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Rules governing hospital merger published

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By Jeff Keeling

If they're to be deemed "better together" by state regulators, the Tri-Cities' two hospital systems will need to create one system that leads to a healthier regional population, greater access to health care and preventive services, reduction in operating expenses, and lower consumer prices. Oh, and they'll need a plan to return to two separate systems if the state

"It is the policy of this state, in certain instances, ***to displace competition among hospitals with regulation*** *to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, in order to promote cooperation and coordination among hospitals in the provision of health services and to provide state action immunity from*

decides they're not adequately meeting those and other expectations. That's the takeaway from a recently published set of Tennessee Department of Health rules governing Tennessee's recently amended "Certificate of Public Advantage" (COPA) law that would allow for the proposed merger, and subsequent reduction in competition, it would create.

In addition to protecting the public, a major reason for what Mountain States Health Alliance CEO Alan Levine called a "robust posture" by the state is to steer clear as much as possible of antitrust action by the Federal Trade Commission (FTC). A recent decision out of Georgia upholding an FTC action surrounding a hospital merger was likely front of mind as lawmakers tweaked the COPA law, called the "Hospital Cooperation Act of 1993," this spring in anticipation of the merger proposal.

"Given the consolidation that's occurred in the industry, both with hospitals and now with the insurance companies, what's readily evident to me is that the state is in a better position to know the healthcare marketplace in each area of the state, and is in a better position to regulate it, than Washington is," Levine told *The Business Journal* Sept. 3.

Wellmont Health System and Mountain States have, since their April betrothal, been trumpeting the notion that they'll be "Better Together" following approval and consummation of a merger. The systems also have known and accepted since then that the state will judge whether they're truly better together, given that a merger will essentially create a monopoly.

The systems knew regulators would consider whether and how much improvement would come in access to care, preventive services, cost to consumers and insurers, operational efficiencies and several other factors when compared to maintaining the status quo, which is inherently preferable at least from an antitrust standpoint.

federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section."

Amended section of Tennessee's Hospital Cooperation Act

"(T)he Department is responsible for active state supervision to protect the public interest and to assure that reduction in competition of health care and related services continues to be outweighed by clear and convincing evidence of the likely benefits for the Cooperative Agreement, including but not limited to improvements to population health, access to services and economic advantages to the public. ***The COPA will be denied or terminated if the likely benefits of the Cooperative Agreement fail to outweigh any disadvantages attributable to a potential reduction in competition resulting from the Cooperative Agreement by clear and convincing evidence****."*

Introduction, Tennessee Department of Health Emergency Rules Governing Hospital Cooperation Act

"We have potentially here a structure to protect the public from the results of this merger. No question about that. There are two parties to keeping that. One is the merged entity. How seriously does it take its responsibility in terms of the index, the requirements? Are they going to be chiseling on it? And is the Commissioner of Health – if this is the only (COPA) in the state – how interested is he going to be? The real advantage of this is we have (Virginia) as well as the state of Tennessee both with a very clear vested interest in seeing this be successful."

D. Bruce Shine, Kingsport attorney

With mid-July's publication of emergency rules promulgated by the Department of Health, the systems learned more about just how high that bar will be. An exhaustive 12-page document drafted by the department's Malaka Watson and dated July 14 is effective through Jan. 10, 2016 – a date likely to be well into the systems' application process for a COPA. Those rules flow from several causes: the revision of the law that allows a

Alan Levine

COPA to be granted and administered by the state; the desire to avoid issues with federal antitrust concerns; and the imminent submission of the Wellmont-Mountain States merger proposal.

The old COPA law wouldn't have allowed a merger. It envisioned "cooperative agreements" for the sharing, allocation or referral of patients, personnel, and some other services traditionally offered by hospitals. The amended law (amended COPA law) – co-sponsored in the Tennessee Senate by Lt. Gov. Ron Ramsey (R-Blountville) and Johnson City Republican Rusty Crowe – adds the following language preceding the "sharing" bit: "consolidation by merger or other combination of assets, offering, provision, operation, planning, funding, pricing, contracting, utilization review or management of health services."

The Department of Health rules, which will be replaced at some point by a version that has gone through the standard review and public comment process, govern application for a COPA, "terms of certification issuance," issuance of a COPA, active supervision by the terms of certification, and modification or termination. They also provide a purpose and definitions, deal with public notice and hearings, and with hearings and appeals.

Bruce Shine is a Kingsport attorney who has followed the local merger talk since it first surfaced in August 2014, and in fact reviewed COPA law for the audience at a public meeting that month in Kingsport. Shine told *The Business Journal* he is cautiously hopeful that the state rules can create a structure that ensures such a massive change – which also includes a major role for East Tennessee State University – brings about the promised benefits. Shine said a required "index" with proposed measures and baseline values related to the overall population's health will be a key. Per the rules, potential measures of such an index can include: improvements in the population's health that exceed measures of national and state improvement; continuity in available services; access and use of preventive treatment; operational savings projected to lower health care costs to payers and consumers; and improvements in quality of services as defined by surveys of the Joint Commission (the accrediting body for health care organizations).

"The index is going to be the critical thing that determines whether this program is working, whether it's servicing the people," Shine said. "And it's going to be pretty specific. The end effect is that it's got to show that the advantage (over the current competitive status quo) is clear and convincing. If it doesn't then they're out of it."

The new COPA law itself adds two new benefits that "may result from the cooperative agreement" to the previous list of five. The existing list primarily centers around cost-efficiency, avoidance of duplication of services and improvements in utilization, while the new items relate more specifically to a region's long-term population health and access to care for people who traditionally struggle to get it. They are, "demonstration of population health improvements in the region served according to criteria set forth in the agreement and approved by the department;" and "the extent to which medically underserved populations have access to and are projected to utilize the proposed services."

What the Supremes have to do with it

The new language (see the long quote at the top of this article) introducing the revised COPA law shows clear state efforts to keep any approved COPA free from federal antitrust action. Just as clearly, it is written to avoid a scenario similar to that undergone by the state of Georgia and Phoebe Putney Health System.

In the Phoebe case, the Federal Trade Commission in 2011 objected to Phoebe Putney's proposed acquisition of rival Palmyra Park Hospital in the Albany, Ga. market. The FTC held that "the deal will reduce competition significantly and allow the combined Phoebe/Palmyra to raise prices for general acute-care hospital services charged to commercial health plans, substantially harming patients and local employers and employees." After two courts sided with Phoebe, the Supreme Court in 2013 reversed the decision. But by then, it was essentially too late to unwind the merger, a reality that did not escape Ms. Watson in her promulgation of the rules. They require a "plan of separation" that would make it feasible "to return the parties to a Cooperative Agreement to a pre-consolidation state."

The Supreme Court was clear on a couple of points. One was that, "the state legislature's objective of improving access to affordable health care does not logically suggest that the State intended that hospital authorities pursue that end through mergers that create monopolies." The other was the finding that "Georgia has not clearly articulated and affirmatively expressed a policy to allow hospital authorities to make acquisitions that substantially lessen competition."

The ruling seems to suggest such a policy would have been a path to "state action immunity," a concept with precedent dating back to a 1943 case, Parker v. Brown. That case found state authorities, "are immune from federal antitrust lawsuits for actions taken pursuant to a clearly expressed state policy that, when legislated, had foreseeable anticompetitive effects."

Bruce Shine

That is what the amended COPA law attempts to do with its language in Section 2 concerning state policy, "in certain instances," to displace competition. That new section also seeks to include hospitals that have been granted COPAs in that immunity. That, too, would answer precedent, at least according to Cornell University Law School's Legal Information Institute. The institute adds this to its description of the state action immunity doctrine: "This doctrine can apply to provide immunity to non-state actors as well if a two-pronged requirement is met: (1) there must be a clearly articulated policy to displace competition; and (2) there must be active supervision by the state of the policy or activity." Whether this newly established policy and the Department of Health's rules are enough to keep the FTC at bay in the event of a Wellmont-Mountain States merger remains to be seen, but Shine said the attempt is obvious.

Another new piece of language in the amended law also raises the bar, and appears designed to placate the FTC as much as it is to protect consumers. It requires the Department of Health to review the COPA at least annually. If "the likely benefits resulting from a certified agreement no longer outweigh any disadvantages attributable to any potential reduction in competition," the department can seek a modification, or terminate it (subject to appeal).

"The statute under which they're operating should give comfort to the public that there's a structure in place that will protect them from the adverse effects of a merger," Shine said. "Whether it works or not is an entirely different matter, and there it lies with the commissioner of the Department of Health."

Levine has reviewed the Department of Health rules. He said that while they're stringent, he'd much rather see the states rather than the federal government in charge of ensuring the merger is beneficial to the region – both to the hospital systems and the public.

"I think the reason they've done that is the state has to presume, from their perspective, that others may try to do it, too (receive a COPA). They want to establish a precedent that they're going to be very engaged and they're going to ask the tough questions, which they should.

"I think it's preferable to have the state taking it seriously and doing their job in a meaningful way because it reduces the risk that others could say that the state hadn't been meeting the second prong (the "active supervision" of the state immunity doctrine)."

Levine referenced studies he said have shown that non-regulated acquisitions that the FTC hasn't seen as anti-competitive have, in some cases, actually led to higher prices or costs in a market. That is the outcome he has previously cautioned could have come about had Wellmont, or Mountain States at some later time, been acquired by a system from outside the region. Levine also expressed confidence that the revised COPA law (and a similar new law in Virginia) and the Department of Health's rules and oversight are more than adequate to assuage federal concerns.

"We're following decades of precedent under the state action immunity. So we are well within the boundary that we should be operating in, and our commitment is that we're going to continue to do that. That's why I'm glad the state has taken a robust posture. They're taking it seriously, which takes away the argument that they're not providing adequate supervision.

"We're certainly not going to take an adversarial posture with the FTC – if they have questions we're certainly going to be responsive. But everything we're doing is transparent, we're doing it above board, we're following precedent, we're following the Supreme Court's ruling, we're going to comply with the state's rules, and I think all of that should give the public comfort, because we're doing it the right way."

Details that will matter

The recently published rules are comprehensive. They're also challenging. They envision, if not require, a new system that's better than the two current ones at providing health care, and that does it less expensively. They also raise plenty of ancillary issues. For instance, the application must describe "how the Cooperative Agreement prepares and positions the parties to address anticipated future changes in health care financing, organization and accountability initiatives." It also must address an issue about which many in the community have expressed concern, as it is required to describe, "impact on the health professions workforce including long-term employment and wage levels and recruitment and retention of health professionals."

The "big three" general issues that emerge, though, relate to population health, access and cost. On the cost side, the application's "description of financial performance" must include details on projected changes in volume, price and revenue resulting from the merger. It must describe, "how pricing for provider insurance contracts (is) calculated and the financial advantages accruing to insurers, insured consumers and the parties to the Cooperative Agreement." In other words, it must show how the merger can result in lower prices for consumers

and better margins for the newly merged system.

The population health and access pieces go somewhat hand in hand. The application must show proposed use of cost savings to fund low or no-cost services – immunizations, mammograms, chronic disease management and the like, "designed to achieve long-term population health improvements."

The rules regarding every factor, from finance and cost to services and population health, are too comprehensive to be thoroughly explained in this space. They can be viewed in their entirety at *bjournal.com/COPArules*. But when it comes to proof of a merger's effectiveness, much will ride on the measures noted above. Will services remain adequately available? Will access and preventive care be sufficient? Will operational strategies – including eliminating duplicated services where appropriate – yield lower health care costs to payers and consumers? Will quality of acute care improve? And will the population get healthier, and do so at a rate that exceeds health improvements of the population as a whole?

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. Levine is confident, and said what he termed "active support" from the business community is a result of people's belief in the COPA process as a path to better, more affordable health care for the region.

"They've done their homework and they've seen the results from Mission. Mission's costs per adjusted admission are lower than all their peers, and Mission's nowhere near as regulated as we're proposing to be," Levine said. "And their charges per admission are lower than their peers. So if the antitrust regulations are designed to prevent pricing going up from beyond what it would have gone up if there was no merger, the case in point is right there."

Timeline-wise, Levine said the systems have not yet filed their letter of intent, but that it should come soon. A joint board task force and "integration council" both are completing due diligence toward a definitive agreement that will form the basis for the post-merger "health improvement organization."

Shine acknowledged that rapid changes in health care have created, "a new ballgame." He called the amended COPA law laudable for its "noble goals and aspirations."

The Department of Health, using its rules and the proposed cooperative agreement as a framework, will know at least theoretically whether this whole experiment is working, Shine said, based on its review of operational and cost data as well as health outcomes.

"What the document that is going to be filed with the Department does is set goals and aspirations, and mechanisms for accomplishing those specific goals," Shine said. "And then the Department says, 'we're going to check into, on a regular basis, whether you've done this.'

"The question becomes, 'can those noble goals and aspirations become a reality, and if so, who's responsible?' Well, first of all, the new merged entity is responsible. Who should bring to their attention the deficiencies? The public and the commissioner."

Much of what comes forth during the application process will be public record, and *The Business Journal* will endeavor to provide useful data online. A copy of the amended COPA law can be viewed at

bjournal.com/newcopalaw. The old version is at *bjournal.com/copalaw*. Information on the systems' merger endeavor, including upcoming public meeting dates, is at *becomingbettertogether.org*.