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BY ELECTRONIC TRANSMISSION

The Honorable Makan Delrahim, Esq.
Assistant Attorney General for Antitrust
United States Department of Justice
950 Pennsylvania Avenue, NW
Washington, DC 20530

Re: Exemptions and Immunities Roundtable

Dear Assistant Attorney General Delrahim:

I am submitting these comments as counsel for Ballad Health. Ballad Health appreciates this opportunity to submit this statement into the record of the Antitrust Division's Roundtable on Exemptions and Immunities.

Ballad Health is an integrated health care delivery system operating in the Appalachian region of Northeast Tennessee and Southwest Virginia. The System is subject to immunity from the antitrust laws. This is the result of decisions in 2017 by the State of Tennessee to grant a Certificate of Public Advantage (COPA) and by the Commonwealth of Virginia to authorize a Cooperative Agreement, each an action that approved the merger of two not-for-profit health systems: Mountain States Health Alliance (MSHA)[1] and Wellmont Health System (WHS).[2] These entities, competitors prior to merging, provide healthcare services through 21 hospitals, other types of facilities, physicians and other healthcare professionals in a service area that encompasses 29 counties between the two states, plus the independent Virginia cities of Bristol and Norton (the "General Service Area," or "GSA").

Each state approved the merger through its Department of Health, in consultation with that state's Attorney General. The approvals were pursuant to the respective state's clearly articulated policy, expressed by statute, to replace competition with regulation for healthcare mergers that make the requisite evidentiary showing that the merger is beneficial for residents,

[1] MSHA is headquartered in Johnson City, TN. Its operations include 14 hospitals with over 1,600 licensed beds, plus two critical access facilities, a Level I trauma center, and the region's only children's hospital, Niswonger Children's Hospital; it employs approximately 400 physicians and mid-level practitioners and provided pharmacy, home health, hospice, diagnostic, skilled nursing, and rehabilitation services.

[2] WHS, headquartered in Kingsport, TN, operates seven hospitals and one critical access hospital (for a total of more than 1,000 licensed beds), plus a Level I and Level II trauma center; it also provided pharmacy, home health, hospice, diagnostic, skilled nursing, and rehabilitation services, and employs approximately 400 physicians and mid-level practitioners.

and that are actively supervised by the state to ensure compliance with its policies. Under federalism principles outlined in longstanding U.S. Supreme Court case law, starting with *Parker v. Brown*, 317 U.S. 341(1943), and most recently reaffirmed in *North Carolina Board of Dental Examiners v. FTC*, 135 S. Ct. 1101 (2015), the merged entity is immune from challenge under the antitrust laws.[3] The merger closed Effective February 1, 2018. The new entity is named Ballad Health.

The rationale for this merger begins with the fact that the Northeast Tennessee-Southwest Virginia region served by Ballad Health faces pervasive health problems, including extremely high rates of diabetes, heart disease, obesity, addiction and untreated mental illness. These problems cannot be fixed just within the hospital; resources must be invested to address the root of these problems. The region is also highly rural, and rural hospitals are finding it difficult to stay open in today's healthcare environment; more than 80 rural U.S. hospitals have closed since 2010, with Tennessee ranking with the second highest number of rural hospital closures of all states. In addition, the population of the region is aging, population growth is stagnant (or declining in many counties), and the childhood poverty rate is worse in the region than in the rest of Tennessee or Virginia. In virtually every county, the younger age cohorts are declining, as is the rate of births, indicating the loss of working age families, and thus, the region's bench for workforce.

Competition between MSHA and WHS over many years fostered a high degree of clinical duplication in the GSA, much of which today is unnecessary to meet demand for the type of services involved, while other access needs are unmet. The merger will generate substantial savings by eliminating unnecessary duplication and enabling a more efficient realignment of resources. Balled Health will, pursuant to enforceable commitments to the states, reinvest these savings into its communities to help reverse the negative health trends and preserve access to care in rural areas.

In its COPA and cooperative agreement with Tennessee and Virginia, respectively, Ballad Health made a large number of enforceable commitments to ensure that the public benefits from the merger. These commitments include protections for patients, employers, employees, physicians and health insurers, and include specific expenditures of $308 million in total over the next ten years, in the areas of behavioral health, academics and research, population health, children's services, rural health services and to enable health information exchange. These expenditures are not conditional on Ballad Health's capture of cost-savings from the merger. Both states have put in place a rigorous supervisory plan to ensure that Ballad Health complies with its obligations and meets the state's policy directives.

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[3] *See California Retail Liquor Dealer's Ass'n v. Midcal Alum.*, 445 U.S. 97, 105 (1980) (for state action immunity apply, there must be (1) a "clearly articulated and affirmatively expressed" state policy to replace competition and (2) the policy must be "actively supervised" by the state itself).

In the remainder of this letter, Ballad Health explains why MSHA and WHS sought to merge and do so through these state processes, and why Ballad Health views the merger, including the antitrust immunity that applies, to be in the best interest of patients and the communities that comprise the GSA. The record developed by the states in the eighteen months between when the applications were filed and final decisions issued is far too large, and the contents of the terms of certification under which Ballad Health must operate far too detailed, to cover these topics comprehensively in this submission. Ballad Health would be pleased to elaborate further on any issues at the Department's request.

It is important to emphasize that Ballad Health does not view the COPA/cooperative agreement model to be a one-size-fits-all solution for every hospital merger that raises antitrust issues. Every hospital geographic market is different from the next, as is every hospital merger. Ballad Health speaks only on its own behalf. Ballad Health highly values and benefits from the vital role of competition to our country's economic freedom, and fully embraces the Supreme Court's statement that "federal antitrust law is a central safeguard for the Nation's free market structures." *North Carolina Board of Dental Examiners,* 135 S. Ct. at 1104. This includes the vital role of antitrust law enforcement by the Department, Federal Trade Commission and State Attorneys General. To be clear, Ballad Health applauds the efforts of the Department and other federal agencies that default to a position of competition rather than regulation. The bar should be high for elimination of competition, and Ballad Health offers its full support to the agencies responsible for implementation of that policy.

Yet, Ballad Health also recognizes the limitations of antitrust enforcement agencies when it comes to health care policy. Antitrust enforcement is about eliminating and preventing restraints on competition. But health care policy transcends competition. In Ballad Health's view, competition has not led to better health of the communities Ballad Health serves. In fact, because of factors outside the competitive hospital environment, the health status of the GSA has worsened, and some of the incentives that result from a competitive hospital environment actually have contributed to this poor result.

As an example, in one GSA community of 40,000 people, there are three hospitals, each with a census of less than 30 percent capacity; in two of those hospitals, this often equates to a census of fewer than 10 patients. Meanwhile, the hospitals employed five general surgeons. Why? The answer is that hospitals are paid based on doing more surgeries. In a region where diabetes is a major contributor to amputations, and where resources have been spent doing amputations and providing an amputee rehabilitation clinic (all of which is reimbursable), there was not a single endocrinologist – a necessary specialty required for managing and preventing advanced disease resulting from diabetes. So, the competitive market responded to a government imposed pricing system (Medicare fee for service), which was a predictable outcome. The reimbursement for endocrinologists is so low, and the payor mix in the community so poor, that the competitive market did not produce an endocrinologist.

Ballad Health believes this is a clear example of where a focus solely on competition is not good health care policy. And Ballad Health believes antitrust policy should take into account the health policy implications in such situations. The reality is, one or more of the hospitals in that community would likely close, absent the merger. One might argue that this would be the rational outcome of a competitive process, but the result would be an unregulated monopoly without the benefit of the commitments made by Ballad Health – commitments that two states have found to be of a substantial nature. It is true that hospitals are paid for the results of poor health through revenues from increased hospitalization (and hospital use rates are higher in the GSA than in Tennessee, Virginia and the nation). Viewing hospital markets through only the lens of competition, however, which is how antitrust enforcement agencies assess hospital mergers, ignores or misses the opportunity when it arises for a different model to influence, in a positive manner, the health status of the community. The latter is a health policy issue outside the scope and expertise of the antitrust enforcement agencies.

Additionally, the Supreme Court also recognizes that "[t]he States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition" and that competition may be supplanted by "other values a State may deem fundamental" when carried out within the bounds of the law. *Id*. Ballad Health believes unique and compelling circumstances in the GSA justify the new model that Tennessee and Virginia have authorized for Ballad Health, and that the structures are in place to advance the states' policy goals concerning access, affordability, quality and innovation in the delivery of health care services in the GSA.

Rationale for the Merger

The origin for this transaction was an internal assessment by WHS in 2014 of its strategic and financial position and goals for its future in the GSA area. WHS recognized that it needed to prepare for financial pressures, regulatory mandates and imperatives for change in light of local conditions and industry trends.

The region has one of the lowest levels of Medicare reimbursement in the country. The federal government calculates a Medicare wage index based on hospital salary and benefits costs compared to the national average. In the GSA, for the Johnson City and the Kingsport-Bristol (TN)-Bristol (VA) Core-Based Statistical Areas, the wage index is substantially lower than the national average (by more than 25% as of 2014). Since 2000, the area's wage index decreased while average area salaries for healthcare employees increased; local wages have risen more slowly than in other areas, but nonetheless are rising. Hospital reimbursements for Medicare services are set by multiplying the wage index by the proportion of services attributed to salaries and benefits. As a result, the federal government reimburses this service area less each year, while labor costs rise. The region's large Medicare population, coupled with declining Medicare reimbursement, results in lower hospital Medicare revenues for more patients – an outcome especially hard on rural hospitals. The region also has a large Medicaid and uninsured population.

The health status in the GSA warrants particular focus for understanding the challenging environment for healthcare providers and policy reasons for seeking transformative change in the region.

Health Conditions in the Geographic Service Area

In his letter to the parties approving the merger and issuance of the COPA,[4] the Tennessee Commissioner of Health, Dr. John J. Dreyzehner, wrote the following:

> The region has a number of health, economic and other factors, which when combined, present a unique and challenging environment for the improvement of quality and access of health care and health outcomes. These unique challenges were reaffirmed in a recent report issued by the Appalachian Regional Commission, Robert Wood Foundation and the Foundation for a Healthy (*Health Disparities in Appalachia*), which found that the performance in the Appalachian Region is worse than the performance in the United States as a whole in seven of the ten leading causes of death: heart disease, cancer, chronic obstructive pulmonary disease, injury, stroke, diabetes and suicide. Additionally, the study found that the "years of potential life lost," a measure of premature mortality, is 25% higher in the Appalachian Region than in the nation as a whole."[5]

Commissioner Dreyzehner provided a number of statistics to illustrate the severity of health conditions in the Ballad Health GSA, relative to Tennessee and Virginia statewide and to the United States as a whole.[6] Virginia State Health Commissioner, Dr. Marissa J. Levine, in her letter authorizing the cooperative agreement in Virginia, did the same.[7] The following conditions and statistics were reported for:

Tobacco and nicotine addiction, which studies have demonstrated cause various cancers, cardiovascular disease and respiratory conditions, as well as low birthweight and other adverse health outcomes, and 443,000 premature deaths annually in the U.S.:

- The percentage of adults who are current smokers is higher in all 21 counties of the GSA than in the U.S. as a whole.

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[4] Letter dated September 19, 2017, from John J. Dreyzehner, MD, MPI, Commissioner, State of Tennessee Department of Health, to Alan Levine, President and Chief Executive Officer, Mountain States Health Alliance, and Bart Hove, President and Chief Executive Officer, Wellmont Health System (hereinafter "Dreyzehner letter"), at 4. In this letter, Commissioner Dreyzehner advised the parties that their application for a COPA was granted (with conditions, which were subsequently satisfied).

[5] *Id.*

[6] *Id.* at 4-5.

[7] Letter dated October 30, 2017, from Marissa J. Levine, MD, State Health Commissioner, Commonwealth of Virginia Department of Health, to Alan Levine, President and Chief Executive Officer, Mountain States Health Alliance, and Bart Hove, President and Chief Executive Officer, Wellmont Health System, at 13.

- In 50% of the Tennessee GSA counties, smoking is more common than in Tennessee as a whole, and in 50% of the Virginia GSA counties, smoking is more common than in Virginia as a whole.

Obesity, which increases the risk of coronary heart disease, type 2 diabetes, cancer, hypertension, stroke, liver and gallbladder disease, sleep apnea, respiratory problems and osteoarthritis:

- Two-thirds of the GSA counties have a higher percentage of adults who are obese compared to the national average.

- Compared to their respective states as a whole, 80% of the Tennessee GSA counties and 100% of the Virginia GSA counties in Virginia have higher percentage of adults who are obese.

Decreased physical activity, which has been associated with type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease and premature mortality; physical inactivity at the county level is directly related to healthcare expenditures for circulatory system diseases:

- Compared with the nation as a whole, in each of the GSA counties, fewer adults report any physical activity.

- Compared with their respective states as a whole, in 90% of the Tennessee GSA counties and 100% of the Virginia GSA counties fewer adults report any physical activity.

Substance misuse, abuse and substance use disorders; drug overdose deaths are a leading contributor to premature deaths and are largely preventable:

- Tennessee has seen a statistically significant increase in the drug overdose death rate, with at 13.8% increase from 2014 to 2015.

- In 2016, Tennessee had one of the highest opioid prescription rates – 107.5 prescriptions per 100 people, compared to the national average of 66.5 prescriptions per 100 people.

- In the Tennessee GSA counties, the opioid prescription rate was 118.5 prescriptions per 100 people, and in the Virginia GSA counties, the rate was 134 prescriptions per 100 people.

- Tennessee had a 43.5% increase in heroin usage, and Virginia a 38.7% increase, from 2014 to 2015. Over the same period for synthetic opioid encounters, Tennessee had a 90.5% increase and Virginia a 57.1% increase.

- "The substance abuse statistics for the 21 counties in the GSA are particularly compelling."
    - Over 50% of the Tennessee GSA counties exceed the state average, with Hancock County the highest.
    - Sullivan County has one of the highest rates of Neonatal Abstinence Syndrome ("NAS") births in the state.
    - The rate of NAS births in the Tennessee GSA counties is almost four times the rate for the rest of Tennessee.
    - 100% of the Virginia GSA exceeds the state rate of NAS births, with two counties having rates more than three times the state rate, and four counties with rates more than two times the state rate.

Other factors that "contribute to a unique and challenging environment in which to improve the quality and access of health care in the region" are evident from the worse showing in the GSA counties than elsewhere in Tennessee and/or Virginia in the high rate of preventable hospital stays (admissions to hospitals for diagnoses treatable in a less costly outpatient setting), the shortage of primary care physicians (GSA statistics "reflect a compelling need for greater recruitment and retention of primary care providers"), and shortage of mental health providers ("[t]he lack of adequate access to mental health providers in the GSA is overwhelming").[8]

Dr. Dreyzehner's letter (as well as Dr. Levine's) also detail significant challenging economic and demographic factors that substantially differentiate the GSA from the rest of Tennessee and Virginia, including in its lower rate of residents who obtain any post-secondary education, higher rate of children in poverty (which is highly correlated with overall poverty rates), lower per capita personal income and median household income, stagnant population growth (only three of the 21 counties had positive growth; the rest had population losses of 1% to 10%), higher percentage of persons aged 65 or older, and very high percentage of the population considered to be rural ("A number of studies have demonstrated rural residents experience many difficulties in accessing health care services, which result in higher morbidity and mortality rates compared to those of their urban counterparts.")[9]

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In addition to the foregoing, the region also experiences the impact of all the wider industry dynamics of reduced payment for services, services moving from the inpatient to

[8] Dreyzehner letter at 5-6.
[9] *Id*. at 7-8.

outpatient setting, and higher patient out-of-pocket costs including copayments and deductibles – which exacerbates revenue pressures because deductibles are increasingly difficult to collect. These trends are particularly challenging for rural hospitals: since January 2010, 87 rural hospitals in the U.S. have closed, including eight in Tennessee and two in Virginia.[10] Four WHS hospitals are rural, have fewer than 50 staffed beds, and an average daily census between 3 and 13. Seven of MSHA's hospitals are rural, have fewer than fifty staffed beds and a census from 1 to 35.

Other industry trends to which hospitals must adapt are the increased need for investment in population health, the management of information, and measurable improvements in cost and quality. The current economic environment prompts movement from more traditional approaches of healthcare delivery to new and more highly integrated care delivery and coordination of care. A component of such change is enhanced value-based and risk-based contracting between health systems and payors. A major benefit from such contracts is that they align the contracting parties' economic incentives to reduce utilization of services and promote wellness by enabling healthcare providers to share with payors in the savings that result from such efforts. The transition to new care models and delivery systems potentially involves significant reductions in hospital volumes and revenues, however, and also requires substantial investment in infrastructure, clinical realignment and governance to design the delivery system around patient-centered care. The Parties were hindered in their ability to do this independently, due to the high financial costs of implementation and risks in managing a dispersed rural population.

The WHS Board decided that WHS must merge with another system or be acquired in order to be successful long-term. This decision led to a search for a strategic partner. WHS issued 22 requests for proposals and received nine responses from health systems, including MSHA. After about a year of considering its options, WHS signed a term sheet in 2015 with MSHA to explore the creation of a new integrated delivery system, with local governance. In February 2016, the parties executed a Master Affiliation Agreement and Plan of Integration ("merger agreement").

MSHA and WHS were by far the two largest health systems in their GSA. They understood that the proposed merger, if pursued in the traditional manner, would likely face challenge under the antitrust laws. (Indeed, FTC staff extensively investigated the proposed merger at the same time the parties were seeking approval from the states, and later urged the states to deny the COPA/cooperative agreement on grounds that the merger was anticompetitive.) MSHA and WHS have consistently believed that this merger, pursuant to a COPA/cooperative agreement and active supervision, was the best outcome for the region. An acquisition of WHS by an out-of-market health system would have spurred MSHA to seek a

[10] *See 87 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at* http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (accessed Aug. 3, 2018).

purchaser to remain competitive with its new and better-capitalized rival. That scenario would have avoided antitrust concerns, but also would have perpetuated the status quo and missed the opportunity to bring substantial beneficial changes to the GSA.

It is also the subject of economic study that out-of-market acquisitions of hospitals are often followed by rate increases. Such an acquisition of WHS or MSHA, or of both by separate purchasers, would be outside the realm of antitrust enforcement. Ballad Health, on the other hand, is subject to ironclad, transparent and readily enforceable price restraint requirements under the COPA and cooperative agreement. FTC staff expressed concerns to Tennessee and Virginia officials that higher pricing would result if the COPA and cooperative agreement were approved. But since the merger has closed, Ballad Health has executed one payor contract. Under this new agreement, health care will cost less, not more, than it did before the merger – disproving the staff's concern.

Sales to out-of-market purchasers would not (i) maintain local governance, (ii) provide the unique opportunity to sustain and integrate health care delivery for residents into a high-quality and cost-effective local system, (iii) provide an enforceable, supervised commitment to limit pricing growth, (iv) keep hundreds of millions of dollars in the region, (v) commit the investment of those dollars to the improved health of this region, and (vi) preserve a substantial number of local jobs.

Ballad Health could point the Department to instances where an out-of-market acquisition led to the closure of a rural hospital, along with the losses of access and jobs that went with it. Contrast that scenario with Ballad Health's approach to the market. Last week, it announced plans to consolidate two hospitals in a rural community. Instead of closing a hospital, one hospital is being repurposed to provide post-acute services and additional new behavioral services needed by the community, while the other hospital – currently operating at below 30 percent capacity – will be better utilized with a higher census of acute patients.[11] In 2016, a for-profit company had offered to acquire one of the two hospitals, and then planned to acquire the second hospital. Its plan was to consolidate the market. This would have resulted in one hospital and the loss of hundreds of jobs. Instead, services are being expanded. Also, even if Ballad were to request to close a hospital, which it could only do with the state's approval, the "essential services" would be required to continue being offered. These essential services include emergency services, physician services, access to obstetrics and other key programs. Contrasting with the "market-based" approaches of the transactions referenced above, Ballad Health believes the health policy objectives of the states are plainly being met by the merger.

Prior to executing the merger agreement, the parties commissioned a nationally recognized healthcare consulting firm to identify and quantify the efficiency savings that would be reasonably available specifically from the merger of MSHA and WHS, through realignment

[11] https://www.beckershospitalreview.com/patient-flow/ballad-health-to-keep-former-rival-hospitals-open-restructure-services-4-notes.html

of resources and avoidance of unnecessary duplication. As a result of this process, quantified merger-specific efficiencies were found in the areas of operations-purchasing (non-labor), work force and clinical savings, totaling approximately $120 million annually. Two examples in the clinical area stand out as particularly instructive areas where efficiency-enhancing consolidation opportunities are unique to this merger.

One example pertains to the area's two Level I Trauma Centers, which are expensive to maintain and redundant in a region, like Ballad Health's, with low population density. No other region in Tennessee operates two Level I centers and even few major metropolitan areas offer two Level I trauma centers (see Miami, Tampa, Orlando, Charlotte). Consolidation of these programs into a single facility is projected to result in substantial cost savings. Moreover, studies show that higher-volume trauma centers result in better patient outcomes. Thus, a consolidation would likely result in lower cost and improved outcomes.

Another example was highlighted in a 2016 *60 Minutes* segment involving Wise County, Virginia, in a report about gaps in access to care for non-hospital health services and misplaced resources.[12] Wise County has a population of 47,000 that is steadily declining, yet the County has three full-service hospitals – two WHS, one MSHA – each with a census below 30. The reporter told the story of uninsured patients with chronic health conditions who were unable to access needed primary care services. Resources that could be spent on lower cost primary care and disease management initiatives were tied up in three acute care hospitals.

How does this happen? Incentives are improperly aligned. Prior to the merger, the hospitals in Wise County – as in many other rural areas today – were incentivized to provide acute care services, invest in physicians who perform high-cost procedures, and expand services for competitive reasons, even if they are duplicative. But fundamental health care needs of the population risk were not being met. The resources are there, but there is no organized incentive to change the model to address the needs of the region. The COPA creates this incentive.

Ballad Health will be able to reduce unnecessary cost, and refocus its resources to provide access for the medically underserved. Shifting physical resources and personnel to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce.

The day after signing the merger agreement, the parties filed an "Application for a Certificate of Public Advantage" with the State of Tennessee and an "Application for a Letter Authorizing Cooperative Agreement" with the Commonwealth of Virginia. In the applications, in addition to addressing a number of other relevant topics, the parties also offered specific commitments on how the merged system would reinvest its cost savings into the region,

[12] *See* "On the road with the Health Wagon," *60 Minutes*, March 24, 2016, available at http://www.cbsnews.com/videos/on-the-road-with-the-health-wagon (accessed July 10, 2016).

proposing to spend hundreds of millions of dollars over ten years to: improve population health; expand mental health, addiction recovery and substance abuse prevention programs; invest resources for children's health; meet physician needs, address service gaps, and preserve and expand rural services and access points; develop academic and research opportunities; support post-graduate healthcare training; facilitate the regional exchange of regional health information exchange; establish an electronic health record system within the merged system; and other commitments.

The legal process under which Tennessee and Virginia respectively evaluate COPA/cooperative agreement applications is described below.

Tennessee COPA Law

In 1993, the Tennessee enacted the Hospital Cooperation Act.[13] It requires the Department of Health, after consultation and agreement from the Attorney General, to issue a COPA if the hospital applicants have demonstrated by clear and convincing evidence that the likely benefits resulting from their proposed transaction outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.[14] The law expresses a policy to encourage integration among health care providers if the overall net effect is to facilitate "further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities;" it continues:

> The cost of improved technology and improved scientific methods for the provision of health care is significantly responsible for increasing the cost of hospital care. Cost increases make it increasingly difficult for hospitals to offer care to Tennessee citizens. Existing law has constrained the ability of hospitals to acquire and develop new and improved equipment and methods for the provision of hospital and hospital-related care. *Cooperative agreements among hospitals in the provision of hospital and hospital-related services may foster further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities.* Hospitals are in the best position to identify and structure voluntary cooperative arrangements that enhance quality of care, improve access and achieve cost efficiency in the provision of care. Because competition is important to the health care sector and some cooperative agreements may have anti-competitive effects that would operate to the detriment of the public, oversight is necessary to ensure that the benefits of the agreements outweigh any disadvantages

[13] Hospital Cooperation Act of 1993, Tennessee Laws Pub. Ch. 331 (1993).
[14] Tenn. Code Ann. § 68-11-1303(e)(1).

> attributable to any reduction in competition likely to result from the agreements. (Emphasis added).[15]

In 2015, the legislature reaffirmed that policy in an amended Hospital Cooperation Act.

> It is the policy of this state, in certain instances, to displace competition among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, in order to promote cooperation and coordination among hospitals in the provision of health services and to provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section.[16]

In evaluating a COPA application, the Department must consider whether the following benefits may result the merger:

- Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens;
- Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities;
- 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;
- Demonstration of population health improvement of the region served according to criteria set forth in the agreement and approved by the department;
- The extent to which medically underserved populations have access to and are projected to utilize the proposed services; and
- Any other benefits that may be identified.

The Department must also evaluate the following potential disadvantages attributable to a reduction in competition following the merger:

[15] Hospital Cooperation Act of 1993, Tennessee Laws Pub. Ch. 331 (1993).
[16] Tenn. Code Ann. § 68-11-1303 (effective May 18, 2015).

- The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations managed healthcare organizations, or other healthcare payors to negotiate appropriate payment and service arrangements with hospitals, physicians, allied healthcare professionals, or other healthcare providers;

- The extent of any reduction in competition among physicians, allied health professionals, other healthcare providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the cooperative agreement;

- The extent of any likely adverse impact on patients in the quality, availability, and price of healthcare 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 agreement.

Over the next 30 months, the parties produced large volumes of detailed information to the Department, in the form of substantial document submissions and comprehensive narrative responses to numerous of interrogatory-type questions, and participated in numerous in-person and telephonic meetings with officials from the Department of Health and the Office of the Attorney General. Contemporaneously, the parties were also responding to a comparably fulsome investigation and assessment of the merger by Virginia officials – first primarily by the Southwest Virginia Health Authority (which recommended approval of the cooperative agreement), then by the Department of Health and Attorney General – under the Commonwealth's cooperative agreement statute and accompanying regulations.

Virginia Cooperative Agreement Law

In 2015, Virginia enacted Virginia Code section 15.2-5384.1, which permits "cooperative agreements" between hospitals that are beneficial to citizens locate in a defined area in southwest Virginia that is coextensive with the region served by the Southwest Virginia Health Authority ("Authority"). It is in this area that Ballad Health's hospitals are located. In creating the Authority, the legislature noted that "rural communities such as those served by the Authority confront unique challenges in the effort to improve health care outcomes and access to quality health care."[17] A cooperative agreement is "an agreement among two or more hospitals for the sharing, allocation by merger or other combination of assets, or referral of patients, personnel,

[17] Va. Code § 15.2-5368(B).

instructional programs, support services, and facilities or procedures or other services traditionally offered by hospitals."[18] The statutes also states:

> The policy of the Commonwealth related to each participating locality is to encourage cooperative, collaborative, and integrative arrangements, including mergers and acquisitions among hospitals, health centers, or health providers who might otherwise be competitors. To the extent such cooperative agreements, or the planning and negotiations that precede such cooperative agreements, might be anticompetitive within the meaning and intent of state and federal antitrust laws, the intent of the Commonwealth with respect to each participating locality is to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority, and to invest in the Commissioner the authority to approve cooperative agreements recommended by the Authority and the duty of active supervision to ensure compliance with the provisions of the cooperative agreements that have been approved. Such intent is within the public policy of the Commonwealth to facilitate the provision of quality, cost-efficient medical care to rural patients.[19]

The Virginia law authorizes a cooperative agreement if the party applicants have demonstrated by a preponderance of the evidence that the likely benefits resulting from their proposed transaction outweigh any disadvantages attributable to a reduction in competition that may result from the agreement. The law requires the Virginia Department of Health to weigh factors very similar to the Tennessee factors listed above. Virginia also must consider whether benefits would include enhancement of population health status, participation in the state Medicaid program and total cost of care.[20]

State Approvals of the Merger

As noted, in September 2017, Tennessee approved issuance of the COPA, and in October 2017, Virginia approved the cooperative agreement. Certain details needed to be finalized with each state thereafter, but the merger closed January 31, 2018, and Ballad Health was created. The Tennessee "Terms of Certification," which state in great detail the requirements Ballad Health must meet under COPA, are contained in more than 100 single-spaced pages. The "New Health System Virginia Commitments" are comparable in their detail. The states' approvals of the merger are expressly conditioned on Ballad Health's to commitment to abide by and be subject to these terms. A substantial number of the final commitments originated with the parties themselves, in their applications to each state at the beginning of this process.

One category of commitments pertains to payor contracting. This submission does not delve into the details of those commitments, but Ballad Health represents to the Department that they provide ironclad protections for insurers, employers, employees, patients and their families

[18] Va. Code § 15.2-5369.
[19] Va. Code § 5.2-5384.1.A.
[20] Va. Code § 5.2-5384.1.E (2).

to ensure pricing practices by Ballad Health that are reflective of a competitive market. This category includes a comprehensive and enforceable set of conditions that will establish a rate of growth in health care prices that will be lower in the GSA than the national average. These commitments to limit pricing growth are one reason why merger received strong support from the region's chambers of commerce and its largest self-insured employers.

Other commitments by Ballad Health include (all expenditures over the next ten years):

- $85 million for behavioral health, to create new capacity for residential addiction recovery services and develop community-based mental health resources, like mobile health crisis management teams and intensive outpatient treatment options.
- $85 million in academics and research, to educate and train healthcare providers that are in short supply in the GSA and build the research capacity of universities and colleges serving the region to spur economic development.

- $75 million to address key population health needs, with a focus on some of the most serious threats to the region's health, including diabetes and infant mortality.

- $27 million directed toward children's services to create pediatric emergency rooms in Kingsport and Bristol, with further expansion of pediatric telemedicine, mobile health and specialty clinics in rural areas.

- $28 million directed toward rural health services, including improved access to same-day primary care services and support for maternal and prenatal health.

- $8 million to enable health information exchange, allowing healthcare providers both inside and outside of Ballad Health to more easily share important health information that improves patient care.

- Keeping all hospitals operated by Ballad Health today open as health care institutions for at least five years, and maintaining essential health care services in all counties where Ballad Health currently operates.
- Bringing a pediatric trauma center to the GSA.

- Negotiating in good faith with all insurance providers and working together with independent physician groups to develop a regional clinical services network. The health system will not require independent physicians to practice exclusively at its hospitals or limit their ability to contract with insurers of their choice.

- Publicly measuring Ballad Health's quality information and focusing on becoming one of the top performing health systems in the nation.

None of the preceding benefits would occur, or would occur with the impact of the combined system, if not for the merger that created Ballad Health.

Conclusion

Ballad Health understands that the subject of exemptions and immunities from the antitrust laws is a critically important one to the Department's mission and to antitrust policy. Ballad Health hopes that, in light of its history and present, this submission adds a productive voice and perspective to the Department's consideration of this topic, and Ballad Health appreciates this opportunity to submit these comments.

Sincerely,

Jeffrey W. Brennan

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