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

TO THE VIRGINIA DEPARTMENT OF HEALTH

ON THE

REVIEW OF THE APPLICATION FOR A COOPERATIVE AGREEMENT FROM WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE

July 17, 2017

Anthem Health Plans of Virginia Inc. (trades as Anthem Blue Cross and Blue Shield in Virginia) ("Anthem") submits these comments to the Virginia Department of Health (the "Department" or the "Commissioner") in response to the Department's decision to deem Wellmont Health System ("Wellmont") and Mountain States Health Alliance's ("MSHA's") (the "Parties'") Letter Authorizing a Cooperative Agreement Application complete. Anthem previously submitted Comments to the Department on the Review of the Cooperative Agreement Application on September 30, 2016 and made a supplemental submission on October 26, 2016.[1] These Comments supplement those submissions.

With this submission, Anthem is also commenting on some of the newly submitted information in both Tennessee and Virginia, including the recently filed expert reports by The Advisory Board, Health Communities Institute ("HCI"), and Compass Lexecon, and the supplemental information submitted in response to requests from the Department.[2]

As Anthem has commented before, the proposed Cooperative Agreement will result in a monopoly hospital system in southwest Virginia and northeast Tennessee, and the oversight proposed by the Cooperative Agreement Application will be inadequate to ensure low prices and high quality health care in that region. Southwest Virginia and northeast Tennessee have unique health care challenges and Anthem strongly supports solutions that will improve the quality of health care and keep costs low for consumers. The challenges these areas face, however, do not require state regulation of a monopoly health system. Virginia's Cooperative Agreement statute allows for this only when there is a "*preponderance of the evidence*" that the proposed benefits of the Cooperative Agreement outweigh the potential disadvantages.[3]

In December, the Commissioner of Health requested additional information from the Parties, stating that such additional information is "necessary to her assessment of whether 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."[4] On January 9, 2017 and April 2017, the Department submitted a supplemental data request as well, seeking historical, baseline and projected data points for a variety of performance and cost indicators.[5] The Tennessee Department of Health also requested additional information from the Parties stating that it "must see a clear, detailed plan to move a potentially combined system forward that demonstrates that the proposed merger is likely to provide a long-term sustained benefit to the public beyond the traditional fee-for-service acute care hospital model. . . Stated

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[1] Hereinafter referred to as "Anthem Virginia Application Comments."

[2] *See* Master Responses to Supplemental Data Request Submitted January 9, 2017 by Virginia Department of Health In Connection with Application for Letter Authorizing Cooperative Agreement by Mountain States Health Alliance and Wellmont Health System, *available at* http://www.vdh.virginia.gov/licensure-and-certification/cooperative-agreement/additionalsupplemental-information-requests/ [hereinafter "The Parties Virginia Supplemental Responses."]

[3] VA Code Ann. §15.2-5384.1E and F.

[4] Letter from Erik Bodin, Director of the Department of Health Office of Licensure and Certification to Alan Levine and Bart Hove on December 22, 2016 at 2, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/Questions_Request-for-Additional-Information.Cooperative-Agreement.Wellmont_Mtn-States-3.pdf.

[5] Letter from Erik Bodin, Director of the Virginia Department of Health Office of Licensure and Certification to Alan Levine and Bart Hove on January 9, 2017, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2017/04/Dec-30-2016-Supplemental-Data-Request.pdf.

differently, the Department must see detailed information in regard to how the investments will be realized outside of the mere commitment to dedicate funding to specific programs."[6]

In response to these requests the Parties submitted three expert reports and additional data and responses in Virginia. Both states have requested extensive information and data from the Parties during this review period and recognize that, in the words of the Tennessee Department of Health, "mere mitigation of existing disadvantages does not result in cognizable benefits or advantages" and "would unlikely rise even to a preponderance of evidence standard."[7] Anthem's position remains that even with these additional submissions, there is not sufficient evidence supporting a decision to grant a letter authorizing a Cooperative Agreement.

Anthem's comments are divided into three sections. First, Anthem outlines the key reasons why the Cooperative Agreement application should be denied. Although Anthem has made many of these points in previous submissions, it bears repeating given that the application has now been deemed complete and the Department must now make this critical decision. Second, Anthem comments more specifically on the "expert reports." Finally Anthem submits a few additional comments on supplemental information submitted by the Parties in Virginia.

Key Reasons Why Virginia and Tennessee Should Deny the Cooperative Agreement Application

- The proposed Cooperative Agreement will result in a monopoly hospital system in southwest Virginia and northeast Tennessee and even the oversight proposed by this Cooperative Agreement Application will be inadequate to ensure low prices and high quality health care. Irrespective of how sophisticated or detailed the state oversight may be, it will be insufficient to anticipate all potential anticompetitive effects from the proposed merger to monopoly. For example, as one recent news article reported in Virginia in the context of the attempt to reopen Lee County Hospital, if the Lee County Hospital Authority loses its certificate, "getting a new one issued might prove impossible since Wellmont and its regional competitor, Mountain States Health Alliance, are seeking to merge. If regulators approve, the combined entity would have a legal monopoly in the region and *could block future competition*"[8] (emphasis added). With a state sanctioned monopoly health care provider in the region it would be extremely unlikely that a new entrant would want to come into the region to try to operate this failing hospital. Overall, competition among healthcare providers fosters consumer benefits in the form of lower costs and higher quality care. This region will lose that if this application is granted.

- There continue to be few to no meaningful commitments to protect the Virginia Medicaid program, including Medicaid Managed Care. The additional information and responses by the Parties continue to neglect this essential issue and provide insufficient

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[6] *Id.*

[7] Letter from John J. Dreyzehner, Commissioner State of Tennessee Department of Health to Robert E. Cooper Jr. and Claire Cowart Haltom on November 22, 2016, *available at* https://www.tn.gov/assets/entities/health/attachments/TDH_Meeting_Follow_up_11.22.16.pdf [hereinafter "TN DOH November Letter").

[8] Luanne Rife, *Concern raised about Lee County's partner in plan to reopen hospital,* THE ROANOKE TIMES, June 21, 2017, *available at* http://www.roanoke.com/business/news/concern-raised-about-lee-county-s-partner-in-plan-to/article_82c204ee-0731-5789-bbe1-002d836c42cd.html.

representations about the merger's substantial impact on the Virginia Medicaid Program. For example, both in Virginia and Tennessee, contracts with Medicaid Managed Care Organizations are competitively negotiated -- despite the Parties' continued statements that such rates are established by formula.[9] Tennessee has a fully Medicaid Managed Care Program under TennCare and Virginia is evolving toward a similar system. Absent significant commitments by the Parties, there is no way to avoid a potentially anticompetitive impact to the Medicaid program. The Department should ensure that the Parties make strong commitments to the Medicaid Managed Care Organizations related to contracting; reimbursement; and ensuring the Cooperative Agreement will not negatively impact network adequacy requirements (geoaccess; time/distance) for Virginia Medicaid beneficiaries. While adding Medicaid Managed Care Organizations to the definition of "Principal Payer" under the Commitments is important, the Parties should go beyond this. Anthem refers the Department to previous submissions for further details on this position.

- The rate caps still do not clearly apply to value-based or risk-based contracts. The newly filed expert reports are focused largely on the likelihood that the Parties will be able to migrate toward population health management and risk-based arrangements, yet the Parties still fail to modify the rate cap provisions to appropriately apply to these forms of contracting. If one of the purported benefits from the Cooperative Agreement is to ensure the Parties will be able to do population health management and value-based arrangements, the Parties should provide detailed information on how the rate caps will work with those forms of payment models to ensure that the Parties are not able to avoid the rate caps through the use of these newer forms of payment models. In addition, Anthem also notes that a significant portion of the population in this region is uninsured and therefore will not be covered by value-based contracts. As such, the Department should consider the extent of the potential benefit within the confines of this important limitation.

- The definition of "Principal Payer" continues, as the FTC noted in its most recent set of comments, to "unjustifiably" exclude a significant number of payers (approximately 200).[10] The Parties purported explanation for why these other payers should not be covered by the rate caps and other provisions is insufficient.

- The Parties continue to fail to provide adequate analysis of alternative arrangements, whether through collaborations with each other short of a merger, joint ventures or affiliations, or mergers with other hospitals. In the Tennessee Department of Health November 22 letter, Commissioner Dreyzehner stated that "based on confidential information provided in supplemental application materials provided by your clients, the sale by one of your clients to a for-profit entity would have resulted in the establishment of a foundation of at least comparable size to the funds proposed in the application for community benefits. . . . Thus the Department believes the amount and timing of funding

[9] *See* The Parties' Virginia Supplemental Responses at Response 3, Exhibit XVI-5 Potential Disadvantages at 1, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2017/04/Response-3.pdf.

[10] Federal Trade Commission Staff Supplemental Submission to the Virginia Department of Health Regarding the Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System, January 13, 2017, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/FTC-Staff-Supplemental-Submission-to-Virginia-1-13-17.pdf.

proposed by your clients should not be considered as a basis for an advantage that would accrue to the region as a result of a Cooperative Agreement -facilitated merger." Importantly, much of the Advisory Board and HCI's reports focus on existing capabilities of the Parties, addressing whether they are ready to make the shift to an integrated delivery system. HCI even notes a few times that certain benefits, such as the Accountable Care Community, could be achieved absent a merger.[11]

- Even if Virginia concluded that the Cooperative Agreement's benefits outweighed the disadvantages by a preponderance of the evidence (which we believe it does not), the sheer oversight required to "actively supervise" the Cooperative Agreement to maintain the antitrust exemption is too great a burden for the Department to bear. In order to maintain the antitrust exemption, the Virginia Department of Health will have to continually "actively supervise" the Cooperative Agreement. Anthem previously outlined this rigorous process in its initial set of comments submitted to the Virginia Regulatory Advisory Panel.[12] This "active supervision" will require significant time, staff and budget, and statutorily the Parties can only reimburse the Commissioner up to $75,000 a year for supervision of an approved Cooperative Agreement, a small sum in comparison to what it will actually cost to "actively supervise."[13] For example, in Exhibit XVI-5 outlining the potential disadvantages of the Cooperative Agreement, the Parties state that the commitment to engage in "commercially reasonable" negotiations with health plans will help ensure it will not use its new found monopoly power going forward. [14] This commitment only has teeth, however when the "judgment itself is subject to the Commonwealth's active supervision,"[15] meaning that the Commonwealth will have to involve itself in contract disputes between Ballad Health (the Parties' merged integrated delivery system) and health insurers. The Commonwealth should not have to engage in this type of detailed oversight.

Specific Comments on the "Expert Reports"

On April 7, 2017, the Parties submitted three reports in support of the Cooperative Agreement Application from the following: (1) The Advisory Board; (2) Health Communities Institute ("HCI"); and (3) Compass Lexecon.[16]

The Advisory Board and HCI were asked generally to evaluate the likelihood that Ballad Health would be able to successfully transition to population health management. Although both reports concluded that the Parties would be successful in transitioning to population health management, they add little to substantiating a "clear, detailed plan to move a potentially combined system forward that demonstrates that the proposed merger is likely to provide a long-

[11] Health Communities Institute, *Ballad Health Population Health Improvement Plan*, *Capacity and Preparedness Assessment and Recommendations*, 2017, at 19.

[12] Submission of Anthem Blue Cross Blue Shield of Virginia to the Regulatory Advisory Panel, July 23, 2015.

[13] VA Code § 15.2-5381.1(J).

[14] *See* The Parties' Supplemental Virginia Responses, Response 3, Exhibit XVI-5 Potential Disadvantages at 3, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2017/04/Response-3.pdf.

[15] *Id.*

[16] The reports claim they are from "independent experts" but, based on Anthem's understanding, they were paid for and reviewed by the Parties before submission, and it is unclear why these reports should not be viewed as anything other than advocacy pieces financed by the applicants.

term sustained benefit to the public beyond the traditional fee-for-service acute care hospital model,"[17] as requested by the Tennessee Department of Health.

As discussed above, the expert reports detail a number of existing, independent capabilities of the Parties. Only those benefits that will occur as a direct result of the merger should be considered by the Department. For example, HCI finds that the Parties could form an Accountable Care Community absent a merger.[18] Notably, the Parties themselves stated to the contrary, claiming that the Accountable Care Community is a merger-specific efficiency.[19] Given that the Parties' own expert concluded otherwise, the formation of an Accountable Care Community should not be weighed as a benefit. Although the reports conclude that the Parties will be able to transition to larger scale population health management work, there is little support for the finding that such a transition could only happen with the proposed merger to monopoly.

Finally, both the HCI and the Advisory Board reports provide further discussion and elaboration on the Parties' commitment to form a clinically integrated network ("CIN") with other independent providers. While commitments to ensure that a substantial number of independent providers will remain in the community and have the opportunity to work collaboratively with the Parties is important, the Parties neglect any discussion of whether the CIN will allow the Parties to jointly contract for all independent providers that participate in the CIN. To the extent that the Parties do intend that the CIN will engage in joint contracting with health plans, it will be as if the independent providers were acquired by the Parties for purposes of analyzing the potential competitive effects. The Parties should be required to state their intention before the Application is granted so that the Department can properly assess the potential competitive effects and decide if any further commitments are needed to ensure proper oversight.

Compass Lexecon was asked to assess (1) whether the likely benefits of the proposed merger outweigh any disadvantages of displacing competition; and (2) whether Ballad Health would be better able to accomplish risk-based contracting and transition to new payment models than the Parties could independently. With respect to the first point, the Compass Lexecon report provides merely a cursory review of the potential competitive harm associated with the merger, even after working on this matter for two years. Notably absent from its report is any sort of traditional competitive effects merger analysis, which is the form of analysis necessary to weigh the likely benefits of the proposed merger against any potential disadvantages of displacing competition. As the FTC stated in its Jan. 13 Comment, "[b]y encouraging VDH to ignore FTC staff's and other commenters' discussion of the market structure, diversion statistics and predicted price increases, the parties are refusing to engage in half of the analysis Virginia law requires."[20] Compass Lexecon is fully capable of engaging in a traditional merger effects

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[17] *Supra* note 7.

[18] Health Communities Institute, *Ballad Health Population Health Improvement Plan*, *Capacity and Preparedness Assessment and Recommendations*, 2017, at 19.

[19] *See* The Parties' Supplemental Virginia Responses, Joint Exhibit-35A *at 17, available at http://www.vdh.virginia.gov/content/uploads/sites/96/2017/04/Responses-1-through-5.pdf (listing the Accountable Care Community as a merger specific benefit).*

[20] Federal Trade Commission Staff Supplemental Submission to the Virginia Department of Health Regarding the Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System, January 13, 2017, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/FTC-Staff-Supplemental-Submission-to-Virginia-1-13-17.pdf.

analysis as it is commonly retained to do so, but neglected to do so here, likely because the outcome would show that the potential disadvantages would outweigh the advantages.

Compass Lexecon, is owned by FTI, and despite this core conflict of interest, was asked to critique FTI's efficiencies analysis. Since only a summary of the FTI reports' findings has been made publicly available in the Parties' application, Anthem cannot evaluate the legitimacy of the projected efficiencies. We again urge the Department to review that closely and validate the report before giving any weight to those purported efficiencies since they are the source of all of the community investments proposed by the Parties.

While the reports do provide some additional information and analysis of the proposed integrated delivery system, Anthem believes these reports do not provide the necessary evidence to support a decision to grant the Cooperative Agreement application.

Specific Comments on Supplemental Information Submitted in Virginia

Anthem also would like to submit a few additional specific comments on supplemental information submitted in Virginia in response to requests from the Department. In December 2016 and January and April of 2017, the Department issued supplemental information and data requests to the Parties and a notification of an incomplete response to the applicants for previously submitted responses.[21] Overall, while the additional information submitted helps to cure some of the incomplete information previously submitted, many of the responses repeat information already provided or continue to be marked proprietary and therefore unavailable publicly. For example, of the 39 supplemental data requests requested in January, 15 have been marked proprietary by the Parties. Many of the responses to the supplemental information request are also marked confidential or proprietary. At the outset, Anthem notes that it is unable to comment fully on these supplemental submissions as it does not have access to all of the important data requested. Anthem urges the Department to closely evaluate those proprietary submissions, both to determine if they should be marked proprietary (and, if not, to release them) and to properly evaluate the application.

With respect to the information Anthem has reviewed, Anthem has two additional comments. First as noted above, certain information in Exhibit Joint-35A regarding the merger specificity of certain benefits is inconsistent with the expert report findings of the Parties' independent capabilities. The Department should closely evaluate and review which benefits truly result from this Cooperative Agreement.

Second, much of the detailed information about future plans remains unknown. For example, the IT assessment remains ongoing and the Parties refuse to provide a detailed timeline and cost estimate until at least 6 months *after* the merger when the assessment concludes.[22] The Parties propose that they will finalize the Ten Year Community Health Improvement Plan only during the first year after closing.[23] And with respect to the CIN, the

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[21] *See* http://www.vdh.virginia.gov/licensure-and-certification/cooperative-agreement/additionalsupplemental-information-requests/.

[22] The Parties' Virginia Supplemental Response at Exhibit-Joint 36C at 5. *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2017/04/Responses-1-through-5.pdf.

[23] The Parties' Virginia Supplemental Response at Exhibit-Joint 35A at 14, *available at* http://www.vdh.virginia.gov/content/uploads/sites/96/2017/04/Responses-1-through-5.pdf.

Parties state that 3-6 months after closing, the Parties will "determine feasibility for formation of a regional clinically integrated network."[24] As discussed above, the formation and functioning of a CIN is critical to the competitive effects analysis and should be determined prior to the granting of any application.

Overall, the Parties continue to state that "WHS and MSHA have attempted to provide as much detail as possible about future plans, but antitrust constraints have limited the extent to which the Parties have been able to discuss and develop specific plans." [25] As Anthem has raised on numerous occasions, the antitrust laws are not so strict as to prevent much of the integration planning the Parties claim is prohibited if properly undertaken. We urge the Department to continue to push back on this.

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Anthem thanks the Department for the continued opportunity to submit comments on this critically important issue for southwest Virginia and northeast Tennessee.

[24] *Id.* at 13.
[25] *Id.* at 41.