillingness to participate in government programs (at competitive rates), or the creation of their own health plan that they would then leverage to their own advantage and to the detriment of the residents of this region

53. In some parts of southwest Virginia and northeast Tennessee, Wellmont and MSHA each own certain acute care hospitals that are essential to have in our network in order to

meet access requirements for a network product. In certain other areas, for example, Bristol and Kingsport, Anthem Virginia and Amerigroup would not need all of the Wellmont and MSHA hospitals to participate in their networks, and therefore could credibly threaten to leverage one facility against another in contract negotiations. Furthermore, there are also local areas where Anthem Virginia and Amerigroup do not need both Wellmont and MSHA physicians in-network to offer an attractive network product. In these local areas where Wellmont and MSHA facilities and physicians compete more directly, the hospital systems have bargaining power.

54. In addition to the loss of current competition between Wellmont and MSHA, I have serious concerns about the impact of the merger on potential additional competition between these systems in the future. The proposed merger will effectively eliminate any potential for competition between the only two systems that operate across a broad area of southwest Virginia and northeast Tennessee, where new entry is highly unlikely.

V. Quality and Innovation

A. Quality

1. Anthem's Q-HIP® Program

55. In health care, as in other sectors of the economy, competition plays a crucial role in driving quality and performance improvement. Providers compete with respect to their ability to deliver the highest quality, best value to patients and to those who pay for the care, such as health insurers like Anthem.

56. As a purchaser of healthcare services, Anthem relies on competition among health care providers to drive improvements in quality. This competition on quality also impacts Anthem's negotiations with providers. For example, absent competition, a provider has a greater ability to resist Anthem's efforts to tie reimbursement rate increases to a provider's performance

on certain quality measures under Anthem's Quality-In-Sights®: Hospital Incentive Program (Q-HIP®).

57. Anthem regularly measures the quality of its hospital providers under its award-winning Q-HIP® program. Q-HIP® promotes adherence to evidence-based medicine and best practices that lead to improvements in patient outcomes and affordability. Anthem uses Q-HIP®'s standard set of measures to compare acute care providers across its network and determine their overall value. Anthem is continually developing and updating this program and its tools to assess and measure provider quality, as assessing health care quality is a complex endeavor. A provider's level of quality is an essential component in determining the value of a given provider to a network.

58. Measuring all aspects of health care quality is impossible, and incentivizing providers to consistently improve on measurable components of quality is difficult. Anthem's Q-HIP® program measures (and therefore incentivizes) providers in a limited number of health outcomes and patient satisfaction areas. Anthem depends on competition among health care providers to drive providers to continuously improve on all aspects of quality. I am concerned that the elimination of competition between Wellmont and MSHA will negatively impact quality of health care in the communities served by these providers, particularly with respect to quality elements that are difficult for Anthem to measure.

2. Wellmont and MSHA's performance in Q-HIP®

59. MSHA and Wellmont participate in Q-HIP® and regularly submit data to Anthem Virginia related to the Q-HIP® inpatient measures. This includes the Wellmont and MSHA Virginia hospitals as well as three hospitals in Tennessee that Anthem Virginia contracts with: Indian Path, Bristol and Holston Valley. Wellmont currently participates with Anthem on

outpatient measures as well, but MSHA does not. However, under the newly negotiated 2015 contract, MSHA will participate in QHIP® on outpatient measures.

60. Q-HIP® participation is a negotiated term in Anthem Virginia's contracts with providers. Many providers negotiate with Anthem as to whether or not they will participate in Q-HIP® and at what level. Typically, Anthem reduces the base reimbursement rate of a provider that participates in Q-HIP® with the expectation that the provider has the ability to obtain a higher rate if it meets certain thresholds.

61. Anthem is concerned that after the proposed merger the parties will have decreased incentives to improve quality. Reliance on the Q-HIP® program alone is not enough to drive quality improvements—market competition among providers is a much more effective tool.

3. Amerigroup's Quality Program

62. Amerigroup has had provider contracts in the East Grand Region for less than a year. Accordingly, it is still in its initial phases of implementing its quality program there. It does, however, currently incorporate certain pay-for-performance and incentive arrangements into its contracts with providers, such as ISHN.

63. In other parts of Tennessee, Amerigroup offers episode-based payment programs and plans to eventually offer these same programs in the East Grand Region as well. Episodes of care focus on the health care delivered in association with acute healthcare events such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple providers in relation to a specific health care event. Episode-based payment seeks to align incentives with successfully achieving a patient's desired outcome during an "episode of care," a clinical situation with predictable start and end points. Episodes reward high-quality

care, promote the use of clinical pathways and evidence-based guidelines, encourage coordination, and reduce ineffective and/or inappropriate care. Episode-based payment is applicable for most procedures, hospitalizations, acute outpatient care (e.g., broken bones), as well as some forms of treatment for cancer and behavioral health conditions (e.g., ADHD). Under the initiative, participating insurance companies will add additional episodes every year with the goal of implementing 75 episodes by the end of 2019.

64. It is too early to opine how well ISHN is doing in its quality incentive program. However, pursuant to its contract, Amerigroup already has paid ISHN a care management fee of approximately $500,000. In October 2015, ISHN admitted to Amerigroup that is has not done anything yet this year to implement care management as it is obligated to do under the contract.

4. Merger's Potential Impact on Quality

65. Wellmont and MSHA, as independent entities, are both relatively well-rated in terms of quality performance under QHIP®. However, my concern is that, in the absence of any competitive alternatives to the combined system, there will be less incentive for Wellmont and MSHA to continue to strive to improve the quality of care they provide.

66. I am not aware of any concrete plans that Wellmont and MSHA have developed around how the their proposed merger will improve quality in southwest Virginia or northeast Tennessee and how such improvements could not be achieved absent the merger. Furthermore, I am concerned that in the absence of a competitive alternative to the merged system, there will be no recourse for a health plan or its members if the merged system's quality levels decline.

B. Innovation

67. Innovation is another important dimension of competition for health care providers. Anthem continually is looking for ways to engage with providers on new, more

effective and efficient ways to deliver health care, including population health management strategies, risk contracts and shared risk arrangements, bundled and episode of care reimbursement. Health care providers tend to be more innovative where they face competition from other providers. For example, in California, Anthem has been able to partner with certain hospitals to create a narrow network product (Vivity) consisting of some of the highest quality hospitals in the Los Angeles area. This is in direct response to the competition that these providers face from Kaiser as an integrated provider and health plan.

68. I am concerned that if Wellmont and MSHA merge, there will be no competitive alternative providers to encourage the merged entity to innovate in how they furnish healthcare services. While the two systems have discussed in general terms how their proposed merger will improve care and help them better manage the health care of the population they serve, I have not seen any detailed discussions of their plans or why any of their innovations could not be done absent the merger. In the absence of competition, I am concerned that this goal will be neglected.

VI. Entry

A. Virginia and Tennessee COPN/CON Laws Restrict Entry

69. Virginia currently has a Certificate of Public Need (COPN) law that requires any potential entrant seeking to open or expand a medical care facility to file an application and receive approval from the Virginia Department of Health. A COPN is required for a wide array of facilities and services, including hospitals, surgery centers, substance abuse treatment, and diagnostic imaging. Anthem monitors the COPN application process and sometimes submits comments or testifies in favor of or against a potential application.

70. Tennessee has a similar Certificate of Need (CON) regime. Anyone who seeks to

establish certain health care facilities and services—including hospitals, certain diagnostic imaging services, and ambulatory surgical centers, among others—must first receive a CON from the Tennessee Health Services and Development Agency. Facility expansions beyond certain dollar thresholds also require a CON.

71. COPN/CON laws significantly restrict potential entry from new competitors or expansion by existing competitors.

B. Sparse History of Entry

72. Over the last ten years there has been virtually no new entry into southwest Virginia and northeast Tennessee by outside providers—all entry and expansion has come from Wellmont and MSHA. For example, in the early 2000s, MSHA expanded from Tennessee into Virginia with the acquisition of Smyth County Hospital. Wellmont has similarly expanded throughout southwest Virginia through various hospital, physician and outpatient facility acquisitions. For example, Wellmont has acquired a number of cardiology physician practices, allowing it to control a majority of the cardiologists in the region and form the Wellmont CVA Heart Institute. In addition, Wellmont acquired Mountain View Regional and Lee Regional in August 2007. These were added to the Wellmont contract in 2008 and received reimbursement rate increases.

VII. Physician and Outpatient Competition

73. I also am concerned about competition for physician services and ancillary services and facilities.

A. Physician Competition in Southwest Virginia and Northeast Tennessee

74. In southwest Virginia and northeast Tennessee, Wellmont and MSHA control a substantial number of physicians—Wellmont employs an estimated 250 physicians and MSHA

employs or negotiates through ISHN for over 350 physicians.

75. Physician negotiations with MSHA have been challenging recently. For example, it took over two years for Anthem to successfully negotiate participation by MSHA contracted physicians in Anthem's HMO network in Virginia. Ultimately, Anthem Virginia was compelled to pay PPO rates for HMO members, which was a rate higher than Anthem pays comparable groups elsewhere in Virginia.

76. I am concerned that the merger could result in the combined system controlling a substantial number of physicians across a number of specialties that could lead to increased prices for physician services.

77. In addition, many hospitals contract on an exclusive basis with independent physician groups to provide certain hospital-based services, such as anesthesiology, radiology, pathology and emergency room services. Often, as part of our negotiations with hospitals, we obtain assurance from the hospital that the hospital-based physicians will participate in our plans at reasonable rates. In regions where there is adequate hospital competition (and thus alternative hospital providers), we can threaten to steer patients to competing hospitals where physicians are also in-network. If Wellmont and MSHA are allowed to combine, we will have no alternative hospitals to leverage in our negotiations.

78. I also am concerned that if the parties merge they could use physician referrals to increase the cost of care in ways other than demanding above market rate increases. For example, after the merger the parties could incentivize physicians to refer care to the highest priced facilities in the system or eliminate incentives for physicians to perform procedures at the lower priced facilities (e.g. ambulatory surgery centers) in favor of higher priced hospital facilities where they may have excess capacity. This is a concern particularly where a hospital

has different rates for the different hospitals in its system. This could substantially drive up costs in the same way that negotiating a higher unit price could.

79. Alternatively, absent competition, value-based payment methods to encourage lower utilization and higher quality may be rejected or stalled in favor of continuing fee-for-service reimbursement for longer than would occur in a competitive market.

B. Outpatient Services Competition in the Region

80. Health care is increasingly being delivered outside the hospital. Outpatient services and other ancillary services are medical procedures or tests that can be done in a medical center without an overnight stay in a hospital. Outpatient clinics, physician offices, and urgent care centers are increasingly utilized by health care consumers and are an important point of service location that often provides high quality services at a lower cost. Outpatient service providers also are an important referral source for hospitals. Accordingly, competition for outpatient services is increasingly important.

81. Just as Wellmont and MSHA control the vast majority of hospitals and providers in the area, they also own many of the outpatient clinics and ancillary services in the area. For example, MSHA owns rehabilitation, urgent care, hospice and laboratory facilities. Wellmont also owns or will own facilities providing all of these same outpatient services to the best of my knowledge. More specifically, Wellmont and MSHA offer overlapping outpatient services in the following Virginia counties: Lee, Russell, Smyth, Washington, Wise and Wyth; as well as in Sullivan County in Tennessee. There may be other counties with overlaps of which I am not aware.

82. Given Wellmont and MSHA's already large share of outpatient services and recent expansion, Anthem is worried that the merger will deter future entry by outpatient service

providers and/or stifle the limited competition that already exists. After the merger, not only will the parties control a substantial share of inpatient services and physicians, but they also will control a substantial share of outpatient services, affording them the ability to control referrals and as a result, the entire continuum of the healthcare delivery system.

I declare under penalty of perjury that the foregoing is true and correct. Executed at Richmond, VA, this 18 day of December, 2015.

Colin Drozdowski

FTC Public Comment
Attachment B

Table 2: Market Shares and HHIs in Prior Healthcare Merger Cases[1]

Case	Combined Share	HHI Increase	Post-Merger HHI	Outcome
University Health (11th Cir. 1991)	43%	630	3,200	Enjoined
ProMedica Health System (6th Cir. 2014)	58%	1,078	4,391	Enjoined
OSF Healthcare (N.D. Ill. 2012)	59%	1,767	5,179	Enjoined
Rockford Memorial (7th Cir. 1990)	68%	2,322	5,111	Enjoined
Mountain States/Wellmont (Inpatient Services)	**71%**	**2,441**	**5,161**	**TBD**

[1] For figures provided in Table 2, *see* United States v. Rockford Mem'l Corp., 717 F. Supp. 1251, 1280 (N.D. Ill. 1989), *aff'd*, 898 F.2d 1278 (7th Cir. 1990); Fed. Trade Comm'n v. Univ. Health, Inc., 938 F.2d 1206, 1211 n.12 (11th Cir. 1991); Fed. Trade Comm'n v. OSF Healthcare Sys., 852 F. Supp. 2d 1069, 1078-79 (N.D. Ill. 2012); ProMedica Health Sys., Inc. v. Fed. Trade Comm'n, 749 F.3d 559, 568, 570 (6th Cir. 2014).

FTC Public Comment
Attachment C

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THE SYNTHESIS PROJECT
NEW INSIGHTS FROM RESEARCH RESULTS

UPDATE
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This document is an update of a previous Synthesis Report available at *www.policysynthesis.org*

The impact of hospital consolidation —Update

By Martin Gaynor, PhD[1] and Robert Town, PhD[2]

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SUMMARY OF KEY FINDINGS

> **Hospital consolidation generally results in higher prices.** This is true across geographic markets and different data sources. When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent.

> **Hospital competition improves quality of care.** This is true under both administered price systems, such as Medicare and the English National Health Service, and market determined pricing such as the private health insurance market. The evidence is more mixed from studies of market determined systems, however.

> **Physician-hospital consolidation has not led to either improved quality or reduced costs.** Studies find that consolidation was primarily for the purpose of enhanced bargaining power with payers, and hence did not lead to true integration. Consolidation without integration does not lead to enhanced performance.

Introduction

In 2006, the Synthesis Project published a research synthesis on the impact of hospital mergers on prices, costs and quality of care (38). Since that time, the literature has expanded a great deal. We review those subsequent findings in this Synthesis Update. In particular, we focus on the impact of hospital mergers on prices and quality, and introduce a review of the evidence on physician-hospital consolidation (absent from the 2006 synthesis). The Patient Protection and Affordable Care Act (ACA) promotes Accountable Care Organizations (ACOs) and the bundling of payments across providers for an episode of care ("bundled payments"). Both of these features of the ACA encourage consolidation between hospitals and physician practices, which in fact has recently accelerated.

What is the relationship between hospital consolidation and prices?

Increases in hospital market concentration lead to increases in the price of hospital care.[1] This finding is consistent with the conclusion of the 2006 synthesis. Since the 2006 report, several econometric studies have revisited the relationship between price and hospital concentration, using data from a variety of sources, thereby expanding the geographic scope of the evidence base. The prior evidence came almost exclusively from California. The more recent evidence comes from more states (Florida, Massachusetts) and from the entire United States (see Table 1). Ultimately, increases in health care costs (which are generally paid directly by insurers or self-insured employers) are passed on to health care consumers in the form of higher premiums, lower benefits and lower wages (see, e.g., Baicker and Chandra (4)).

Table 1: Summary of hospital concentration studies since 2006

Author/ Year	Location of data	Time frame of analysis	Results
Akosa Antwi et al. (2009)	CA	1999–2005	Prices increased twofold over period and growth is highest in monopoly markets; however, changes in market concentration are not associated with differential price growth.
Dranove et al. (2008)	CA & FL	1990–2003	The association between hospital concentration and price increased during the 1990s and leveled off during the 2000s.
Melnick and Keeler (2007)	CA	1999–2003	Hospital concentration is positively associated with price growth; hospitals in large systems experienced higher price growth.
Moriya et al. (2010)	US	2001–2003	Insurer concentration is negatively associated with hospital prices; hospital price/concentration relationship is insignificant.
Wu (2008)	MA	1990–2002	Hospitals for which a rival hospital closed experienced a price increase relative to controls.

[1] Hospital concentration measures the extent to which a market is dominated by a few (or one) hospitals. All else equal, the higher the market concentration, the less vigorous is the resulting price competition. Consolidation within a market (e.g., via mergers) reduces independent market participants and by doing so increases market concentration.

Price increases exceeded 20% when mergers occurred in concentrated markets.

ANTITRUST ENFORCEMENT

In recent years, the Federal Trade Commission (FTC) has become more aggressive in challenging cases and has had dramatically more success than during the 1980s and 1990s. At the time of the 2006 synthesis, after a decade and a half long series of unsuccessful attempts to block hospital mergers, the Federal Trade Commission (FTC) had just successfully litigated its first hospital merger case. In this case, the FTC challenged a consummated merger and the court found that the merger between Evanston-Northwestern Hospital and Highland Park Hospital (both located in Evanston, Ill.) led to an increase in prices. The decision in this case is important because it established that proximate not-for-profit hospitals in urban areas can increase market power by merging. Importantly, the case also established that, post-acquisition, hospitals are willing to use their increased market power to raise prices.

The findings in the Evanston-Northwestern case gave the FTC a firm footing for litigation of hospital merger cases. Since 2006, the FTC has successfully brought suit to stop several hospital mergers. Of particular note is the ProMedica case, in which a federal judge granted the FTC an injunction in its antitrust challenge of ProMedica's acquisition of a hospital.[2] It is the first prospective merger court victory for the enforcement agencies in decades.[3]

[2] United States of America Federal Trade Commission Office of Administrative Law Judges, Docket No. 9346, In the Matter of ProMedica Health System, Inc., December 12, 2011 *(http://www.ftc.gov/os/adjpro/d9346/120105promedicadecision.pdf).*

[3] Prospective merger analysis seeks to assess the competitive harm from a transaction principally based on information available prior to the consummation of the transaction.

Prices paid to hospitals by private health insurers within hospital markets vary dramatically (22). The evidence points to differences in hospital bargaining leverage as a principal driver of the difference between relatively expensive and inexpensive hospital systems within the same hospital market.

Some evidence suggests that growth in prices is related to market concentration. An important policy question is whether, in addition to leading to a one-time price increase, hospital mergers increase the rate of growth of hospital prices. A few studies have addressed this issue (see Table 1), with the most recent studies giving somewhat conflicting answers to this question. Melnick and Keeler find a positive correlation between price growth and market concentration (28). On the other hand, Akosa Antwi et al. find that monopoly markets experienced the highest rates of growth, but there was little relationship between changes in concentration and the growth of prices (2).

Hospital mergers in concentrated markets generally lead to significant price increases. Several studies have taken a retrospective look at the impact of recent hospital mergers on prices paid to hospitals by health insurers. This research focuses on a "case study" merger and examines the change in inpatient prices after the merger compared with a set of "control" hospitals (see Table 2). The magnitude of price increases when hospitals merge in concentrated markets is typically quite large, most exceeding 20 percent. Analyses that use data spanning large geographic regions that encompass many hospital mergers also find that, for the most part, hospital mergers in concentrated markets result in significant price increases.

Table 2: Summary of hospital merger event studies since 2006

Author/ Year	Location of mergers	Time frame of analysis	Results
Dafny (2009)	US	1999–2005	Merging hospitals had 40% higher prices than non-merging hospitals.
Haas-Wilson and Garmon (2011)	Evanston, IL Mergers of Evanston-NW & Highland Park and St. Therese & Victory Memorial	1990–2003	Post-merger, Evanston-NW hospital had 20% higher prices than control group; no price effect at St. Therese–Victory.
Tenn (2011)	SF Bay Area, CA Sutter/Summit merger	1999–2003	Summit prices increased 28.4% to 44.2% compared with control group.
Thompson (2011)	Wilmington, NC New Hanover-Cape Fear merger	2001–2003	3 of 4 insurers experienced a large price increase; 1 insurer experienced a decrease in prices.
Town et al. (2006)	US	1990–2002	Aggregate hospital merger activity increased the uninsured rate by .3 percentage points.

Hospital competition improves quality.

What is the relationship between hospital consolidation and quality?

At least for some procedures, hospital concentration reduces quality. Since the 2006 synthesis report, many new econometric studies have examined the impact of hospital competition on quality of care, using data from a variety of sources, including studies from outside the United States. The new econometric studies can be divided into two types: those that examine markets with administered prices and those that examine markets with market determined prices.

Hospital competition improves quality under an administered pricing system. Studies of the impact of competition on hospital quality under an administered price regime are based on the U.S. Medicare program and the English National Health Service (NHS), which made a transition to administered prices in a 2006 reform. The evidence presented in the 2006 synthesis was entirely from the Medicare program. The findings from those studies were mixed, but the strongest evidence was that tougher competition led to enhanced quality of care. Those results are reinforced by newer studies from the NHS, which uniformly show a positive impact of competition on the quality of care. The 2006 reform in the NHS was intended to create competition among hospitals for patients, by allowing patients to choose their hospital, while setting regulated prices in a manner very similar to the Medicare DRG-based system.[4] The studies all show a substantial impact of the introduction of hospital competition in the NHS on reducing mortality rates (see Table 3). While it is not possible to draw direct conclusions about the United States based on evidence from the United Kingdom, these studies add to the growing evidence base that competition leads to enhanced quality under administered prices.

Table 3: Summary of hospital quality-competition studies with administered prices since 2006 (continued on next page)

Author/ Year	Location of data	Time frame of analysis	Does competition increase quality?	Results
Cooper et al. (2011)	England	2002–08	Yes	Acute myocardial infarction (AMI) mortality fell significantly faster after the reforms in less concentrated markets. This led to 300 fewer AMI deaths per year.
Gaynor et al. (2010)	England	2003–04, 2007–08	Yes	All-cause and AMI mortality fell significantly faster after the reforms in less concentrated markets. There were no effects on length of stay, expenditures or productivity. This led to 4,791 life years saved from deaths from all-causes averted, and 1,527 AMI life years saved. Benefits outweigh costs.
Bloom et al. (2010)	England	2006	Yes	Hospitals in less concentrated markets have better management, and better management leads to reduced mortality. Adding an additional hospital close by improves management quality and thereby reduces heart attack mortality by 10.7%.

[4] The NHS reforms introduced: patient choice among hospitals, regulated prices, and performance incentives for hospital managers. Previously a local public entity selectively contracted with hospitals (often sole source) to provide care for their patients. Contract negotiations focused on price, not quality. Patients had little choice and hospital managers had little incentive to compete for patients on quality. See Cooper et al. (13), Gaynor et al. (20) for more details.

PHYSICIAN-HOSPITAL CONSOLIDATION

It is important to distinguish between consolidation and integration. Consolidation is simply bringing together two (or more) previously independent entities. Integration implies more—in particular, elimination of unnecessary duplication, creating systems to bring the previously separate entities together, and comprehensive management of the organization as a whole.

Limited data show that consolidation between physicians and hospitals is increasing. Increasing numbers of physicians are working as hospital employees and increasing numbers of physician practices are owned by hospitals. The number of physicians working as employees grew from around 31 percent in 1996–97 to 36 percent in 2004–05 (26). Another survey found that the percentage of primary care physicians employed by hospitals rose from under 20 percent in 2000 to over 30 percent in 2008 and the percentage of specialists employed by hospitals rose from just over 5 percent to 15 percent (25). The percentage of physician practices owned by hospitals rose from around 20 percent in 2002 to over 50 percent by 2008 (25). On the other hand, the percentage of hospitals with other kinds of physician-hospital relationships, such as physician hospital organizations (PHOs) and independent practice associations (IPAs), has fallen steadily from 2000 through 2010 (3).

Physician-hospital consolidation studied so far did not involve true integration.

PHYSICIAN-HOSPITAL CONSOLIDATION, CONT.

Consolidation between physicians and hospitals is of great interest both because of the potential consolidation has for creating integration, and the impetus created by the ACA's push towards creating Accountable Care Organizations (ACOs) and emphasis on bundled payments. In theory, there are substantial gains to be made from consolidation. However, there are also concerns that consolidation may have adverse impacts on competition. Consolidation can simply be an attempt by providers to enhance bargaining power vis à vis insurers.

The research evidence on physician-hospital consolidation does not find evidence supporting either clinical gains or cost reductions (9, 27). The most likely reason is that most consolidation did not lead to true integration. Evidence on this topic comes from examination of physician-hospital organizations in the 1990s. Current consolidation is too recent to allow for studies of its effects. While the successes of certain prominent integrated organizations, such as Geisinger Health System, InterMountain Healthcare, or the Mayo Clinic, are frequently mentioned as support for gains from consolidation, these are ad hoc examples, selected for their positive results. They do not constitute research evidence.

Table 3: Summary of hospital quality-competition studies with administered prices since 2006 (continued from previous page)

Author/ Year	Location of data	Time frame of analysis	Does competition increase quality?	Results
Beckert et al. (2012)	England	2008–09	Yes	Hip replacement patients are significantly more likely to choose higher-quality hospitals. A 5% increase in a hospital's mortality rate decreases demand by 6.9%. Hospital mergers substantially reduce the responsiveness of demand to mortality.
Gaynor et al. (2011)	England	2003–04, 2007–08	Yes	Coronary artery bypass graft surgery (CABG) patients' responsiveness to hospital mortality rates is substantially higher after the reforms. A 1% increase in a hospital's mortality rate reduces its market share by over 4% after the reforms. The change in elasticity due to the reform led to a significant reduction in mortality.

Competition improves quality where prices are market determined, although the evidence is mixed (Table 4). There have also been substantial additions to this literature since the 2006 synthesis. The findings from these studies are more mixed than the findings of recent studies of markets with administered prices. This stands to reason: if hospitals can compete on both price and quality, then when they face tougher competition they will choose to compete by whichever means is most effective. If buyers are considerably more responsive to price than quality (for example, if price is easier to measure), then enhanced competition can lead to lower prices, but also less attention to quality. On the other hand, if quality is particularly salient, then tougher competition can enhance quality.

All of the U.S. studies except for one find that competition improves quality, while the English studies uniformly find negative effects.[5] The difference appears to most likely be due to differences in the possibility of patient choice between the United States and England (in the 1990s).

In the United States, prices are negotiated by price-sensitive insurers. These insurers have strong incentives to obtain lower prices, since their customers, typically employers, are responsive to price differences. Insurers, however, do not engage in sole-source contracting. They contract with sets, or "networks," of hospitals. Patients are thus free to exercise choice of hospital within a network (which is often quite broad). Hospitals have an incentive to compete on quality in order to attract patients within a network. As a consequence, there are both price and quality incentives in play.

In contrast, in England in the 1990s, negotiation was done by a single local public entity (Primary Care Trust, or PCT) for all individuals in a geographic area, and contracts were sole source. Purchasers could use savings obtained via lower prices to purchase more care (particularly elective care). Hospitals' operating incomes came from contracts with purchasers. Information on quality was not publicly available. This led to negotiations focused on price, not quality. As a consequence, patients had little or no choice of hospital, and there was far less incentive for hospitals to compete on quality to attract patients.

[5] The English studies are of a prior reform in the 1990s which emphasized price competition (see Propper et al. (31) for more details).

Physician-hospital consolidation is often motivated by enhanced bargaining power.

A major next step for research in this area is sorting out the factors that determine whether competition will lead to increased or decreased quality. Whether competition leads to increased or decreased quality depends on its relative impacts on how responsive hospital choice is to price versus quality. Future research can focus on trying to recover estimates of these key elements, as well as understanding institutional and policy factors that affect the competitive environment.

Table 4: Summary of hospital quality-competition studies with market determined prices since 2006

Author/ Year	Location of data	Time frame of analysis	Does competition increase quality?	Results
Sohn and Rathouz (2003)	California	1995	Yes	Competition reduced angioplasty mortality.
Encinosa and Bernard (2005)	Florida	1996–2000	No	Low hospital operating margin (possibly due to competition) led to more patient safety events.
Propper et al. (2004)	England	1995–98	No	Hospitals facing more competitors had higher mortality rates in a deregulated environment.
Capps (2005)	New York	1995–2000	Yes	Hospital mergers had no impact on many quality indicators, but did lead to increases in mortality for AMI and heart failure patients.
Propper et al. (2008)	England	1991–99	No	Mortality increased at hospitals with a larger number of competitors following deregulation.
Howard (2005)	US	2000–02	Yes	Demand for kidney transplants is responsive to graft failure. As demand becomes more responsive, hospitals have to compete harder to attract or retain patients.
Abraham et al. (2007)	US	1990	Yes	Quantity increases with the number of hospitals. This will happen only if quality increases or price falls. This therefore implies that an increase in the number of hospitals increases competition.
Cutler et al. (2010)	Pennsylvania	1994–95, 2000, 2002–03	Yes	Removing barriers to entry in the form of certificate of need laws led to entry and increased market shares for low mortality rate CABG surgeons.
Escarce et al. (2006)	California, New York, Wisconsin	1994–99	Yes	Mortality for patients with a variety of conditions is lower in less concentrated markets in California and New York. There are no effects in Wisconsin.
Rogowski et al. (2007)	California	1994–99	Yes	Mortality for patients with a variety of conditions is lower where hospitals have more competitors.
Romano and Balan (2011)	Chicago Primary Metropolitan Statistical Area (PMSA)	1998–99, 2001–03	Yes	A hospital merger in the Chicago suburbs had no effect on some quality indicators, and harmed some others.

PHYSICIAN-HOSPITAL CONSOLIDATION, CONT.

Consolidation is often motivated by a desire to enhance bargaining power by reducing competition. Burns et al. (10) find that hospital-physician alliances increase with the number of HMOs in the market. They infer that providers may be consolidating in order to achieve or enhance market power. More recently, Berenson et al. (6) conducted 300 interviews with health care market participants, and reported that increased bargaining power through joint negotiations is one of several reasons for hospital-physician alliances.

Ciliberto and Dranove (12) and Cuellar and Gertler (14) are econometric studies that examine the impact of physician-hospital consolidation. Both papers look at the effects of physician-hospital consolidation on hospital prices. The two studies find opposite results—Cuellar and Gertler find evidence consistent with anticompetitive effects of physician-hospital consolidation, while Ciliberto and Dranove find no such evidence.

It appears that consolidation is often motivated by a desire to enhance bargaining power by reducing competition, but the limited evidence on whether this leads to higher hospital prices is mixed.

Conclusions and Policy Implications

Additions to the evidence base since the 2006 research synthesis reinforce the findings that hospital competition leads to lower prices. The expanded evidence on competition and quality shows that competition leads to higher quality when there are administered prices. The evidence is less straightforward when prices are market determined, although the majority of studies show that competition improves quality. Our review of the research on physician-hospital consolidation does not suggest that such consolidation (absent true integration) will lead to cost reductions or clinical improvement, and may lead to enhanced market power for providers.

Policy developments since the 2006 synthesis give policy-makers both some cause for optimism and some cause for concern.

- **The FTC's recent successes in blocking horizontal hospital mergers should prevent further consolidation, thereby constraining price increases and likely improving the quality of care.**
- **Nonetheless, many hospital markets remain highly concentrated and noncompetitive. And, the prospect that the ACA could encourage greater physician-hospital consolidation gives some cause for concern.**
- **While the current evidence base is not very supportive of initiatives to encourage physician-hospital integration, given the current interest in this kind of consolidation and the promotion of ACOs and bundled payments, more evidence is clearly needed on the impacts of consolidation on costs, quality and prices.**

THE SYNTHESIS PROJECT (Synthesis) is an initiative of the Robert Wood Johnson Foundation to produce relevant, concise, and thought-provoking briefs and reports on today's important health policy issues.

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THE SYNTHESIS PROJECT

NEW INSIGHTS FROM RESEARCH RESULTS

POLICY BRIEF NO. 9
JUNE 2012

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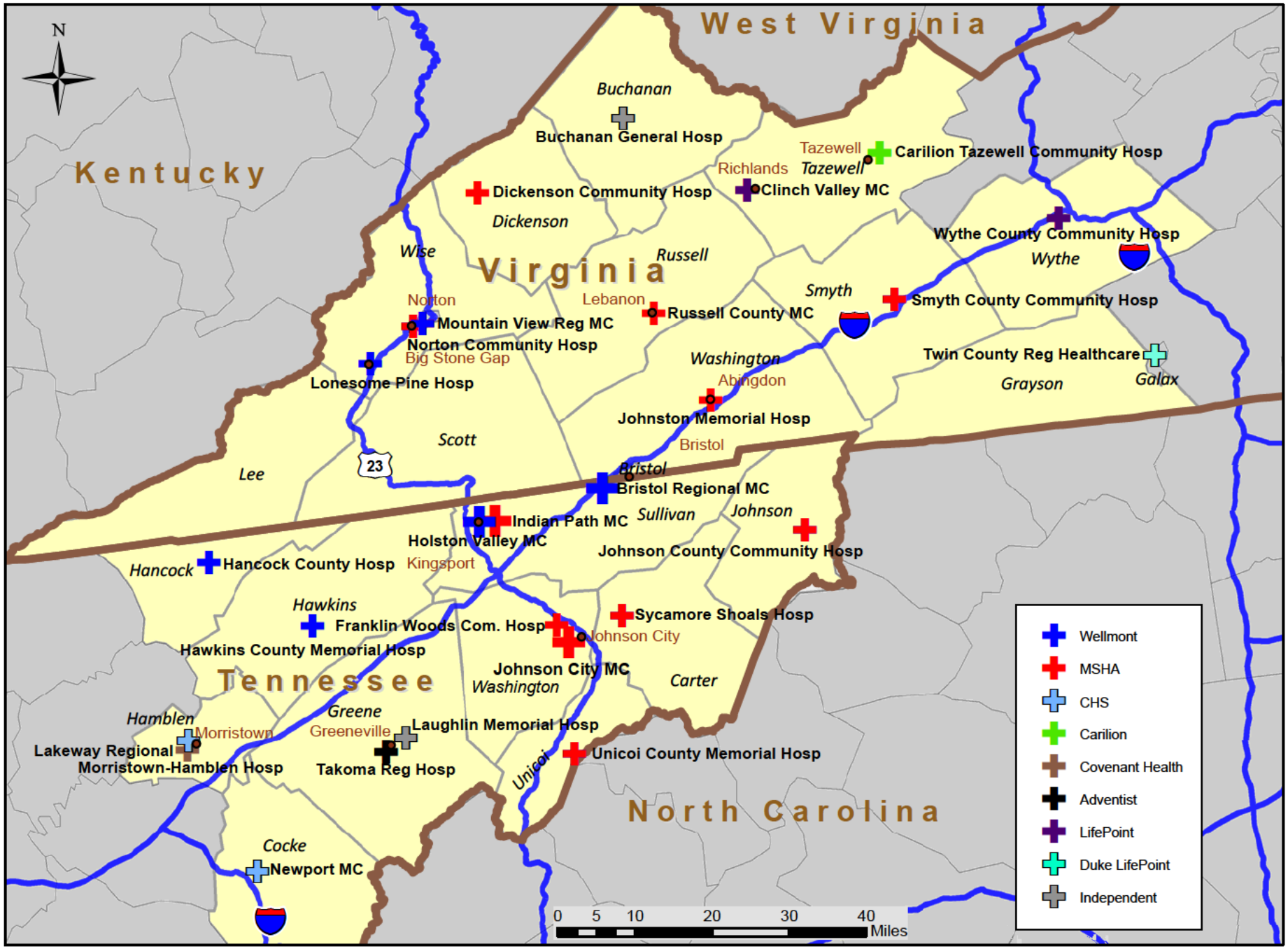
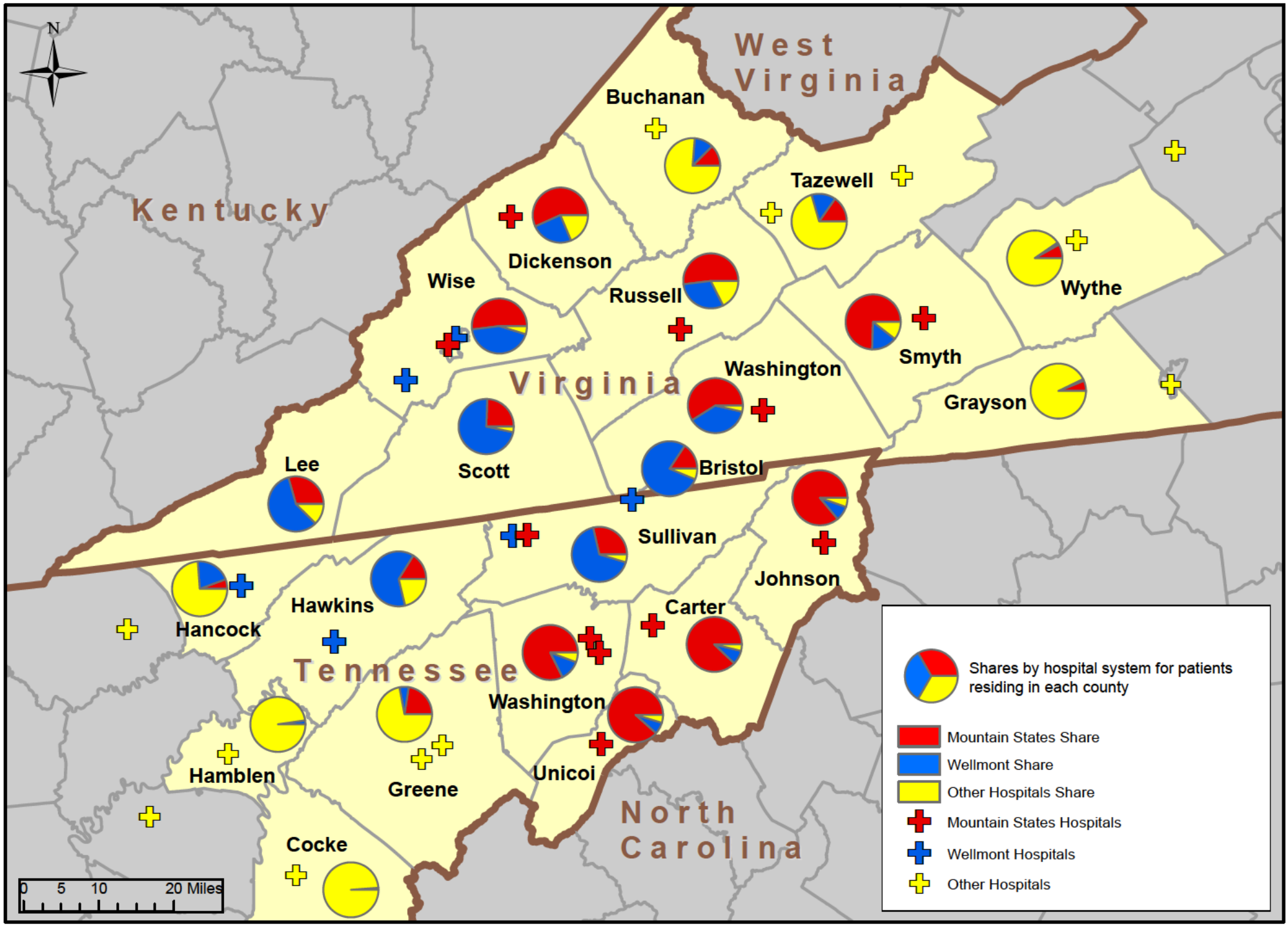
FTC Public Comment
Attachment D

General Acute Care Hospitals in the 21-County Area



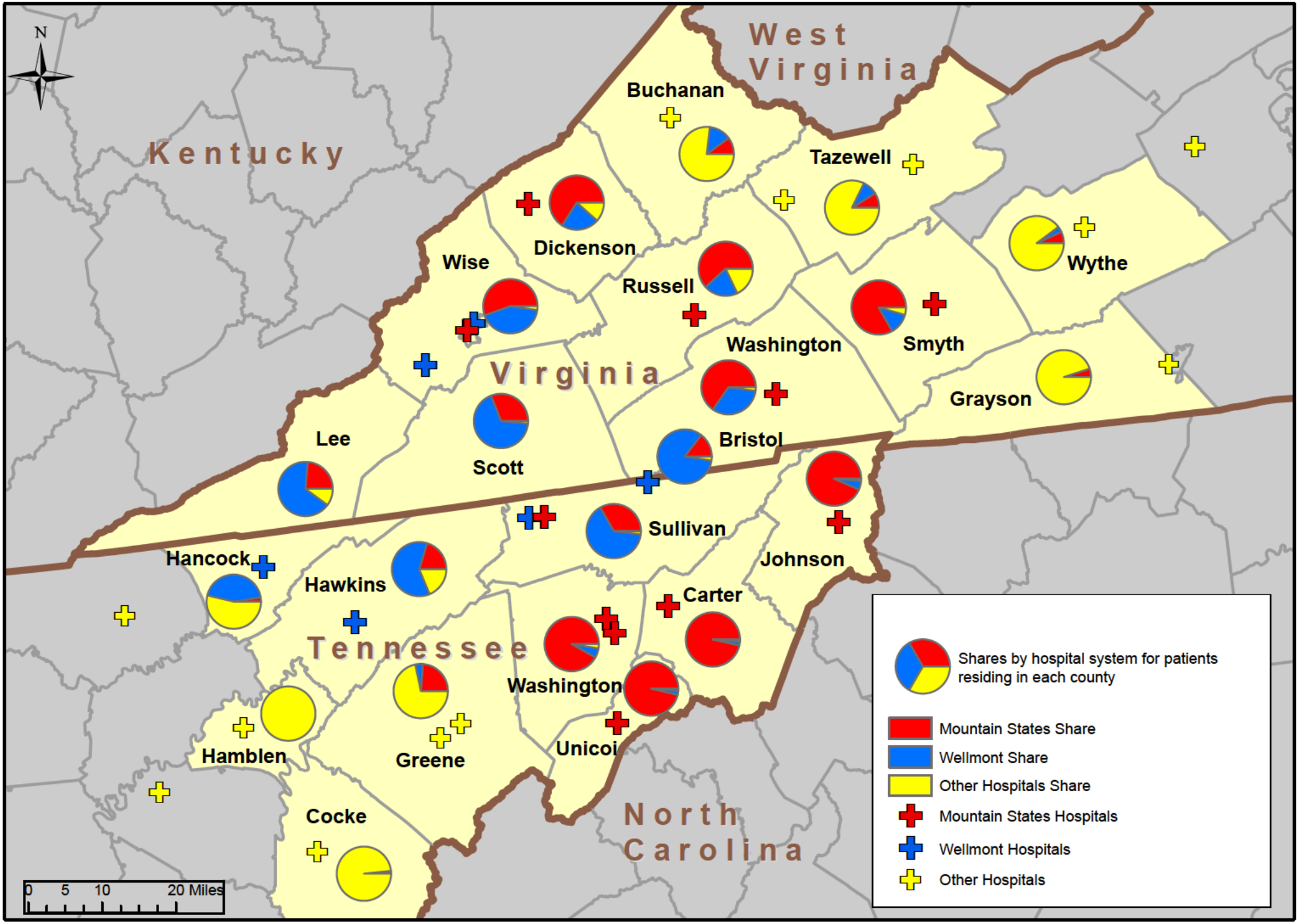
FTC Public Comment
Attachment E

Shares of Commercial Inpatient Admissions by County by Hospital System



Source: Virginia and Tennessee State Hospital Discharge Data (2014).
Note: Shares for each county are based on commercial patients residing within that county and account for all hospitals located in Tennessee and Virginia, including hospitals located outside the scope of the map.

Shares of Commercial and Non-Commercial Inpatient Admissions by County by Hospital System



Source: Virginia and Tennessee State Hospital Discharge Data (2014).
Note: Shares for each county are based on commercial and non-commercial patients residing within that county and account for all hospitals located in Tennessee and Virginia, including hospitals located outside the scope of the map.

FTC Public Comment
Attachment F

July 21, 2014

The Honorable Janet L. Sanders
c/o Antitrust Division
Office of the Attorney General
One Ashburton Place
Boston, MA 02108

Re: Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp., Superior Court Civil Action No. 14-2033-BLS
CC: Massachusetts Health Policy Commission

Dear Judge Sanders:

We, the undersigned, submit to you this comment in our capacity as academic economists with expertise in the subjects of antitrust, competition policy, and health economics. We are concerned that the consent judgment in the above-referenced matter will not fully address the substantial alleged anticompetitive effects of the acquisitions proposed by Partners Healthcare Systems, Inc. ("Partners"). We urge you to reconsider your support of the proposed settlement and to file for injunctive relief to ensure the transactions cannot be consummated until and unless a full trial on the merits can be held. Our review of the public documents issued by the Massachusetts Health Policy Commission, together with our collective understanding of healthcare organizations and markets (underpinned by extensive academic research, cited below), leads us to believe that the evidence would show that these acquisitions are not in the public interest. Moreover, we do not believe that the proposed restrictions on Partners' conduct included in the consent judgment will offset the consumer harm that is likely to arise from the acquisitions of South Shore and Hallmark hospitals and their physician affiliates. Below, we provide three distinct arguments underlying our conclusions.

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1. There is scant empirical evidence that horizontal or vertical integration among healthcare providers of this scale leads to efficiencies.

The proposed settlement permits several acquisitions with horizontal as well as non-horizontal ("vertical") overlaps. We challenge the implicit conclusion by the Attorney General that these transactions are likely to generate merger-specific, verifiable benefits to consumers.

In its response to the Health Policy Commission's Cost and Market Impact Review of the South Shore and Harbor Associates acquisitions, Partners claimed the deal would "yield economic and operational efficiencies, all of which will, in turn, result in the delivery of high quality, cost effective health care to all patients served in the South Shore and contribute to moderating the

rate of growth in health care expenditures for the benefit of patients and employers."[1] Unfortunately, systematic evidence from hundreds of hospital mergers around the nation provides little empirical support for these assertions.

A 2006 survey article authored by two prominent health and antitrust economists and sponsored by the Robert Wood Johnson Foundation concluded that *hospital mergers yield modest cost savings at best*, and only when hospitals combine operations (as opposed to sharing a corporate parent).[2] The authors also find that consolidation generally leads to significantly higher prices, and to lower, rather than higher, quality of care. A 2012 update to the 2006 survey reviewed subsequent research and affirmed the prior findings.[3] In other words, hospital mergers have consistently failed to generate the benefits promised by their proponents.

There are important non-horizontal components to these transactions, as Partners will acquire several physician groups and clinics affiliated with South Shore and the other hospitals. We are hopeful that such affiliations among various healthcare providers can generate savings and quality improvements, but there is no convincing evidence to date that combining physicians and hospitals under common ownership tends to result in cost savings. In a lengthy review of the literature, Burns, Goldsmith, and Sen (2013) conclude that "Research on the effect of integration on physician productivity and hospital profitability has produced *mixed results*."[4] A recent study found that increases in the market share of hospitals that own physician practices are associated with increases in area prices and spending.[5]

The stated objectives of organizations formed through hospital-physician partnerships have much in common with a key initiative of the Affordable Care Act, the Accountable Care Organization (ACO). Hence the early performance of ACOs is probative. The Centers for Medicare and Medicaid Services recently reported that slightly less than half of ACOs participating in the Medicare Shared Savings Program achieved savings relative to the CMS benchmark – about what one would expect from a random sample of healthcare delivery organizations.[6] However, ACO sponsors presumably expected better-than-average savings given the significant fixed and ongoing investments required to form and operate these novel and heavily-regulated entities.

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[1] Partners HealthCare, Brigham and Women's Hospital, and South Shore Hospital's Response to the Health Policy Commission's Preliminary CMIR Report dated December 18, 2013. Submitted to the Health Policy Commission on January 17, 2014. http://www.connectwithpartners.org/wp-content/uploads/2014/01/PHS-BWH-SSH-CMIR-Response.pdf

[2] William B. Vogt and Robert J. Town, "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" *The Synthesis Project*, no. 9 (2006): 11, available at http://www rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html.

[3] Martin Gaynor and Robert J. Town, "The Impact of Hospital Consolidation—Update," *The Synthesis Project*, 2012, available at http://www rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261.

[4] Lawton Robert Burns, Jeff Goldsmith, and Aditi Sen, "Horizontal and Vertical Integration of Physicians: A Tale of Two Tails," *Advances in Health Care Management* 15, 2013, 39-117.

[5] Laurence C. Baker, M. Kate Bundorf, and Daniel P. Kessler, "Vertical Integration: Hospital Ownership Of Physician Practices Is Associated With Higher Prices And Spending," *Health Affairs* May 2014 vol. 33 no. 5 756-763.

[6] CMS reported that 54 of 114 ACOs participating in MSSP in 2012 "had lower expenditures than projected. Of these, 29 achieved savings sufficiently large to trigger shared savings. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-30 html.

We do not intend to suggest that ACOs or their analogues for non-Medicare populations are not promising mechanisms for improved care delivery (both in terms of cost and quality). Rather, we observe that the success of ACOs is yet unknown, and permitting combinations that are extremely difficult to unwind if they prove unsuccessful requires a significant leap of faith on three dimensions: (1) clinical care coordination can be successful; (2) the benefits of clinical care coordination cannot be achieved through joint ventures or contracts; (3) the benefits exceed the likely anticompetitive effects.

2. The parties' background and arguments do not warrant exceptional treatment

No court has yet to permit an otherwise illegal merger to proceed on the grounds that efficiencies sufficiently offset alleged harm.[7] Notably, the courts require "proof of extraordinary efficiencies" in circumstances where market concentration is high.[8] In our view, neither Partners' historical record nor its post-acquisition plans appear sufficiently compelling to meet this standard.

While Partners' planned investments in the South Shore might not occur absent the proposed acquisitions, it is not clear that net benefits to consumers will be positive. Partners has not suggested that the acquisitions are intended to generate financial losses, hence it is plausible to assume that the investments must be repaid over time through higher charges to payers (or, equivalently, lower pass-through of cost savings). Partners plans to invest $200 million to support its new investments in the South Shore.[9] If realized efficiencies exceed this figure, there is potential for net consumer benefits. Yet Partners' claimed efficiencies – which HPC's experts have deemed significantly inflated – amount to only $158.6 million over an eight-year period.[10, 11] And, as noted earlier, systematic evidence from prior mergers suggests that savings are unlikely.

Partners' track record also fails to inspire confidence that this new set of acquisitions will generate the hoped-for efficiencies. Since its inception in 1994, Partners has pursued a strategy of expansion and integration. Currently, Partners includes 8 general acute care hospitals and contracts on behalf of several others. Its physician group, Partners Community Healthcare, Inc. (PCHI), comprises more than 5,500 physicians.[12] As a result of a 2012 acquisition, Partners also owns a health plan.[13] In spite of two decades of expansion and integration, Partners Healthcare is consistently identified as having *higher prices and higher medical expenses than other, less*

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[7] *FTC v. ProMedica Health Sys.*, No. 3:11 cv 47, 2011 WL 1219281, at *57 (N.D. Ohio, Mar. 29, 2011)
[8] "High market concentration levels require proof of extraordinary efficiencies, . . . and courts generally have found inadequate proof of efficiencies to sustain a rebuttal of the government's case," United States v. H&R Block, Inc., 833 F. Supp. 2d 36, 89 (D.D.C. 2011).
[9] Massachusetts Health Policy Commission, "Review of Partners Healthcare System's Proposed Acquisitions of South Shore Hospital and Harbor Medical Associates," HPC-CMIR-2013-1 and HPC-CMIR-2013-2, February 19, 2014, at 6.
[10] "Why our Partnership with South Shore Hospital Will Improve Care and Reduce Costs," 1/17/2014 press release. This estimate does not include potential savings to the federal Medicare program, but only a small fraction of Medicare savings accrue to Massachusetts residents. However, the HPC CMIRs note the risk of higher costs to Medicare because hospital-affiliated physicians may bill for facility fees in addition to professional charges for office-based care.
[11] We refrain from remarking on the efficiencies and investments detailed for the Hallmark transaction, as the CMIR has yet to be finalized and Partners has not issued a response as of this writing.
[12] Massachusetts Health Policy Commission, "Review of Partners Healthcare System's Proposed Acquisition of Hallmark Health Corporation," HPC-CMIR-2013-4, July 2, 2014, at 7.
[13] https://www nhp.org/whoweare/Pages/Partners-Healthcare.aspx.

integrated, systems.[14] Moreover, several reports issued by Massachusetts state agencies, including the Office of the Attorney General, have concluded that high prices are not well-correlated with higher quality of care. These studies have also raised significant concerns about adverse impacts of current and future consolidation on local healthcare spending.[15]

3. The proposed agreement does too little to curb the exercise of market power alleged to arise from the acquisitions of South Shore Hospital, Harbor Associates and Hallmark Health System.

In most cases, antitrust enforcers favor structural remedies – e.g., blocking or dissolving mergers – for a variety of reasons well-described in a recent speech by Deborah Feinstein, the Director of the Bureau of Competition at the Federal Trade Commission.[16] Perhaps the most important of these reasons is that regulators can only guess at the "but for" world and attempt to design conduct requirements that seem likeliest to produce that world. Such endeavors are likely to be most successful in mature industries where price and quality are relatively easy to measure, demand and cost are relatively stable, and innovation is limited.[17] These conditions do not characterize healthcare markets of today. Nevertheless, the Attorney General has stated that the restrictions in the consent judgment would accomplish more than successfully blocking this set of acquisitions.[18] Economic theory and evidence suggest otherwise.

First, the requirement that Partners offer payers the right to engage in "component contracting," whereby payers may pick and choose which components of the Partners system they wish to include in their various insurance products, does not eliminate the unilateral incentive for each component to raise price following a merger.[19] Ordinarily, firms are reluctant to raise price because they may lose customers to rivals. But if two erstwhile competitors share a corporate parent, then when one raises its price, some of its customers shift their business to the other firm. This keeps the revenues "in the family", which blunts any disincentive to raise prices. Thus, a

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[14] For example, the Massachusetts Center for Health Information and Analysis recently reported the following: (1) Partners had "acute hospital price levels in 2012 that were higher than the network median price across all payers' networks"; (2) "Physician groups that were associated with Partners and Atrius Health had relative price levels that were significantly higher than the network median price levels across most payers in 2011"; (3) "Partners was the only physician group system examined that had a health status adjusted TME [Total Medical Expense] above the network average physician group TME in the top three payers' networks." Center for Health Information and Analysis, "Annual Report on the Massachusetts Health Care Market" August 2013, at 29.

[15] For a summary of the 16 reports issued between 2008 and 2013, see http://www mahp.com/assets/pdfs/MAHP-cost-drivers-in-the-cwealth.pdf.

[16] Deborah L. Feinstein, "Antitrust Enforcement in Health Care: Proscription, Not Prescription," June 18, 2014, at 14-15. Available at http://www ftc.gov/public-statements/2014/06/antitrust-enforcement-health-care-proscription-not-prescription

[17] Ken Heyer, "Optimal Remedies for Anticompetitive Mergers," 2012, *Antitrust* 26(2): 26-31.

[18] "While a lawsuit could have blocked Partners' expansion to South Shore Hospital, it also would have maintained the unacceptable status quo in the health care market. Today's resolution goes well beyond that by reducing the negotiating power of Partners, limiting its ability to acquire physicians, and controlling costs across its entire network," June 24, 2014, "AG Final Resolution with Partners Would Alter Provider's Negotiating Power, Restrict Growth and Health Costs," available at http://www mass.gov/ago/news-and-updates/press-releases/2014/2014-06-24-partners-settlement html

[19] In years 1-7 of the agreement, the four components are: Academic Medical Center Contracting Component, Community Contracting Component, South Shore Contracting Component, and Hallmark Health Contracting Component. In years 8-10, the South Shore and Hallmark Health components will be merged with the Community Contracting Component. http://www mass.gov/ago/docs/press/2014/partners-settlement-062414.pdf at 17-18.

merger of rivals will result in prices above the levels that would prevail if the rivals were truly independent. This is true even in the absence of explicit price coordination among the co-owned former rivals.

Indeed, the Evanston Northwestern-Highland Park hospital merger in the northern suburbs of Chicago in 2000 provides a case in point. Shortly after the merger, inpatient prices charged to commercial payers increased by nearly 50%, far exceeding price increases among various control groups in the Chicago area.[20] Moreover, extensive empirical analysis shows that quality did not improve relative to other area hospitals.[21] In light of this evidence, the merger was deemed anticompetitive by an administrative law judge in 2005, a determination that was affirmed on appeal to the full Commission in 2007.[22] Concluding that "divesting Highland Park after seven years of integration would be a complex, lengthy, and expensive process," the Commission ordered the parent entity (Evanston Northwestern Healthcare) to establish a separate and independent contract negotiating team for Highland Park Hospital. Apparently no insurer has yet availed itself of this option, suggesting that payers recognize that the benefits of separate negotiation (which subsumes component contracting) are minimal. To our knowledge, prices have not reverted back to competitive levels, despite the supposed return of competitive pricing incentives. The FTC has since distanced itself from this remedy.[23] A recent simulation of such a remedy in a different setting – a proposed hospital acquisition in Northern Virginia – also shows that separate bargaining would have done little to mitigate post-merger price increases had the FTC and Virginia Attorney General not successfully blocked the transaction.[24]

Second, the price and total medical expenditure (TME) growth caps imposed by the consent judgment will only bind if (a) prices and spending growth would otherwise increase; and (b) prices and spending can be easily calculated and monitored. Healthcare inflation and spending growth are no longer foregone conclusions. Total U.S. healthcare spending actually declined between Q42013 and Q12014, notwithstanding a substantial increase in the insured population. There are many ongoing initiatives to "bend the cost curve," so this may not prove to be a one-time event. To take but one example, the 2011 shift by Medicare to bundled payment for dialysis treatments led to a 20 percent reduction in the use of expensive biologic drugs over the course of a single year, and an additional 39 percent reduction the subsequent year.[25] If the cost curve does "bend", residents of Massachusetts will reap more of the benefits in a less concentrated provider market, and this settlement enables the opposite. We also note that the TME cap may be raised if

[20] Deborah Haas-Wilson and Christopher Garmon, "Hospital Mergers and Competitive Effects: Two Retrospective Analysis," *International Journal of the Economics of Business*, 2011, 18(1): 17-32.
[21] Patrick S. Romano and David J. Balan, "A Retrospective Analysis of the Clinical Quality Effects of the Acquisition of Highland Park Hospital by Evanston Northwestern Healthcare, " *International Journal of the Economics of Business*, 2011, 18(1): 45-64.
[22] In the Matter of Evanston Northwestern Healthcare Corporation and ENH Medical Group, Inc., No. 9315, August 6, 2007, available at www ftc.gov/os/adjpro/d9315/070806opinion.pdf.
[23] "The Commission did accept a conduct remedy in its challenge to the combination of Evanston and Highland Park hospitals....We have repeatedly rejected this sort of conduct remedy since." Deborah Feinstein, "Antitrust Enforcement in Healthcare: Proscription, not Prescription," June 19, 2014, at footnote 43.
[24] Gautam Gowrisankaran, Aviv Nevo, and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," Accepted, *American Economic Review*, June 2014. For additional details on the transaction in question, see http://www ftc.gov/enforcement/cases-proceedings/061-0166/inova-health-systems-foundation-prince-william-health-system.
[25] 2013 Atlas of CKD & ESRD, U.S. Renal Data System, available at http://www.usrds.org/2013/pdf/v2_ch11_13.pdf

non-Partners hospitals exceed the HPC's benchmarks, and moreover that it pertains only to the segment of Partners' patients enrolled in a "Risk Arrangement." According to the most recent data available (from 2012), only 11% of Partners' commercial business falls in this category.[26]

Even if the caps were to bind, implementation and monitoring will be exceedingly difficult. There is widespread agreement that price is extremely hard to measure in the healthcare sector. In addition, and as the dialysis example illustrates, payment modalities are evolving away from fee for service and toward more sophisticated approaches such as bundling. Even the apparently straightforward TME is challenging to measure, as it must be adjusted for patients' health risk and changes in health plan benefit design. And as many have noted, price and spending caps do not address quality of the services provided, which could be reduced in order to maintain desired margins.

Third, there are no protections in place after the agreement expires. If the acquisitions are indeed anticompetitive, and if the restrictions imposed by the consent judgment bind, when they expire the residents of the Commonwealth will face the full extent of the market power of a system strengthened by the Attorney General's decision to drop its investigation into Partners' historical contracting practices and to permit the new series of acquisitions to proceed unchallenged. There are few well-documented analyses of conduct by hospitals following the expiration of similar agreements, as remedies of this form are rare. However, the limited evidence available is not encouraging.

For example, in 1997 New York State's Attorney General agreed to drop its opposition to the merger of Long Island Jewish Medical Center and North Shore Health System in exchange for a series of post-merger commitments, including a 2-year price-growth cap. In 2000, hospital executives reported significant improvements in reimbursement rates due to their stronger negotiating position.[27]

Another example is the "Community Commitment" required by the judge who denied the FTC's 1996 request for an injunction to bar the merger of Butterworth Health Corporation and Blodgett Memorial Medical Center in Grand Rapids, Michigan.[28] The Commitment, entered as a court order, included a price freeze for 3 years, followed by a price growth cap set at the Consumer Price Index (CPI) for an additional 4 years. Immediately following the expiration of the price cap

[26] Public Comment by the Massachusetts Health Policy Commission in re Commonwealth of Massachusetts v. Partners Healthcare System, Inc., South Shore Health and Educational Corp., and Hallmark Health Corp., Superior Court Civil Action No. 14-2033-BLS, http://www.mass.gov/anf/docs/hpc/hpc-submission-into-court-authorized-public-comment-period.pdf

[27] "After Merger's Bumpy Start, North Shore-L.I.J. is Clicking," *New York Times,* December 17, 2000. http://www nytimes.com/2000/12/17/nyregion/after-merger-s-bumpy-start-north-shore-lij-is-clicking html?src=pm&pagewanted=1

[28] David Balto and Meleah Geertsma, "Why Hospital Merger Antitrust Enforcement Remains Necessary: A Retrospective on the Butterworth Merger," *Journal of Health Law*, 2011, 34(2): 129-165.

in 2004, the parent system raised prices 12 percent.[29] In recent years, price increases have far exceeded CPI, including 8 percent price increases in each of 2010 and 2011.[30]

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In closing, we emphasize that there is no longer any meaningful debate in the academic community about whether provider competition is beneficial to consumers. In contrast, there is significant evidence that efficiencies do not necessarily or generally follow from provider mergers. Partners' 20-year track record of integration paired with high prices and high medical costs casts serious doubt on its assertions that the proposed acquisitions would yield substantial efficiencies, let alone of the magnitude necessary to outweigh the alleged anticompetitive effects.

We urge the court and the Attorney General not to be unduly swayed by submissions from community members and organizations in support of this judgment. Most hospital mergers – particularly among non-profit organizations – draw substantial support from the affected communities due to strong community ties. But the harmful impact of these mergers on prices and insurance premiums generally affects a broader group of stakeholders, many of whom lack the incentive or resources to voice their objections. In addition, they do so at the risk of alienating powerful healthcare providers who may subsequently retaliate with impunity.

The court should be given the opportunity to weigh the evidence concerning whether the series of acquisitions permitted by the consent judgment will substantially lessen competition, per Section 7 of the Clayton Act and the Massachusetts Consumer Protection Act, M.G.L. c. 93 A.

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[29] "Spectrum Hikes Charges 12 Percent," *Grand Rapids Business Journal*, June 4, 2004, available at http://www.grbj.com/articles/63939
[30] "Spectrum Health Plans Another Significant Rate Hike at Grand Rapids Hospitals," June 7, 2011, mlive.com., available at http://www mlive.com/business/west-michigan/index.ssf/2011/06/spectrum_health_plans_8_percen html

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