VIRGINIA ASSOCIATION OF HEALTH PLANS

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To: The Southwest Virginia Health Authority

RE: Comments to the Southwest Health Authority regarding the received application for Cooperative Advantage by Mountain States Health Alliance and Wellmont Health System.

The Virginia Association of Health Plans (VAHP) submits these written comments to the Southwest Virginia Health Authority (Authority) regarding the Application for a Cooperative Agreement submitted by Mountain States Health Alliance (Mountain States) and Wellmont Health System (Wellmont) and deemed complete by the Authority on August 26. VAHP represents 10 insurance carriers operating in the Commonwealth, including commercial and Medicaid Managed Care Organization (MCO) payers.

The payer marketplace provides a wide range of offerings in Southwest Virginia of both public and private consumers. Medicare, Medicaid and Medicaid Managed Care Organizations (MCOs) payers make up 70.3%, according Exhibit 15.1 of the application, of the discharges for the two health systems. The amount of government business is likely to increase under the Affordable Care Act. The commercial market makes up 17.5% of the two systems' discharges. There are 3 health insurers offering individual products filed with the Virginia Federal Health Exchange totaling 28 commercial plans in the Southwest Region of Virginia, 6 insurers with over 300 plans both on and off the exchange in the small and large group markets and 3 plans offering Medicare Advantage Plans. Our payers have concerns with the ramifications of granting a COPA on our customers.

The application lacks critical specificity, does not address the lack of competition that would result from the merger, and in our estimation, the disadvantages outweigh the advantages of granting the applicants a virtual monopoly in the region. If granted by the Commonwealth, the Cooperative Agreement would allow Mountain States and Wellmont to combine and effectively eliminate competition in seven counties in Southwest Virginia in a way that would otherwise violate federal and state antitrust laws.

The Authority sent the applicants a list of 68 questions in June asking for more specific information in regards to the effect of the COPA on competition, how the new system will be properly supervised by the Commonwealth and more specifics on the commitments the Parties have made so the public could adequately evaluate a completed application. In the Parties response to those questions, many answers lacked specifics, were general in nature, and some were outright left unanswered.

Now that the application is deemed complete, the Authority's task is to make a recommendation to the Commissioner of Health as to whether the application should be approved. According to the statute, the Authority is to weigh the benefits as they pertain to:

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;

b. Enhancement of population health status consistent with the regional health goals established by the Authority;

c. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;

d. Gains in the cost-efficiency of services provided by the hospitals involved;

e. Improvements in the utilization of hospital resources and equipment;

f. Avoidance of duplication of hospital resources;

g. Participation in the state Medicaid program; and

h. Total cost of care. [1]

The purported benefits that the Parties claim are exceedingly vague and unsubstantiated. For some, the goal the Parties have set themselves is no greater than what they are already achieving now, without a merger. For example, the new system's commitment to continued access to health care includes a commitment to retain all hospitals currently in operation for a five-year period. This commitment does not speak to what will happen to these facilities after the five-year period, nor does it speak to recently closed hospital locations such as the facility in Lee County. The Authority requested more specific information in their supplemental questions numbers 3 and 6 on the commitment to maintain Virginia hospital facilities. The Parties responded by restating the commitment already included in the application maintaining it was impossible to give information outside of the five-year timeframe and made no commitments to other hospital facilities other than those currently in operation.

There are additional holes in the application as to how the new system will be evaluated for its performance if they are granted a Cooperative Agreement. For example, the Parties are committing to report performance on a variety of quality, access and service metrics. The Authority specifically asked the Parties what metrics they were committing to report beyond those that they already report.[2] The Parties' response continues to be vague and appears to not commit to report any additional metrics. The only commitment they make that goes beyond their current reporting is a pledge to participate in the Commonwealth's effort to create a common system performance scorecard. Improving quality and access is a crucial claimed benefit of the Cooperative Agreement and should be addressed with specificity by the Parties. It is difficult to weigh the added value and benefit without the specifics on how the new scoring will work.

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[1] Virginia Acts of Assembly CHAP0741. 2015 General Assembly Session. http://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+CHAP0741.

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

The Authority attempted to garner more specific information regarding the Parties new scoring system for efficiencies in Supplemental Request 5, asking for more detail on the proposed Alignment Policy and Scoring System. In their response, the Parties simply repeated information already provided in their Application; they did not provide any additional detail.

As stated in our comments to the Authority on August 26, not only have the Parties failed to fully explain how their proposed scoring system will work, but the system they have proposed is an inadequate way of protecting consumers. Their system would allow them to pick and choose which commitments they will actually meet. Moreover, the Parties propose weighting each commitment category equally. This does not account for the vast differences in the impact on patients and the community from non-compliance with various commitments. For example, the commitment to maintain three full-service tertiary hospitals does not have the same importance to patients and the community as the commitment to combine the "best of both organizations' career development programs" –- yet both carry equal weight under the proposed scoring system. Indeed, Mountain States and Wellmont could choose not to comply with a single commitment in two crucial categories, "Commitment to Improve Community Health" and "Expanding Access and Choice," and yet still receive a "passing" score. If the Parties are proposing a scoring system that they intend the Commonwealth to use to actively supervise the merger, it should be required to submit detailed information about how it will work.

The regulatory framework is not in place in the application to actively supervise the Parties if the merger is granted. In Supplemental Question 56, the Authority astutely noted that the Parties were only committing to "report" on a number of metrics rather than committing to outcomes, and that merely reporting was not enough for the state to exercise active supervision. As a result, the Authority asked the Parties to explain how the Commonwealth should respond if the "reporting" is insufficient. The Parties have provided no such response -- instead stating that "reporting obligations of the New Health System and the Department of Health's oversight of these commitments will be agreed upon by the Commonwealth and the Parties *prospectively* in sufficient detail."[3] Any supervision by the Commonwealth would be correcting problems that have already occurred, not preventing problems from arising. This makes active supervision almost impossible for the Commonwealth with the only real solution toward holding the Parties accountable is activating the plan for separation.

As the Authority's advisors noted, the Parties suggest that supervision and oversight by the Commonwealth will greatly minimize the impact of reduced competition. They do not, however, explain fully how the oversight should work or describe the elaborate resources that will be necessary to actively supervise the Cooperative Agreement.

Active supervision of a health system pursuant to a Cooperative Agreement requires extensive time and resources. The Commonwealth should have a system developed to actively supervise the New System. It is impossible to know the potential benefit of a properly regulated entity – or the potential harm that could ensue from a lack of proper oversight – without knowing the regulatory framework the Commonwealth intends to impose to assess whether the new entity will comply with their commitments. This lack of detail makes the application inadequate for weighing the benefit of the proposed commitments in gains in improvements in the utilization of hospital resources, avoidance of duplication of resources, and enhancements to access and quality of care.

[3] Supplemental Response at 60.

The Parties claim one of the most significant benefits of the merger is to generate savings through consolidation of duplicate support services as well as duplicate patient services, particularly in areas with lower demand. The Parties fail to provide any specifics on which services or programs will be reduced, claiming that: (1) the antitrust laws prohibit them from discussing the information to formulate such detailed plans; and (2) the Parties expect the Commonwealth will contribute to this determination.[4]

The Parties should provide more detail on this benefit. It is the Parties' burden to prove to the Commonwealth why the proposed benefits outweigh the potential disadvantages. It is not up to the Commonwealth to determine what the efficiencies and benefits are. While there can be antitrust concerns if competitors share certain sensitive information that could affect their *current* conduct, such concerns do not preclude the parties from describing their *future* plans if a Cooperative Agreement is granted. And to the extent that the Parties need to share sensitive information to develop such plans, there are ways this can be done consistent with the antitrust laws through the use of third-party intermediaries.

Even more concerning than the lack of specificity in the benefits is the negative effects the lack of competition in the region that will result from the Parties being granted a COPA. The consolidation will likely drive up prices and result in less choices for the region's consumers.

The Authority is to weigh the disadvantages of the lack of competition using the following factors:

> *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;*
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> *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;*
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> *c. The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and*
>
> *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.*[5]

In their application and the response to the Authority's questions, the Parties fail to explain what disadvantages will occur due to lack of competition as a result of the Agreement. The Parties significantly understate the competitive risks from the combination, stating that they did not foresee ***any*** adverse impacts on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement."[6] This claim completely ignores the reality of the proposed

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[4] Supplemental Response at 58.

[5] Virginia Acts of Assembly CHAP0741. 2015 General Assembly Session. http://lis.virginia.gov/cgi-bin/legp604.exe?151+ful+CHAP0741.

[6] Mountain States and Wellmont's Application for a Cooperative Agreement at 7 (emphasis added).

merger. An analysis performed recently by Competition Economics LLC found that the merger is "anti-competitive" across the board.[7]

The Parties are the only inpatient hospital service providers in seven counties in southwest Virginia. The Authority asked the Parties to explain why their market share analysis included two counties closer to other metropolitan areas in Virginia and Tennessee—Roanoke and Knoxville. Upon revising their market share calculations in response to this question, the Parties' combined market share is higher than 90% in most cases.[8] Under any standard such shares are extremely high and will result in very likely anticompetitive harm.

During the August 26 Authority meeting, the Parties used the number of independent outpatient physicians in the region as proof that competition will continue. However, there is an ongoing trend in the industry for outpatient providers to contract with a hospital system. A recent study by Avalere Health and Physicians Advocacy Institute shows that the number of medical practices under hospital ownership has jumped by 86% nationally in the last three years. 31,000 physician practices have been acquired over that time period by a hospital system. It is rational to expect that the pressure of a granted Cooperative Advantage would lead many outpatient facilities to contract with the new hospital system, exacerbating this trend. If this provider consolidation continues in Southwest Virginia, the new hospital entity will employ a vast majority of both the inpatient and outpatient providers and have an unprecedented control of the market in the region.[9]

This lack of competition will likely lead to higher prices across the board for both commercial and Medicaid business. A joint study published in December of 2015 shows that hospital costs for the privately insured are 15.3% higher in regions with a hospital monopoly over those with four or more providers.[10] Another leading study published in the Journal of the American Medical Association, shows that the resulting higher prices associated with these mergers often do not translate to more access to care or better quality care for patients.[11] These type of price increases are dangerous to the overall health of patients in Southwest Virginia, and could negatively impact access as well as quality of care. However, the commercial market will not be the only market affected.

VAHP is very concerned with the effect the lack of competition will have on Medicaid MCOs. There are currently five Medicaid MCOs participating in Southwest Virginia representing the Commonwealth's Medicaid Managed Care Program. All five contract with both health systems. The cooperative agreement application makes a commitment to not be an exclusive provider to only one Medicaid MCO

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[7] "An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance". Doane, Michael and Luke Froeb, Competition Economics LLC. January 2015.

[8] Mountain States Health Alliance and Wellmont Health System Response to May 27, 2016 Southwest Health Authority Question, at 7 ("Supplemental Response").

[9] "Physician Practice Acquisition Study", Avalere Health and Physician Advocacy Institute. September 2016. http://www.physiciansadvocacyinstitute.org/Portals/0/PAI-Physician-Employment-Study.pdf

[10] "The Price Ain's Right? Hospital Prices and Health Spending on the Privately Insured", Cooper, Zach Ph.d (Yale University), Stuart Craig (University of Pennsylvania), Martin Graynor, Ph.d (Carnegie Mellon University), John Van Reenen, Ph.d (London School of Economics). December 2015.

[11] "The Potential Hazards of Hospital Consolidation". Xu, Tim, Albert Wu, and Martin Makery. Journal of American Medical Association. October 6, 2015.

and there is a requirement that Medicaid beneficiaries have choice between at least two Medicaid MCOs. This gives the combined entity the ability to not contract with the remaining three.

In the cooperative application, the systems state that Medicaid and Medicare payments are non-negotiable. That would be correct under the Virginia Medicaid and Medicare Fee for Service fee schedules. But, currently, the vast majority of Medicaid and Medicare beneficiaries are managed by Medicaid managed care organizations as well as Medicare Advantage plans, and those rates are absolutely negotiable. The two systems negotiate with health plans to serve this population today, and have not yet made commitments to protect the Commonwealth's Medicaid enrollees.

By Virginia statute, impact to the Medicaid program should be considered when weighing the advantages and disadvantages of the cooperative agreement. And since Virginia is in the midst of transitioning the full Medicaid program under a managed care system, in essence, any impact to the Medicaid Managed Care Program is what needs to be considered in the evaluation of granting a Certificate of Public Advantage.

The application does not deem Medicaid MCOs as "principal payers", only commercial payers who provide more than 2 percent of the New Health System's total net revenue are defined as principal payers. All rate commitments and rate caps are pledged to the principal payers, and not MCOs. With 70.3% of the discharges of the Parties being government payers, certainly Medicare and Medicaid should be counted as principal payers.

In closing, the application, in its current form, should not be approved. Provider competition reduces cost and it is clear the Certificate of Public Advantage would diminish this competition in Southwest Virginia. The Authority is statutorily required to weigh the advantages versus the disadvantages of the Cooperative Agreement and make a recommendation to the Commissioner of Health. The Application lacks critical specifics on the benefits and commitments the Parties have promised. It also lacks a thorough analysis regarding the loss of competition in the region and its effects on cost. Based on the lack of information and the harm imposed to competition and corresponding rise in prices that would result, we urge the Authority to recommend to the Commissioner of Health that the Cooperative Agreement not be approved.

Best regards,

Doug Gray
Executive Director
Virginia Association of Health Plans