COPAs – Certificates of Public Advantage
A Panel Discussion

Healthcare Dynamics in the 21st Century
2018 Southern Region Conference
National Association of Attorneys General

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April 11, 2018
Chapters in the Ballad Health Story

I. Strategic Options Process
II. COPA Consideration
III. COPA Application Process
IV. COPA Implementation
The Market

- 21-County Service Area in East Tennessee and Southwest Virginia
  - Population of nearly 1 million people
  - Most of these counties rank at the bottom of both states and are some of the unhealthiest counties in the country
  - Major challenges with opioid abuse, neonatal abstinence syndrome, obesity, tobacco use
  - Vast majority of the Service Area is rural
  - Significant economic challenges
  - Aging population
  - Two Competing Health Systems
The Rural Health Systems

- 6 Acute Care Hospitals
- 1 Critical Access Hospital
- 1,111 Licensed Beds
- 320 Physicians and Mid-Level Providers
- $800M Annual Revenue

- 13 Acute Care Hospitals
- Region’s Only Dedicated Children’s Hospital
- 1,669 Licensed Beds
- 400 Physicians and Mid-Level Providers
- $1.1B Annual Revenue
I. Wellmont’s Strategic Options Process

• Board-led process
• Kaufman Hall & Associates as strategic options advisor analyzed current competitive position
• Began formulating strategic alternatives available (remaining independent vs. an affiliation)
• Detailed financial projections and position developed for “stay independent” strategy
• Critical success factors developed for independent strategy
• Strategic alternative scenarios developed based on analytics reviewed
• Board deliberated on best forward path
RFP Process

- Round One: All Qualified Bidders
- Round Two: Eliminated For-Profits
- Round Three: Super-Regional Non-Profits & Mountain States Health Alliance (“MSHA”)
MSHA Proposal

- Merger of Equals
- Single Board, Management Team
- Apply Savings to Improve Population Health
- COPA Required
II. The COPA Consideration

• COPA History

• Tennessee Statute

• Virginia Statute

• Southwest Virginia Health Authority
A Brief History of COPAs

• In the 1990s, several states enacted laws to immunize behavior by hospitals and other health care providers that otherwise might be subject to antitrust scrutiny

• COPA laws historically were intended to reduce “unnecessary” duplication of health care resources and control health care costs

• Although these laws vary in scope of coverage and approach, they generally purport to immunize cooperative agreements among hospitals or health care providers based on the state action doctrine
  – Requires states to articulate a clear and affirmative policy to displace competition in favor of regulation and provide active supervision of any approved agreements
COPA Examples

- Although several state COPA laws extend to hospital mergers that otherwise might violate antitrust laws, very few hospital mergers have ever been approved under COPA regulations
  - Minnesota (HealthSpan Hospital System, 1994)
  - North Carolina (Mission Health System, 1995)
  - Montana (Benefis Health System, 1996)
  - South Carolina (Palmetto Health System, 1998)
  - West Virginia (Cabell/St. Mary’s, 2016)*
  - Tennessee and Virginia (Wellmont/Mountain States, 2017)

- Resurgence in COPA laws and regulations
  - Response to Affordable Care Act and other health care reform initiatives

- FTC has noted that some states may be passing COPA legislation in response to political pressure to exempt specific hospital mergers from antitrust scrutiny

*COPA approved, but merger has not yet been consummated
State Action Cornerstones

- Clear Articulation
  
  FTC vs. Phoebe Putney., 133 S. Ct. 1003 (2013)

- Active Supervision
  
  N.C. Board of Dental Examiners vs. FTC., 135 S. Ct. 1101 (2015)
“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. A hospital may negotiate and enter into cooperative agreements with other hospitals in the state, if the likely benefits resulting from the agreements outweigh any disadvantages attributable to a reduction in competition that may result from the agreements.”

Hospital Cooperation Act of 1993, T.C.A. §§ 68-11-1301-1309
“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, 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 to 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.”

V.C.A. § 15.2-5384.1
The Decision: Wellmont – Mountain States Combination

Size and Scale
• Would create largest health system in East TN; third-largest in TN; top 20 nonprofit, non-Catholic health system in US

Governance
• All governing board members from Tri-Cities; local hospital governance unaffected; commitment to physician role in governance

Management
• Opportunity to reduce management and administrative expenses; platform to execute Centers of Excellence; opportunity for new clinical services; knowledgeable physician communities; platform for population health management; expansion of network for self-insured employer groups

Clinical
• Blended management team could assemble strengths of both organizations

Finance
• Potential for cost savings and new revenue; significant cash reserves; platform to manage future payment reductions

Affiliations
• Best platform to define role and scope; opportunity to develop partnership with ETSU

Employees
• Largest employer in Tri-Cities (15,000) and East TN; second-largest healthcare employer in TN

“If not us, who? If not now, when?”
III. The COPA Process

- **February 2016** - Mountain States and Wellmont submit COPA applications

- **September 2016** - COPA applications deemed complete; statutory review begins

- **September 19, 2017** - Tennessee grants COPA with conditions

- **October 30, 2017** – Virginia grants Cooperative Agreement with conditions

- **February 1, 2018** – Merger Closes
The COPA Process - Advantages

• Mountain States and Wellmont proposed that the COPA would result in significant benefits and cost savings for patients in Southwest Virginia and Northeast Tennessee

• Financial Commitments Totaling More than $450 Million
  – Expanded Access to Healthcare Services ($140M)
    ▪ $85M for Behavioral Health Services
    ▪ $27M for Children’s Health Services
    ▪ $28M for Rural Health Services
  – Health Research and Graduate Medical Education ($85M)
  – Population Health Improvement ($75M)
  – Region-Wide Health Information Exchange ($8M)

• Proposed various price and quality commitments intended to mitigate potential for anticompetitive consumer harms
The COPA Process in Tennessee

- Public hearings and written comments
- Meetings with state health department and attorney general’s office
- Expert consultations and reports
The COPA Process in Virginia

- Southwest Virginia Health Authority Process
  - Authority hired three consultants to facilitate the process
  - Public meetings and written comments
  - FTC participation in meetings
  - Recommendation that VDOH approve

- Virginia Department of Health
  - Meetings with state health department and attorney general’s office
  - Economic analysis from a third party
A Few of the Covenants

• Quality of Care
  – Clinical Council
  – Quality Reporting

• Access to Services
  – Maintain all 3 Tertiary Referral Hospitals
  – Special State Interest to Protect Rural Hospitals
  – Repurpose Authority/Process
  – Deletion of Services
  – Charity Care

• Managed Care
  – Addendum 1

• Physician Services
  – 35% Employment Cap
Active Supervision

- **Tennessee**
  - Terms of Certification
    - 116 Page Document
    - Requires Plans to be Approved by Department of Health
    - Incremental Spending is Measured Annually
    - Prohibitive Covenants
    - Quarterly & Annual Reports
    - COPA Monitor

- **Virginia**
  - 151 Page Order
  - Conditions of Approval
    - 49 Conditions (17 Pages)
    - Many of the Conditions are the same as (or similar to) the Tennessee Terms of Certification
    - Some Virginia-Specific Conditions
IV. The COPA Implementation

- The Plans
- The Waivers
- New Legislation
- The Index
Health Index

• **Population Health Sub-Index**
  – Measures smoking, obesity, drug deaths, vaccines, teen pregnancy rate, infant mortality, etc.
  – Tennessee: 25 Measures
  – Virginia: 13 Measures (subset of Tennessee measures)

• **Access to Care Sub-Index**
  – Measures preventable hospitalizations, cancer screenings, specialist recruitment, etc.
  – Tennessee: 28 Measures
  – Virginia: 29 Measures (nearly identical to Tennessee)

• **Other/Quality Sub-Index**
  – Measures quality of care provided at Ballad hospitals (CMS safety measures, etc.)
  – Tennessee: 16 Quality Measures; 83 Monitoring Measures
  – Virginia: 17 Quality Measures; 82 Monitoring Measures (nearly identical to Tennessee)

• **Economic Sun-Index**
  – Addendum 1 limits Ballad's ability to increase prices to payors who negotiate rates
  – Tennessee: Pass/Fail based on Compliance with Addendum 1
  – Virginia: Pass/Fail based on Compliance with Addendum 1
Health Index Final Score (Calculated Annually)

• Determine Economic Sub-Index Score: Pass/Fail

• Multiply:
  – Population Health Sub-Index Score by 50%
  – Access to Care Sub-Index Score by 30%
  – Other Sub-Index Score by 20%

• Add results together to get Final Score.
# Measuring the Public Advantage

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<th>Final Score</th>
<th>Public Advantage Clear and Convincing?</th>
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<tr>
<td>&gt; 85</td>
<td>Yes</td>
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<tr>
<td>60 ≤ 85</td>
<td><strong>Unclear.</strong> All facts and circumstances to be considered in determination of continuing Public Advantage. May constitute Noncompliance and/or result in proposal by the Department of a COPA Modification.</td>
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<td>&lt; 60</td>
<td><strong>No.</strong> COPA revoked absent compelling circumstances, including without limitation additional COPA Modifications proposed by the Department.</td>
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States with COPA Laws

• [MAP TO BE INSERTED]