



Rhode Island – Legal and Regulatory Options for Addressing Health System Consolidation

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OPTIONS FOR RHODE ISLAND TO OVERSEE HEALTH SYSTEM CONSOLIDATION



DETAILS OF THE
MARKET & MERGER



FTC PROTOCOL AND
ANALYSIS



POTENTIAL STATE
OPTIONS

RHODE ISLAND HAS A RELATIVELY COMPETITIVE MARKET FOR HOSPITAL SERVICES

- Providence –Warwick was one of the least concentrated metro areas in the U.S. (by inpatient HHI) and became significantly less concentrated from 2013 to 2017

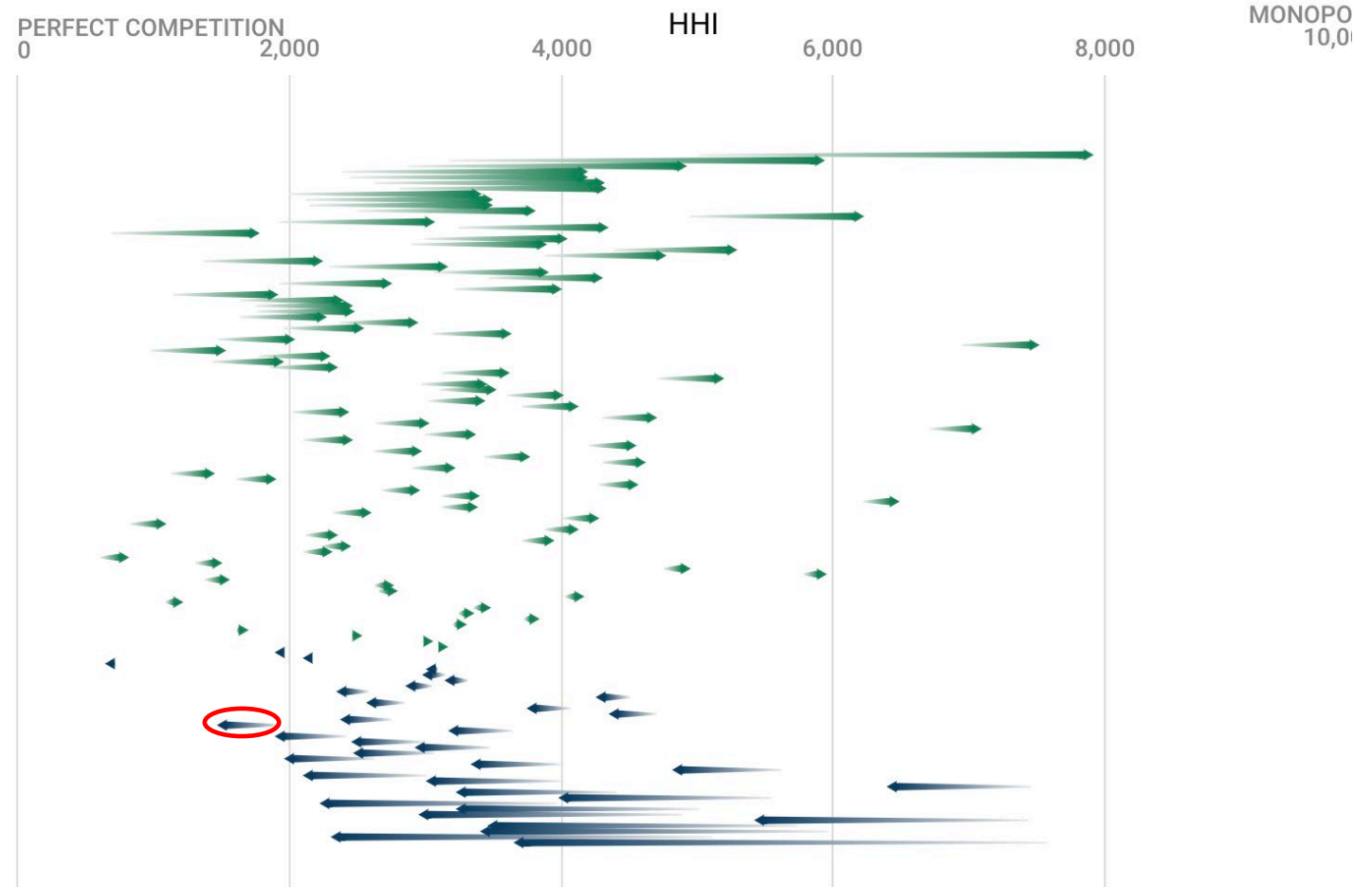
Source: Health Care Cost Institute, Healthy Marketplace Index,
<https://healthcostinstitute.org/hcci-origins/healthy-marketplace-index/hmi>

Change in Hospital Market Concentration by U.S. Metro 2013-2017

HHI INCREASED

HHI DECREASED

Hover or click to highlight



COMPETITION APPEARS EFFECTIVE IN RI

- Providence-Warwick also experienced some of the lowest price increases in the U.S.

Source: Health Care Cost Institute, Healthy Marketplace Index,
<https://healthcostinstitute.org/hcci-origins/healthy-marketplace-index/hmi>

Comparing Changes in Hospital Market Concentration and Prices 2013-2017

Concentration Level ⓘ

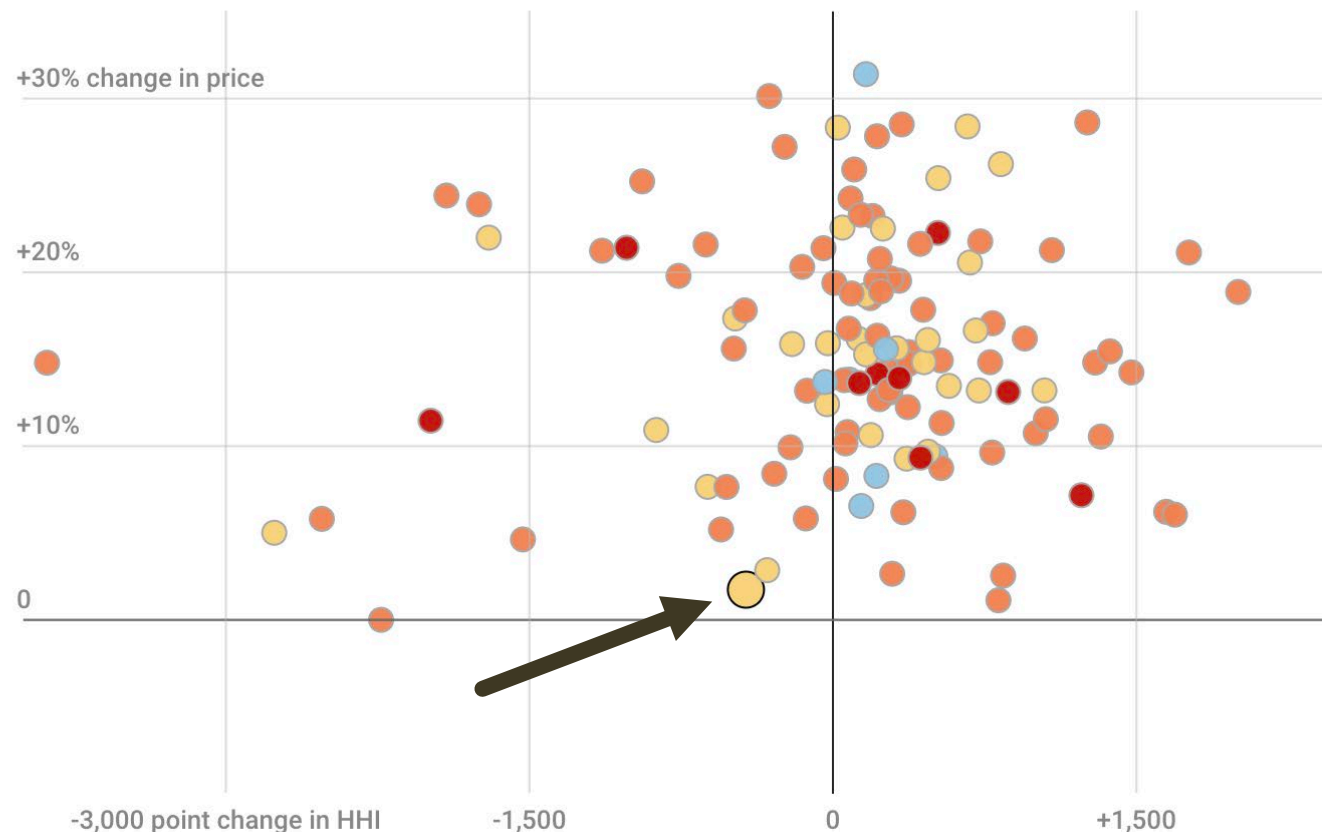
UNCONCENTRATED

MODERATE

HIGH

VERY HIGH

👉 Hover or click to highlight



PRICES IN PROVIDENCE INCREASED NEAR THE NATIONAL AVERAGE FROM 2013 TO 2017

Hospital Market Concentration

UNCONCENTRATED

MODERATE

HIGH

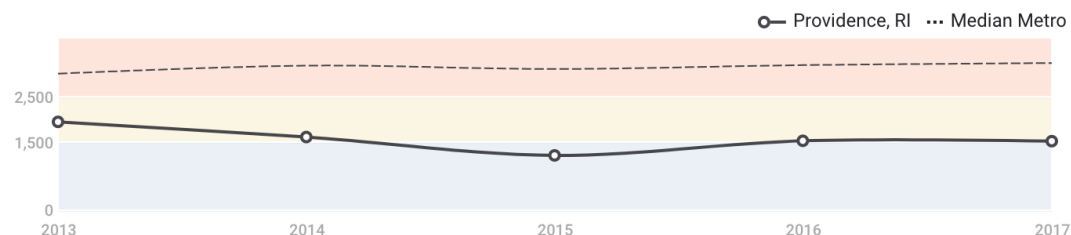
VERY HIGH

Hover over the chart below to see more.

Hospital Market Concentration (HHI)

-425

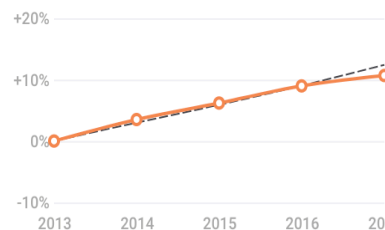
Change in HHI since 2013



Overall Price

+11%

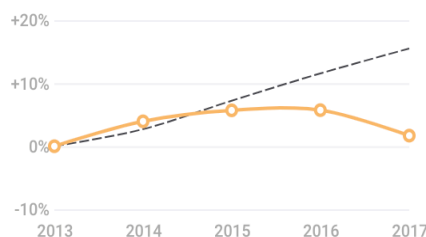
Change since 2013



Inpatient Price

+2%

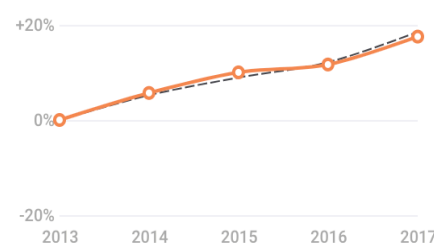
Change since 2013



Outpatient Price

+18%

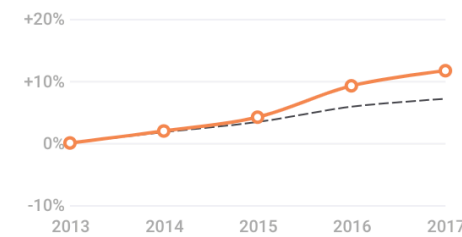
Change since 2013



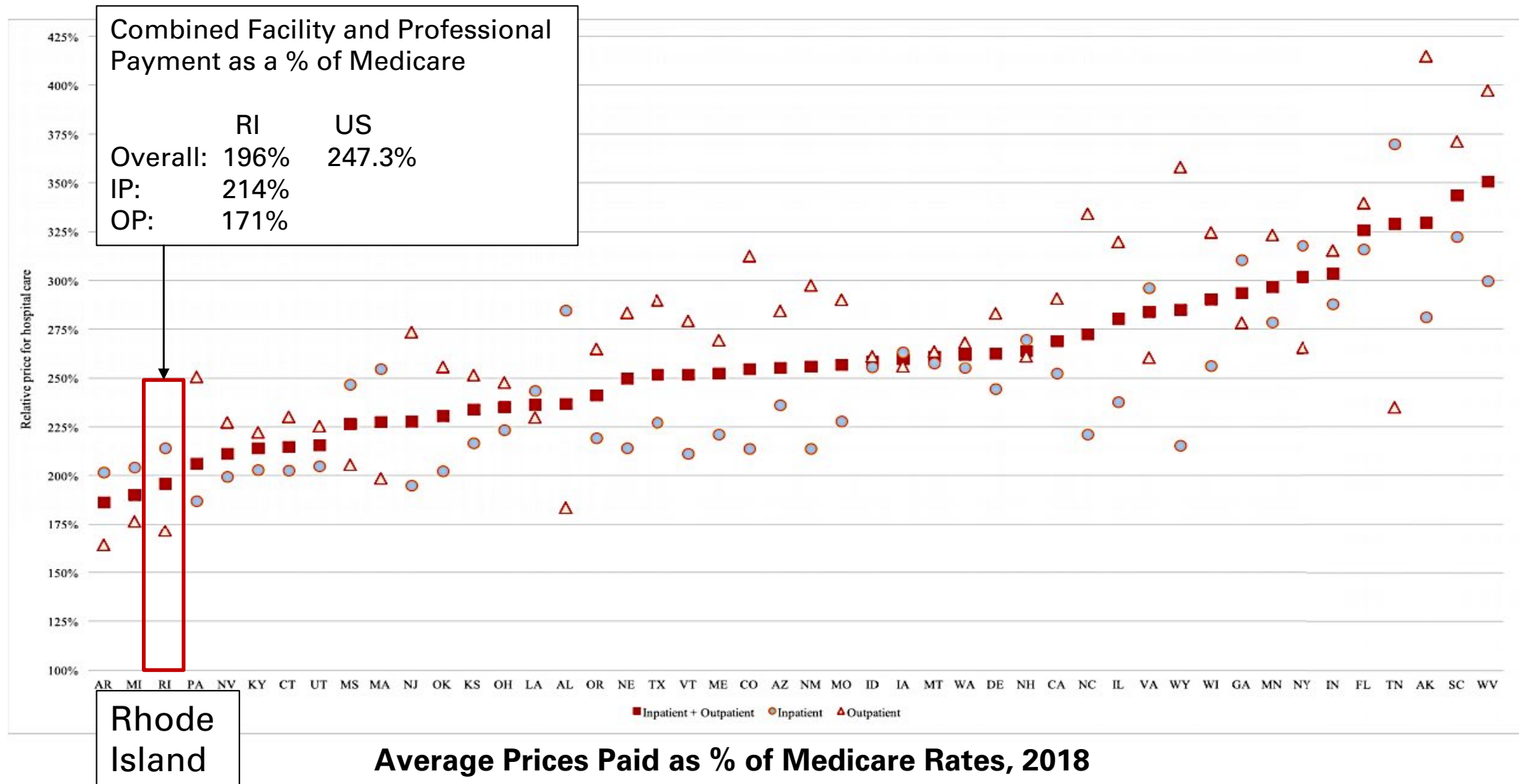
Professional Price

+12%

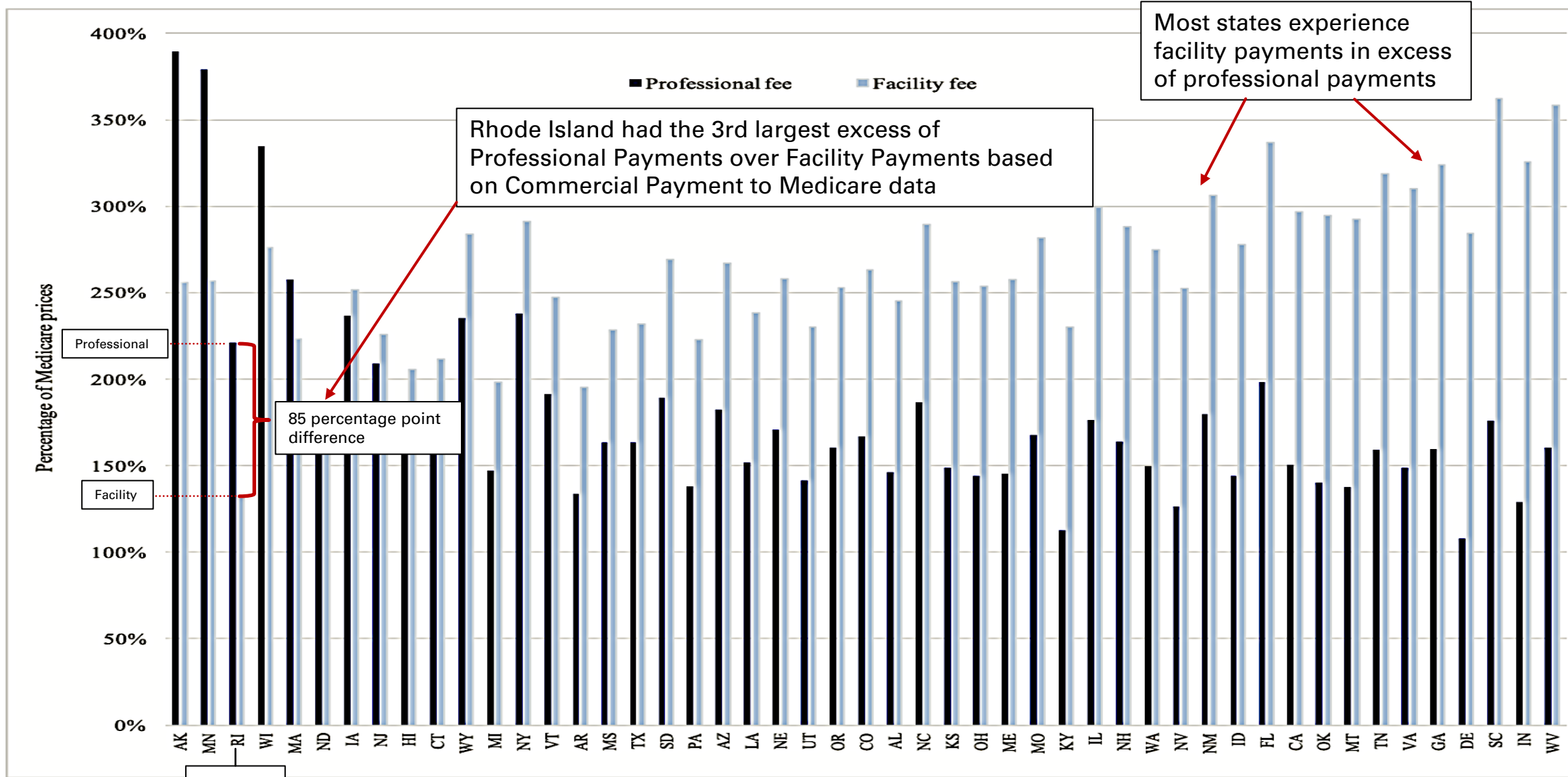
Change since 2013



HOSPITAL & PROFESSIONAL PRICE LEVELS ACROSS STATES



RELATIVE FACILITY AND PROFESSIONAL PRICES, BY STATE 2016-2018



REVIEW OF RHODE ISLAND PROVIDER PRICE LEVELS

- Providence-Warwick MSA has low to moderate levels of hospital concentration and relatively low hospital price growth (HCCI data 2013-2017).
- Rhode Island Hospital commercial price levels (combined total facility and professional) were among the lowest in the U.S. per the 2018 RAND report on commercial payments relative to Medicare.
- While Rhode Island's commercial facility payments are the lowest in the US (per RAND 3.0), professional payments* were found to be among the highest (5th highest out of 46 states in 2018).
- Data from the Health Care Cost Institute (HCCI) seem to corroborate these observations – showing low to flat growth in hospital inpatient commercial payments in the Providence-Warwick MSA and for the state as a whole - but more rapid physician commercial payment growth 2013-2017.
- Data from HCCI Annual Cost Report Appendix 2013 – 2017 by State show more rapid growth in Rhode Island:

	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>Pct. Change</u>
HCCI Physician Price Index	90.79	94.5	97.83	106.2	111.4	22.70%
						2nd most rapid growth among States 2013-17

* RAND Professional Payments are only those associated with a facility service
RHODE ISLAND - LEGAL AND REGULATORY OPTIONS TO ADDRESS HEALTH CARE CONSOLIDATION 2020-2021

EVIDENCE OF RAPID PHYSICIAN/HOSPITAL CONSOLIDATION 2016-2018

- The Providence-Warwick MSA has experienced relatively rapid consolidation of physician groups 2016-2018 (1):

Name	2018 Share of Physicians in Health Systems	2018 Share of Physicians in Largest Health System	2016 Share of Physicians in Health Systems	2016 Share of Physicians in Largest Health System	2016-2018 Pct Point Change Physicians in Health Systems	2016-2018 Pct Point Change Physicians in Largest Health System
Providence-Warwick	61.0%	23.3%	40.3%	17.0%	20.8	6.4
	9th Highest		27th Highest		2nd Largest Pct. Point Change	
Providence is 9th highest out of 60 MSAs with population > 500,000						
By Comparison:						
Highest MSA	70.8%	Portland OR				
Fastest Growth MSA						22.4 SF/Oak/Hayward

(1) Geographic Variation in the Consolidation of Physicians into Health Systems, 2016–18. Kimmey et al. Health Affairs Data Watch. January 2021.

DETAILS OF THE PROPOSED MERGER

Lifespan

- 5 Hospitals – Newport, Bradley, Rhode Island Hospital, Hasbro Children's Hospital, and Miriam
- 49.9% of Market Share in 2019*

Care New England

- 3 Hospitals – Butler, Kent, Women & Infants
- 28.5% of Market Share in 2019*
- Many of these hospitals are within 5 miles of each other, all are within approximately 1 hr.

* Market share estimates based on Care New England 2019 Financial Reports

Care New England Competition



COMMERCIAL PAYMENT AS A PERCENTAGE OF MEDICARE FOR FACILITY AND PROFESSIONAL SERVICES 2018

	Low Combined Facility & Professional	Low Facility Prices	High Professional Prices
	A	B	C
Line	Total Facility & Professional IP and OP	Facility Payment IP and OP	Professional Payment (1) IP and OP
1 US	247%	263%	171%
2 Rhode Island	196%	185%	256%
Relative Position vs. other states	2nd lowest out of 46 states	Lowest out of 46 states	5th highest of 46 states
3 Care NE	118%	109%	191%
4 Lifespan	182%	168%	268%
Hospital & System Detail			
5 Memorial Hospital of RI	122%	117%	150%
6 Kent Co Mem.	189%	186%	205%
7 Women and Infants	91%	82%	186%
8 Care NE Overall	118%	109%	191%
9 Newport Hospital	179%	169%	222%
10 Rhode Island Hospital	175%	160%	280%
11 The Miriam Hospital	205%	196%	252%
12 Lifespan Overall	182%	168%	268%

(1) Professional Services only includes those associated with a facility claim

Source: RAND 3.0

OPTIONS FOR RHODE ISLAND TO OVERSEE HEALTH SYSTEM CONSOLIDATION



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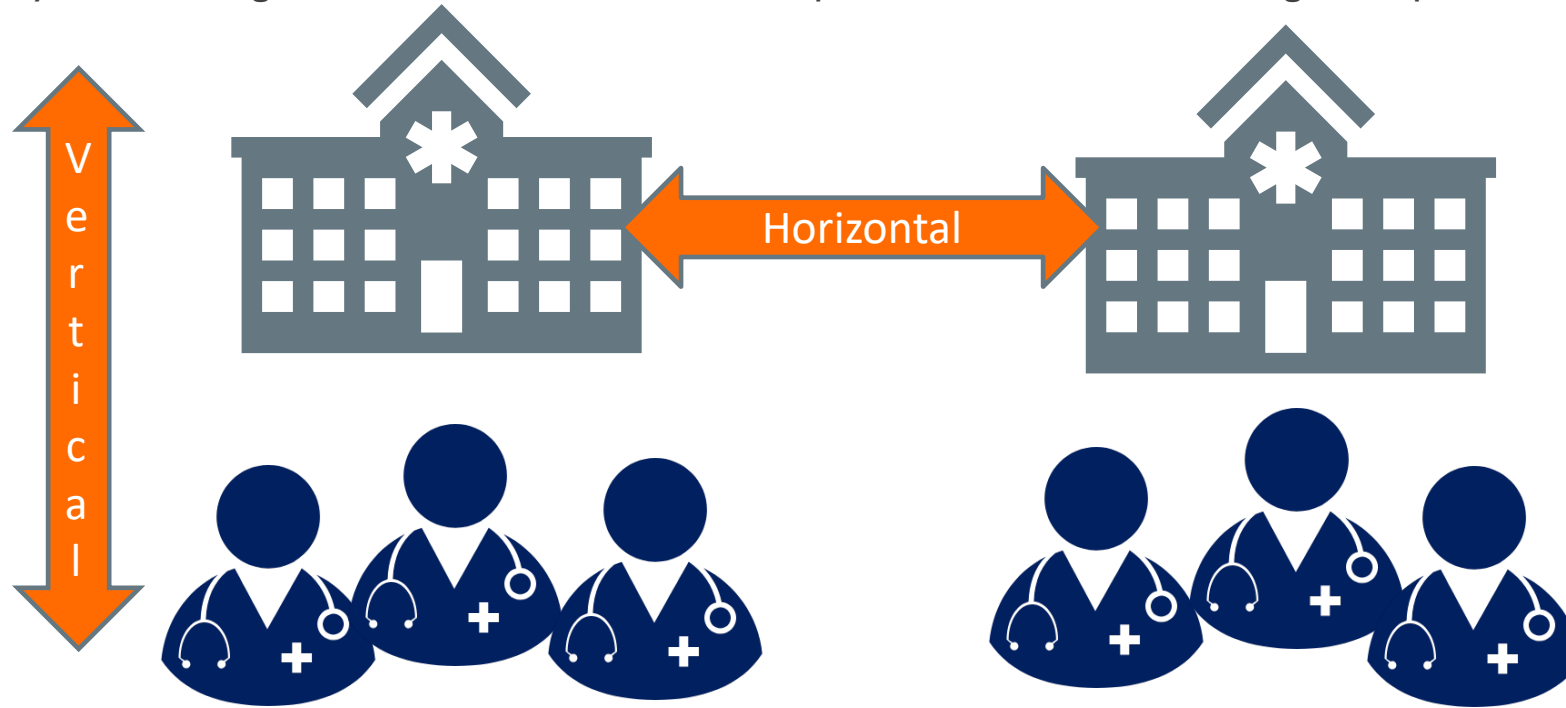
FTC PROTOCOL AND
ANALYSIS



POTENTIAL STATE
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FTC PROTOCOL AND ANALYSIS

- Hart-Scott-Rodino Filing Threshold 2020 - \$94M
- FTC will analyze the merger to determine whether the potential benefits outweigh the potential harms to competition



FTC MERGER ANALYSIS

- §7 Clayton Act prohibits mergers where the effect “may be substantially to lessen competition, or tend to create a monopoly”
- Diversion Analysis
 - Are the merging entities direct competitors and substitutes?
 - If one merging system were removed from an insurer’s network, where would a patient go for services?
 - Diversion Ratio – Fraction of patients diverted to hospitals in the merging system if the other system were not available
- Market Share and Concentration Analysis
 - Herfindahl-Hirschman Index (HHI) – sum of the squares of market shares
 - Horizontal Merger Guidelines and case law establish thresholds of **post-merger HHI over 2500** and **an increase of over 200 points** in HHI to be presumptively anticompetitive and illegal.
 - Based on 2019 Market share estimates, Lifespan-Care New England merger would have an estimated **post-merger HHI > 6300** and **an approximate increase > 2800 points**.
- Descriptive Analysis of Geographic and Service Overlaps
 - Compare inpatient discharge data covering 1 year
 - Considers which hospitals are chosen by all commercial patients who reside in the geographic market
 - Aids in determining extent of competition between merging entities

COMPARISON OF HOSPITAL MERGER CASES CHALLENGED BY FTC

RHODE ISLAND - LEGAL AND REGULATORY OPTIONS TO
ADDRESS HEALTH CARE CONSOLIDATION 2020-2021

Case	Combined Mkt Share	HHI Increase	Post-Merger HHI	Outcome
University Health (11 th Cir. 1991)	43%	630	3200	Enjoined
ProMedica Health System (6 th Cir. 2014)	58%	1078	4391	Enjoined
OSF Healthcare (N.D. Ill 2012)	59%	1767	5179	Enjoined
Rockford Memorial (7 th Cir. 1990)	68%	2322	5111	Enjoined
Advocate Health Care Network (7 th Cir. 2016)	60%	1782	3943	Enjoined
Penn State Hershey Medical Center (3 rd Cir. 2016)	76%	2582	5984	Enjoined
Hendrick/ Abilene/ Brownwood (Inpatient)	85%	3391	7266	TX COPA
Shannon/ SACMC (Inpatient)	62.3%	1467	4171	TX COPA
Jefferson County/Einstein Health Care*	60%	1200	4500	Dist. Ct. Denied Challenge

FTC Public Comment on Certificate of Public Advantage Applications of Hendrick Health System and Shannon Health System, September 11, 2020, Appendix B, Jefferson County FTC Complaint,

DATA ON RESULTS FROM HEALTHCARE MERGERS



Horizontal (Part 1)

- **Increased Prices:** Post-merger hospital prices increased 20-44% (Dafny, 2009; Haas-Wilson & Garmon, 2011; Tenn, 2011; Gaynor & Town, 2012)
- **Mixed to Negative on Quality:** Hospital acquisition associated with modestly worse patient experiences, reduced quality, or no effect (Gaynor et al. 2013; Koch et al. 2018; Short and Ho, 2019; Beaulieu, Dafny, et al., 2020)

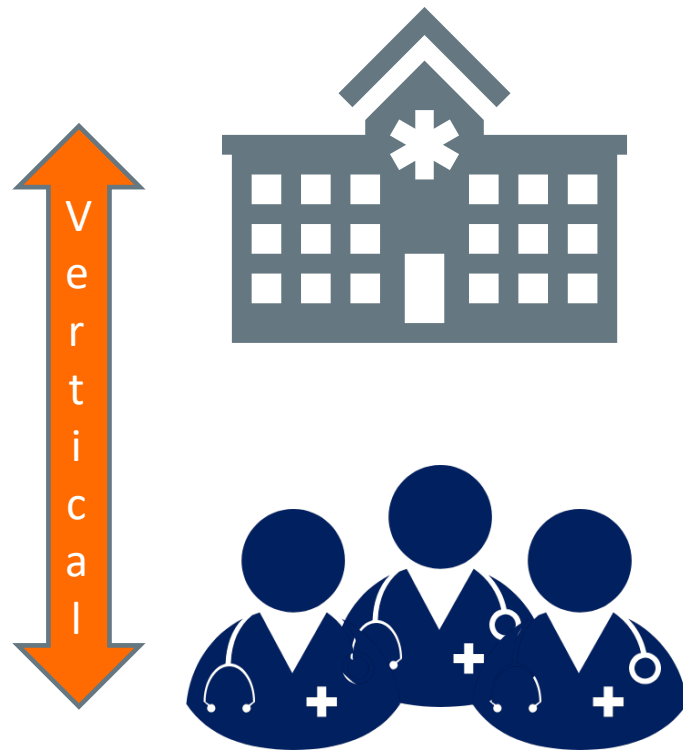
DATA ON RESULTS FROM HEALTHCARE MERGERS



Horizontal (Part 2)

- **Increased Premiums:** Higher hospital concentration associated with higher ACA premiums (Boozary, et al., 2019)
- **Reduced Wage Growth:** Hospital mergers reduced wage growth by 6.3% for nurses and pharmacists (Prager and Schmitt, 2019)
- **Higher Costs:** Hospitals in larger systems have higher operating costs than hospitals in smaller systems (Burns et al., 2015)

DATA ON RESULTS FROM HEALTHCARE MERGERS



Vertical

- **Higher Physician Prices:** Physician prices increase post-merger by an average of 14% (Capps, Dranove, & Ody, 2018)
 - Cardiologist prices increased by 33.5% (*Id.*)
 - Orthopedist prices increased by 12-20% (Koch and Ulrick, 2017)
- **Higher Clinic Prices:** Hospital-acquired clinic prices increased 32–47% within four years (Carlin, Feldman & Dowd, 2017)
- **Higher Hospital Prices** (Baker, Bundorf, Kessler, 2014)
- **Little to no quality improvements** (McWilliams et al. 2013; Neprash et al. 2015; Short and Ho, 2019)

FTC EVALUATION OF POTENTIAL BENEFITS

- Any claimed benefit must be sufficiently substantiated by the merging parties. FTC has become wary of empty promises.
- Merging entities must be able to verify by reasonable means :
 - The likelihood and magnitude of each asserted efficiency,
 - How and when each would be achieved (and any costs of doing so),
 - How each would enhance the merged firm's ability and incentive to compete, and
 - Why each would be merger-specific. (FTC Comment on Hendrick-Abilene merger).
- When a proposed merger is likely result in substantial loss to competition (by hitting thresholds), the Merger Guidelines require a showing of **extraordinary efficiencies** to overcome the harm.
 - "Efficiencies almost never justify a merger to monopoly or near monopoly."



FTC RESPONSE TO RATE REVIEW MECHANISM

- FTC has not viewed rate review mechanisms as a substitute for competition.
 - Harms result from more than prices
 - Doubtful that conduct remedies can drive as meaningful cost savings and quality improvements as competition can
 - Reductions in cost may affect quality
- FTC views conduct remedies as typically temporary, difficult to measure and enforce, and often insufficient to meet their goals
- Require very specific guidelines that would adapt to new payment models over time, strong accountability and enforcement mechanisms.

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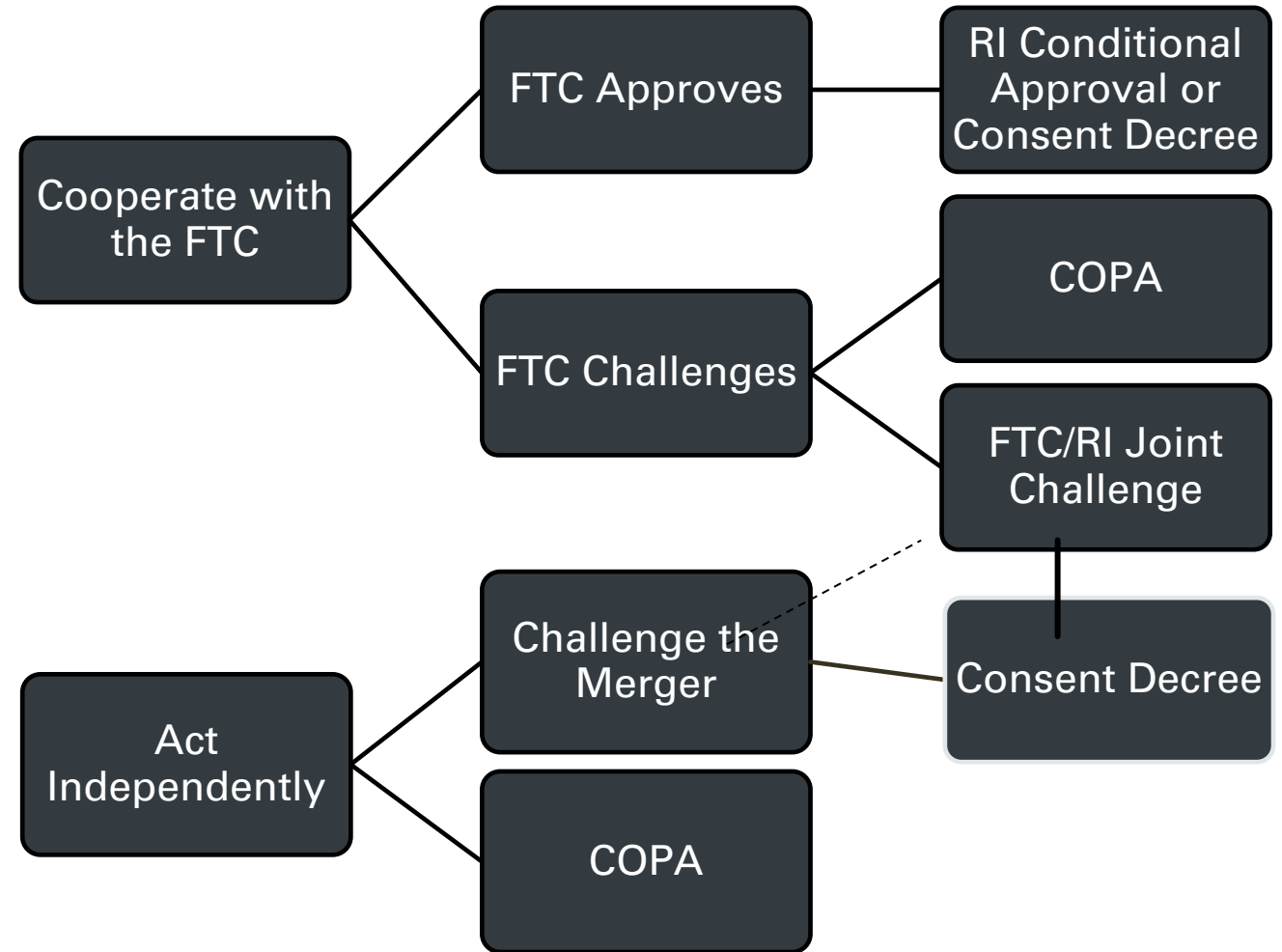


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POTENTIAL STATE
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RHODE ISLAND'S OPTIONS TO MERGERS



CHALLENGE OR REJECT THE MERGER

- DoH/AG can reject the merger as part of the Merger Review Process governed by the Hospital Conversion Act.
 - DoH required to consider a range of criteria, including impact on affordability and “issues of market share especially as they affect quality, access, and affordability of services.” R.I. Gen. Laws §23-17.14-11 and 216 RICR 40-1 — 23.(c)(1).
 - AG required to review the merger under the RI Antitrust Act (6 R.I. Gen. Laws Ann. §6-36-5), which makes it unlawful to to establish or attempt to establish a monopoly to exclude competition or fix prices.
- AG can challenge the merger as violating §7 of the Clayton Act
- AG can partner with the FTC in its challenge.

CONDITIONAL APPROVAL

- DoH and the AG can impose conditions on the merged entity as part of their merger approval process under the Hospital Conversions Act.
- Typical Conditions Imposed in RI
 - Maintain existing services for certain amount of time
 - Participate in quality initiatives
 - Entities agree to participate in CurrentCare
 - Reporting requirements
 - Participation in Medicaid
 - Use charitable assets for the intended purpose
- Remains open to FTC review and challenge
- Long-term risk of agency capture and legislative influence

CONSENT DECREE

- Attorney General can negotiate conditions on the merged entity in exchange for not challenging the merger under Federal antitrust law.
- Must be approved by a judge.
- More difficult to modify over time.
- Consent decree terms are typically time limited.
- Remains open to FTC review and challenge.

CONSENT DECREES

A Typology of Consent Decrees	Examples
1. Insurer-Provider negotiation requirements	Require access to binding arbitration Require use of firewalls in contract negotiations
2. Limitations on contract terms	Prices, price increases, or margins
3. Prohibit or require certain contract provisions	Prohibit most favored nations clauses, gag-clauses, anti-steering provisions
4. Prohibit or require conduct	Require release from a noncompete clause Prohibit CON challenges
5. Ensure access to certain populations and certain services.	Ensure access to low-income individuals and/or women's health services

Source: Berenson, King, Gudiksen, Murray, and Shartzter, Addressing Health Care Market Consolidation and High Prices, Urban Institute Report January 2020

STATE ACTION DOCTRINE AND CERTIFICATES OF PUBLIC ADVANTAGE

- State Action Doctrine
 - Judicially created doctrine to resolve conflicts between federal antitrust policy and state policies that authorize anticompetitive conduct.
 - The Supreme Court in *Parker v. Brown* established that states may prioritize other interests above competition, and in doing so immunize such activities from state and federal antitrust review. 317 U.S. 341 (1943).
 - Can apply to direct state action or conduct by private entities engaged in state-sanctioned activity.

CERTIFICATE OF PUBLIC ADVANTAGE

- To confer state action immunity, states must satisfy a two-pronged test set out in *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum*, 445 U.S. 97 (1980) by:
 - Clearly articulating its intention to subvert competition in favor of other public priorities; and
 - Engaging in active supervision
- State legislatures typically enact a generic COPA statute that grants the hospitals and/or health care providers the ability to enter into cooperative agreements and then apply to the state for a specific Certificate of Public Advantage.
- The Certificate of Public Advantage or the Terms of the Certificate typically outlines in detail the terms and conditions of the specific merger and state oversight.
 - 9 states have established COPAs related to health care provider mergers.

CLEAR ARTICULATION OF INTENT

- Maine COPA Statute
- The Hospital and Health Care Provider Cooperation Act, supports cooperation among providers, provides for the issuance of certificates of public advantage, and provides an exemption from federal antitrust scrutiny (under the state action doctrine). The articulated purpose of the law is:
- “The Legislature finds that it is necessary and appropriate to encourage hospitals and other health care providers to cooperate and enter into agreements that will facilitate cost containment, improve quality of care and increase access to health care services. This Act provides processes for state review of overall public benefit, for approval through certificates of public advantage and for continuing supervision. It is the intent of the Legislature that a certificate of public advantage approved under this chapter provide state action immunity under applicable federal antitrust laws.” [22 M.R.S. §§ 1841-52.](#)



ACTIVE SUPERVISION

- Required when private entities are engaging in anticompetitive conduct, not state actors themselves.
- Active state supervision:
 - Is not pro forma review
 - States must engage in a formal, independent analysis of behavior.
 - States must monitor and enforce terms of the COPA agreement regularly to ensure continued alignment with state policy.
 - Active supervision is required for the duration of the COPA.
 - Costs of conducting this oversight can and should be paid for by the merged entity.

CONDITIONS VS. COPA

Consent Decree/Conditional Approval

- Accomplished through existing processes
- Enables FTC review to continue
- Conditional approval is vulnerable to capture, political changes, or legislative intervention
- Consent decree is less vulnerable and less flexible than conditional approval and COPAs
- Both generally time limited

COPA

- Allows merger to proceed free from federal or state antitrust challenge so long as the state provides active supervision.
- Requires passage of generic COPA legislation
- If designed well, can provide comprehensive oversight, control costs, and offer benefits to the state.
- Ongoing oversight – not term limited.
- Less vulnerable to agency capture or administration change
- Risk of legislative intervention remains
- Can design the COPA to disincentivize its repeal

THE PROCESS TO IMPLEMENT A COPA IS FORMIDABLE

- Enabling COPA statutes are generic and indicate how the COPA meets the two-part test for state action immunity.
- The published rules laying out the process can vary tremendously and become the source of what the merged entity commits to do and, ultimately, the conditions the state imposes on the entity (the reading file contains the 16-page rule developed by the Tennessee Department of Health as a strong prototype)
- The rule address the application process, with pages of detail asking how the Cooperative Agreement between the merging entity specifically plans to achieve the state's articulated objectives. Examples of topics to be addressed include: governance, financial performance, patient access, quality improvement, organizational and clinical integration, financial and clinical metrics, impact on market competition, and contingency plans of separation of the parties.
- The rule also details the elements documenting the state's active supervision of the terms of certification.
- The reading file also contains the text of the 2+ page Certificate of Public Advantage the TN Department of Health awarded to the Ballad Health, the result of the merger of two systems. It documents key milestones that occurred over a two-year period (long because both Tennessee and Virginia had to cooperate on granting COPA and because the judgment on whether to award the COPA was a difficult one and was informed by extensive consultation and public comments.)
- The Certificate provides the high-level conditions under which the Certificate is granted.

COPAS LEAVE STATE VULNERABLE IF THEY ARE TERMINATED

- **Studies show COPAs can control prices reasonably well with active oversight, but prices increase rapidly after termination.**
- **Despite promises of quality improvement, there is a lack of evidence demonstrating that COPAs effectively protect or improve quality**

POTENTIAL MOTIVATIONS AND FUTURE STRATEGIES OF CONSOLIDATED ENTITIES

- A consolidated system in Rhode Island could ultimately seek to:
 - Pursue insurer negotiation and political strategies to increase prices and revenues using newly established market power and associated political power
 - Pursue physician consolidation strategies to generate a steady stream of referrals to system hospitals
 - Make use of physician organizational strategies to raise physician fees and revenues
 - Direct newly generated revenues to:
 - Accumulate system cash and reserves to enhance bond ratings for future borrowings to facilitate facility expansions, the purchase of new technologies and additional physician practice acquisitions;
 - Increase spending on payroll and executive salaries; and
 - Increase political donations and lobbying efforts.

(evidence of hospital behavior cited in “Politics, Hospital Behavior and Health Care Spending” Cooper et al. 2017)

ADDITIONAL CONSIDERATIONS – NEED TO DEFINE TERMS OF A SUCCESSFUL COPA

- **Oversight Entity**
 - Creation of an Oversight Board (e.g. Green Mountain Care Board)
 - Independent COPA Monitor
 - State Agency (DoH, DoI)
- **Detailed and Timely Quality Reporting Measures**
 - In Tennessee, a Clinical Council reviews 83 specific quality measures and computes quality score based on algorithm.
 - Low scores can result in corrective action plan.
 - Must publicly report high priority quality measures, including those used by the Joint Commission and CMS
- **Monitor and Mitigate Depressed Wage Growth**
 - See, [Elena Prager & Matt Schmitt, *Employer Consolidation and Wages: Evidence from Hospitals*, Washington Center for Equitable Growth Working Paper \(2019\)](#),
- **Investments in Charity Care, Health Services, Population Health Improvement, Graduate Medical Education**
 - Tennessee and Virginia required Ballad to invest \$380 million over 10 years in community reinvestment funds.
 - In North Carolina, Mission was required to document savings of at least \$74 million (5% of base-year revenues) and pass the savings to the community as free or discounted care.
 - In South Carolina, 10% of the system's annual profits must be used to fund outreach programs in cancer and maternal and child health.
- **Adverse Impact on Competition Other than Price Effects**
 - See, [Martin Gaynor, *What to Do About Health-Care Markets: Policies to Make Health-Care Markets Work* \(March 2020\)](#).

COPAS IN OTHER STATES



STATES WITH COPAS

	State(s)	Health System	Year COPA Began	Year COPA Ended
Existing COPAs	Texas	Hendrick/Abeline	2020	Ongoing, but can be voluntarily terminated by the hospital with 30 days notice
		Shannon/ SACMC	2020	Ongoing, but can be voluntarily terminated by the hospital with 30 days notice
	Tennessee/Virginia	Ballad Health System	2018	Ongoing, but suspended due to COVID-19
	West Virginia	Cabell Huntington Hospital	2016	Ongoing, will expire 2024
	South Carolina	Palmetto Health System	1998	Ongoing, but most oversight ended in 2003
Previous COPAs	Montana	Benefits Health System	1996	Repealed 2019
	North Carolina	Mission Health System	1995	Repealed 2015
	Maine	Maine Health System	2009	Expired 2015
	Minnesota	HealthSpan System	1994	-

EARLY COPAS

- **North Carolina 1995 (Mission Health System, 2 hospitals in Asheville, NC)**
 - After 20 years of oversight, Mission Health lobbied state legislature to repeal COPA statute in 2015. In Feb. 2019, Mission Health was acquired by HCA.
 - During oversight period, price increases were ambiguous (whether COPA impacted price increases depends on what hospitals are used as controls), but after COPA termination, prices rose substantially, and now Asheville has a for-profit monopoly provider system without state oversight.
- **Montana 1996 (Benefis Health System, 2 hospitals in Great Falls, MT)**
 - After 10 years of oversight, Benefis lobbied state lawmakers to repeal its COPA.
 - During oversight period, prices tracked those in similar duopoly markets, but significant price increases occurred after termination (~20%)
- **South Carolina 1998 (Palmetto Health System, 2 hospitals in Columbia ,SC)**
 - Most conditions were removed in 2003 (after 6 years of oversight) and in November 2017, Palmetto Health merged with Greenville Health System to create the largest health system in South Carolina (Prisma Health System).
 - COPA is being used to challenge further acquisitions by the merged entity (2020).
- **Maine 2009 (MaineHealth acquisition of Southern Maine Medical Center, Portland/Southern ME)**
 - COPA was scheduled to terminate after 6 years.
 - Garmon and Bhatt (2020) reported
 - SMMC prices were slightly lower than average during the COPA, but they increased close to 40% following the COPA termination.
 - Mixed quality results during the COPA, and a “marked deterioration in patient outcomes” after the COPA,
 - These effects may have occurred due to additional consolidation by MaineHealth.

EXAMPLES OF CONDITIONS IN COPA REGULATIONS

- Limitations on prices or price growth
- Improvements in quality
- Investments in community, specific facilities, charity care, quality initiatives, IT etc.
- Require participation in risk-based payment models
- Commitment to continued operations and continued types of care – rural health care, children's health, behavioral health, charity care etc.
- Employee protections and restriction on physician employment
- Annual reports including an updated Plan of Separation, which must be verified by a qualified third-party
- Agreements negotiate in good faith/ Not to refuse to negotiate
- Limitations on use of potentially anticompetitive contract terms
- Limits on out of network pricing and balance billing practices
- Articulation of specific metrics to measure each claimed benefits along with independent sources of data for verification

COST CONTROLS IN PREVIOUS COPAS

State	Price Caps	Other Contract and Negotiation Requirements
Tennessee and Virginia (Ballad)	<ul style="list-style-type: none"> • CMS Medicare Market basket amount plus 0.25%. • Applies to all payers, including small commercial payers, Medicare Advantage, and Medicaid payers. 	<ul style="list-style-type: none"> • No most-favored-nation, all-or-nothing, anti-tiering, or anti-steering clauses • Must negotiate in good faith with all payors, including those with low market shares • Exclusive contracts need approval
Montana (Benefis)	<ul style="list-style-type: none"> • Total Revenue Cap of Total Cost Target plus 6% adjusted for inflation using the Bureau of Labor Statistics Hospital Producer Price Index. • Cumulative amount of excess revenue from patient sources not to exceed \$3.5 million annually. 	
South Carolina (Palmetto)	<ul style="list-style-type: none"> • System must maintain pricing parity with “similar facilities” • Reduced gross charges for all payers • Growth in gross revenue may only result from higher patient volume 	
North Carolina (Mission)	<ul style="list-style-type: none"> • Overall profit margin caps (set at larger of 3% or average of comparable NC hospitals) • Limits on average inpatient and outpatient cost growth to a set of comparable NC hospitals. 	<ul style="list-style-type: none"> • Fair dealings with insurers including no MFNs or tying of physician and hospital services

OVERSIGHT OF PHYSICIANS WITHIN A COPA

- **Prevent Merged Entity from using Market Power to Increase Physician Prices**
 - Include physicians in any price, margin, or profit cap imposed in a COPA
 - Ballard's price increase cap applied to all physicians for whom Ballard negotiated reimbursement rates with payers. Prices for risk-based contracts were also capped but had a more complicated formula.
 - Other COPAs did not have such specific caps, but employed physician costs were included in profit and margin caps.
 - COPA restrictions only apply to physicians for whom the merged entity contracts, so it may give physicians an incentive to set up a separate organization to negotiate independently with payers in a joint venture with the merged entity.
 - Alternative Payment Models are less effective at governing providers with market power, as they can demand higher prices.
- **Protect Physicians from Monopsony Power of Merged Entity**
 - Prohibit merged entity from limiting any independent physicians from providing services to other facilities, health plans, or provider networks.
 - Prohibit merged entity from exclusive contracting for physician services, unless approved by the Department of Health or other agency
 - Require the merged entity to maintain an open medical staff at all its facilities and not restrict any physicians' ability to see their patients admitted to facility in the merged system.
 - Cap the number of physicians that may be employed by the merged system in any specialty.
 - COPAs in NC, SC, and TN/VA capped physician employment between 20 and 35% of each specialty.

PLAN OF SEPARATION

- COPAs risk termination by future legislatures.
 - In several states, legislatures have repealed COPA requirements exposing consumers to unregulated healthcare entities with significant market power.
- Essential to establish a plan of separation in the event the COPA is terminated.
 - Should specifically designate how the merged entity will return competition to its pre-merger status.
 - Should be updated annually.
 - Retain flexibility of the some COPA terms, while making it challenging to eliminate key protections.

PROTECTIONS AGAINST TERMINATION

- Detailed Plan of Separation to be Enacted Upon Termination
 - Review annually for feasibility by team of experts in care coordination and antitrust enforcers
 - Include civil monetary penalties for COPA repeal or failure to comply with the terms of the COPA
 - Should be substantial
- Require public hearings and comment prior to COPA termination.
- Require 2/3 vote by the legislature to terminate the COPA.
- Require Contribution to a Fund that will be Forfeited if COPA is Terminated

TEXAS: THE DANGEROUS COPA

- Exceptionally high post-merger market share
 - Diversion ratio analysis
 - Market share and concentration analysis
 - Descriptive Analysis
- *All three analyses showed that the merger was likely to be anticompetitive because the hospitals were close competitors*
- FTC Critique of Texas COPA:
 - No specificity about how they were going to limit rate increases
 - Rate review regimes difficult to implement, monitor, and enforce
 - Unlikely to replicate competitive forces; rate review has no impact on quality or access
 - Voluntary termination
 - Strong incentive to circumvent oversight
 - Practically infeasible to unwind merger if entity voluntarily terminates COPA

TENNESSEE AND VIRGINIA: THE ENGAGED COPA

- Tennessee/Virginia - Merger made Ballad Health System the single hospital provider for a large rural region spanning parts of northeast Tennessee and southwest Virginia
- Conditions included price increase cap (CMS-approved Medicare Market basket amount plus .25%), quality of care commitments, a prohibition of certain contractual provisions, and a commitment to return cost savings to the local community.
- **Tennessee**
 - Heavy involvement of state attorney general as part of a multi-agency review process
 - COPA statute allowed DOH to consult with FTC, so the DOH solicited comments from FTC as part of review
- **Virginia**
 - DOH consults with AG, but AG role is primarily advisory

COMPLIANCE AND PENALTIES: THE TENNESSEE MODEL

Compliance:

- COPA monitor, AG, and DOH Commissioner have access to all nonprivileged documents relating to any matters contained in the COPA
- Require detailed annual reports including financial information, quality metrics, employment statistics, details of population health investments, charity care, and an updated plan of separation

Penalties:

- System has 60 days to correct any noncompliance. If deficiency is not cured, state may:
 - Prohibit payment of bonuses or other incentive compensation above base salary to any executive officer
 - Require the COPA Parties to make a remedial contribution in the amount determined by the Department to the Population Health Initiatives Fund,
 - Require a COPA Modification;
 - Impose monetary penalties or other equitable relief. Fines for specific non-compliance infractions are specified and range from \$10,000 to \$1,000,000.
 - Terminate the COPA and Enact Plan of Separation *Note: This action would end the State Action Immunity and allow state and federal regulators to enforce antitrust laws, but as a practical matter, antitrust enforcers have been reluctant to break up an existing monopoly that was legally acquired, even after state oversight is gone.*

COMPARISON OF TWO COPA STATUTES

	Tennessee	Texas
Benefits Considered	7 Specific criteria including enhancement in care, investments in population health, cost-efficiencies; entity must share metrics and independent data source to determine if entity is meeting metrics	Unspecified – “the likely benefits resulting from the proposed merger agreement must outweigh any disadvantages attributable to a reduction in competition that may result from the proposed merger.”
Disadvantages Considered	May consider any disadvantages attributable to a reduction in competition e.g. adverse effects on others (including payors, HMOs, etc.), any likely adverse impact on the quality, availability, and price of healthcare services, and whether less restrictive measures are possible	Unspecified
Remedies	Seek modification of COPA with parties’ consent, limit payment of executive incentive compensation, impose fines, termination	AG can require the hospital to perform a certain action or refrain from a certain action or revoke the hospital's certificate of public advantage
COPA Termination	Annual Plan of Separation	Unspecified “corrective action plan”

LESSONS FROM TN/VA OVERSIGHT

- **COPA oversight is resource intensive**
 - Important to have merging entities pay for expenses of review and oversight
- **COPAs can be a tool to support population health and rural hospitals**
- **States must balance specificity and flexibility in COPA conditions.**
 - Balance specificity at the outset with flexibility to make needed adjustments in the future
 - Critical to guard against efforts to dilute or avoid compliance with COPA conditions
- **States must define what a successful COPA looks like.**
 - Possible measures include: (a) no closures of rural facilities; (b) maintenance or improvement of access to key health services; (c) increases in prices and overall health spending in line with comparable markets with more competition; (d) population health improvement among key metrics; and (e) clinical integration
 - Failure on any measure should trigger assessment of adjustment or termination of COPA (unwinding merger)
- **COPAs are risky, and states must remain vigilant.**
 - COPA entity has strong incentives to evade scrutiny
 - “Unscrambling the egg” is hard, so actionable plans of separation are important
 - Data collection is critical
 - Long-term commitment; challenge of regulatory fatigue, turnover in staff and administration, and political pressure on legislature to rescind COPA

Source: Erin Fuse Brown *Hospital Mergers and Public Accountability: Tennessee and Virginia Employ a Certificate of Public Advantage*, Milbank Memorial Fund Report, September 2018



OPTIONS FOR PRICE CONTROL IN THE CONTEXT OF A COPA

- Many of the price limitation provisions in past COPAs are similar to current OHIC constraints (i.e., limits based on a price or input cost index plus some grace factor)
- **Option 1:** Rely on existing OHIC limits on negotiated hospital-insurer facility prices and alternative payment models.
- **Option 2:** Impose a specific expenditure growth cap that can be applied to the merged entity (in the context of a COPA) covering all facility, professional and non-hospital services.

A SECOND OPTION FOR OVERSIGHT OF A MERGED ENTITY

- **Option 2:** A specific expenditure growth Cap can be applied to the merged entity (in the context of a COPA) covering all facility, professional and non-hospital services.
 - Given the recent rapid price growth for professional services, potential rapid growth in non-hospital services, the fact that the OHCI limitations do not legally apply to ERISA accounts the state should consider the imposition of an overall expenditure Cap for the merged entity.
 - This overall expenditure Cap could be benchmarked to a Multiple of comparable Medicare spending for facility, professional and non-hospital services.
 - The State of Washington currently makes use of such a spending Cap to govern the level of commercial payments for its Public Options program (implemented January 2021).
 - Washington limits payments from commercial insurers covering public option enrollees to 160% of aggregate Medicare Payments for the same services.
 - The program also applies a payment floor for Primary Care services of at least 135% of Medicare.
 - This approach allows for variations in payment by service as long as aggregate commercial payments are less than or equal to 160% of what Medicare would have paid for the same services.
 - This separate expenditure Cap would apply a tight growth standard given Medicare growth projected to be very low in future years.

OPTION 2: TECHNICAL AND FUNDING CONSIDERATIONS

- Such an expenditure cap could be based a weighted average multiple of current facility, professional and non-hospital price levels (roughly 170%)
- Analyses can be performed using Medicare Cost Report data to demonstrate that these payment levels are sufficient for these hospitals to still earn adequate margins at current operating cost levels.
- Medicare Cost Report data for each hospital or data from the state's APCD could be used for this benchmarking activity, particularly if the APCD includes Medicare claims data.
- The state could also use its authority in the context of the COPA to require the merged entity to submit paid data on all facility, professional and non-hospital services on a quarterly basis for compliance assessment.
- These paid claims data could be linked to comparable Medicare services on a quarterly basis (with less lag time) to determine compliance with the Cap.
- Washington state has successfully been able to link commercial claims to Medicare payment levels with the support of actuarial consultants.
- Funding for data collection, analysis and compliance evaluation can be generated through assessments.

An architectural rendering of a modern hospital complex. The buildings feature vibrant, multi-colored facades in shades of green, blue, yellow, and orange. A wide, paved pedestrian plaza with a curved path runs alongside the buildings. Several people are depicted walking and sitting on the plaza, adding a sense of scale and activity. A traffic light and a pedestrian crossing sign are visible on the left. The sky is clear and blue.

EXPANDING HEALTH CARE MARKET OVERSIGHT IN RHODE ISLAND

BROADER HEALTH CARE MARKET OVERSIGHT

- Complements and supplements COPA oversight
- Standardizes the Market
- Guards against risks of COPA Termination

POSSIBLE REGULATORY OVERSIGHT MODEL

- Rhode Island may consider emulating the regulatory oversight structure, authority and capabilities of the Vermont Green Mountain Care Board (GMCB) to oversee a large merged provider entity and/or its broader health system.
- The GMCB was created in 2011 with the passage of ACT 48 and charged with oversight of the State's Single Payer initiative. Also charged with overseeing delivery system reform, regulating providers (primarily hospitals) and insurers and providing evaluations of health system performance.
- It is the primary health policy entity in the state, which in addition to its core regulatory functions, provides a public forum for discussions about the state's health policy, requires public reporting by major provider entities and performs analytic reviews of key policy issues.
- The Board has oversight authority and adequate resources to regulate hospital budgets, encourage the transition to Alternative Payment Models, oversee the State-wide All Payer ACO and regularly communicate with hospitals, other providers and private insurers regarding their activities to meet the state's health policy goals.
- The GMBC has no direct oversight of Physician fees/expenditures.

CHARACTERISTICS OF THE GMCB

- The GMCB is governed by 5 board members, appointed by the Governor, with broad authority to:
 - 1) Set commercial provider payment levels;
 - 2) Perform private insurer rate review/approvals;
 - 3) Approve certificate of need applications;
 - 4) Review and approve hospital proposed annual budgets; and
 - 5) Approve and certify the Statewide All Payer ACO budget.
- The GMCB also administers the State's All Payer Claims Database.
- Of note, is the GMCB oversight of Statewide All Payer ACO, which is the dominant provider-based entity, with a budget of about \$1.4 billion, covering the state's 14 acute care hospitals and most other health care providers.
- Board Members serve six-year terms, are salaried employees, have experience with health care policy financing issues and are prohibited from being affiliated with an entity regulated by the GMCB.
- The GMCB's budget is approximately \$8 million per year funded by a combination of state general funds and assessments on hospitals and private insurers operating in the Vermont.
- The agency employs a professional staff of approximately 25 FTEs (led by an Executive Director) with backgrounds in health policy, finance, accounting, quality of care and data base administration.

CHARACTERISTICS AND STRUCTURE OF THE GMCB

- The GMCB has the following regulatory authorities:
 - 1) Administration of the State APCD;
 - 2) Private insurer rate review/approvals for the small group market;
 - 3) Review and approval of certificate of need applications; and
 - 4) Review and approval of hospital annual budgets.
- Of note is the GMCB's oversight of the Statewide All Payer ACO, which is the dominant provider-based entity, with a budget of about \$1.4 billion.
- The GMCB's budget is approximately \$7 million per year funded by a combination of state general funds and assessments on hospitals and private insurers.
- The agency employs a professional staff of 27 FTEs.
- The Board's staff are frequently tapped on to provide analytic support regarding key health policy issues, can convene stake holders for these deliberations.

ADVANTAGES OF THE DEVELOPMENT OF AN OVERSIGHT BOARD

- A Board such as the GMCB could:
 - Provide a useful and independent forum for health policy discussion and review;
 - Coordinate various health policy activities - such as acting as the entity responsible for the state's Total Medical Expenditure (TME) Benchmark initiative;
 - Perform specific analytic and monitoring responsibilities, such analysis of spending trends by provider category;
 - Assist the DoH and the AG in analyzing the impact of proposed provider mergers/acquisitions;
 - Initiate and oversee other health care cost containment strategies should existing regulatory initiatives fail to control expenditure growth in line with state targets;
 - Provide primary oversight of a COPA for the merged provider entity;
 - Apply assessments on a merged entity to generate funds for required oversight functions; and
 - Prepare a public report and oversee a plan of separation of the merged entities in the event the COPA is terminated.

POTENTIAL RISKS ASSOCIATED WITH EXPANDED REGULATORY OVERSIGHT

- A risk with expanded regulatory oversight is the potential for Regulatory Failure and Regulatory Capture - where the regulated industry successfully influences the regulatory body to implement policies that advance its interests.
- The Capture theory has been articulated by both conservative and liberal groups – sometimes for ideological purposes.
- Although instances of regulatory Capture have occurred, current literature concludes that in most cases the frequency and dangers of Capture are exaggerated and there is a lack of empirical analysis demonstrating serious negative effects.
- Also, the risks associated with Regulatory Failure and Capture can also be mitigated by:
 - The imposition of time requirements for regulatory action (to avoid regulatory delays);
 - Strict adherence to the requirements of the Administrative Procedures Act and enhanced transparency requirements;
 - The appointment of board members with no ties to the regulated industry;
 - Other structural measures to ensure the independence of the regulatory agency and its staff; and
 - Limitations on future employment of staff and board members by the regulated industry.

OPTIONS FOR IMPROVING STATEWIDE MARKET OVERSIGHT

- Consider Expanding OHIC Regulations to Cover Physicians and Non-Hospital Facilities and Services (imaging centers, urgent care clinics, etc.)
- Consider Changing CPI-based Inflationary Cap to one based on Medicare Market Basket Index and Medical Expenditure Index
- Consider the tiering of allowed provider rate increases, similar to a proposal by the Governor of Massachusetts in 2017
- Consider Expanding Oversight of Physician Consolidation and Acquisition Activities
- Consider Creating an Oversight Body that would govern both the COPA and Health Care Activities Statewide



QUESTIONS AND DISCUSSION

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