Overcoming Antitrust Obstacles to Mergers by Committing to Population Health Improvement

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Federal antitrust laws have long shaped the way business is conducted throughout the United States, including within the healthcare industry. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use the Sherman Antitrust Act, the Clayton Antitrust Act, and the Federal Trade Commission Act to preserve competition by blocking mergers and acquisitions that would enhance market power to levels that hinder competitive activity. According to the Horizontal Merger Guidelines set forth by the FTC and DOJ in 2010, a merger creates market power if "it is likely to encourage one or more firms to raise price, reduce output, diminish innovation, or otherwise harm customers as a result of diminished competitive constraints or incentives."[1]

Antitrust laws are intended to protect consumers, but the laws also create a number of challenges for healthcare providers. The healthcare industry plays by different rules than other segments of the economy. In most cases, the consumer to whom services are provided (the patient) does not directly bear most of the cost for the services. Rather, government and commercial payers pick up most of the bill. Patients often do not even select their providers; instead, providers are usually selected by either physician referrals or health plan provider panels. Furthermore, hospitals are limited in their ability to align with referral sources by the fraud and abuse laws and are required to provide emergency services to individuals regardless of their ability to pay.

As the healthcare payment model transitions from fee-for-service to value-based payments, healthcare providers are driven to decrease costs and redundancies while still improving quality of care and maintaining sufficient operating margins to remain sustainable. During this transition, while hospitals are working to operate under both fee-for-service and value-based models, larger health systems will likely remain viable by leveraging economies of scale and expanding services. However, many smaller hospitals will likely struggle to maintain positive margins. As a result, more hospitals will seek ways to increase efficiency, profitability, and access to care by pursuing consolidation.

Consolidation can reduce duplication of resources, create efficiencies based on the optimal use of facilities and other assets, and generate greater services for consumers. Nevertheless, when consolidation results in enhanced market power, antitrust laws come into play.

1 Horizontal Merger Guidelines, U.S. DOJ & FTC (Aug. 19, 2010), https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf.

Community-Based Healthcare Impact

Healthcare, especially in rural communities, is at a crossroads. Previous federal policies and economic prosperity led to dramatic growth in hospital construction and often resulted in two or more hospitals serving the same community. Now, as reimbursement declines and economic conditions worsen, many hospitals face significant challenges in maintaining their operations in an economically tenable manner.[2]

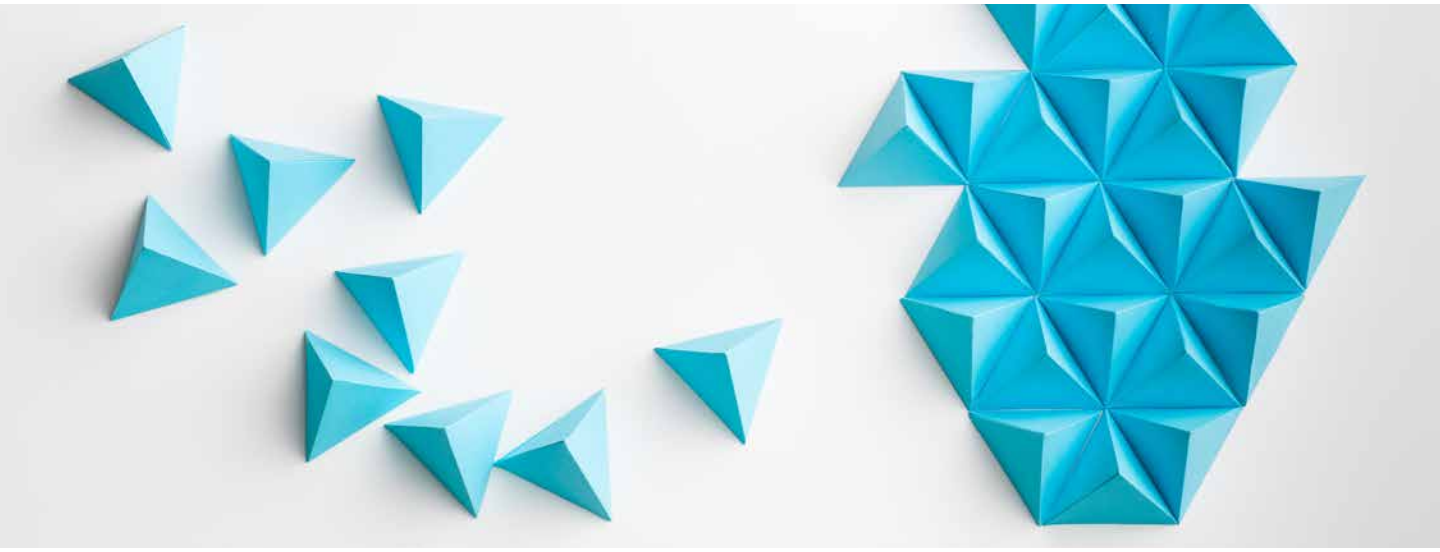
As the healthcare system moves from volume-based to value-based payments, the presence of competing hospitals in the same service area does not always make economic sense. Under the traditional fee-for-service model, there needed to be sufficient competition in a service area to control per-unit prices. However, with value-based payment models, the focus shifts to improving the quality of care and reducing costs. Competing local hospitals that offer duplicative services in the same market sometimes lack the patient volumes to sustain a full array of high-quality, low-cost clinical services, especially if patient populations are stagnating. Moreover, as hospitals are forced to invest in order to remain competitive, hospitals with constrained capital and narrow-to-negative margins, such as those serving rural communities, struggle to survive.

Benefits of Collaboration

In order to generate the efficiencies needed to sustain financial viability and improve the quality of care, many hospitals and health systems are collaborating, sometimes in the form of mergers. Large health systems in particular have honed in on the benefits of collaboration, as evidenced by the wave of large health system mergers in the past year. Some examples include:

- In June 2017, the Greenville (SC) Health System agreed to merge with Palmetto Health to create the largest hospital system in South Carolina.

2 *See, e.g., Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Application for Letter Authorizing Cooperative Agreement*, Sw. Va. Health Auth. (July 13, 2016), https://swvahealthauthority.files.wordpress.com/2016/07/msha-responses-to-questions-bates.pdf.



- In December 2017, Advocate Health Care (Downers Grove, IL) and Aurora Health Care (Milwaukee, WI) announced plans to merge into Advocate Aurora Health, the 10th largest not-for-profit, integrated healthcare system in the U.S., serving nearly 3 million patients.
- In the same month, Dignity Health (San Francisco, CA) and Catholic Health Initiatives (Englewood, CO) signed a definitive agreement to merge, creating the nation's largest not-for-profit hospital system based on operating revenue.
- In February 2018, Bon Secours Health System (Marriottsville, MD) revealed plans to merge with Cincinnati-based (OH) Mercy Health System to create the fifth-largest Catholic health system in the U.S. If approved, the merged system would serve patients across seven states, including Maryland, Virginia, Ohio, Kentucky, New York, South Carolina, and Florida.

While these mergers are impressive in scale, many are anxious to see whether the merged systems can generate efficiencies across divergent markets. A study conducted by researchers at Clemson University and the University of Alabama shows that acquisitions by out-of-state market systems across the United States from 2000 to 2010 resulted in a 14% to 18% increase in negotiated payments with managed care companies at the acquired hospital.[3] However, it is not yet clear how this translates in a value-based payment system.

Antitrust Considerations and Alternatives

Most proposed consolidations and mergers of hospitals serving the same market trigger antitrust review because the transactions will likely impact market share. In many states, there are statutory mechanisms that allow local authorities to approve the transactions and effectively nullify the impact of federal antitrust laws. The statutes, which are usually referred to as Certificates of Public Advantage, or COPAs, are issued by the state agency[4] to healthcare providers[5] and

3 Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, U.N.C. (Aug. 25, 2014), http://www.unc.edu/~mcmanusb/AppliedMicroSeminar/papers/Lewis_Pflum_hosp_bp.pdf.

4 State agency commonly referring to the state Department of Health or, in some cases, the attorney general.

5 Healthcare providers commonly defined as licensed, certified, or registered healthcare professionals; licensed healthcare organizations; licensed healthcare facilities; and freestanding outpatient facilities.

afford immunity from prosecution under state antitrust laws. A COPA, or its equivalent, essentially shields a transaction from federal antitrust enforcement and instead subjects the transacting parties to state oversight on certain agreed-upon metrics. As long as the statutory requirements and state oversight are sufficient to satisfy the state action doctrine, a COPA may protect the parties from prosecution under federal antitrust laws.

FTC leadership has not been amicable with respect to state use of COPA statutes. During a January 2016 speech before the American Health Lawyers Association, then-FTC Chairwoman Edith Ramirez commented, "In my view, these legislative efforts [COPA waivers] to immunize combinations from the antitrust laws are misguided and risk harming consumers."[6]

The FTC's position has not changed with the transition to Acting Chairman Maureen K. Ohlhausen. Ohlhausen stated at the November 2017 ABA Fall Forum, "On my watch, we have tried push back against both these laws [Certificate of Need and COPA] and their specific application to problematic transactions through our advocacy program... [O]ur Office of Policy Planning is currently in the early stages of organizing a 2018 workshop that will take an even deeper dive on the COPA issue."[7]

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Despite the position taken by the FTC, states that have enacted COPA statutes recognize that, as stated in the North Carolina COPA statute, "cooperative agreements among physicians, hospitals, and others for the provision of healthcare services may foster improvements in quality of healthcare, moderate increases in cost, and improve access to needed services in rural areas[.]"[8]

When granted, a COPA allows healthcare providers—who otherwise might be prohibited from doing so—to merge or acquire other providers without the risk of antitrust enforcement.[9] Thus, a COPA is only granted if the state agency decides that the advantages of the collaboration outweigh foreseeable disadvantages.

In order to meet COPA requirements, providers must demonstrate that the proposed transaction will benefit the local community and that the benefits outweigh the possible impacts resulting from reduced competition. Some common COPA benefits[10] include:

- Enhancing quality care
- Preserving availability of care
- Creating cost efficiencies
- Improving utilization of resources
- Avoiding depletion of resources

6 John Commins, *FTC Chair Makes Clear Hospital Consolidation Hurdles*, HealthLeaders Media (May 19, 2016), http://www.healthleadersmedia.com/leadership/ftc-chair-makes-clear-hospital-consolidation-hurdles.

7 Transcribed comments published by FTC November 16, 2017.

8 N.C. Gen. Stat. § 131e-175 *et seq*. (1993).

9 Collaboration commonly defined as cooperative agreements, mergers, and joint ventures.

10 Benefits referenced, in part, from North Carolina, South Carolina, and Tennessee statutes.

Something Old, But Something New

Approximately 24 states have COPA, or similar, statutes in place, most dating back to the 1990s. However, only four states (Maine,[11] North Carolina,[12] South Carolina,[13] and Tennessee[14]) have issued a COPA. Recently, Virginia and West Virginia have enacted Cooperative Agreement legislation; those statutes have already been used by health systems.

In 1997, Baptist Healthcare System of South Carolina merged with Richland Memorial System to become Palmetto Health Alliance. In 2009, MaineHealth acquired Southern Maine Medical Center and Pen Bay HealthCare.

North Carolina issued a COPA in July 1995 when Memorial Mission Hospital and St. Joseph's Hospital in Asheville, North Carolina, applied to form Mission Health System. In reviewing the anticipated benefits and disadvantages, the North Carolina Department of Human Resources (NCDHR) concluded that the merger would expand access to needed care for underserved populations, improve utilization of resources, lower costs, and increase efficiency. Nevertheless, the NCDHR still imposed several conditions to minimize the negative impacts of increased market power. The conditions included maintaining Joint Commission accreditation of Asheville Medical Center, continuing charity care at the same levels, composing a new board of directors, and satisfying specified reporting requirements.

Case Study: COPAs Crossing Borders

A COPA came into play in the merger of two Tennessee-based hospital systems that operate in Northeast Tennessee and Southwest Virginia. Mountain States Health Alliance in Johnson City and Wellmont Health System in Kingsport knew their proposed transaction would draw scrutiny under antitrust laws because they share common markets in which no other hospital operates. As a result, the parties opted to pursue approval under the previously unused Tennessee COPA statute and worked with Virginia lawmakers to seek passage of state-level legislation giving Virginia agencies similar authority allowed under the Tennessee COPA.

Virginia House Bill 2316, enacted by the 2015 General Assembly, amended the Code of Virginia to address the unique healthcare challenges that exist in Southwest Virginia. The Code section authorized parties to submit an application for a Cooperative Agreement to the state health commissioner if the application had received a recommendation for approval by the Southwest Virginia Health Authority. Once a recommendation was received, an application for a Cooperative Agreement was submitted by both Mountain States and Wellmont in February 2016, and Virginia acted to specifically address the potential merger.

The Virginia application explained that competition for market share between Mountain States and Wellmont in Southwest Virginia led to allocation of system resources for duplicative revenue-producing services. The competitive environment rendered the then-separate systems unable to make the population health management or community health improvement investments that were desperately needed based on the health status of the population.[15]

11 MaineHealth acquisition of Southern Maine Medical Center and Pen Bay HealthCare (MaineHealth, 2009/2010).

12 Memorial Mission Hospital merger with St. Joseph's Hospital (Mission Health System, 1997).

13 Baptist Healthcare System of South Carolina merger with Richland Memorial Hospital (Palmetto Health Alliance, 1997).

14 Mountain States Health Alliance merger with Wellmont Health System (Ballad Health, 2017).

15 *Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Application for Letter Authorizing Cooperative Agreement*, Sw. Va. Health Auth. (July 13, 2016), https://swvahealthauthority.files.wordpress.com/2016/07/msha-responses-to-questions-bates.pdf.

Three years after the proposed merger was first announced, the efforts of Mountain States and Wellmont culminated in their receipt of a COPA from Tennessee in September 2017 and a Cooperative Agreement from Virginia in October 2017. The Tennessee COPA approval concluded there was a clear and convincing standard that a merger would create a public benefit that would outweigh any potential disadvantages for the residents of Northeast Tennessee.

With these approvals, Mountain States Health Alliance and Wellmont Health System merged to form Ballad Health, an entity comprised of 21 hospitals and approximately 15,000 full- and part-time employees. The COPA and the Cooperative Agreement imposed conditions that Ballad Health invest significantly in the health of the communities it serves. Most notably, Ballad must spend at least $308 million over the 10-year period beginning in July 2018 on the following specifically identified initiatives: 1) $85 million on health research and graduate medical education, 2) $85 million on behavioral health services, 3) $75 million on population health improvement, 4) $28 million on rural health services, and 5) $27 million on children's health services. In short, the parties committed to making the investments, which competition had previously prevented or reduced. Other conditions placed on Ballad include:

- Ballad may not contractually require any health plan to recognize it as an exclusive provider.
- Ballad must coordinate in good faith with independent physician groups to develop a single, region-wide clinical services network.
- Each COPA hospital that is subject to Joint Commission accreditation shall, at all times, be fully accredited by the Joint Commission.
- Ballad shall spend a minimum of $70 million over 10 years to eliminate differences in salary/pay rates and employee benefit structures among the employees of the new health system.

The approval letter from the Commissioner of the Tennessee Department of Health, Dr. John J. Dreyzehner, addressed the importance of these conditions. The letter stated that the applicants' commitment to provide financial investments, the active supervision regulatory structure implemented by the Department, and the specific quality measures that the new health system will monitor—and on which it will be measured—all provide incentives for the system to enhance the quality of care.

The Tennessee Department of Health also used the COPA to impose restrictions in the form of payer pricing containment and mandatory cost efficiencies. Moreover, the COPA requires Ballad Health to adopt a charity care policy similar to the existing policies of both Mountain States and Wellmont Health to address medically underserved populations in the region.[16]

Ballad intends to collaborate with independent physician groups to develop a region-wide, clinical services network to share data, best practices, and efforts for improving patient outcomes and the overall health of the region. In order to reduce the impact of the merger on independent providers, Ballad will seek to collaborate with independent providers willing to decrease unnecessary readmissions, diminish variation in clinical care, improve outcomes, and reduce overall costs. Ballad intends to submit both quarterly and annual reports, including financial data used, to observe its progress against benchmarks.[17]

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The Right Expertise

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The investments Ballad committed to make would not be possible if the inefficiencies of operating two separate organizations had continued. As a result of the merger, Ballad can provide the continuum of care needed to improve health outcomes while reducing total costs of care.

When a hospital system first begins to consider a consolidation or merger with another system, it is important for officials to consider the likelihood of the merger or consolidation attracting scrutiny from federal antitrust officials. If the transaction is likely to receive scrutiny, hospital officials should determine if a COPA option is available in their state. However, hospitals must realize that managing the COPA application process requires expertise and focus that is capable of navigating the maze of regulations and requirements. The necessary expertise may not be available in-house, which makes obtaining a COPA more challenging, and lack of expertise could defeat a COPA application

16 Letter of approval from Dr. John J. Dreyzehner, Tenn. Dept. of Health, to Alan Levine, CEO, Mountain States Health All., & Bart Hove, CEO, Wellmont Health Sys. (Sept. 19, 2017), https://www.tn.gov/content/dam/tn/health/documents/Ap- proval_Letter_granting_COPA.pdf.

17 *Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Application for Letter Authorizing Cooperative Agreement,* Sw. Va. Health Auth.w (July 13, 2016), https://swvahealthauthority.files. wordpress.com/2016/07/msha-responses-to-questions-bates.pdf.

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