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To:	Levine, Marissa (VDH); OLC-Cooperative Agreement (VDH)
Cc:	Dafny, Leemore
Subject:	public comment regarding MSHA/Wellmont Cooperative Agreement Application
Date:	Friday, January 13, 2017 10:47:11 AM
Attachments:	Comment on Wellmont-MSHA Cooperative Agreement Application by Professors and Academic Economists.pdf

Dear Dr. Levine:

Attached please find a public comment from 46 professors and academic economists regarding the MSHA/Wellmont Cooperative Agreement Application. None of the signatories has a financial interest in the outcome of the application. We hope the comment provides valuable, unbiased context for your decision.

Please do not hesitate to contact me if I can answer any questions about this submission.

Sincerely,

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January 13, 2016

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Re: Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System

Dear Dr. Levine:

We, the undersigned, submit this comment in our capacity as professors and academic economists with expertise in the subjects of antitrust, competition policy, and health economics. The opinions that follow reflect our review of public documents related to the proposed Cooperative Agreement,[1] as well as our collective understanding of healthcare organizations and markets (underpinned by academic research, cited below).

We urge the Department of Health to reject the Cooperative Agreement Application submitted by Mountain States Health Alliance and Wellmont Health System ("Applicants"). The proposed merger would (by the admission of the Applicants) eliminate head-to-head competition between rival hospitals in Northeastern Tennessee and Southwest Virginia.[2] An extensive body of economic literature[3] finds that hospital mergers

[1] 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* "VA Cooperative Agreement Application" or "Application").

[2] Virginia Cooperative Agreement Application, p. 2 ("Without the State Agreements, the proposed consolidation of Wellmont and Mountain States would likely be challenged under state and federal antitrust laws."). *See also* Mountain State Health Alliance and Wellmont Health System Application for Certificate of Public Advantage, State of Tennessee, Feb. 16, 2016, available at http://tn.gov/assets/entities/health/attachments/COPA_application.pdf (hereinafter, "TN COPA Application"), p. 15. Comment from Wellmont & Mountain States to Tenn. Dep't of Health, p. 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").

[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. 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. Gautam Gowrisankaran, Aviv Nevo, and Robert Town, "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry," 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. Leemore Dafny, "Estimation and Identification of Merger Effects: An Application to Hospital Mergers," Journal of Law & Economics, August 2009, 52(3): 523-550. M. G. Vita and S. Sacher. "The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study," *The Journal of Industrial Economics*, 49: 2001, 63–84.

among close competitors lead to higher prices, on average, while evidence of cost savings and quality improvements is scant. The Federal Trade Commission (FTC), which has substantial expertise reviewing healthcare mergers and investigates only a small fraction of these,[4] is in the midst of an extensive review of this transaction.[5] Thus far, the FTC's staff has publicly stated the transaction raises "significant concerns."[6] For reasons described below, we believe many of the conditions and commitments in the Cooperative Agreement Application will do little to offset the harm likely to arise from the reduction in competition between the Applicants. The changing and complex nature of the healthcare marketplace also renders such commitments exceedingly difficult to monitor and enforce.

Furthermore, we are also concerned about the scope of the first Cooperative Agreement that would be overseen by the Authority.[7] Monitoring the post-merger conduct of such a large system spanning multiple geographic areas and states is a complex, resource-intensive endeavor. The Authority would effectively be regulating a privately-held, virtual monopoly in a context where performance is difficult to measure (as opposed to, say, electricity transmission). Moreover, if the Application were approved, it would be difficult to predict the performance levels that the competing systems might have achieved over time (absent the merger) – making it hard to update (let alone enforce) performance targets. If the Applicants fail to fulfill their commitments, unwinding the merger to restore the lost competition would be, per the FTC, "highly disruptive – if not virtually impossible."[8] We urge you to deny this Cooperative Agreement Application and to encourage the parties to pursue their stated goals by making strategic choices and alliances with more limited detrimental impacts on competition in local healthcare markets.

Below, we provide three distinct arguments underlying our views.

1. *The proposed Cooperative Agreement is insufficient to curb the exercise of market power that will arise from the merger.*

A key reason that antitrust enforcers favor structural remedies to address anticompetitive consolidation (e.g., divestitures) – or blocking anticompetitive combinations in the first place – rather than conduct remedies (e.g., a promise to keep prices low) is that regulators

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[4] Edith Ramirez, "Keynote Address of FTC Chairwoman Edith Ramirez," Antitrust in Healthcare Conference, Arlington, VA; May 12, 2016.

[5] "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", Sep. 30, 2016, *available at* https://www.ftc.gov/system/files/documents/public_statements/956893/160614mshawellmont.pdf. (*hereinafter* "FTC Comment in VA")

[6] Ibid.

[7] 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/.

[8] FTC Comment in VA.

can only guess at the "but for" counterfactual world that would obtain in the absence of the merger and attempt to design conduct requirements that seem likeliest to produce that world.[9] 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.[10] *These conditions do not characterize healthcare markets of today*.

The Applicants propose to commit to a schedule of price growth with private insurers linked to national hospital and medical consumer price indices.[11] They have also made commitments to publicly report various quality metrics and to share cost savings with consumers. We address the first two classes of commitments below, and the third (cost savings) later under point three.

First, the Applicants' proposal to link maximum price increases to national price indices will not impede their ability to exercise post-merger market power for at least four reasons: (a) the goods and services in question, as well as the contracting unit, are evolving; (b) there are ample opportunities to generate higher revenues even when prices are constant or falling; (c) there are no provisions to limit initial prices charged to new payers or entities seeking to self-insure; and (d) the provisions cannot address possible increases in quality or innovation in care delivery that might otherwise have occurred in more competitive markets.

Reasons (a) and (b) are deserving of additional explanation. As a whole, the American healthcare system is shifting away from a fee for service ("FFS") reimbursement structure toward reimbursement arrangements that place healthcare providers at risk for the total spending of enrollees. Although the Cooperative Agreement may limit the negotiated prices for services traditionally purchased on a FFS basis, the agreement does not protect prices for new or evolving units of services, such as "primary care for a patient month" or "uncomplicated back pain bundle." For example, if a system is unable to raise prices for individual lab tests, it could effectively do so by instead defining a "bundle" for all inpatient labs (likely refined by patient diagnosis, such as heart attack) and including a hefty markup on the average combined lab tab in the transition. Furthermore, even if price increases will be restricted, there are many ways for a healthcare system to increase revenues by changing the quantities and types of services it performs. For example, the newly-merged system may shift services from low-cost to high-cost sites of care, e.g. performing procedures in a

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[9] For a comprehensive discussion of the concerns surrounding conduct remedies, see 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.

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

[11] Southwest Virginia Health Authority, "A Review of the Commonwealth of Virginia Application for a Letter Authorizing a Cooperative Agreement Filed by Mountain States Health Alliance and Wellmont Health System," Dec. 22, 2016 at 117—151, *available at* https://swvahealthauthority.files.wordpress.com/2016/12/cooperative-agreement-report-december-22-2016.zip.

hospital-based operating room rather than a cheaper ambulatory surgery center, or decelerate the movement toward lower-priced care options.

Second, while the Applicants' commitments to public reporting of quality metrics is welcome, public reporting is possible even absent the merger. Moreover, in the absence of competition, public reporting of quality is less likely to motivate improvements. While quality reporting is laudable, this commitment does not offset the potential harms from reduced competition.

In sum, the applicants' confidence that the restrictions in the Cooperative Agreement would limit the exercise of the combined system's market power is unfounded.[12]

2. ***There is scant empirical evidence that horizontal or vertical integration among healthcare providers leads to cost savings. The Applicants propose to fund "hundreds of millions of dollars" in regional health investments "solely based on savings to be realized from merger efficiencies," calling into question whether these investments will be realized.***

The applicants state that their "monetary commitments are possible solely based on savings to be realized from merger efficiencies, and cannot be made without the merger."[13] Unfortunately, systematic evidence from hundreds of hospital mergers around the nation finds very limited evidence of cost savings, let alone of this magnitude.

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*.[14] The authors caution that most studies of post-merger cost trends suffer from "significant problems" with study methodologies. To date, only one study[15] has documented substantial post-merger savings, and only for a subset of mergers: "one-

[12] "Market power will not be gained as a result of the Cooperative Agreement. The New Health System will be actively supervised by Virginia and Tennessee officials. This supervision will ensure that the New Health System will act in furtherance of the public policies that underlie Virginia's Cooperative Agreement statutory and regulatory provisions and Tennessee's Certificate of Public Advantage." *See* Virginia Cooperative Agreement Application, at 64.

[13] Mountain States Health Alliance and Wellmont Health System, Response by Applicants to FTC Staff Submission on September 30, 2016 and Supporting Memorandum to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application (Oct. 14, 2016), at 33. See also Id.

[14] 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. Gaynor and Vogt's 2006 survey and Gaynor and Town's 2012 update (citation follows) also find that consolidation generally leads to significantly higher prices, and to lower, rather than higher, quality of care. 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.

[15] David Dranove and Richard Lindrooth, "Hospital Consolidation and Costs: Another Look at the Evidence," *Journal of Health Economics*, 2003, 22(6): 983-997.

to-one" mergers among independent hospitals who surrender one of their facility licenses and combine operations.

The transaction in question would also combine services across distinct service lines, as both systems own various provider practices and outpatient facilities in addition to their 20 hospitals. Although we are hopeful that such affiliations among various healthcare providers can generate savings and quality improvements, to date there is limited evidence that combining physicians, outpatient services, 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 "[r]esearch on the effect of integration on physician productivity and hospital profitability has produced *mixed results*."[16] In addition, a number of studies completed in the years following the Burns et al. review find that prices as well as total spending for physician services *increase* when hospitals acquire physician practices.[17]

The recent performance of Accountable Care Organizations (ACOs), alliances formed to bear risk for medical spending of Medicare enrollees, provides another data point with regard to the ability of provider organizations to reduce healthcare spending and maintain and improve quality. The Centers for Medicare and Medicaid Services (CMS) reported in 2014 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.[18] More recently, a study in the New England Journal of Medicine found that savings generated under ACO models were small at best, and that savings were consistently greater in independent primary care groups than in vertically-integrated hospital-provider groups.[19]

Thus, the empirical evidence to date does not suggest that health system integration tends to lower costs. This leads us to conclude the public health investments proposed by the applicants are unlikely to occur, or will need to be funded by higher system revenues (i.e., higher area spending on healthcare services) or funds that would be present even absent the merger.

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[16] 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.

[17] 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. Hannah T. Neprash, BA, Michael E. Chernew, PhD, Andrew L. Hicks, MS, et al., "Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices," *JAMA Intern Med*. 2015;175(12):1932-1939. Cory Capps, David Dranove, and Christopher Ody, "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending," Northwestern University Institute for Policy Research Working Paper WP-15-02.

[18] 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. *See* http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2014-Press-releases-items/2014-01-30.html.

[19] J. Michael McWilliams, M.D., Ph.D., Laura A. Hatfield, Ph.D., Michael E. Chernew, Ph.D., Bruce E. Landon, M.D., M.B.A., and Aaron L. Schwartz, Ph.D., "Early Performance of Accountable Care Organizations in Medicare," *New England Journal of Medicine*, 374:2357-2366, 2016, *available at* http://www.nejm.org/doi/full/10.1056/NEJMsa1600142.

3. The commitments offered by the applicants will be costly and difficult to enforce.

The Authority is undoubtedly aware of the extensive resources that will be necessary to supervise the newly-formed system and to ensure it is held accountable for its commitments. These costs should be counted against any projected benefits of the transaction.

We are also concerned about the enforceability of the Applicants' commitments. These concerns have both conceptual and practical bases. As an example of the former, consider the Applicants' promises to fund community investments through cost reductions. Assessing whether post-merger cost reductions are in fact being used for this purpose requires well-accepted, relevant, and comprehensive measures of cost. However, such measures do not exist. An ideal metric might be "quality-adjusted cost of care per risk-adjusted life-year," but there are no standard methods for calculating such a measure. This measure may also be "gameable" because it depends heavily on diagnoses reported and care provided by the regulated entity. It is difficult to commit to passing through cost savings – or to investing the savings in community health initiatives and the like – if one cannot confidently measure those savings. In sum, promises to return merger efficiencies to the community are unenforceable.

A recent case in Massachusetts underscores the practical challenges associated with attempts to enforce commitments similar to those included in the Cooperative Agreement before the Authority. Massachusetts Superior Court Judge Janet Sanders rejected a proposed settlement between a dominant provider system in Eastern Massachusetts and the Massachusetts Attorney General, finding that the agreement, which included price growth caps and "other so-called 'conduct-based' remedies," did not "reasonably or adequately address the harm that is almost certain to occur as a consequence of the anticompetitive conduct."[20] Judge Sanders expressed "serious concerns as to the enforceability" of the agreement, concluding that where "there are substantial questions regarding enforcement, this alone is sufficient to reject it."[21]

Under the terms of the proposed agreement in Massachusetts, an independent "Compliance Monitor" funded by the merging parties was to be largely responsible for enforcing the terms of the agreement. The Compliance Monitor was granted significant powers and resources, including access to the new system's financial accounts and healthcare data and the ability to retain experts to assist in its monitoring and evaluation of the parties'

[20] Memorandum of Decision and Order on Joint Motion for Entry of Amended Final Judgement by Consent, In re: Commonwealth vs. Partners Healthcare System, Inc., Massachusetts Superior Court, Suffolk, Jan. 29, 2015, *available at* http://www.mass.gov/ago/docs/press/2015/partners-memo-of-decision-and-order.pdf.

[21] Ibid.

compliance with the agreement.[22] And yet, Judge Sanders questioned the enforceability of the agreement because "there is reason to doubt that this Court has the technical competence or resources required to *resolve the disputes that are certain to arise*."[23] Disputes between the Applicants and the Authority would presumably present judges in Virginia with the same conundrum.

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In closing, we emphasize that there is no longer any meaningful debate in the academic community about whether competition among hospitals and other healthcare service providers is beneficial to consumers. Decades of empirical evidence on hospital and health system mergers cast serious doubt on the Applicants' assertions that the proposed combination would yield substantial efficiencies, let alone of the magnitude necessary to fund the proposed investments. In sum, the commitments offered by the Applicants with regard to price growth caps, cost savings, and quality should be heavily discounted when weighing the costs and benefits of the proposed Cooperative Agreement. Moreover, these commitments are costly and difficult – if not impossible – to enforce.

We urge you to deny this application and to encourage the parties to pursue their stated goals by making strategic choices and alliances with more limited detrimental impacts on competition in local healthcare markets.

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[22] The text of the proposed consent judgment is available at http://www.mass.gov/ago/docs/press/2014/partners-settlement-062414.pdf.
[23] Ibid, emphasis added.

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