From:	Berry Winter, Lindsay
To:	Levine, Marissa (VDH)
Cc:	Bodin, Erik (VDH); Sarah Oxenham Allen (SOAllen@oag.state.va.us); Ricketts, Jeff (VA)
Subject:	SUPPLEMENTAL SUBMISSION OF ANTHEM TO THE COMMISSIONER OF HEALTH ON THE REVIEW OF THE COMMONWEALTH OF VIRGINIA APPLICATION FOR A LETTER AUTHORIZING A COOPERATIVE AGREEMENT FROM WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE
Date:	Thursday, October 12, 2017 11:53:22 AM
Attachments:	Final VA Cooperative Agreement Enforcement Submission.pdf

SUBMITTED ELECTRONICALLY VIA MARISSA.LEVINE@VDH.VIRGINIA.GOV

RE: SUPPLEMENTAL SUBMISSION OF ANTHEM HEALTH PLANS OF VIRGINIA, INC. (TRADES AS ANTHEM BLUE CROSS AND BLUE SHIELD IN VIRGINIA) TO THE COMMISSIONER OF HEALTH ON THE REVIEW OF THE COMMONWEALTH OF VIRGINIA APPLICATION FOR A LETTER AUTHORIZING A COOPERATIVE AGREEMENT FROM WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE

Dear Commissioner Levine:

Anthem submits these comments to the Virginia Department of Health in response to the Tennessee Department of Health's decision to grant a Certificate Of Public Advantage ("COPA") to Wellmont Health System and Mountain States Health Alliance and the Southwest Virginia Health Authority's September 22, 2017 Revised New Health System Virginia Commitments. These comments supplement those that Anthem previously submitted, including those submitted in September and October 2016 and most recently in September 2017.

Anthem strongly urges the Department to deny the Parties' Application for a Cooperative Agreement in Virginia. As Anthem has reiterated in past submissions, the proposed Cooperative Agreement will not protect Virginia citizens from the significant anticompetitive harm that will result should the Parties' merge. This is not changed by the Tennessee decision to grant a COPA. Indeed, the terms of the Tennessee COPA illustrate how the process for considering and changing the commitments is only the tip of the iceberg in terms of dedication of resources that are required for active supervision under state action, and provide further support for the Department to deny the application.

Thank you for the opportunity to provide additional comments.

Sincerely, Lindsay

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

TO THE COMMISSIONER OF HEALTH

ON THE REVIEW OF THE COMMONWEALTH OF VIRGINIA APPLICATION FOR A LETTER AUTHORIZING A COOPERATIVE AGREEMENT FROM WELLMONT HEALTH SYSTEM AND MOUNTAIN STATES HEALTH ALLIANCE

October 12, 2017

I. Introduction

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 Tennessee Department of Health's decision to grant a Certificate Of Public Advantage ("COPA") to Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("MSHA") (the "Parties" or "the New Health System") and the Southwest Virginia Health Authority's ("SWVA Health Authority's") September 22, 2017 Revised New Health System Virginia Commitments ("Revised Commitments"). These comments supplement those that Anthem previously submitted, including those submitted in September and October 2016 and most recently in September 2017.

Anthem strongly urges the Department to deny the Parties' Application for a Cooperative Agreement in Virginia. As Anthem has reiterated in past submissions, the proposed Cooperative Agreement will not protect Virginia citizens from the significant anticompetitive harm that will result should the Parties' merge.[1/] This is not changed by the Tennessee decision to grant a COPA. Indeed, the terms of the Tennessee COPA illustrate how the process for considering and changing the commitments is only the tip of the iceberg in terms of dedication of resources that are required for active supervision under state action, and provide further support for the Department to deny the application.

- **A Cooperative Agreement cannot fully protect health care consumers from the anticompetitive harm that will result from a proposed merger to monopoly.** Even if fully implemented, the commitments that the Parties pledge to fulfill will not replicate the benefits of a competitive market.

- **It is unlikely that the Parties will fully meet their commitments, which anticipate achieving unrealistic efficiencies, only if achieved, that will enable them to fund hundreds of millions of dollars in various undertakings.**

- **Importantly, the Revised Commitments in Virginia as currently drafted do not assure adequate supervision by the State.** If a Cooperative Agreement in Virginia is approved, it is essential that there be active and ongoing supervision of the arrangement to assess the extent to which the Parties' numerous commitments are being met, determine whether and how such commitments should be modified in light of changing circumstances, and apply a

1/ Anthem points the Department to recent developments with Mission Health in North Carolina as evidence of the potential adverse long term effects of a COPA. Only months after the Mission Health COPA was dissolved (a COPA the Parties themselves repeatedly have referenced as a model), the health system announced, it will go out of network with the largest payer in North Carolina as of October. *See Mission Health System Cancels Contract with Blue Cross NC; Withdraws from Network Effective October 5*, BLUECROSS BLUESHIELD OF NORTH CAROLINA (July 5, 2017), http://mediacenter.bcbsnc.com/news/mission-health-system-cancels-contract-with-blue-cross-nc-withdraws-from-network-effective-october-5. It did this to seek higher rates, seeking to leverage its status as a dominant provider system as a result of merging pursuant to a COPA. Should Virginia dissolve the Cooperative Agreement and the Parties act in a similar manner, residents of southwest Virginia similarly may face hospital systems that have increased their market leverage during the years they were under the Cooperative Agreement.

series of remedies, up to and including termination of the Cooperative Agreement, if the Parties fail to meet their commitments.

- This is necessary to assure – to the extent possible – that the potential advantages promised by the Parties are realized, and the potential disadvantages due to the loss in competition are reduced.

- Moreover, under the law, the Parties are not entitled to the antitrust immunity they seek unless their conduct is subject to active and ongoing supervision by the State.

- The Tennessee Terms of Certification ("TN TOC") go far beyond the oversight regime that has been outlined so far in Virginia. While it is uncertain whether the Tennessee oversight is sufficient, it should at least establish a "floor" for the type of oversight that should be exercised in Virginia.

- If Virginia's oversight is less than that exercised in Tennessee, it would raise questions regarding the sufficiency of the Virginia government supervision.

- In addition, subjecting the Parties' to inconsistent supervision requirements will be inefficient for the Parties, and confusing to the public.

- **Establishing a level of oversight in Virginia consistent with that in Tennessee would require substantial financial resources and expertise that the Commissioner lacks and which would be hard to obtain.**

  - The ongoing supervision could cost millions of dollars annually.

  - The oversight must be done by the State – delegating it to an entity with numerous market participants such as the Southwest Virginia Health Authority – would not meet the requirements for state action immunity under recent Supreme Court precedent.

  - By statute, Virginia cannot seek more than $75,000 from the Parties to defray the cost of monitoring the Cooperative Agreement. This limitation does not apply in Tennessee, which has placed much of the cost of monitoring compliance on the Parties.

- Whatever oversight is established must be transparent to the public. It is critical that the Cooperative Agreement process and oversight remain transparent to the public. The Tennessee TOC fails to adequately ensure ongoing transparency by not requiring that all of the various reports be made publicly available. Virginia should ensure all reporting and monitoring is open to the public.

The following comments explain in greater detail why the Revised Commitments are inadequate and highlight differences between the requirements in Tennessee and what is currently contained in the Virginia commitments.

II. It is essential that if a Cooperative Agreement is granted, there be active and ongoing supervision.

Anthem maintains its position that the Cooperative Agreement should not be granted. One of the principal reasons for our position is that the required active supervision is too burdensome for the Department to handle both for monetary and resource reasons (discussed later in the comments). Any active oversight program **must cover a broad range of measures, be dynamic so as to allow for changes over time, provide for adequate infrastructure and mechanisms to provide meaningful oversight, and be adequately funded.** The Revised Commitments in Virginia do not meet these requirements, and Anthem questions whether they can be changed – and receive the requisite resources – to be adequate.

Active and ongoing supervision is required to assure that the benefits of the Cooperative Agreement outweigh the disadvantages (a decision that must be made annually) and that the state action exemption continues to apply to the New Health System. While the active supervision established in the TN TOC is not flawless (as discussed in more detail in Anthem's most recent submission in September 2017), it provides for a much more extensive regulatory regime, particularly with respect to enforcement, than what is currently contemplated in Virginia. The following sections address in greater detail how the Tennessee oversight system is different and what should be implemented in Virginia, at a minimum, if the Department were to grant a Cooperative Agreement.

III. The Revised Commitments do not assure adequate compliance and supervision.

The Revised Commitments are inadequate to ensure compliance and adequate supervision over the proposed Cooperative Agreement. While the Tennessee proposed regulatory regime has deficiencies, it should be at least a floor for Virginia's oversight program. The Tennessee COPA oversight provisions are described in its TN TOC, which takes the form of a contract between the Parties and the State. Anthem recognizes that the Department may be contemplating that if the Cooperative Agreement is approved, it would include a set of conditions that would go beyond what is currently in the Revised Commitments. However, since such conditions have not been publicly proposed yet, Anthem must comment on what has been made publicly available at this time – namely the Revised Commitments and any other requirements established by Virginia statute and regulations.

Anthem notes at the outset that it has serious concerns about the SWVA Health Authority having been delegated too much responsibility in the Cooperative Agreement review process. While the SWVA Health Authority is tasked with making the initial recommendation on the Cooperative Agreement Application, it does not have ultimate decision-making authority, nor can it for state action immunity to apply. [2/] An entity that consists of a majority of active market participants is not a state entity and therefore itself cannot be responsible for the active supervision component of the state action doctrine. [3/] Because the SWVA Health Authority consists of representatives of hospitals (including the Parties' hospitals), medical schools, health providers in southwest Virginia, and the area that will be impacted by a Cooperative Agreement should one be granted, it is critical that the Commissioner thoroughly evaluate the proposed Cooperative Agreement and make an independent

2/ *See* VA Code § 15.2-5384.1D (2015).
3/ *North Carolina State Bd. of Dental Examiners v. Fed. Trade Comm;n*, 135 S. Ct. 1101, 1114-17 (2015).

decision as to whether it should be approved, and if so, under what conditions, and oversee the active supervision.

Should the Department decide to grant the proposed Cooperative Agreement, it must provide for at least as comprehensive of a set of oversight conditions as imposed in Tennessee, either in the form of a contract, terms or certification, or some other type of conditions. If the Virginia requirements fall short of those in Tennessee, it will raise several critical questions including:

- How is Virginia assuring that the benefits of the Cooperative Agreement outweigh the disadvantages when it is providing far less oversight and requiring far fewer and less detailed commitments than in Tennessee? The Parties should be subject to comparable levels of oversight in each state, otherwise persuasive arguments could be made that Virginia is not actively supervising the Cooperative Agreement.

- Is oversight in Virginia sufficient to assure state action immunity when it is so much less than in Tennessee?

- How can the New Health System and both states coordinate efficiently on the Cooperative Agreements if they have inconsistent oversight mechanisms?

Given these serious issues that would arise should the oversight in Virginia be less than exists in Tennessee, Anthem outlines below areas where it views the proposed Cooperative Agreement oversight process in Virginia as inadequate and falling short of what is required in Tennessee.

1. Oversight Mechanisms

The TN TOC provides for multiple oversight entities and mechanisms as part of the active supervision of the COPA. These include the following:

- COPA Compliance Officer;
- COPA Monitor;
- Audit System; [4/]
- Onsite Inspections;[5/] and
- Advisory Council.

These entities are discussed in further detail below. However, generally by creating a variety of different oversight mechanisms, Tennessee is seeking to ensure that oversight of the Cooperative Agreement is not left to one entity or one mechanism, but rather, handled by different entities with varying responsibilities, ultimately overseen by the Department of Health. Importantly, the COPA

4/ The audit system has not yet been developed but must be within two (2) months of issuance of the Cooperative Agreement. TN TOC 6.03(b)(i). The TN TOC also requires the New Health System to "authorize any other audits that are deemed reasonably necessary by the Commissioner, the Attorney General, or the COPA Monitor." TN TOC 6.03(b)(ii).

5/ TN TOC permits onsite inspections to assess compliance. TN TOC 4.02(a)(ii)(B). Virginia also permits the Commissioner to conduct onsite inspections to ensure compliance. VA Code §15.2-5384.1(G); *see also* VA. R. & REGS. GOVERNING COOPERATIVE AGREEMENTS, 12VAC5-221-100(D) (2017). The Parties also must make available to the Department any requested records and shall allow access to interview employees, agents, etc. 12VAC5-100-221(E).

Monitor – the entity charged with evaluating the New Health System's performance under the Index, various reports and the continuing public benefit – is retained by, and reports directly to, the Tennessee Department of Health.

The Virginia statute allows the Commissioner to establish mechanisms of compliance and monitoring [6/] but to date the only entity proposed is the Joint Task Force. The Joint Task Force will be comprised of two New Health System members and two SWVA Health Authority members and is in charge of "guid[ing] the collaboration between the Authority and the New Health System" and "track[ing] the progress of the New Health System toward meeting the commitments of the Cooperative Agreement." [7/] This entity does not have any enforcement powers, however, and Anthem questions whether it will have the resources, expertise, and objectivity to adequately track progress on the commitments.

Importantly, Virginia also lacks a process, discussed further below, for handling complaints about the Cooperative Agreement, as exists with the COPA Compliance Officer in Tennessee. An established and transparent process for policing the Cooperative Agreement through a variety of mechanisms and entities is essential.

2. Reporting Requirements

The TN TOC contains a variety of reporting requirements, including an annual report, quarterly reports and other forms of ongoing or periodic reports. Virginia also requires reporting by the parties but the requirements lack specificity and are far less comprehensive than as what is required in Tennessee.

With respect to the annual report, both Virginia and Tennessee require this as part of the active supervision process to evaluate the benefits against the disadvantages each year. The TN TOC, however, lays out 18 different categories of information that must be included. [8/] In Virginia, the Revised Commitments do not address the requirement of an annual report, merely making reference to the fact that it assumes the Department will require one. [9/] An annual report is required by statute in Virginia and 12VAC5-221-110(A) outlines eight categories of information that "shall" be included in the annual report. The requirements in 12VAC5-221-110(A) are general and high level and leave too much room for omission of critical information by the Parties. Virginia should develop specific requirements as Tennessee has done. The following are an example of some of the categories of information required by the TN TOC that are not currently delineated in Virginia:

1. A summary comparison by category of patient-related prices charged during the year in review and the preceding year;

2. A summary of steps taken to reduce costs and improve efficiency;

3. Any services or functions that were consolidated during the year in review and the resulting cost savings in excess of $2M;

4. A comparison of the New Health System with similar systems;

6/ VA Code §15.2-5384.1(G); *see also* 12VAC5-221-100(D).
7/ Revised Commitment 33.
8/ TN TOC Exhibit G: Forms of Annual Report and Quarterly Report.
9/ *See e.g.* Revised Commitments at 13.

5. An updated Plan of Separation (although this is required in Virginia pursuant to (12VAC5-221-110(B)); and

6. An updated organization chart of the New Health System. [10/]

The annual report in Virginia should require at least the same level of information and detail as currently delineated in Tennessee.

Both Tennessee and Virginia require the Parties also to file quarterly reports that contain key financial metrics. The quarterly reports in Tennessee however, must contain more information than is required in Virginia, such as:

- income and cash flow statements;
- quality metrics;
- Compliance Officer Quarterly Reports;
- reports on population health or community meetings; and
- performance comparisons by quarter[11/] (rather than just yearly as is required in Virginia). [12/]

The quarterly reports in Virginia should require at least the same level of information and detail as required in Tennessee.

Finally, in Virginia, the Revised Commitments require various "credible reports" to be submitted as a means of monitoring most of the commitments. [13/] The Revised Commitments do not specify anything further with respect to what must be included in the reports, who the reports should go to, or the mechanism for review of the reports. To the extent credible reports are the metric for verifying the Parties' fulfillment of a commitment, that metric must be specific and enforceable.

3. Scoring System

The proposed scoring systems in Virginia and Tennessee are similar in that in both states the New Health System will receive a numerical score for various measures which then will be weighted. Virginia only has two final score categories: >60 -- indicating there is a continuing benefit and <60 -- resulting in revocation of the Cooperative Agreement. Tennessee has allowed for an intermediary score category (less than 85 but greater than 60) to result in what is categorized as an "unclear" score. A score of "unclear" may result in noncompliance, modification or revocation of the COPA. As a result of this important difference in scoring, if the New Health System receives a score of 70, for example, the Cooperative Agreement could pass in Virginia but need to be modified or revoked in Tennessee. Virginia should create a similar intermediary category and the scoring systems should not result in divergent outcomes across state lines.

4. Managed Care Pricing Limitations and Other Requirements

The Tennessee TOC — and specifically Addendum 1 — outline a detailed process for managed care pricing limitations and refunds and penalties in the event of excessive payments. The TN TOC

10/ TN TOC Exhibit G.
11/ *See* TN TOC 6.04(c); *see also* TN Exhibit G.
12/ Revised Commitment at Commitment 31.
13/ *See e.g.,* Revised Commitments, Commitments 3, 5, 10, 11, 12, 14, 16.

states that the pricing limitations are "intended generally to minimize any adverse impact caused by the Affiliation, on the ability of Payors to negotiate appropriate payment and service arrangements with the New Health System, and to ensure that post-Closing pricing is fair to both consumers and Payers."[14/] The pricing limitations apply to all payors (current or future), [15/] categorized as Large or Small Network Payors, but with slightly different limitations. [16/]

Depending on the category of service — inpatient services; outpatient services; physician services; charge-based services; and cost-based items—there are different limitations in place. For example, for Large Payors' inpatient services, "Inpatient Payment Indices" (based on adjusted inpatient pricing per unit of DRG weight) are compared against the Cumulative Hospital Inflation Adjustment.[17/] The Outpatient Payment Indices are similar, but use APC Relative Weights assigned by Medicare rather than DRG weights. [18/]

In the event that the New Health System's pricing is excessive, there is a mechanism for issuing refunds to a payor and/or health care consumers. [19/] The New Health System must report excessive pricing to the COPA Compliance Officer but payors may also report it as well. [20/] There is also a provision that prohibits the New Health System from moving or converting non-hospital services to hospital services without first notifying the COPA Monitor so that indices can be established for such services.[21/]

While the TN TOC outlines a detailed set of pricing limitations, there are a number of significant exceptions that create pathways for the New Health System potentially to circumvent the limitations. Most notably, all value-based payments are excluded from the pricing limitations.[22/] This exclusion is problematic because, without pricing limitations on value-based models, the New Health System could effectively use its new monopoly power to strong arm payors into one-sided value-based payment models that circumvent the COPA's price regulations. This could be increasingly important to the extent value-based models become more common.

In Virginia, the proposed pricing regulation has some similarities to the approach taken in Tennessee but also has some differences, particularly with respect to the benchmark being used, and its lack of detail or completeness. Virginia Revised Commitments Combined Commitment 1 and 2 proposes to use the latest CMS-approved Medicare Market Basket (currently 2.7%) plus 0.25% as a benchmark for the proposed pricing limitation. If a payor offers a quality component in its fee schedule, the rate cap currently would be 2.95%. If a payor does not offer a quality component in its fee schedule, then the rate cap would be 1.25% higher, at 4.2%. Importantly, however, the pricing limitation does not apply to 7 categories of payments including (1) any "portion of a managed care contract payments for attaining quality targets or goals"; (2) post-acute-care providers; (3) bundled payments, and others. Virginia also has not provided for a specific process for monitoring, reporting or enforcing excessive prices as in Tennessee.

14/ TN TOC 5.01.
15/ TN TOC Addendum 1 at 1.2.
16/ TN TOC Addendum 1 at 13.
17/ TN TOC Addendum 1 at 2.1 and 2.2(a).
18/ TN TOC Addendum 1 at 3.1.
19/ TN TOC Addendum 1 at 3.4 and TN TOC Addendum 1 at Part IX.
20/ *See* TN TOC Addendum 1 at 3.4 (discussing the excessive payment testing).
21/ TN TOC Addendum 1 at Part IV.
22/ TN TOC Addendum 1 at 1.4(c).

As Anthem has expressed in past submissions, the Parties should not be free to obtain a rate increase each year equal to the Medicare Market Basket plus 0.25%, whether or not the health system has met any quality metrics. In contrast, Anthem and many other payors are conditioning *any* increase in rates on achieving certain levels of quality. In addition, by excluding seven (7) broad categories of payments from the pricing limitations, and in particular, including an exclusion for quality-based payments, the exclusions swallow up the rule. What is to stop the New Health System from negotiating most of its payments into quality contracts (something they have committed to try to do if they are granted a Cooperative Agreement) and thereby obtain higher price increases than contemplated by combined Commitment 1 and 2? Virginia should not exclude any type of payment from the pricing limitations and should develop workable pricing limitations for every category of payment.

Finally, Anthem continues to have concerns about how the proposed pricing limitations will impact government-sponsored programs, including the Virginia Medicaid Managed Care Program. As mentioned in past submissions, there is no commitment that would truly protect Virginia Medicaid beneficiaries, but if the Commissioner makes the decision to approve the Cooperative Agreement, the only way to provide some Medicaid protections would be to include the following requirements:

- An "Any Willing Payer" requirement
    - The merged entity should be required to contract with any Medicaid Managed Care Organization ("MMCO") that holds a contract with the Virginia Department of Medical Assistance Services ("DMAS").
    - There should be Mandatory Dual Eligible Special Needs Plans ("D-SNP") contracting requirements with all Managed Care Organizations ("MCOs") who hold a Medicare Improvements for Patients and Providers Act agreement with DMAS.
- A requirement that the merged entity contracts with any MMCO contract at 100% of DMAS (the Virginia Medicaid fee schedule).
- A requirement that the New Health System provide the same (limited) protections bestowed on principal commercial payers to the MMCOs who contract with DMAS.
- A requirement that the merged entity participate in MMCOs contracts' value based purchasing program as required in the Virginia MCO contract.
- A commitment that the New Health System not close any service or facility that will directly impact access to Virginia Medicaid beneficiaries. That can best be assessed by utilizing the federal and state geographic access requirements which consider travel and distance for Medicaid beneficiaries.

5. Structure to address noncompliance

The Parties have made numerous monetary and non-monetary commitments, and it is unlikely that they will satisfy all of them. For example, the Parties have committed to incremental spending of $85M on behavioral health, which starting in Year 3 and running through Year 10 is $10M each year. A similar commitment was made for health research and graduate medical education (incremental commitment of $85M over ten years). Monetary commitments of this magnitude and length of time are significant and it is questionable they will be met by a health system that does not even exist yet. The New Health System also claims they will be able to maintain all of the existing hospitals for at least five years (with two exceptions) and obtain substantial efficiencies. What should be done if the

Parties, as is likely to occur, fail to meet a large number of their commitments, but their score still meets the arbitrary 60 point cutoff they propose for a "passing grade?"

Unlike in Virginia, Tennessee provides for a range of actions should a **noncompliance** occur. First, if a noncompliance occurs, the parties must respond with a "notice to cure" within 15 days and then must "cure" the noncompliance, or make substantial progress toward curing it, within 60 days from the notice to cure. [23/] If the noncompliance cannot be cured (and one of the two exceptions does not exist [24/], the Department may institute a **corrective action** which could include one or more of the following: [25/]

- Prohibiting bonus payments;
- Requiring a remedial contribution [26/];
- Requiring a COPA modification;
- Imposing any remedy described in TN TOC 9.08; and
- Termination of the COPA.

The Tennessee Department of Health may also sue for specific performance or require a COPA modification in the event of noncompliance. [27/]

Virginia does not currently provide for most of these intermediate provisions. The statute and regulations give the Commissioner the "authority to investigate as needed," including the authority to conduct onsite inspections, to ensure compliance with the cooperative agreement. [28/]. If a noncompliance is observed, enforcement proceedings can be initiated but no remedies are clearly established, short of revocation or modifications that are consented to by the Parties. [29/] Virginia should develop a similar system for noncompliance as exists in Tennessee, with specific enforcement provisions outlined, not simply stating that investigation is permissible. [30/] In addition, it should shorten the notice process for "material adverse events" from thirty (30) days to fifteen (15) days to require a quicker response as is mandated in Tennessee. [31/]

23/ TN TOC 6.05(a)-(b).
24/ TN TOC 6.05(b).
25/ TN TOC 6.05(d).
26/ The remedial payments are outlined in TN TOC Exhibit H: Remedial Contributions. There are three different fine ranges ($10,000 – $100,000; $101,000 – $250,000; and $251,000 – $1,000,000). Exhibit H also outlines which TN TOC fine range applies to which violation. For example, noncompliance for managed care contracting and pricing limitations will result in a fine in the range of $101,000 – $250,000.
27/ TN TOC 9.02(a)-(c).
28/ VA Code §15.2-5384.1(G); *see also* 12VAC5-221-100(D).
29/ *See* VA Code §15.2-5384.1(H); *see also* 12VAC5-221-130(C) (listing a number of factors that could lead to the revocation of a Cooperative Agreement); 12VAC5-221-130(B) permits the Commissioner to modify the Cooperative Agreement in the context of a compliance proceeding, but only upon consent by the Parties.
30/ *See id; see also* TN TOC 6.05.
31/ *See* Revised Commitment 12 (allowing the New Health System 30 days to notify the Commissioner should a "material adverse event" occur).

6. Public Input

In Tennessee, the TN TOC requires that the Local Advisory Council assist in hosting a public hearing annually to allow the public to comment on the New Health System's annual report and the ongoing performance of the New Health System. [32/] It also requires that certain quality reports [33/] and the New Health System's charity care policy [34/] be made publicly available.

In Virginia, the Commissioner must make public her annual determination of compliance with a Letter Authorizing the Cooperative Agreement. [35/] There are no other statutory or regulatory requirements to make anything else public. The Revised Commitments merely require that quality metrics[36/] and the New Health System's charity care policy [37/] are made publicly available.

Virginia must ensure that the active oversight of this Cooperative Agreement is transparent and open to the public. Tennessee should require that the reports that are submitted by the New Health System be publicly available. Virginia should do that as well, and should provide for future public hearings on the benefits and disadvantages of the Cooperative Agreement.

7. COPA Modifications

We are now reaching the end a long application review process. But If Virginia approves a Cooperative Agreement, it will only mark the beginning of what must be a stringent and ongoing oversight process. Moreover, any metrics, commitments and accompanying oversight developed today will need to be modified and adjusted continuously over time to address the experience that the Department and the Parties have with implementing the Cooperative Agreement, as well as unforeseen events and changed circumstances.

The TN TOC allows for modifications of all kinds. The specific process is laid out primarily in Section 8 of the TN TOC. The Department and the Parties may propose modifications. While the TN TOC contemplates that the Department and the Parties will work together to reach agreement on any modifications, ultimately, the Department retains the authority to enforce compliance of the COPA through imposed modifications should that be necessary. [38/]

In Virginia, the regulations permit the Commissioner to modify the mechanisms of monitoring the Cooperative Agreement upon notice to the Parties. [39/] The Commissioner may also seek to modify the Cooperative Agreement in the context of a proceeding to determine whether compliance with the Cooperative Agreement no longer meets the requirements of Virginia Code § 15.2-5384.1. [40/]

32/ TN TOC Exhibit F (3).
33/ TN TOC 4.02(d).
34/ TN TOC 4.03(e).
35/ 12VAC5-221-150(E).
36/ Revised Commitment at Commitment 8.
37/ Revised Commitment at Commitment 9.
38/ *See* TN TOC 8.01 (*stating that* "the Department shall have all rights conferred upon it pursuant to the COPA Act, including the right to terminate the COPA and enforce the Plan of Separation"). Imposing a COPA modification is one of the corrective actions the Department may take in the event of noncompliance. TN TOC 6.05(d).
39/ 12VAC5-221-100(G).
40/ 12VAC5-221-130(A)-(B).

However, such modifications are only permitted upon consent by the Parties.[41/] This provision, requiring Party consent effectively means the Commissioner is limited in how it can enforce compliance with modifications, unlike in Tennessee. Virginia should ensure the Department can modify the Cooperative Agreement for any reason and use COPA modifications in its enforcement and oversight process.

IV. Even if a fulsome active supervision process is created, it is doubtful that the Department will have sufficient resources to actively oversee the Cooperative Agreement.

As illustrated throughout this submission, oversight of a Cooperative Agreement is substantial, costly and long term. In Tennessee, active supervision will include the following:

(1) Retention of the **COPA Compliance Office**. This office (which is within the New Health System) is primarily tasked with establishing a process for and resolution of complaints related to compliance with the COPA and the TN TOC. TN TOC Exhibit F outlines a number of additional detailed duties and responsibilities for this office related to the complaint process.

(2) Retention of an outside **COPA Monitor,** whose duties include the following:

- Review required reports from the New Health System for completeness and compliance;
- Review semi-annual reports of the COPA Compliance Officer concerning complaints related to the COPA or TOC;
- Conduct audits on a regular basis;
- Review and make recommendations to the Commissioner concerning any requests for modification of any provision of the COPA or TOC;
- Report to the Commissioner and Department on any findings of noncompliance or any areas where the New Health System did not achieve target outcomes and/or failed to meet the Index scores, along with any recommendations of enforcement mechanisms;
- Prepare a COPA Monitor Annual Report to include: the Index scores, updates on compliance, the status of existing corrective actions; any recommended enforcement mechanisms, if necessary; any additional findings of the COPA Monitor; and any other information requested by the Department; [42/] and
- Perform the following tasks related to the Managed Care Contracting Pricing Limitations:
    i. Review and approval of calculations and payment indices [43/];
    ii. Approval of any changes to DRG weights [44/];
    iii. Approval of any annual charge increases [45/];
    iv. Approval of any cost-based mark-up policy [46/];
    v. Review reporting of excess payments and any refunds needed [47/];

41/ 12VAC5-221-130(B).
42/ TN TOC Exhibit F (4).
43/ TN TOC Addendum 1 at 2.1.
44/ TN TOC Addendum 1 at 2.4.
45/ TN TOC Addendum 1 at Part VI(b).
46/ TN TOC Addendum 1 at Part VII(c).
47/ TN TOC Addendum 1 at 9.1(c); 9.2.

vi. Approval of any additional time needed with respect to obligations under the Managed Care Contracting Pricing Limitations [48/];
vii. Review quality or value-based contracts [49/];
viii. Annually evaluate the managed care contracting pricing limitations in the maintenance of ongoing Public Advantage [50/];

Under the TN TOC, the COPA Monitor "will be an independent firm with sufficient expertise (or the ability to contract for such expertise) in hospital finance and accounting, auditing, population health management, community health improvement, and data/statistics." [51/]

(3) The **Commissioner** is tasked with the following duties, among others:
- Review findings and recommendations from the COPA Monitor;
- The determination or finding of the continued existence of Public Advantage (or lack thereof);
- In coordination and consultation with the Attorney General, determine necessary Enforcement Mechanisms based on findings identified by the COPA Monitor. [52/]

(4) The **Division of Health Planning** is responsible for coordinating the ongoing monitoring of the New Health System through the COPA Monitor, staff support to the Local Advisory Council, and advice to the Commissioner. The duties and responsibilities include:
- Contract management;
- Coordination with the COPA Monitor;
- Staff Support to the Local Advisory Council; and
- Drafting the Department Annual Report within 30 days of publication of the COPA Monitor Annual Report. [53/]

(5) The **Local Advisory Council** will ensure that the Population Health Fund Initiative is being spent correctly; host the annual public hearing and publish an annual report with community feedback for review by the COPA Monitor and Department. The Council is comprised of 8 to 10 community leaders from a range of organizations and backgrounds residing in the Geographic Service Area. [54/]

Importantly, the Parties must cover "all charges incurred by or on behalf of the Department for Active Supervision (including the Terms of Certification), including without limitation the ongoing expenses of the COPA Compliance Officer, COPA Monitor, the Local Advisory Council, the Commissioner and the Department's Division of Health Planning, the Attorney General, and any other experts, examiners, assistants, or representatives of the Department." [55/] **In essence, all active supervision expenses in Tennessee will be borne by the New Health System.** In Virginia, however, the statute limits the amount that the Parties can be assessed for supervision of the COPA to

48/ TN TOC Addendum 1 at 9.5.
49/ TN TOC Addendum 1 at 10(a).
50/ TN TOC Addendum 1 at 11.
51/ TN TOC Exhibit F (4).
52/ TN TOC Exhibit F (5).
53/ TN TOC Exhibit F (6).
54/ TN TOC Exhibit F (3).
55/ TN TOC 6.03(c).

$75,000. [56/] This is grossly inadequate. Given this statutorily imposed limit, how can the Department be expected to adequately supervise this Cooperative Agreement, given the cost, resources and expertise that will be required?

V. Conclusion

Anthem thanks the Department for the continued opportunity to provide comments on this critical decision for southwest Virginia. Anthem urges the Department to closely consider the significant resources and monetary investment that will need to be made to actively supervise this Cooperative Agreement. Anthem believes that the investment needed is too burdensome and the potential disadvantages of the Cooperative Agreement outweigh the potential benefits, and accordingly the Cooperative Agreement should be denied. In the event Virginia decides to grant the Cooperative Agreement that should only be done after a more stringent oversight process is established and agreed to by the Parties.

56/ VA Code §15.2-5384.1(J) (stating that the Commissioner may assess an annual fee but not to exceed $75,000). The regulations impose a $20,000 annual report fee but it is Anthem understands this would also fall under the $75,000 cap.