COMMONWEALTH of VIRGINIA

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Via Email & Hand Delivery
The Honorable Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner
Virginia Department of Health
109 Governor Street
Richmond, Virginia 23219

Dear Commissioner Levine:

Virginia Code Section 15.2-5384.1(F)(2) (hereinafter the "Virginia Cooperative Agreement Statute") empowers you to consider approving a cooperative agreement between Wellmont Health System ("Wellmont") and Mountain States Health Alliance ("MSHA") (together "the Parties" forming the "New Health System"). The statute also requires that you consult with the Attorney General regarding your assessment. I am pleased to provide this letter in satisfaction of that requirement.

Issue Presented

In reviewing a proposed cooperative agreement, the State Health Commissioner ("the Commissioner") is directed by statute to consider a number of statutorily enumerated potential benefits and disadvantages and to approve the cooperative agreement if she finds that "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."[1]

Synopsis

Competition generally is believed to drive provision of high quality products and services at the most affordable prices. Even when a market is highly regulated, such as healthcare, aspects of competition can still assure consumers of higher quality, lower prices, and more choice for goods and services than they would have without competition.

[1] VA. CODE ANN. § 15.2-5384.1(F)(2).

The State of Tennessee's contingent approval of a certificate of public advantage ("COPA") for the merger in Tennessee, together with the possibility that, in the event of Virginia's disapproval, the Parties may elect to proceed with the merger in Tennessee and dispose of their Virginia facilities, complicates the analysis of this issue. Although some aspects of the merger could be weighed as significant disadvantages from an anticompetitive standpoint if this cooperative agreement were viewed in a vacuum, I understand the need to weigh them in the context of Tennessee's approval of the merger plan.

Note that approval of the merger by a neighboring state and the possibility of hospital closures in Virginia if the merger is denied by Virginia are not included as statutory considerations in the Virginia Cooperative Agreement Statute. This scenario is nonetheless extremely significant when applying all of the other statutory factors. A decision by the Parties to sell off piecemeal or abandon Virginia facilities could have catastrophic repercussions for the availability of healthcare in the affected regions and I appreciate that the risk of such a result will affect your assessment.

Background

Chapter 53.1 of Virginia Code Title 15.2, which established the Southwest Virginia Health Authority ("the Authority"), was amended in 2015 to empower the Authority to review proposed "cooperative agreements" between hospital systems and to deny or to recommend approval of such agreements to the Commissioner. Cooperative agreements are agreements "among two or more hospitals for the sharing, allocation, consolidation by merger or other combination of assets."[2] If approved and actively supervised on an ongoing basis by the Commissioner, a cooperative agreement shields what might otherwise be a prohibited combination from liability under state and federal antitrust laws.

The Virginia Cooperative Agreement Statute requires that both the Authority and the Commissioner approve the cooperative agreement for it to take effect. The statute explicitly outlines factors that both the Authority and the Commissioner must consider when weighing the benefits and disadvantages of the agreement.

The Parties submitted an Application for a Letter Authorizing a Cooperative Agreement ("Application") in February 2016. The proposed merger combines the two dominant hospital systems in Southwest Virginia and Northeast Tennessee—Wellmont and MSHA. Wellmont is a Tennessee not-for-profit integrated health system formed in 1996 and consists of seven hospitals serving the region, one of which has a Level I Trauma Center, one of which has a Level II Trauma Center, and one of which is designated as a critical access hospital. Five hospitals are located in Tennessee and two are located in Virginia.

MSHA is also a Tennessee not-for-profit health system. It was founded in 1998 and serves the same region. MSHA has fifteen hospitals, including a hospital with a Level I Trauma

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[2] *Id.* § 15.2-5369.

Center, a children's hospital, several community hospitals, two critical access hospitals, and one behavioral health hospital. Ten of MSHA's hospitals are located in Tennessee and five are in Virginia, including one of its critical access hospitals. Neither hospital system is headquartered in Virginia nor does either hospital system have a Level I or II Trauma Center or a tertiary care hospital in Virginia. The majority of the health care facilities in each hospital system are in Tennessee.

On December 22, 2016, the Authority delivered to the Commissioner a report of its findings in 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 ("Authority Report"). The Authority Report found that "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."[3] The Authority Report compiles much of the data that the Authority reviewed in the form of written submissions and public comment, and documents commitments that the Parties made as part of their proposed cooperative agreement (the "Commitments").[4] Subsequently, the Parties revised their Commitments; the latest version is dated October 9, 2017 ("the Revised Commitments")[5]. Following review of the conditions of Tennessee's approval and the Revised Commitments, the Authority provided additional recommendations to the Commissioner.[6]

The statute requires consideration of whether any of the following benefits may result from the proposed cooperative agreement:

- Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction;
- Enhancement of population health status consistent with the regional health goals established by the Authority;
- Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
- Gains in the cost-efficiency of services provided by the hospitals involved;
- Improvements in the utilization of hospital resources and equipment;
- Avoidance of duplication of hospital resources;
- Participation in the state Medicaid program; and
- Total cost of care.

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[3] AUTHORITY REPORT at 167.
[4] *See* AUTHORITY REPORT at 118-149.
[5] http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/VDH-cooperative-agreement-revised-commitments-10-9-17.pdf
[6] http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/Southwest-Virginia-Health-Authority-10-16-17.pdf

The statute also requires consideration of the following disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement:

- The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;
- The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;
- The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and
- The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.

In preparation for providing this information and examining the merger as the Commonwealth's chief antitrust enforcer,[7] my Office retained Dr. Robert Town and Cornerstone Research to conduct an independent expert economic analysis of the proposed consolidation, with particular attention to the statutory guidelines outlined in the Virginia Cooperative Agreement Statute.

Dr. Town's Report ("Town Report") provides an economic analysis of the Parties' Application as originally proposed and applies market conditions and the Parties' Commitments to the statutory factors in Section 15.2-1584.1(E). Importantly, the Town Report was completed in advance of Tennessee's decision to approve the merger. While the Town Report details the many ways this merger may be anticompetitive, its applicability to the current situation is less relevant in view of the Tennessee approval and the Parties' Revised Commitments.

Analysis

Competition is fundamental to efficient markets, which provide consumers with the best products at reasonable prices. Even though healthcare is a highly regulated market, competition still plays a critical role with respect to price, quality, and patient choice for health care products and services. The Virginia Cooperative Agreement Statute contemplates that there may be situations in which a near monopoly overseen by a state regulator can provide superior outcomes with respect to price, quality of care, and patient choice when compared with the free market. Therefore, the question is not whether the proposed cooperative agreement is anticompetitive—the Parties concede that together they currently have a 73% market share for hospital services in

[7] This Office received notice of the proposed merger from the Parties pursuant to Virginia Code § 55-532 and is also reviewing the transaction under its common law and statutory authority.

the region.[8] Rather, the analysis turns on the relationship between the possible disadvantages of the combination and its potential benefits, including any further commitments to improve health in the region that the parties to the cooperative agreement choose to make.

In performing this evaluation, I have addressed the enumerated statutory factors and considered the Parties' Commitments and Revised Commitments that the Parties made to the Authority, as documented by the Authority Report and the Authority's letter dated October 16, 2017.[9] The Authority is composed of healthcare professionals, elected officials, and others in Southwest Virginia with a sincere interest in securing quality healthcare for citizens in the region. I share that interest, and it is in that spirit that I provide you with this evaluation.

As noted above, the Parties have made a number of commitments to preserve competition, improve quality of care, and foster population health; nevertheless, the disadvantages likely to result from the reduction in competition are substantial. Within the parameters of the statute, you may impose further conditions on the Parties if you approve their Application. My analysis necessarily does not take into consideration any additional commitments promised by or conditions imposed upon the Parties in your final decision.

Accordingly, I am providing you with the following analysis, based primarily on the Office's role as the Commonwealth's antitrust enforcer. Nothing in this analysis should be seen as infringing on your expertise in evaluating the healthcare benefits of the proposed merger.

Potential Benefits of a Proposed Cooperative Agreement

The Virginia Cooperative Agreement Statute requires that the Commissioner consider eight categories of potential benefits, including "[e]nhancements of hospital and hospital-related care flowing from the cooperative agreement."[10] Your discussions with the Parties have resulted in Revised Commitments from them that are likely to result in enhancements of hospital and hospital-related care.[11] In a different context, it would be important to note that at least some of these improvements could likely be realized in the absence of a merger.

The Virginia Cooperative Agreement Statute also requires the consideration of the "[e]nhancement of population health status consistent with the regional health goals established

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[8] The Parties define the relevant geographic area included in the cooperative agreement as 21 counties, including the counties of Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe (including the Independent Cities of Bristol and Norton) in Virginia, and Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee. Application at 14.

[9] http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/Southwest-Virginia-Health-Authority-10-16-17.pdf

[10] VA. CODE ANN. § 15.2-5384.1(E)(2)(a).

[11] http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/VDH-cooperative-agreement-revised-commitments-10-9-17.pdf

by the Authority."[12] The Parties have generally described population health initiatives they intend to execute after the merger. While these initiatives need more rigorous implementation plans, they are unambiguous benefits of the merger. It is also important to note that, even in the absence of a merger, these systems would likely continue to invest in these types of proposals because it is in their best interests to do so and because of the general trend toward value-based care in the healthcare industry, which requires these improvements for providers to get higher reimbursements from insurers.

Perhaps the most important potential benefit to consider is the "[p]reservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care."[13] Southwest Virginia has already experienced disruption of healthcare delivery in the region due to a recent hospital closure, and the Authority is understandably concerned about the future of the healthcare network in the region. A guarantee that the Parties would maintain existing facilities is a material benefit. It is important to note that while the Parties have committed that all hospitals in operation at the effective date of the consolidation will remain operational as some form of clinical or health care institution for at least five years, the New Health System may adjust the scope of services or re-purpose these hospital facilities as long as essential services are provided.

Another required consideration is whether there are "[g]ains in the cost-efficiency of services provided by the hospitals involved."[14] The Parties claim that the consolidation will generate efficiencies that will fund a number of projects over a ten-year period. Certain cost efficiencies theoretically could be obtained by other mergers with hospital systems that do not currently compete in the region and therefore would not result in such significant regional consolidation.

The statute requires as well consideration of "[i]mprovements in the utilization of hospital resources and equipment"[15] and the "[a]voidance of duplication of hospital resources."[16] The Parties claim that the consolidation will eliminate an inefficient allocation of hospital resources in Southwest Virginia that has resulted from the vigorous competition between the two hospital systems. While there may be some benefits attributable to these considerations, capital spending by hospitals in Virginia is heavily regulated by Certificate of Public Need law, meaning that the Parties have only been able to make such investments in the first instance after demonstrating a public need.[17]

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[12] VA. CODE ANN. § 15.2-5384.1(E)(2)(b).
[13] *Id.* § 15.2-5384.1(E)(2)(c).
[14] *Id.* § 15.2-5384.1(E)(2)(d).
[15] *Id.* § 15.2-5384.1(E)(2)(e).
[16] *Id.* § 15.2-5384.1(E)(2)(f).
[17] 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 at 44.

Also required is consideration of "[p]articipation in the state Medicaid program."[18] Given that the Parties are large, integrated healthcare systems that participate in the state and federal Medicaid program, it is expected that the New Health System would continue to participate in the state Medicaid Program. In the Parties' Application, they claim that increased scale resulting from the merger will benefit state Medicaid recipients' access to care, although the mechanism is not apparent.[19]

Finally, the statute requires consideration of the "[t]otal cost of care."[20] The Parties' price cap commitments, population health initiatives, cost efficiency claims, and efforts to avoid duplication of services are all relevant to the total cost of care, as are potential impacts on reimbursement costs.

Disadvantages Attributable to Any Reduction in Competition

There are four enumerated categories of disadvantages that must be considered. These categories, however, are not exhaustive.

The statute requires consideration of "[t]he extent of any likely adverse impact of the proposed cooperative agreement on the ability of . . . health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers."[21] The proposed merger will have the effect of eliminating competition between the two largest competitors in the 21-county area, who together currently have a 73% market share for hospital services in the region.[22] The proposed price caps, while ameliorative, may not completely counteract the anticompetitive effects of the consolidation because of the New Health System's increased bargaining leverage over non-price dimensions of the business (*e.g.*, how hospital utilization will be monitored and controlled, billing and administrative arrangements, and which cost tier a hospital will occupy).[23] Therefore, there may be future impacts associated with potential increases in payor rates with respect to premiums, co-payments, deductibles, and out-of-pocket costs.

Note that these possible negative impacts may be far smaller than those that would be created by the closure of some or all of the Parties' facilities in Virginia, which is a risk if the

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[18] VA. CODE ANN. § 15.2-5384.1(E)(2)(g).
[19] Application at 32-33. Notably, the status of both healthcare systems in the region would be considerably improved, and therefore, this proposed consolidation would not need to be explored, had Virginia and Tennessee expanded their Medicaid programs as contemplated under the Affordable Care Act.
[20] VA. CODE ANN. § 15.2-5384.1(E)(2)(h).
[21] VA. CODE ANN. § 15.2-5384.1(E)(3)(a) (emphasis added).
[22] Application at 55-56.
[23] TOWN REPORT at 70.

cooperative agreement is not approved. If you elect to approve the merger, you may wish to rely on the price-cap structure in Tennessee's approval, as recommended by the Authority.[24]

"The extent of any likely adverse impact on patients in the quality, availability, and price of health care services" is another required consideration.[25] Although some of the Revised Commitments address the potentially adverse impact on the quality of patient care, issues remain as a result of the merger because of the principle in healthcare economics that hospitals compete in two stages: first, they compete on price to be included in commercial payor networks, and second, they compete on non-price dimensions to attract patients (*e.g.*, location, amenities, and quality of care).[26] The Revised Commitments related to standardization, a common clinical IT platform, and quality reporting practices are designed to offset, in part, the negative aspects resulting from the removal of competition in this second stage.

The statute also requires consideration of "[t]he extent of any reduction in competition among . . . health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement."[27] The Town Report indicates that the New Health System's share will be 50% or higher in several physician service areas and over 80% in at least four service areas.[28] This level of market consolidation will allow the New Health System to have greater negotiating leverage with payors and reduce incentives for competition-driven quality improvements as described above. These effects will likely be partially offset by the Parties' Revised Commitments related to independent physicians.[29]

The final enumerated disadvantage to be considered is "[t]he availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement."[30] Prior to Tennessee's decision and the uncertainty for Virginia created by that approval, the status quo, or other, less restrictive joint ventures, would have presented certain compelling characteristics because many of the Parties' claimed benefits, as well as many of the commitments, are not contingent on the proposed merger itself. Given the landscape as currently configured, these alternatives no longer carry the same degree of weight.

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[24] http://www.vdh.virginia.gov/content/uploads/sites/96/2017/10/Southwest-Virginia-Health-Authority-10-16-17.pdf
[25] VA. CODE ANN. § 15.2-5384.1(E)(3)(c).
[26] TOWN REPORT at 43-45, 75-82.
[27] VA. CODE ANN. § 15.2-5384.1(E)(3)(b).
[28] TOWN REPORT at 22 & 121.
[29] Commitments 23-25, AUTHORITY REPORT at 140-141.
[30] VA. CODE ANN. § 15.2-5384.1(E)(3)(d).

Conclusion

The proposed consolidation combines Wellmont and MSHA, the only two large, integrated hospital systems in Southwest Virginia and Northeast Tennessee, and will create a near monopoly for generalized acute care services in a 21-county region across the two states. The result could be increased premiums, deductibles, and out-of-pocket expenses for consumers. The consolidation could also have a detrimental effect on quality because, by removing hospital competition from Southwest Virginia, it will remove one of the leading drivers of quality improvements in the industry. The Parties' Revised Commitments offset, in part, several of these negative impacts in various ways.

There are certain benefits to the consolidation, especially with respect to a five-year freeze on facility closures, an issue of significant resonance in the region. Some of these benefits are difficult to evaluate comprehensively based on the materials provided by the Parties.

These positives and negatives cannot be viewed in a vacuum. The approval of the merger by Tennessee, and any uncertainty you determine that approval creates for Virginia if the cooperative agreement is not approved, is a consideration that is not subject to the type of analysis dictated by the statute and performed above, but certainly may have very real implications for healthcare in Southwest Virginia. With kindest regards, I am

Very truly yours,

Mark R. Herring

Mark R. Herring
Attorney General