

BEFORE THE WEST VIRGINIA  
HEALTH CARE AUTHORITY

In Re: **Cabell Huntington Hospital, Inc.,**  
Applicant

Cooperative Agreement No. 16-2/3-001

**DECISION**

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**I. JURISDICTION**

During the 2016 session, the West Virginia Legislature enacted Senate Bill 597 which was signed by the Governor on March 18, 2016. It was made effective upon passage. The Bill vested the West Virginia Health Care Authority ("Authority"), in conjunction with the West Virginia Attorney General ("Attorney General"), with the authority to consider, approve or reject certain cooperative agreements between a hospital member of an academic medical center and other hospitals or health care providers. This legislation provides for the oversight and supervision of cooperative agreements which are approved by the Authority and Attorney General. Under the statute, cooperative agreements which are approved by the Authority and the Attorney General are exempt from scrutiny under state and federal antitrust laws.

## II. ISSUE

The issue to be decided is whether the applicant, Cabell Huntington Hospital, Inc., qualifies for a certificate of approval.

## III. PROJECT DESCRIPTION

This project involves the acquisition of the ownership interests of St. Mary's Medical Center, Inc. ("SMMC") by Cabell Huntington Hospital, Inc. ("CHH") (the "Acquisition"). SMMC is a 393 bed acute care hospital located in Huntington, Cabell County, West Virginia. Pallottine Health Services, Inc. ("PHS") is currently the sole member of SMMC. Following the Acquisition, CHH will replace PHS as the sole member of SMMC, and, in effect, acquire SMMC, SMMC's two subsidiaries, St. Mary's Medical Center Foundation, Inc. ("SMMCF") and St. Mary's Medical Management, Inc. ("SMMM"), and substantially all of the assets and liabilities of SMMC, SMMCF, and SMMM. In addition, certain property used in the operation of SMMC, which is currently owned by PHS, will be transferred to SMMC upon consummation of the transaction. CHH will also acquire substantially all the assets and liabilities of Vanguard Financial Services, Inc., SMMC's billing and collection agency.

In addition to inpatient and outpatient services, SMMC operates several ambulatory care facilities, off-campus magnetic resonance imaging ("MRI") services, an emergency room, laboratory, imaging, and physician services in Ironton, Ohio. SMMC also operates three schools in cooperation with Marshall University, a School of Nursing, School of Medical Imaging, and School of Respiratory Care, located off-campus in its Center for Education.

CHH is a 303 bed acute care hospital also located in Huntington, Cabell County, West Virginia. CHH is a teaching hospital affiliated with Marshall University Schools of Medicine and Nursing. CHH is also a member of an academic medical center which includes the Joan C. Edwards School of Medicine and University Physicians and Surgeons, Inc., d/b/a Marshall Health, the School's Faculty Practice Plan. CHH submits that it is a qualified hospital as defined by W.Va. Code § 16-29B-28(a)(6).

The objective of the Acquisition is the creation of a hospital system in Huntington, Cabell County, West Virginia, with two campuses. CHH proposes to continue to operate SMMC as a faith-based institution.

### **BACKGROUND**

In 2014, PHS determined that because of the dwindling number and advanced age of the Pallottine Sisters, as well as the increased complexity of health care regulations, it could no longer sponsor SMMC and made the decision that the hospital should be sold. A Request for Proposal was submitted to a number of potential purchasers, including CHH. CHH responded to the request and after extensive negotiations, a contract for the purchase of SMMC through the substitution of CHH for PHS as the sole member of SMMC was executed in November of 2014. It is this document which constitutes the Cooperative Agreement for which CHH seeks approval.

An application for a Certificate of Need ("CON") for the project was filed by CHH on April 30, 2015. Steel of West Virginia, Inc., ("SWVA") requested affected party status and requested a hearing. A hearing was conducted by the Authority on December 21 and 22, 2015. Briefs were submitted by the parties and after deliberation, the Authority

issued its decision on March 16, 2016, approving the Certificate of Need application submitted by CHH.

#### **IV. PROCEDURAL HISTORY**

On March 25, 2016, the Authority received an Application for Approval of Cooperative Agreement on behalf of CHH (Exhibit 3). On April 8, 2016, the Authority deemed the application complete (Exhibit 6).

On April 8, 2016 public notice of CHH's application and notification of the public comment period was published in the State Register. (Exhibit 5).

At the conclusion of the public comment period, i.e., April 18, 2016, the Authority received comments from the Federal Trade Commission ("FTC") and SWVA and fifteen (15) individuals. (Exhibit 7). The fifteen individuals that filed public comments all opposed the merger. Many individuals expressed concerns that the merger would create a monopoly and adversely impact quality of care and the cost of services. On May 5, 2016, the Authority received a Response to Public Comments from CHH. (Exhibit 8). On May 5, 2016, the Authority received CHH's Motion to Deny FTC Bureau of Competition Staff's Request for Affected Party Status (Exhibit 9). On May 5, 2016, the Authority opened a limited second period for public comment (Exhibit 10). The Authority issued a Protective Order on May 11, 2016 (Exhibit 11). At the conclusion of the public comment period, on May 16, 2016, the Authority received three comments. (Exhibit 12). The individual that submitted a public comment opposed the merger. The FTC responded to CHH's Motion to deny its Request for Affected Party Status (Exhibit 13).

### **REQUEST FOR HEARING**

The statute vests the Authority with the ability to order a public hearing if it finds it necessary to make an informed decision on the application. The Authority conducted a hearing in the underlying matter, taking testimony on whether the CON should be granted to CHH for the acquisition for SMMC and that record is part of this file. In addition, the Authority solicited public comments twice in this matter and issued a protective order allowing members of the public to submit documents under protective seal to allow the Authority a wider view of the evidence. SWVA objected to CHH's Response to Public Comments. However, the Authority has not yet developed procedural rules in this matter and believes that CHH has the ability to submit a Response to the Public Comments. Further, the Authority allowed parties to respond to CHH's submission allowing for a full and complete opportunity for all interested parties to submit comments and have an opportunity to be heard before the Authority rendered its decision. This allowed the Authority a full and complete record upon which to base its decision. Based upon the breadth of the record and the ability of the parties to submit evidence, the Authority does not believe that a hearing is necessary to make an informed decision. Accordingly, the Authority determines that no hearing will be held in this matter.

### **REQUEST FOR AFFECTED PARTY STATUS BY FTC**

On April 18, 2016, FTC staff requested affected party status in its initial public comment. As the basis for this request, FTC staff contends that it is an affected person under W.Va. Code § 16-2D-2 and § 16-29B-28(e)(4). FTC states that the Bureau of Competition works to protect consumers and the public interest, promote free and open

competition, and prevent anticompetitive business practices in order to allow consumers access to quality goods and services at competitive prices.

On May 4, 2016, CHH moved to deny FTC staff's request for affected party status arguing that "Staff" is not an agency or organization representing consumers pursuant to W.Va. Code § 16-2D-2(a)(2). CHH argues that this provision does not grant standing to component divisions of agencies-including the Mergers IV Division of the Bureau of Competition of the FTC, where Staff is situated-that have no independent agency status. Thus, CHH argues that a submission by the staff members, as opposed to the FTC itself, would not be entitled to affected party status.

On May 16, 2016, FTC Staff filed its response, arguing that the CHH did not deny that the FTC is an agency or organization representing consumers. Further, the FTC Staff argue that it is "without dispute that the Commission has directed the FTC Staff, which of course is part of the FTC, to investigate and challenge the agreement at issue here." (Opposition to CHH's Motion to Deny FTC's Request for Affected Party Status at p. 2) FTC Staff argues that, like any "agency or organization, the FTC's functions are carried out by its employees." See, 16 C.F.R. § 0.7(providing that the FTC "may delegate...certain of its functions to a division of the Commission...or an employee or employee board").

The Authority finds that FTC Staff meets the definition of an affected person under W.Va. Code § 16-2D-2(a)(2). The FTC is an organization representing consumers and by statute can delegate its functions to its staff. Accordingly, it meets the definition to become an affected party in this matter. W.Va. Code § 16-29B-28(e)(4) states that "any individual, group or organization who submitted written comments regarding the

application and wishes to present evidence at the public hearing shall request to be recognized as an affected party.” Since no hearing shall be held, this analysis now appears to be moot.

#### **V. CRITERIA FOR CERTIFICATE OF APPROVAL**

The recently passed Senate Bill 597 codified as W.Va. Code § 16-29B-26, 16-29B-28 and 16-29B-29 (West Virginia Cooperative Agreement Law or “WVCAL”) set forth the goals for cooperative agreements as well as the applicable criteria to be considered by the Authority. The following goals are specified by the statute:

- (A) Improve access to care;
- (B) Advance health status;
- (C) Target regional health issues;
- (D) Promote technological advancement;
- (E) Ensure accountability of the cost of care;
- (F) Enhance academic engagement in regional health;
- (G) Preserve and improve medical education opportunities;
- (H) Strengthen the workforce for health-related careers; and,
- (I) Improve health entity collaboration and regional integration, where appropriate.

The statute requires that the application for approval of a cooperative agreement specify the methods for achieving:

- (A) Population health improvement;
- (B) Improved access to health care services;
- (C) Improved quality;
- (D) Cost efficiencies;
- (E) Ensuring affordability of care;
- (F) Enhancing and preserving medical education programs; and
- (G) Supporting the authority’s goals and strategic mission, as applicable.

In evaluating the potential benefits of a proposed cooperative agreement, the Authority is directed by the statute to “consider whether one or more of the following benefits may result from the proposed cooperative agreement:

- (A) Enhancement and preservation of existing academic and clinical educational programs;
- (B) Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse provided to citizens served by the authority;
- (C) Enhancement of population health status consistent with the health goals established by the authority;
- (D) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
- (E) Gains in the cost-efficiency of services provided by the hospitals involved;
- (F) Improvements in the utilization of hospital resources and equipment;
- (G) Avoidance of duplication of hospital resources;
- (H) Participation in the state Medicaid Program; and
- (I) Constraints on increases in the total cost of care."

The statute provides that the Authority's evaluation of any disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement shall include but not be limited to the following factors:

- (A) The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers;
- (B) The extent of any reduction in competition among physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals that are likely to result directly or indirectly from the proposed cooperative agreement;
- (C) The extend of any likely adverse impact on patients in the quality, availability and price of health care services; and



- (D) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.

The statute provides that “the Authority shall give deference to the policy statements of the Federal Trade Commission.”<sup>1</sup> The statute further provides that the Authority shall review the record, any commitments made by the applicant and any conditions imposed by the authority and that “the Authority shall approve a proposed cooperative agreement and issue a certificate of approval if it determines, with the written concurrence of the Attorney General, that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement.”<sup>2</sup>

The goal for any cooperative agreement would be to:

**A. Improve Access to Care**

CHH states that the hospitals have made commitments, in both the AVC and the Application for Cooperative Agreement that will improve access to health care. (CHH Response to Public Comment p. 4). Among other things, the hospitals will implement community wellness programs to connect with medically underserved communities<sup>3</sup>, accept Medicaid patients residing in Ohio and Kentucky at rates established by those states for in-state providers<sup>4</sup>, and assess community health needs and implement programs and outreach initiatives.<sup>5</sup> CHH argues that the Authority has already concluded in its CON Decision that the proposed cooperative agreement will improve

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<sup>1</sup>W.Va. Code § 16-29B-28(d)(4)(C)

<sup>2</sup>W.Va. Code § 16-29B-28-(f)(3)

<sup>3</sup>AVC at ¶ 3(b)

<sup>4</sup>AVC ¶ 3(e)

<sup>5</sup>CHH Application at p. 8

access to care by, among other things, better positioning the two hospitals to offer more specialized services to the community that neither hospital individually is able to currently provide. CHH notes that the Authority specifically concluded that “patients will experience serious problems obtaining complex, specialized health care locally” in the absence of the cooperative agreement.<sup>6</sup> CHH argues that currently residents must travel to Columbus, Cincinnati or other larger metropolitan area in order to access such services.

SWVA argues that CHH is simply describing the status quo. (SWVA’s Response to CHH’s Response to Public Comments at p. 8) SWVA argues that CHH has not responded to this argument in “any way, and has failed to show that any of the above plans would be a measurable and/or impactful improvement over the status quo.” (*Id.*)

The Authority finds that CHH meets the goal of improving access to care. The evidence indicates that the Acquisition will result in the merged-entities’ ability to offer subspecialty care to patients. For example, Dr. Hoyt Burdick, Chief Medical Officer for CHH, testified that, “critical mass for tertiary subspecial level work is much more achievable in a system that has a larger population rather than two medium-sized hospitals trying to build tertiary services or recruit tertiary or quaternary national experts to work in a smaller system.”<sup>7</sup> Thus, the combined-entity is stronger together than they are apart and this level of care will be able to be offered by the merged-entity and cannot be offered by either hospital separately because they lack sufficient volume to recruit physicians to establish a program.

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<sup>6</sup>In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 89, p 40; see also, 26, 37, 39

<sup>7</sup>In re: Cabell Huntington Hospital, Con File No. 14-2-10375-A, Ex. 82, Tr. I, p. 161

## **B. Advance Health Status**

CHH argues that the WVCAL established a procedure by which the hospitals must disclose their performance on a representative sample of quality metrics to the Authority, which will publish the information on its website. W.Va. Code § 16-29B-28(g)(1)(B). CHH notes that “[s]hould performance of hospitals in any calendar year [fall] below the fiftieth percentile for all United States hospitals with respect to the quality metrics” selected by the Authority, the hospitals must implement a corrective action plan to be supervised and enforced by the Authority. W.Va. Code § 16-29B-28(g)(1)(C). CHH states that the hospital made other commitments such as adopting uniform protocols and best practices. (Application pp. 7-8) CHH notes that the Authority’s CON Decision previously concluded that the cooperative agreement will allow service line consolidations at the hospitals that are “reasonable and designed to take advantage of increased patient volumes.”<sup>8</sup> CHH argues that the Authority specifically granted credence to the substantial body of literature which finds that higher patient volumes generally result in increases in quality of care delivered and as such concluded that the cooperative agreement will increase the quality and coordination of care to location residents.<sup>9</sup>

SWVA argues that these provisions “will not advance health status: they simply provide the illusion of a backstop intended to help maintain quality after the loss of competition.” (SWVA Response to CHH’s Response to Public Comments at p. 8). SWVA argues that the Centers for Medicare and Medicaid Services (“CMS”) already offers consumers the Hospital Compare system on the web so there is fundamentally no new public disclosure in this provision. SWVA argues that CHH has failed to identify any

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<sup>8</sup>In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 89, p. 35

<sup>9</sup>Id. at pp. 26, 36-37

service lines where either hospital is below a measurable, research-identified volume threshold above which quality improves. (Id. at p. 9).

The Authority finds that CHH meets the goal of advancing health status. CHH is required to conduct a needs assessment of its community in formulating the population health improvement goals<sup>10</sup>. It is entirely reasonable for CHH to conduct a community needs assessment prior to its goal development. The fact that the goals have not been set forth now is not fatal since the needs of the community have not been evaluated. In addition, as more fully discussed later in the Decision, the merger-acquisition allows for the integration of protocols which will increase quality facility wide. In addition, the statute provides national quality benchmarks be reported to the Authority.<sup>11</sup>

### **C. Target Regional Health Issues**

CHH argues that among other commitments, the hospitals will develop quality and population health goals, implement community needs plans, conduct community health assessments, and integrate the hospitals' electronic records and other health data systems. (CHH Response to Public Comment at p. 4; AVC at p. 9-10). CHH argues that these commitments will allow the hospitals to prioritize and address unique health problems facing the community. (CHH Application at p. 7). CHH submits that the issue of population health was a major focus of the evidence considered by the Authority at the CON hearing, wherein it concluded that the cooperative agreement would allow the hospitals to promote "more effective management of population health."<sup>12</sup>

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<sup>10</sup>AVC, Definitions, ¶ 19

<sup>11</sup>W.Va. Code §§16-298-28(g)(1)(B) & (C)

<sup>12</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 89, p. 26

SWVA argues that none of CHH's statements are material, precise, measurable, or merger-specific. (SWVA Response to CHH's Response to Public Comments at p. 9). SWVA argues that CHH has not offered a concrete plan as to how to address those unique health problems facing the community, or how the proposed acquisition-merger will better position it to do so.

The Authority finds that CHH meets the goal of targeting regional health issues. As stated earlier, CHH is required by the AVC to conduct a community needs assessment six months after the Acquisition closes. It is unreasonable to expect CHH to have a plan to address the needs of the community at this time since it has not had an opportunity to conduct its community needs assessment. Therefore, SWVA's argument is not credible on this point. In addition, with respect to SWVA's argument that none of CHH's statements are merger-specific, this requirement is based on the Merger Guidelines. As stated more fully later in this Decision, the WVCAL is an issue of health care law under the WVCAL statute and whether CHH can meet the requirements set forth in that specific state statute, not a federal antitrust matter.

**D. Promote technological advancement**

CHH argues that the hospitals have committed to preparing SMMC for healthcare reform, and have committed to implementing a fully interactive medical record system, among other commitments. (CHH Response to Public Comments at p. 4-5; AVC at p. 10). In addition, CHH argues that the Authority has concluded in the CON Decision that the cooperative agreement will allow for the development of more specialized acute care services for local residents by both hospitals.<sup>13</sup>

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<sup>13</sup>In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 89, pp. 26, 37, 39, 40

SWVA argues that CHH's claims regarding its commitment to "promote technological advancement through the merger-acquisition are non-specific and often only tangentially related to technological advancement." (SWVA Response to CHH's Response to Public Comments at p. 9) SWVA argues that the only technological advancement of an integrated and interactive electronic medical record is not merger-specific. (Id. at p. 10).

The Authority finds that CHH meets the goal of promoting technological advancement. CHH and SMMC made enforceable commitments in the AVC to establish a fully integrated and interactive medical record system at both hospitals so that patient's encounters will be more readily available.<sup>14</sup> SWVA argues that this is not a merger-specific efficiency. The Authority addresses this argument later in this Decision.

**E. Ensure Accountability of the Cost of Care**

CHH argues that accountability will be ensured by the Attorney General's approval of rates and reimbursements. W.Va. Code § 16-29B-28(i)(1)(B). In addition, the WVCAL requires disclosure of any reimbursement agreement with a commercial health plan or insurer. (Id.; W.Va. Code § 16-29B-28(g)(1)(A)(iv)). Neither of these regulatory mechanisms is time-limited. In addition, for ten years following closing, rate increases cannot exceed benchmark rates using the methodology formerly employed by the Authority in its rate review process. (AVC at ¶ 2(a)).

SWVA argues that CHH has not responded to its critique of the provisions related to the Attorney General's ability to review and approve "list prices for hospital services and reimbursement contracts with third-party payors and the WVHCA's ability to require

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<sup>14</sup>AVC ¶ 3(c)

that the monopolistic hospital simply 'disclose' third-party payor contracts in an annual report will somehow ensure accountability of the cost of care." (SWVA Response to CHH's Response to Public Comments at p. 10). Rather, SWVA argues that CHH has not asserted that these provisions "exist and they are sufficient to protect consumers." (Id.) SWVA maintains that these provisions fail in their purpose. (Id.)

The Authority finds that CHH has demonstrated compliance with the goal of ensuring accountability of costs. CHH submitted two reports demonstrating compliance with this statutory goal. First, CHH submitted the The Camden Group's Business Plan of Efficiencies (BPOE) in the CON proceeding. This report projected \$36 million in savings<sup>15</sup>. CHH submitted the Deloitte Report prepared by Lisa Ahern in which she opines \$16 million in merger-specific annual recurring cost saving three years following close of the Acquisition. Ms. Ahern opined in her summary that "the annual recurring cost-saving efficiencies and net-one time costs are based on her analysis verified by data, documents, testimony, and other information obtained by the Parties and other third party sources...and that the efficiencies are merger-specific and could not be achieved by either party on an independent basis or through a reasonable alternative means, including a transaction involving St. Mary's and a party other than Cabell."<sup>16</sup> Further, Ms. Ahern opined that the geographic proximity of CHH and SMMC "allows for a high degree of integration, otherwise not obtainable by a consolidation between more distant partners."<sup>17</sup> Although not required, the Deloitte Report is merger-specific and consistent with federal antitrust laws. Both of these reports demonstrate cost savings. As discussed later, these

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<sup>15</sup>FTC Response to CHH Response to Public Comments at p. 14

<sup>16</sup>Ahern Rpt. Summary of Opinions, Section III

<sup>17</sup>Ahern Rpt. at ¶ 129

reports both are reliable and probative on this issue. While SWVA argues that the rate provisions in the statute are insufficient, these fears are speculative based upon SWVA's interpretation of the statute. In addition, CHH has agreed to terms in the AVC to restrict its rates as discussed throughout this Decision.

**F. Enhance Academic Engagement in Regional Health**

CHH states that both hospitals will maintain clinical training programs offered to the Marshall University School of Medicine ("MUSOM") and support education of primary care physicians who will serve the rural areas of West Virginia. (CHH Response to Public Comment at p. 5)(CHH Application at 11-12). CHH argues that "the enhancing of existing programs of health science education" was a factor specifically identified by the Authority in the CON matter as a basis for finding that the cooperative agreement is needed. (CON Decision at p. 26).

SWVA argues that the FTC argued that there are entities still interested in acquiring St. Mary's that have shown a strong commitment to medical education. (SWVA Response to CHH's Response to Public Comments at p. 10). SWVA argues that the CON matter cannot be dispositive since it did not consider actual potential alternatives.

The Authority finds that CHH has demonstrated compliance with the goal of enhancing academic engagement in regional health. The testimony of Dr. Yingling during the CON hearing indicated that state support for the School of Medicine constitutes roughly 10 – 11% of the School's budget as compared to 30 – 40% provided by the hospitals<sup>18</sup>.

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<sup>18</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 82, Tr. I. pp. 179-180



Dr. Yingling further testified that if funding were eliminated at the heart center within the community based hospital, then a cardiology fellowship would be in significant jeopardy.<sup>19</sup> The Authority finds that the level of monetary commitment that CHH and SMMC have made to fund the School of Medicine is a significant commitment to enhancing academic engagement in regional health. CHH further states that it will support education of primary care physicians who will serve in rural communities. While SWVA contends that this is merely the status quo and that other entities still interested in acquiring SMMC will make the same commitments, this is speculation. As stated later in this Decision, the services are too critical to the community to jeopardize and based upon concrete testimony of physicians that testified before the Authority not all purchasers' value medical training. CHH has made a firm commitment both to SMMC and the community. (Response to Public Comments at p. 5).

**G. Preserve and improve medical education opportunities**

CHH argues that among other commitments, the hospitals will expand their relationship with MUSOM, maintain SMMC's Schools of Nursing, Radiology, and Respiratory Care, and support SMMC's Clinical Pastoral Education Program. (CHH Response to Public Comment at p. 5; CHH application at p. 11).

SWVA argues that there are entities still interested in acquiring St. Mary's that have shown a strong commitment to medical education. (SWVA Response to CHH's Response to Public Comments at p. 10). SWVA argues that the CON matter cannot be dispositive since it did not consider actual potential alternatives.

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<sup>19</sup> In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 82, Tr. I. p. 183

The Authority finds that CHH has met demonstrated compliance with the goal of preserving and improving medical education opportunities. As stated earlier and discussed more extensively later in this Decision, CHH has made a commitment to fund the school of medicine. In addition, CHH has agreed to expand its relationship with MUSOM and to maintain SMMC's Schools of Nursing, Radiology, and Respiratory Care and to support SMMC's Clinical Pastoral Education Program. While SWVA contends that this is merely the status quo and that other entities still interested in acquiring SMMC will make the same commitments, this is speculation. These services are critical to the community and too critical to jeopardize. For example, Dr. Burdick testified that "in primary care and our specialty areas for both St. Mary's and Cabell ... [m]ost residents end up practicing within 50 miles of their training program."<sup>20</sup> In addition, as discussed later in the Decision based upon concrete testimony of physicians not all purchasers' value medical training. CHH has made a firm commitment both to SMMC and the community. (Response to Public Comments at p. 5).

#### **H. Strengthen the Workforce for Health-Related Careers**

CHH argues that in addition to the commitments already discussed, the hospitals commit to releasing physicians and other employees from non-compete duties; maintaining open staffs by privileges granting requirements; and committing \$25,000,000 to recruit physicians at both hospitals. (CHH Response to Public Comment at p. 5; AVC at p. 6-7). CHH argues that the CON Decision specifically concluded that the cooperative agreement will "allow for greater recruitment of professionals" to the area. (CON Decision at p. 26.)

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<sup>20</sup> In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 82, Tr. I. p. 159.

SWVA argues that “it is patently absurd for Cabell to suggest that the acquisition merger-which will result in the elimination of a specific number of high-paying health-related positions-will somehow ‘strengthen the workforce for health-related careers.’” (SWVA Response to CHH’s Response to Public Comment at p. 11). SWVA argues that the merger-acquisition will clearly weaken the workforce for health-related careers as various positions will be eliminated. (Id.)

The Authority finds that CHH has demonstrated compliance with strengthening the workforce for health-related careers. CHH made commitments, in the amount of \$25,000,000, to recruiting physicians at both hospitals. (CHH’s Response to Public Comments at p. 5). CHH made enforceable commitments in the AVC to have an open staff<sup>21</sup> and to release the covenant not to compete for any physician or health care provider employed and non-physician employee with privileges<sup>22</sup>. These provisions will help strengthen the workforce in clinical, patient care related fields which will in turn lead to better quality of care.

**I. Improve Health Entity Collaboration and Regional integration, where appropriate**

CHH states that the hospitals will refrain from opposing CON applications in specified circumstances, work collaboratively with small, rural community hospitals, and continue the provision of rapid transportation capability through HealthNet. (Response to Public Comment at p. 5; AVC at p. 6) CHH further states that regional integration was a goal identified by the Authority in the CON matter when it concluded that the cooperative agreement will “promote the development of a community-oriented, integrated health care

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<sup>21</sup>AVC ¶ 1(c) & (d)

<sup>22</sup>AVC ¶ 1 (a) &(e)

network consistent with the policy recommendations set forth in Chapter 4 and 5 of the 2000-2002 State Health Plan<sup>23</sup>.”

SWVA argues that the benefits cited by CHH are vague and not merger-specific. (SWVA Response to CHH’s Response to Public Comment at p. 11). SWVA argues that the only item cited by CHH that is potentially merger-specific is its agreement not to oppose CON applications in certain circumstances. SWVA argues that this, however, does not tie to the goal of improving health entity collaboration and regional integration, where appropriate. SWVA argues that the other two benefits, maintenance of the current commitments the hospitals have to work with rural hospitals and the continued provision of access to aeromedical services, are “ironic” since CHH claims that those same, small hospitals are its competitors. (Id.)

The Authority finds that CHH has demonstrated compliance with the goal of improving health entity collaboration and regional integration, where appropriate. CHH outlined a plan for continued commitment to work collaboratively with community hospitals in its application to enhance services, including the provision of HealthNet services. In addition, CHH also indicated that the merged entity would continue to support MUSOM.

The applicant shall state the goals and methods for achieving:

**(A) Population Health Improvement**

CHH and SMMC submit that the proposed population has more significant health challenges than the population in the United States generally. The State of West Virginia, and particularly the area served by CHH and SMMC, has significantly higher rates of

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<sup>23</sup>In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 89, p. 21

many chronic conditions such as obesity, diabetes, heart disease, and cancer.<sup>24</sup> Behavioral issues prevalent in the community, such as drug use, smoking, and poor nutrition, have made these conditions particularly difficult for health care providers to address in a meaningful way.<sup>25</sup> CHH argues that combining two strong hospitals aligned with other providers along the care continuum as well as stakeholders in the community creates a unique opportunity to marshal resources in a coordinated way and tackle these longstanding, expensive problems that reduce quality of life for so many of the state's most vulnerable citizen and communities.

CHH argues that the creation of a new CHH and SMMC-anchored health care system with the tools to determine how to keep people in the community healthy, instead of just treating those that are sick, is consistent with a national shift in how health care is delivered and paid for.<sup>26</sup> CHH notes that public and private payors are increasingly incentivizing improvements in the quality of health rather than paying based on the volume of care provided.<sup>27</sup> Population Health Management ("PHM") provides a framework for designing, implementing, and measuring the impact of a plan to improve a

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<sup>24</sup>See, e.g., Robert Wood Johnson Foundation County Health Rankings and Roadmaps, *available at* <http://www.countyhealthranks.org/app/west-virginia/2015/rankings/cabell/county/outcomes/overall/snapshot>

<sup>25</sup>See *id.*; West Virginia Dept. of Health and Human Services, 2013 West Virginia Behavioral Risk Factor Surveillance Report, *available at* <http://www.wvdhhr.org/bph/hsc/pubs/brfss/2013/BRFSS2013.pdf>

<sup>26</sup>See Centers for Disease Control, Best Practices for Community Health Needs and Assessment and Implementation Strategy Development (2011) ("CDC Community Health Report") at 61 ("It is increasingly acknowledged that a sustainable system of financing will require a shift in incentives away from filling hospital beds and conducting procedures and towards keeping populations healthy. In this context, hospitals that invest in building population health capacity in the near term may be optimally positioned to thrive economically in the long term."), *available at*

<http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>

<sup>27</sup>Notably, the Centers for Medicaid and Medicare Services ("CMS") has stated its intention to move care delivery into models that incentivize a focus on quality and outcomes. New delivery and payment models that encourage looking at improving an entire population and incentivizing coordination of care range from patient-centered medical homes (PCMH) and bundled payment care improvement initiatives ("BPCI"), to Accountable Care Organizations (ACOs) and global population-based payments linked to quality. These models require significant resources, a critical mass of patients for spreading actuarial risk, and an integrated approach that is more achievable at a system level with both SMMC and CHH than by either hospital standing alone

community's overall health by "address[ing] health needs at all points along the continuum of health and well-being through participation of, engagement with, and targeted interventions for the population."<sup>28</sup> Under the Assurance of Voluntary Compliance ("AVC") entered into between CHH, SMMC and the Attorney General, the parties have committed to developing "Population Health Goals, including Quantitative Benchmarks that may be used to assess whether those goals have been met"<sup>29</sup> and to being accountable for making progress toward those goals over the next *decade*. CHH argues that PHM is a principal driver for the transaction which positions it and SMMC to succeed in the face of this post-health care reform paradigm shift.<sup>30</sup>

PHM is not only driving health care reform across the county, but is uniquely suited to addressing the entrenched health problems in the community served by CHH and SMMC. CHH argues that the transaction creates a singular opportunity to effectively implement PHM by creating a true continuum of care under united, local leadership and supported by an integrated electronic health records ("EHR"). CHH notes that the transaction will link the primary care and outpatient specialists of Marshall Health and SMMM with the two hospital campuses and more effectively foster partnerships with public providers (Valley Health, FQHC) and private providers with longstanding relationships with the hospitals (Huntington Internal Medicine Group, Scott Orthopedics, Radiology Incorporated). CHH argues that delivering care using a team of coordinated, aligned providers at all levels of care, and communicating and tracking care through a single EHR, provides the cornerstones for implementing PHM. By being able to gather

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<sup>28</sup>See, e.g., "Understanding Population Health," Population Health Alliance, *available at* <http://www.populationhealthalliance.org/research/understanding-population-health.html>

<sup>29</sup>AVC ¶ 4(c); *see also* AVC ¶ 3(a)

<sup>30</sup>See generally Cooperative Agreement

and analyze data reflecting care delivered by both hospitals and affiliated providers, the new system will be able to identify and implement best practices targeted at patterns and trends across the population. This kind of broad, region-wide perspective and ability to prioritize and address the unique health problems facing the community, under leadership rooted in the community, is critical to improving health in the Tri-State area.

At the same time PHM as implemented by a regional system will be effective at confronting the health challenges that face large segments of the population, gathering information from patients seeking care at both hospital campuses and affiliated outpatient facilities will also allow CHH and SMMC to focus on health disparities of smaller subpopulations (e.g., under-insured Health Exchange participants, WV Medicaid healthcare utilization outliers, I.V. drug users). Post-transaction, an integrated EHR can help identify healthcare quality deficiencies, unnecessary variances in care and utilization outliers in real-time across the population served by the system.

In addition to coordinated care delivery among providers and data-driven strategies, another key tool for implementing PHM is to partner with public health organizations, a process that the transaction would streamline and make more effective. CHH argues that building on existing relationships, but with the pooled resources and singular leadership, a regional system with a unified community outreach function will be able to harness joint efforts with organizations such as Cabell-Wayne County Health Department Regional Health Connect and other public, church-based, and non-profit community entities focused on health issues. CHH argues that this kind of community-wide examination of all factors that affect the health of the population, and all resources

that can be brought to bear to improve it, is something that a locally invested, regional system would be best positioned to lead.<sup>31</sup>

On April 18, 2016, SWVA filed two public comments in response to CHH's Application for Approval of Cooperative Agreement. The initial public comment dated April 14, 2016, indicated that SWVA requested additional information from the Authority and the West Virginia Attorney General. Specifically, SWVA requested the identity of every bidder for St. Mary's Medical Center together with the bids and documentation regarding the review and investigation by the West Virginia Attorney General which lead to the AVC. SWVA requested that the public comment period be held in abeyance until this information was provided.

On April 18, 2016, the Authority received SWVA's second set of public comments. SWVA argued that with respect to CHH's assertions that "a larger entity will achieve new breakthroughs in population health management, it 'provides no supporting evidence for this assertion.'" (SWVA Public Comment dated April 18, 2016, at p. 13). SWVA further states that "[t]here are no medical or economic studies cited to support the notation that a larger health system is better able to engage medically distressed or underserved populations, or that the health of populations in a region served by a monopolistic hospital is, in general, better by any measures than those served by two competitive hospitals." (Id.) SWVA argues that CHH "fails to offer any meaningful assurance that the merger-acquisition and consequent creation of a new regional monopoly with broad power is the only way to achieve population health improvement." (Id.)

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<sup>31</sup>CDC Community Health Report, at 13 ("Building shared ownership for health among diverse stakeholders in local communities offers the benefits of mobilization and leveraging of resources to achieve measurable improvements in health status and quality of life.")



FTC argues that the “AVC provides no details regarding the merging parties’ plans for population health management.” (FTC Public Comment at p. 53). FTC argues that “nothing in the AVC provides any detail regarding the specific population health goals the parties will pursue, how they will go about pursuing them, or a timeframe for pursuing them.” (Id.)

The Authority finds CHH demonstrated compliance with the statutory criteria of population health improvement. CHH entered into the AVC that contains terms for developing goals for population health improvement for the next ten years. The AVC defines population health goals as “those goals incorporated into a community health needs assessment as required by the Affordable Care Act.” (AVC at Definition, ¶ 19). Accordingly, CHH is required to conduct a needs assessment of its community in formulating the population health improvement goals. It is entirely reasonable for CHH to conduct a community needs assessment prior to its goals development. The fact that the goals have not been set forth now is not fatal since the needs of the community have not been evaluated. In this document, CHH and SMMC agree that within six months following the closing of the transaction they will develop population health goals including centers of excellence with quantitative benchmarks and a proposed timeline to be provided to the Attorney General. This is a reasonable timeframe.

In addition, Raymona Kinneberg, an expert in health planning, testified in the underlying CON matter. She explained that “there’s been a major shift in how the people who pay for healthcare look at healthcare. Historically, it’s been on a fee for service basis. You provide inpatient care and you get paid for that stay. What’s happening now is there’s a push to view the whole individual so that you’re not just being paid on a fee for service

basis. There's bundled payments, there's a drive to make sure that there are no readmissions."<sup>32</sup> Ms. Kinneberg then opined that the transaction would "enable [CHH and SMMC] to work together to provide those services [population health ideas] to the service area as a whole and have stronger programs that will keep people healthy." (Id. at p. 32). In addition, Dr. Burdick, also testified regarding population health improvement. Dr. Burdick testified that "medical literature over time in specific areas has shown volume-related improvements---or the potential for volume related improvements in quality"<sup>33</sup>. He further stated that "population health...is attempting to address and improve the health of a defined population...[a]nd that health means healthcare, but it also means prevention, wellness, hospital avoidance, which is a new area. In that model the payment is also shifting... and those alternative payment models increasingly are based on risk."<sup>34</sup> He further testified that "an actuary will tell you there has to be a critical mass if you're going to accept risk of any kind, particularly in the healthcare insurance arena....[s]o there's a criticality of mass in certain payment models that are evolving."<sup>35</sup> He further stated "[t]hat is why independent small community hospitals are predicted by bond rating agencies and others to not be as successful moving forward unless they find a strategy that allows them to have economies of scale and the quality outcomes... as far as critical volume."<sup>36</sup>

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<sup>32</sup>In re Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex. 82, Tr. I. p. 30-31

<sup>33</sup>Id. at p. 153

<sup>34</sup>Id. at pp154-155

<sup>35</sup>Id.

<sup>36</sup>Id.

SWVA has argued that CHH has failed to meet this burden because it did not cite any studies or give any meaningful assurances that population health will be achieved. FTC argues that CHH offers no concrete plans.

However, in addition to the terms and timeframes of the AVC, CHH provided expert testimony on this issue regarding how the proposed transaction would enhance population health in the service area by bringing stronger programs to the service area. This is possible with the volumes of the two merged hospitals. Ms. Kinneberg and Dr. Burdick testified that this Acquisition would improve population health. Dr. Burdick further testified that a merger of the two hospitals would enhance quality because the increased volume in specific areas has shown to lead to better outcomes. This will lead to better quality of care to service area patients and thus overall population health improvement, in the important areas of joint replacement, cardiac interventions, live births, and certain advanced cancer surgeries<sup>37</sup>.

**(B) Improved Access to Health Care Services**

CHH argues that access to health care is affected by a number of distinct factors of which price and quality are discussed separately below are important elements. CHH notes that also important is the availability of services in proximity to a patient's residence and workplace. CHH argues that as evidence presented during the CON hearing established, without the combination of their resources, there are services which neither hospital has sufficient capital or volume to provide. Further, CHH argues that, as testified to by Dr. Hoyt Burdick, "critical mass for tertiary subspecial level work is much more achievable in a system that has a larger population rather than two medium-sized

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<sup>37</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. pp. 153-154

hospitals trying to build tertiary services or recruit tertiary or quaternary national experts to work in a smaller system.”<sup>38</sup>

CHH and SMMC are both not-for-profit hospitals which provide care without regard to a patient’s ability to pay. The Cooperative Agreement assures that SMMC will remain a not-for-profit hospital providing services to the medically underserved population.

CHH argues that working together, the two hospitals can jointly assess community health needs and implement coordinated wellness, prevention and educational outreach programs. CHH argues that the ability of a combined system to attract highly qualified physician specialists and sub-specialists will enhance access to quality care in the community. A combination of financial resources and a critical mass of patients and data, together with the enhanced ability to recruit highly trained specialists to the area, creates the opportunity to expand services. Highly complex orthopedic and cancer surgery may be offered locally. A kidney transplant program becomes a realistic possibility. Finally, CHH notes that the Cooperative Agreement requires that SMMC continue to be operated as a full service acute care hospital. Thus, those patients who wish to receive hospital services at SMMC will continue to have that opportunity.

SWVA directs the Authority to CHH’s presentation during the underlying CON proceeding and notes that “at no point during these proceedings did Cabell ever offer concrete assertions that it intended to expand service lines, and indeed most of the claimed efficiencies arise from consolidation of services, not their expansion. (SWVA Public Comment at p. 13).

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<sup>38</sup>In re: Cabell Huntington Hospital, Con File No. 14-2-10375-A, Ex. 82, Tr. I, p. 161

The Authority finds CHH demonstrated compliance with the statutory criteria of improved access to health care services. In the AVC and the Application for Approval of Cooperative Agreement, CHH stated that it would implement community wellness programs to connect with the medically underserved.<sup>39</sup> In addition, as previously discussed, CHH committed to conducting a community needs assessment.<sup>40</sup> In addition, Ms. Kinneberg testified “[y]ou’ve got two moderately sized hospitals; one 303 beds, one 393 beds. In combination, they are almost 700 beds, and we’ll have the ability to attract more subspecialists...[t]he ability to recruit is somewhat based on the number of patients that you serve and the opportunity for specialists and subspecialists to be able to provide specialized services.”<sup>41</sup> While SWVA asserts that CHH did not offer concrete assertions that it intended to expand service lines, CHH is required to conduct a community needs assessment as part of this proposed transaction which will identify any needed new services. Further, as indicated by Ms. Kinneberg’s testimony the ability to attract subspecialists is volume driven and therefore, planning to add these services prior to approval of this transaction would have been futile.

**(C) Improved Quality**

The Institute of Medicine has defined quality as “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”<sup>42</sup> It contemplates providing patients with appropriate services in a technically competent way with good

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<sup>39</sup>AVC ¶ 3(b)

<sup>40</sup>AVC Definitions ¶ 19

<sup>41</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 29

<sup>42</sup>Institute of Medicine Committee on Quality of Health Care in America, Crossing the Quality Chasm: A New Health System for the Twenty First Century, Washing, D.C. National Academy Press at p. 32

communication, shared decision making and cultural awareness – all without regard to ability to pay. CHH argues that the combination of the resources of CHH and SMMC creates the opportunity to improve health care in numerous and important ways. The combination makes possible the adoption at both facilities of uniform protocols and best practices. Dr. Kevin Yingling, Dean of the School of Pharmacy at Marshall University, testified that “in a unified system there will be unification of a lot of protocols and practice protocols that will bring efficiency and improvement of quality of care.”<sup>43</sup>

Secondly, CHH argues that together the two hospitals can establish a modern database and a fully integrated and interoperable medical records system so that patient encounters at each hospital can be readily available to treating physicians at either hospital in real time. This fact is particularly important for hospitals located in close proximity to each other where a given patient may seek services at one hospital one day and at another on a different day. No population health strategy can succeed without robust integrated data analytics for the entire population across the entire continuum of care. CHH argues that while there are some rudimentary efforts to coordinate population health information through state health information exchanges (WVHIN) and emergency room data (EDIE), neither compares to the power of a single platform electronic medical record system and a consolidated data warehouse. The importance of such an integrated system was described by Dr. Burdick in testimony during the CON hearing. He stated “[a]nd one of the most promising aspects of that whole report to me is for the first time the Huntington community to have a consolidated, interactive medical record between the two major healthcare campuses, that—you can’t put a price on that.”<sup>44</sup>

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<sup>43</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 187

<sup>44</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 156

As noted above, CHH argues that the combined system will be better able to adopt and implement wellness, prevention and education programs to tackle in a coordinated way existing community health issues such as problems with substance abuse and illegal drug use. The Cooperative Agreement makes it possible for the combined system to implement new services which neither hospital standing alone has the resources or volume to provide separately. Such services may include highly complex surgery or the creation of a kidney transplant program. Numerous articles from members of the academic community and governing specialty organizations support the proposition that high volume is associated with better outcomes across a wide range of procedures and conditions.<sup>45</sup>

SWVA argues that CHH offers “no evidence that the merged entity will result in quality improvements.” (SWVA Public Comments dated April 18, 2015 at p. 14). SWVA further argues that there is nothing “merger specific” about CHH’s stated plans. (Id.) SWVA further notes that there is “no reason that Cabell and St. Mary’s could not establish an integrated regional medical records database.” (Id.) Further, there is “no reason that Emergency Room protocols could not be normalized between the hospitals, if the differences represent a challenge to patient care.” (Id.)

The Authority finds CHH demonstrated compliance with the statutory criteria of improved quality. Based upon the combined testimony of Dr. Burdick and Dr. Yingling the combined entity will enhance the quality of care. Dr. Yingling testified that a “unified system” will bring efficiencies and improvement of quality of care and unification of

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<sup>45</sup>Institute of Medicine, Interpreting the Volume–Outcome Relationship in the Context of Health Care Quality: Workshop Summary (2000), at pp. 4-5

protocols and practice. Dr. Yingling further testified that “there’s gross inefficiencies within the health record. I think there's great advantages for having a unified system.”<sup>46</sup> Dr. Yingling further testified that “[b]oth hospitals understood that quality meant that you needed to use evidence-based medicine to have a sepsis protocol in both hospitals....[t]he problem was they were different...[s]o...in a unified system there will be unification of a lot of protocols and practice protocols that will bring efficiency and improvement of quality of care.”<sup>47</sup> Likewise, Dr. Burdick testified that a consolidated, interactive medical record system would improve quality of care by allowing engaging physicians in integrated leadership roles with resources in the community and allowing for real time real time population management.<sup>48</sup> The Authority finds this testimony directly on point regarding the issue of whether the proposed project will enhance quality of care in the service area. Both Dr. Yingling and Dr. Burdick testified that this proposal would enhance quality in various ways. Dr. Yingling specifically by a unification of protocols and practices between the two hospitals and Dr. Burdick by a unification of patient medical records. This is a concrete and tangible improvement in the quality of care. FTC’s expert contends that there is nothing unique to this agreement that facilitates the adoption of protocols. However, this argument is rebutted by the direct testimony of Dr. Yingling which said that this Acquisition will unify protocols between the two hospitals.

**(D) Cost Saving Efficiencies**

In 2014, The Camden Group, performed a comprehensive study of the efficiencies which are likely to result from the cooperative agreement between CHH and SMMC. The

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<sup>46</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 190

<sup>47</sup>*Id.* at 187

<sup>48</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 156



results of this study were contained in a report styled Business Plan of Operational Efficiencies (“BPOE”) dated November 12, 2014, which was admitted in evidence in the CON proceedings. The BPOE projected \$36 million in efficiencies.

CHH submitted a further analysis of the savings specific to this transaction which will result from the cooperative agreement which was performed by Deloitte Consulting LLP. The Deloitte Report, authored by Lisa Ahern, determined that this transaction makes possible, which could not be achieved if another purchaser acquires SMMC, \$16 million in annual recurring cost saving three years after closing.<sup>49</sup> (CHH’s Response to Public Comments at p. 9). These savings will result from operating efficiencies, including third-party vendor agreements, consolidation and staffing efficiencies. CHH argues that the transaction will improve quality, particularly by consolidating highly complementary services. In particular, the geographic proximity of the two hospitals allows for a high degree of integration, otherwise not obtainable by a consolidation between more distant hospitals.<sup>50</sup>

SWVA argues that the only “merger-specific cost saving efficiencies claimed by Cabell arise from the elimination of jobs and there is absolutely no evidence that any of these alleged cost saving efficiencies will ever be passed on to the consumers of healthcare.” (SWVA Public Comments dated April 18, 2015 at p. 14). SWVA further argues that CHH is allowed to increase rates under the new law making the region less and less competitive. (Id.)

FTC argues that in an attempt to rehabilitate its cost savings claims, CHH submitted the Deloitte Report. (FTC’s Response to CHH’s Response to Public

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<sup>49</sup>Ahern Rpt. ¶ 228

<sup>50</sup>Ahern Rpt. ¶ ¶ 34, 129, 144, 191

Comments at p. 14). FTC argues that this report estimates that the proposed cooperative agreement will result in \$16 million in merger-specific annual recurring cost savings. FTC argues that this is less than half of The Camden Group's BPOE estimate of \$36 million that CHH submitted to the Authority. FTC argues that this calls into question the reliability of both reports. FTC argues that the Deloitte Report's cost savings estimate represents a very small percentage of the two hospital's combined operating costs. Therefore, FTC argues "[e]ven a modest post-merger price increase will exceed the merging parties' claimed cost savings, even assuming all those savings will be fully passed through to consumers, which the merging parties have not shown." (Id.)

Dr. Thomas Respass, a clinical quality expert, of Baker & McKenzie Consulting, LLC, examined the Deloitte Report and concluded that there are no significant cognizable net cost savings to be achieved by the proposed cooperative agreement. Dr. Respass's report finds that Ms. Ahern ignored or dismissed evidence of obstacles to consolidation, the Deloitte Report's projected cost savings estimates are not supported by ordinary course documents or other evidence, projection of staffing cuts differ from those made in the BPOE, projections for medical and other hospital supplies rely on a price matching for projects and services and assumes that the combined entity will purchase at the lower of the two prices. In addition, under the Merger Guidelines, merging parties bear the burden of proving that their proposed efficiencies are merger-specific.<sup>51</sup> FTC argues that apart from the Deloitte Report, CHH has put forth no new evidence or arguments regarding its claimed benefits from the transaction.

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<sup>51</sup>Merger Guidelines § 10

The Authority finds CHH demonstrated compliance with the statutory criteria of cost efficiencies. CHH submitted two reports demonstrating compliance with this statutory goal. First, CHH submitted the The Camden Group's BPOE. This report projected \$36 million in savings. CHH also submitted the Deloitte Report prepared by Lisa Ahern which projects \$16 million in merger-specific annual recurring cost savings. Both of these reports demonstrate cost savings. While the FTC argues that these reports are contradictory and unreliable, the Authority is not persuaded by this argument. Rather, the FTC itself explained the variance in the reports, the BPOE was not merger-specific and the Deloitte Report was merger-specific. Accordingly, the Deloitte Report more conservatively limits the merger efficiencies and therefore projects less cost savings. In addition, the FTC argues that only efficiencies that are merger-specific must be considered pursuant to the Merger Guidelines.

However, this is not a federal antitrust case. While it is true that the Authority is directed to give deference to the policy guidelines of the FTC<sup>52</sup>, the West Virginia Legislature specifically provided an exemption from state and federal antitrust laws for any actions of hospitals and health care providers under the Authority's jurisdiction when made in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the board.<sup>53</sup> In addition, the WVCAL sets forth a different standard for approval than that advocated by either SWVA or FTC. The WVCAL provides that an application can be approved even if it would produce a loss of competition, so long as any likely adverse impact from that loss of competition is outweighed by a variety of

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<sup>52</sup>W.Va. Code 16-29B-28(d)(4)(C)

<sup>53</sup>W.Va. Code 16-29B-26

benefits.<sup>54</sup> In contrast, the “federal antitrust laws focus on lessening of competition, a showing which tends to be dispositive.” (CHH Response to Public Comments at p. 2) While a consideration of efficiencies is permitted, it is limited to whether they are substantial enough to act as a counterbalance against any loss of competition that otherwise would occur<sup>55</sup>. Accordingly, the Authority will not apply a standard reserved for an antitrust action to a state law matter. The only criteria that CHH must meet are the criteria set forth in the WVCAL. Accordingly, if CHH can satisfy the balancing test set forth in the WVCAL it can be approved for a cooperative agreement. In this instance, CHH has established a cost savings. The BPOE established that \$36 million in cost savings will be realized. The Deloitte Report, which would even be credited under federal antitrust laws if that were the standard, established \$16 million in annual recurring cost savings three years after closing.

**(E) Ensuring Affordability of Care**

As will be discussed more fully below, CHH argues that there are a number of safeguards in place to restrain price increases post transaction. These include provisions in the AVC entered into on November 4, 2015, between CHH and SMMC and the Attorney General, the Letter Agreement with Highmark Blue Cross and the recently enacted W.Va. Code § 16-29B-28. In addition, CHH argues that the efficiencies and cost savings discussed above also reduce costs and reduce the necessity for price increases.

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<sup>54</sup>W.Va. Code 16-29B-28-(f)(3)

<sup>55</sup>Merger Guidelines § 10.(stating that to make the requisite determination [of whether the proposed merger is likely to be anticompetitive in the relevant market], the Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger’s potential to harm customers in the relevant market, e.g. by preventing price increases in that market,“)

SWVA notes that the AVC and Letter of Agreement with Highmark (“LOA”) are time limited. (SWVA Public Comments dated April 18, 2016, at p. 14). SWVA further argues that “nothing in the AVC or the non-public LOA preserves or enhances competition in the private health insurance market, as there is no protection for new and potentially innovative market entrants seeking to negotiate discount contracts with the new, monopolistic hospital, beyond the Attorney General’s right to refuse discount contracts deemed anti-competitive set forth in § 16-29B-28(i)(1)(B).” (Id. at pp. 14-15).

FTC argues that conduct remedies, such as the AVC, will not replace the competitive “intensity lost as a result of a merger.” (FTC Public Comment at p. 40). FTC further argues that courts, antitrust enforcers, and economists are “highly skeptical of such conduct restrictions and strongly prefer structural remedies such as divestiture...” (Id.) FTC argues when addressing likely benefits of the agreement, that while the Attorney General has the power to reject reimbursement agreements that are “anti-competitive”, the statute provides no guidance as to what constitutes an “anti-competitive” reimbursement agreement. (Id. at p. 57). FTC argues that it is impossible to predict how this provision will be implemented going forward or whether it will provide meaningful restraint on anticompetitive price increases.

The Authority finds CHH demonstrated compliance with the statutory criteria of ensuring affordability of care. First, in approving or denying an application, the Authority may consider “[a]n agreement entered into by a [hospital party to a cooperative agreement and any state official or state agency imposing certain restrictions on rate increases...”<sup>56</sup> The statute further provides that this agreement shall be enforceable in accordance with

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<sup>56</sup>W.Va. Code § 16-29B-28(i)(1)(A)

its terms<sup>57</sup>. CHH entered into the AVC agreeing to limit its rates to a benchmark rate to ten years post transaction.<sup>58</sup> CHH agreed, that in the event that should the Authority cease to establish benchmark rates the methodology previously used by the Authority will be utilized<sup>59</sup>. The terms of the AVC will limit the rates that the combined entity may charge. While these terms are time limited the AVC also needs to be reviewed in conjunction with the statute, which grants approval power over rates and reimbursements to the Attorney General which are not time limited. See, W.Va. Code § 16-29B-28(i)(1)(B). While SWVA and FTC argue that the rate provisions are vague, these arguments are speculative. Accordingly, the Authority finds that CHH has demonstrated compliance with affordability of care.

**(F) Enhancing and Preserving Medical Education Programs**

CHH argues that one of the important results of consummation of the transaction is the assurance it provides of continued support for medical education in the region served by the two hospitals. As explained by Dr. Dean Shapiro, Dean of the Joan C. Edwards School of Medicine, the hospitals provide the teaching laboratories in which physicians are trained and learn the practice of medicine.<sup>60</sup> CHH argues that the support provided by the two hospitals to the Marshall University School of Medicine is critical to the continued viability of the medical school. As Dr. Yingling explained in testimony in the CON proceeding, substantially more monetary support to the School of Medicine comes from the hospitals than from the State of West Virginia. Testimony of Dr. Yingling during the CON hearing indicated that state support for the School of Medicine constitutes

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<sup>57</sup>Id.

<sup>58</sup>AVC ¶ 2(a)

<sup>59</sup>Id.

<sup>60</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 170

roughly 10 – 11% of the School's budget as compared to 30 – 40% provided by the hospitals.<sup>61</sup> Were SMMC to be acquired by another hospital system, the level of support provided by SMMC could be drastically reduced or eliminated. As expressed by Dr. Burdick, “[s]o my greatest fear is that the resident support system through Medicare for St. Mary's Medical Center is optional and an alternate buyer who is not committed to Marshall Medical School as our community is might have different feelings about supporting graduate medical education.”<sup>62</sup>

The testimony of Dr. Shapiro concerning the experience of the Medical College of Ohio when a hospital system decided that it no longer wanted to be involved in medical education and eliminated 100 residency positions within the space of a few months constitutes a vivid example of the importance of hospital support for medical education.<sup>63</sup> And, as explained by Dr. Yingling, if SMMC ceased to participate in the cardiology educational programs of the medical school, these programs could be seriously jeopardized.<sup>64</sup>

The recruitment of highly qualified physicians, specialists and sub-specialists, combined with the ability to expend services offered locally will enhance the educational opportunities for student, residents and fellows.

SWVA argues that CHH was not the only bidder for SMMC and other bidders included not for profits. (SWVA Public Comments dated April 18, 2016, at p. 15). SWVA argues that the only way to assess CHH's assertions is to actually obtain the bids to make

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<sup>61</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. pp. 179-180

<sup>62</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 157

<sup>63</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 167

<sup>64</sup>Id. at p. 183

this determination. SWVA argues that it is unlikely that another not-for-profit hospital would seek to obtain SMMC and then strip out its support for medical education.

The Authority finds CHH demonstrated compliance with the statutory criteria of enhancing and preserving medical education programs. Dr. Shapiro testified that he “vividly remembered” merger discussions with University of Toledo and a private entity which fell apart.<sup>65</sup> He testified that “as part of the detangling of this relationship, that organization decided it no longer wanted to be involved in medical education and essentially...eliminated a hundred residency positions within the space of a few months’ notice.” (*Id.*) Dr. Yingling testified that programs could be seriously jeopardized. While SWVA argues that it no other not for profit would eliminate medical education, Dr. Shapiro gave compelling testimony regarding the fact that medical education can be compromised as the result of a merger and that these changes can happen quickly in a community. Further, Dr. Yingling testified that medical education programs in cardiology could be seriously jeopardized. This is particularly alarming in an area in which risk factors for cardiology services are so high, such as those for obesity and smoking. The Authority finds the testimony of Dr. Shapiro and Dr. Yingling compelling. Dr. Shapiro gave a personal accounting concerning how quickly a merger can compromise medical education. This is more than mere speculation. Based upon the importance of these programs to the service area residents, the Authority is unwilling to jeopardize these programs. Accordingly, CHH has demonstrated compliance with this provision of the statute.

**(G) Supporting the Authority’s Goals and Strategic Mission as Applicable**

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<sup>65</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 167



CHH argues that as the Authority found in its Decision awarding the Certificate of Need to CHH, the proposed project "will reduce duplication, increase efficiency, quality, and coordination of care and allow for greater recruitment of professionals, promoting more effective management of population health, enhancing existing programs of health science education, all while maintaining and potentially expanding access to essential acute care services to West Virginia residents."<sup>66</sup> The Authority explained that this is a core principle and purpose of the Certificate of Need law. Additionally, the Authority found that the Acquisition "will promote the development of a community-oriented, integrated health care network consistent with the policy recommendations set forth in Chapter 4 and 5 of the 2000-2002 State Health Plan."<sup>67</sup>

SWVA cites to W.Va. Code § 16-29B-1 which states: "the health and welfare of the citizens of this state is being threatened by unreasonable increases in the cost of health care services." SWVA further points the Authority to the language that directs the Authority to gather data regarding costs and to implement a system of cost controls. SWVA argues that its evidence indicates that monopolistic health care systems have a direct impact on patient costs, and that controlling for all other factors, monopolistic health care systems have costs "15% [higher] for the end user than facilities in competitive markets." (SWVA Public Comments dated April 18, 2016, at p. 15). SWVA states that Huntington "already has the third-highest cost for private insurance per capita out of 306 health care referral regions in the country." (*Id.*) SWVA further argues that the only benefits of the merger-acquisition cited by CHH that are "unique to Cabell's acquisition of

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<sup>66</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 89, p. 26

<sup>67</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 89, p. 21

St. Mary's are those specific cost savings that arise from the elimination of redundant positions between the two facilities..." (SWVA Public Comments dated April 18, 2015 at p. 16).

The Authority finds CHH demonstrated compliance with the statutory criteria of supporting the Authority's goals and strategic mission as applicable. The Authority finds that based upon the testimony of Dr. Burdick and Ms. Kinneberg that residents of the service area will experience enhanced subspecialty services as a result of this Acquisition because the merged entity will be able to attract subspecialty physicians to the service area. Based upon the AVC, a population needs assessment will be conducted and the needs of the community will be assessed and after this assessment new services can be offered. The benchmark rate methodology, which existed for many years, will manage the hospital rates for a ten year period and the Attorney General has rate oversight of the merged entity's rates post transaction. This is consistent with the Authority's mission to protect the health and well-being of the citizens of this State by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective, high quality health care services.<sup>68</sup>

#### **VI. ANALYSIS OF BENEFITS LIKELY TO RESULT FROM THE PROPOSED COOPERATIVE AGREEMENT**

In evaluating the potential benefits, the Authority shall consider whether one or more of the following benefits may result from the proposed cooperative agreement:

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<sup>68</sup>W.Va. Code 16-29B-1

(A) **Enhancement and preservation of existing academic and clinical education programs**

CHH states that it is a member of an academic medical center which includes Marshall University Joan C. Edwards School of Medicine ("the School of Medicine") and its faculty practice plan, University Physicians and Surgeons, Inc., d/b/a Marshall Health ("Marshall Health"). CHH is the primary teaching hospital affiliated with the School of Medicine. CHH provides a high level of monetary support each year to enable the School of Medicine to meet its financial needs. It also assists the School of Medicine in the recruitment and retention of faculty members. SMMC is also a teaching hospital which provides vital clinical training to student residents and fellows, particularly in the area of cardiology, cardiovascular services and internal medicine. It also provides much needed financial support to the School of Medicine. More importantly, as pointed out by Dr. Shapiro, the hospitals serve as the laboratory for training students, residents and fellows in the practice of medicine.<sup>69</sup> There are currently 158 residents and 27 fellows participating in clinical training at CHH and SMMC.

CHH notes that the clinical training programs offered to the School of Medicine by SMMC will continue following the sale of SMMC. CHH argues that this constitutes a major benefit of the Cooperative Agreement. CHH argues that it and SMMC through their history of support for the School of Medicine have demonstrated their understanding of the importance of educating physicians who will practice in this state and their commitment to support this objective. CHH argues that if SMMC were to be acquired by a national or regional chain with no ties to the area, the vital support provided by SMMC

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<sup>69</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 170

may be diminished or eliminated. CHH argues that the testimony of Dr. Shapiro, Dr. Burdick and Dr. Yingling during the CON hearing confirms the risk to medical education if the Cooperative Agreement is not consummated.<sup>70</sup>

On April 18, 2016, the Authority received FTC's public comments. FTC states that CHH's argues that if SMMC is acquired by a hospital system other than CHH the medical school support might be reduced or even eliminated. (FTC Public Comment dated April 18, 2016, at p. 51). FTC argues that this claim is pure speculation. FTC argues that CHH can point to no evidence that an alternative purchaser of St. Mary's would not be willing to continue supporting medical education.

The Authority finds CHH demonstrated compliance with the statutory criteria of enhancement and preservation of existing academic and clinical education programs. As previously discussed, Dr. Shapiro testified that he "vividly remembered" merger discussions with University of Toledo and a private entity which fell apart. He testified that "as part of the detangling of this relationship, that organization decided it no longer wanted to be involved in medical education and essentially...eliminated a hundred residency positions within the space if a few months' notice." (Id.) Dr. Yingling testified that programs could be seriously jeopardized. While SWVA argues that no other not-for-profit would eliminate medical education. Dr. Shapiro gave compelling testimony regarding the fact that medical education can be compromised as the result of a merger and that these changes can happen quickly in a community. Further, Dr. Yingling testified that medical education programs in cardiology could be seriously jeopardized. This is particularly alarming in an area in which risk factors for cardiology services are so high

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<sup>70</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. pp. 156-168, pp. 166-167, pp. 182-184

such as those for obesity and smoking. The Authority finds the testimony of Dr. Shapiro and Dr. Yingling compelling. CHH and SMMC have made tangible commitments to continue medical education. Dr. Shapiro gave a personal accounting concerning how quickly a merger can compromise medical education. This is more than mere speculation. Based upon the importance of these programs to the service area residents, the Authority is unwilling to jeopardize these programs. Accordingly, CHH has demonstrated compliance with this provision of the statute.

**(B) Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse provided to citizens served by the Authority**

As previously explained, CHH argues that consummation of the transaction will enhance the quality of hospital care in a number of important ways. Previous discussions are incorporated herein by reference. In addition, because SMMC provides the only inpatient behavioral health services, the transaction will make possible the coordination of mental health services at CHH with the inpatient services at SMMC. Further, CHH argues that the combined system will have the aligned incentives and improved ability to successfully implement coordinated programs to deal with substance abuse.

FTC argues that many of the claimed quality improvements lack substantiation and are not merger-specific (FTC Public Comment dated April 18, 2016 at p. 51). FTC further argues that the proposed cooperative agreement eliminates quality competition between Cabell and St. Mary's, which it argues "likely leading to a substantial reduction in the quality of care provided by the combined entity compared to which would have resulted without the cooperative agreement." (FTC Public Comment dated April 18, 2016, at pp. 51-52). FTC further argues that as Dr. Patrick Romano, of the University of California

Davis, who was retained to examine CHH's proposed cost savings and quality benefits claims concludes, there is nothing unique to "this cooperative agreement that facilitates the adoption of uniform protocols or best practices." (FTC Public Comment dated April 18, 2016, at p. 52).

The Authority finds CHH will enhance the quality of related care including mental health services and treatment of substance abuse provided to citizens served by the Authority. Based upon the combined testimony of Dr. Burdick and Dr. Yingling the combined entity will enhance the quality of care. Dr. Yingling testified that a "unified health care record" will bring efficiencies and improvement of quality of care and unification of "protocols and practice" which are "great advantages for having a unified system."<sup>71</sup> Dr. Yingling further testified that "[b]oth hospitals understood that quality meant that you needed to use evidence-based medicine to have a sepsis protocol in both hospitals....[t]he problem was they were different...[s]o...in a unified system there will be a unification of a lot of protocols and practice protocols that will bring efficiency and improvement of quality of care." (*Id.*) Likewise, Dr. Burdick testified that a consolidated, interactive medical record system would improve quality of care by engaging physicians in integrated leadership roles with resources in the community and allowing for real time population management.<sup>72</sup> The Authority finds this testimony directly on point regarding the issue of whether the proposed project will enhance quality of care in the service area. Both Dr. Yingling and Dr. Burdick testified that this proposal would enhance quality in various ways. Dr. Yingling specifically testified that the Acquisition would bring a unification of protocols and practices between the two hospitals. Dr. Burdick testified that

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<sup>71</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 189-190

<sup>72</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 156.

the Acquisition would bring a unification of patient medical records. This is a concrete and tangible improvement in the quality of care. In addition, because SMMC provides the only inpatient behavioral health services, the Acquisition will make it possible for CHH to coordinate care with the inpatient services at SMMC and to successfully implement substance abuse programs. FTC's expert contends that there is nothing unique to this agreement that facilitates the adoption of protocols. However, this argument is rebutted by the direct testimony of Dr. Yingling which said that this Acquisition will unify protocols between the two hospitals.

**(C) Enhancement of population health status consistent with the health goals established by the Authority**

As previously explained, CHH argues that the ability to deal with population health will be substantially enhanced by the combination of resources and information of the two hospitals. A single hospital system can better analyze community needs and formulate and implement education and other programs to engage them.

FTC rebuts CHH's contention that the AVC includes a commitment by the parties to developing population health goals. The FTC argues that the AVC "provides no details regarding the merging parties' plans for population health management." (FTC Public Comment dated April 18, 2016, at p. 53). FTC argues that there are "no specific health goals that the parties will pursue, how they will go about pursuing them, or a timeframe for pursuing them." (*Id.*) Therefore, there are no concrete plans for the Authority to enforce population health management.

The Authority finds CHH demonstrated compliance with the statutory criteria of population health improvement. CHH entered into the AVC that contains terms for developing goals for population health improvement for the next ten years. The AVC

defines population health goals as "those goals incorporated into a community health needs assessment as required by the Affordable Care Act."<sup>73</sup> Accordingly, CHH is required to conduct a needs assessment of its community in formulating the population health improvement goals. Quality goals and population health goals, including centers of excellence with quantitative benchmarks and a proposed timeline shall be provided to the Attorney General within six months following the closing of the transaction. It is entirely reasonable for CHH to conduct a community needs assessment prior to its goals development. The fact that the goals have not been set forth now is not fatal since the needs of the community have not been evaluated. The AVC gives a six month time frame for this to take place, which again, is a reasonable timeframe.

In addition, Raymona Kinneberg, an expert in health planning, testified in the underlying CON matter. She explained that "there's been a major shift in how the people who pay for healthcare look at healthcare. Historically, it's been on a fee for service basis. You provide inpatient care and you get paid for that stay. What's happening now is there's a push to view the whole individual so that you're not just being paid on a fee for service basis. There's bundled payments, there's a drive to make sure that there are no readmissions."<sup>74</sup> Ms. Kinneberg then opined that the transaction would "enable [CHH and St. Mary's] to work together to provide those services [population health ideas] to the service area as a whole and have stronger programs that will keep people healthy." (Id. at p. 32). In addition, Dr. Hoyt Burdick testified regarding population health improvement that "medical literature over time in specific areas has shown volume-related

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<sup>73</sup>AVC Definition at ¶ 19

<sup>74</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 30-31



improvements---or the potential for volume related improvements in quality .”<sup>75</sup> He further stated that “population health...is attempting to address and improve the health of a defined population...[a]nd that health means healthcare, but it also means prevention, wellness, hospital avoidance, which is a new area. In that model the payment is also shifting...and those alternative payment models increasingly are based on risk.”<sup>76</sup> He further testified that “an actuary will tell you there has to be a critical mass if you’re going to accept risk of any kind, particularly in the healthcare insurance arena....[s]o there’s a criticality of mass in certain payment models that are evolving.”<sup>77</sup> He further stated “[t]hat is why independent small community hospitals are predicted by bond rating agencies and others to not be as successful moving forward unless they find a strategy that allows them to have economies of scale and the quality outcomes... as far as critical volume.”<sup>78</sup>

SWVA has argued that CHH has failed to meet this burden because it did not cite any studies or give any meaningful assurances that population health will be achieved. FTC argues that there are no concrete plans. However, in addition to the terms and timeframes of the AVC, CHH provided expert testimony on this issue regarding how the proposed transaction would enhance population health in the service area by bringing stronger programs to the service area. This is possible with the volumes of the two merged hospitals. Ms. Kinneberg and Dr. Burdick’s testified that this Acquisition would improve population health. Dr. Burdick further testified that a merger of the two hospitals would enhance quality because the increased volume in specific areas has shown to lead to better outcomes. This will lead to better quality of care to service area patients and

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<sup>75</sup>Id. at p. 153

<sup>76</sup>Id. at pp. 154-155

<sup>77</sup>Id. at p. 155

<sup>78</sup>Id.

thus overall population health improvement, in the important areas of joint replacement, cardiac interventions, live births, and certain advanced cancer surgeries.<sup>79</sup>

(D) **Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care**

Consistent with its existing practices, it is the intention of CHH that the two hospitals will work collaboratively with small community hospitals in rural areas within the region served by them through the provision of tertiary specialty services not available in their respective area. The hospitals will continue to expand existing training and educational programs conducted at community hospitals and with community health care providers. Programs provided to community hospitals include training in advanced cardiac life support, pre-hospital trauma life support, and a 16-hour emergency trauma nursing course, a pediatric education course for pre-hospital professionals, and a 16-hour advanced life support course for nurses, physicians and paramedics. The hospitals will continue their support for the School of Medicine to further the School's mission of educating primary care physicians who will serve the rural areas of the state. The hospitals will continue to provide rapid transportation capability through the HealthNet Aeromedical service.

FTC argues that CHH did not directly address this statutory goal. (FTC Public Comment dated April 18, 2016, at p. 54). Rather, FTC argues that CHH instead claims "that the combined hospitals will continue to provide support to small community hospitals—including the provision of tertiary services, training and educational programs—as well as support for the Marshall University School of Medicine, and air transportation capabilities. But the application does not articulate any reason why these

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<sup>79</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 154

programs were at risk without the proposed cooperative agreement or demonstrate that the proposed cooperative agreement will improve access to these programs.” (*Id.* at p. 54).

The Authority finds CHH demonstrated compliance with the statutory criteria of preservation of hospital facilities in geographical proximity to the communities traditionally serviced by those facilities to ensure access to care. CHH outlined a plan for continued commitment to work collaboratively with community hospitals in its application to enhance services, including the provision of HealthNet services. In addition, CHH also indicated that the merged entity would continue to support MUSOM.

**(E) Gains in the cost-efficiency of services provided by the hospitals involved**

As previously explained, CHH argues that consummation of the transaction makes possible very substantial cost savings. FTC argues that CHH relies upon the Camden Group’s BPOE which estimated annual cost savings which were admitted into evidence and relied upon by CHH at the CON hearing. After that hearing, CHH had Lisa Ahern of Deloitte Consulting LLP prepare a new efficiencies analysis (“Deloitte Report”) which estimates merger specific saving resulting from the proposed cooperative agreement. FTC argues that although the Application referenced the Deloitte Report, it fails to acknowledge that this report is a major departure from the earlier Camden Report. FTC, therefore, argues that the Authority should be wary of relying on either analysis. The Deloitte Report uses entirely different methodologies to project cost saving and it makes different recommendations in several significant areas. The FTC submits that the merging parties acknowledge that the BPOE did not estimate merger-specific cost

savings as instructed by the Merger Guidelines.<sup>80</sup> The Merger Guidelines instruct that only merger-specific efficiencies should be credited. Further, FTC argues that this is the standard that should apply in evaluating this cooperative agreement. FTC argues that even the Deloitte Report's "cost savings estimate rests on speculation and, in many important areas, is unsupported by ordinary-course business documents demonstrating that the claimed savings are likely to be achieved." (FTC Public Comment dated April 18, 2016, at p. 55). In addition, CHH provided the Authority with a brief summary of the Deloitte Report's conclusions with no evidence or analysis explaining why its cost savings are substantiated, merger-specific, or reduced to account for offsetting costs.

The Authority finds CHH demonstrated compliance with the statutory criteria of cost efficiencies. CHH submitted two reports demonstrating compliance with this statutory goal. First, CHH submitted the The Camden Group's BPOE. This report projected \$36 million in savings. CHH submitted the Deloitte Report prepared by Lisa Ahern, which projects \$16 million in merger-specific annual recurring cost savings. Both of these reports demonstrate cost savings as stated earlier in this Decision. While the FTC argues that these reports are contradictory and unreliable, the Authority is not persuaded by this argument. Rather, the FTC itself explained the variance in the reports, the BPOE was not merger-specific and the Deloitte Report was merger-specific. Accordingly, the Deloitte Report more conservatively limits the merger efficiencies and therefore projects less cost savings. In addition, the FTC argues that only efficiencies that are merger-specific must be considered pursuant to the Merger Guidelines.

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<sup>80</sup>Merger Guidelines § 10

However, this is not a federal antitrust case. While it is true, that the Authority is directed to give deference to the policy guidelines of the FTC, the West Virginia Legislature specifically provided an exemption from state and federal antitrust laws for “[a]ny actions of hospitals and health care providers under the board’s jurisdiction, when made in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the board.”<sup>81</sup> The Legislature further stated that it intended to “immunize cooperative agreements approved and subject to supervision by the authority and activities conducted pursuant thereto from challenge or scrutiny under both state and federal antitrust law.”<sup>82</sup> In addition, the WVCAL sets forth a different standard for approval than that advocated by either SWVA or FTC. The WVCAL provides that an application can be approved even if it would produce a loss of competition, so long as any likely adverse impact from that loss of competition is outweighed by a variety of benefits. In contrast, the “federal antitrust laws focus on lessening of competition, a showing which tends to be dispositive.” (CHH Response to Public Comments dated May 4, 2016, at p. 2) While a consideration of efficiencies is permitted, it is limited to whether they are substantial enough to act as a counterbalance against any loss of competition that otherwise would occur. As previously stated, the criteria that CHH must meet are the criteria set forth in the WVCAL statute. Accordingly, if CHH can satisfy the balancing test set forth in the WVCAL it can be approved for a cooperative agreement.

**(F) Improvements in the utilization of hospital resources and equipment**

The Cooperative Agreement enables the two hospitals to avoid purchasing unnecessarily duplicative equipment. Rather than each hospital acquiring costly

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<sup>81</sup>W.Va. Code § 16-29B-26

<sup>82</sup>Id.

equipment to compete with the other, equipment needs will be evaluated on a system-wide basis. The combined purchasing power of the two hospitals will create significant savings in supply and equipment costs. Combined resources of the two hospitals will also enhance the hospital's access to necessary capital.

FTC argues that CHH provides no evidence regarding how much unnecessary duplicative equipment the hospitals are separately purchasing today. Further, FTC argues that CHH has not identified the specific investments that it believes to have been wasteful or duplicative. As a consequence, FTC argues that there is no way to assess how much the merging parties will save as a result of the cooperative agreement, and thus no way to weigh these saving against the likely harm to competition resulting from the cooperative agreement.

The Authority finds CHH demonstrated compliance with the statutory criteria of improvements in the utilization of hospital resources and equipment. As a result of this Acquisition, CHH and SMMC will clearly not be purchasing duplicative equipment because rather than purchasing equipment for two separately run facilities those needs will be assessed on a system wide basis. This makes common sense and is reasonable.

**G. Avoidance of duplication of hospital resources**

CHH intends to implement each of the recommendations contained in the Camden Report in order to eliminate unnecessary duplication of hospital services. The Camden report projects that the implementation of recommendations contained therein will result in savings which this transaction makes possible, but which could not be achieved if another purchaser acquires SMMC.

FTC argues for the reasons outlined in section VI.E. that the Authority should not rely upon the BPOE in evaluating whether the proposed cooperative agreement will eliminate unnecessary duplication of hospital resources. FTC argues that the BPOE's estimates are largely speculative and unsubstantiated. Further, FTC submits that the merging parties admit that the BPOE's claimed efficiencies are not merger-specific, as the Merger Guidelines require.

The Authority finds CHH demonstrated compliance with the statutory criteria of avoidance of duplication of hospital resources. The BPOE outlines the cost savings from the elimination of unnecessary resources. As stated earlier, the Authority will rely upon the findings of the BPOE. If CHH can satisfy the balancing test set forth in the WVCAL it can be approved for a cooperative agreement.

**H. Hospital participation in state Medicaid program**

Both CHH and SMMC are West Virginia not for profit hospitals which have participated and will continue to participate in the state Medicaid program as well as in Medicaid programs in Ohio and Kentucky.

FTC states that CHH makes no claim that the proposed cooperative agreement will facilitate hospital improvement in the state Medicaid program. Accordingly, FTC argues that the cooperative agreement does nothing to advance this statutory goal.

The Authority finds CHH demonstrated compliance with the statutory criteria of participation in state Medicaid program. Both CHH and SMMC indicated that they will continue to participate in the state Medicaid program. This is a commitment made by the Applicant and the Authority can properly rely upon in rendering the Decision.<sup>83</sup>

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<sup>83</sup>W.Va. Code 16-29B-28-(f)(6)

i. **Constraints on increases in total costs of care**

CHH argues that gains in cost efficiency, improvements in resource utilization and the avoidance of the duplication of resources will contribute to constraining the total costs of care. In addition, as will be discussed more fully below, there are a number of instrumentalities in effect which will ensure that inappropriate increases in the total costs of care will not occur. These instrumentalities include an agreement entered into with the Attorney General styled an AVC, a letter agreement with Highmark Blue Cross and the recently enacted legislation which requires that rate increases be approved by the Attorney General and provides a mechanism for the return to payors of charges which exceed by more than two percent the Consumer Price Index for hospital inpatient care and the Consumer Price Index for outpatient services. Each of these instrumentalities is discussed fully in subsequent sections of this Decision.

FTC argues that the AVC's price controls provisions are "deeply flawed." (FTC Public Comment dated April 18, 2016, at p. 57). FTC states that the AVC limits hospital rate increases to benchmark rates calculated by the Authority for purposes of rate regulation. However, FTC notes that rate regulation was recently abolished making it unclear how this provision will operate. The AVC prevents the combined entity from terminating evergreen contracts. FTC argues that this "merely preserves the status quo while the cooperative agreement eliminates competition, which thereby effectively prevents health plans from negotiating more favorable terms for contracts." (*Id.*) FTC finally argues that the AVC is temporary and once it expires the combined entity's ability to raise prices will increase as a result.



FTC states that while the Attorney General has the power to reject reimbursement agreements that are “anti-competitive”, the statute provides no guidance as to what constitutes an “anti-competitive” reimbursement agreement. (Id. at p. 57). FTC argues that it is impossible to predict how this provision will be implemented going forward or whether it will provide meaningful restraint on anticompetitive price increases.

The Authority finds CHH demonstrated compliance with the statutory criteria of ensuring affordability of care. First, the Authority may consider “[a]n agreement entered into by a hospital party to a cooperative agreement and any state official or state agency imposing certain restrictions on rate increases...”<sup>84</sup> The statute further provides that this agreement shall be enforceable in accordance with its terms.<sup>85</sup> CHH entered into the AVC agreeing to limit its rates to a benchmark rate for a period of ten years post transaction. CHH agreed, that in the event the Authority should cease to establish benchmark rates the methodology previously used by the Authority will be utilized.<sup>86</sup> The terms of the AVC will limit the rates that the combined entity may charge. While these terms are time limited the AVC also needs to be reviewed in conjunction with the statute, which grants approval power over rates and reimbursements to the Attorney General which are not time limited. See, W.Va. Code § 16-29B-28(i)(1)(B). While SWVA and FTC argue that the rate provisions are vague, these arguments are speculative. Accordingly, the Authority finds that CHH has demonstrated compliance with affordability of care.

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<sup>84</sup>W.Va. Code § W.Va. Code 16-29B-28(i)(1)(A)

<sup>85</sup>Id.

<sup>86</sup>AVC at ¶ 2(a)

**VII. ANALYSIS OF DISADVANTAGES ATTRIBUTABLE TO ANY  
REDUCTION IN COMPETITION LIKELY TO RESULT  
FROM THE PROPOSED COOPERATIVE AGREEMENT**

The WVCAL provides the Authority's evaluation of the possible disadvantages of a cooperative agreement shall include consideration of four separate issues attributable to a reduction in competition. Each of these issues will be discussed separately below but before considering the specific issues as set forth in the statute, it is important to understand the role of competition in the analysis.

While competition is highly valued in our free market system, it is not an end in itself. Rather, it is valued because of the benefits it can provide to consumers. In the antitrust case of *Brooke Group Ltd.*, the United States Supreme Court pointed out that "the principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively."<sup>87</sup> In the recent *ProMedica* case, the Court of Appeals noted that "the goal of antitrust law is to enhance consumer welfare."<sup>88</sup> In *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979) the Court (quoting Bork, *The Antitrust Paradox* 66 (1978)), explained that "Congress designed the Sherman Act as a 'consumer welfare prescription'." It is in this context that the potential disadvantages set forth in the statute should be evaluated.

The FTC submits that the WVCAL set out criteria to be considered in evaluating the proposed cooperative agreement. Specifically, the Authority "shall approve a proposed cooperative agreement and issue a certificate of approval if it determines, with the concurrence of the Attorney General, that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a

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<sup>87</sup>*Brooke Group Ltd. V. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 221 (1993)

<sup>88</sup>*ProMedica Health Sys., Inc. v. FTC*, 749 F.3d 559, 571 (2014)

reduction in competition from the proposed agreement.”<sup>89</sup> (FTC Public Comment dated April 18, 2016, at p. 5). The FTC also states that the Authority shall “give deference to the policy statements of the Federal Trade Commission.”<sup>90</sup> (FTC Public Comment dated April 18, 2016, at p. 6). The FTC argues that the Merger Guidelines outline the merger-enforcement policy and analytical framework used by the federal antitrust agencies to evaluate the potential benefits (efficiencies) and the competitive impact of a proposed merger. The FTC argues that the Merger Guidelines are similar to the factors that the Authority must consider under the WVCAL. FTC argues that hospitals generally compete in two stages: first, for inclusion in a health plan’s network; and, second, to attract patients and physician referrals to their respective facilities. (FTC Public Comment dated April 18, 2016, at p. 8). FTC argues when competing hospitals merge, two different kinds of adverse effects may occur: higher prices charged to the health plan or employers (which are then passed on to consumers) and non-price effects such as reduced quality and availability of services. (Id.)

By letter dated May 4, 2016, CHH filed a Response to Public Comments. CHH argues that the WVCAL sets out a procedure under which the antitrust laws may be supplanted by a regulatory scheme that the West Virginia Legislature has deemed appropriate and sufficient to address issues related to competition.<sup>91</sup> CHH notes that the FTC Staff claims that the “types of benefits and disadvantages” listed in the statute “are similar to” those considered in an antitrust case and “argue the matter on traditional antitrust grounds.” (CHH Response to Public Comments dated May 4, 2016, p. 1). CHH

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<sup>89</sup>W.Va. Code § 16-29B-28(f)(3)

<sup>90</sup>W.Va. Code § 16-29B-28(d)(4)(C)

<sup>91</sup> W.Va. Code 16-29B-26,28(c)

argues that the WVCAL does not call upon the Authority to “resolve the very antitrust issues it was designed to displace.” (Id. at p. 2). Rather, CHH argues that “[i]t sets out a fundamentally different standard for approval that [FTC] and Steel do not either meaningfully or thoughtfully apply.” (Id.) CHH argues that the “federal antitrust laws focus on a lessening of competition, a showing of which tends to be dispositive.” (Id.) While consideration of transaction efficiencies is permitted, it is limited to whether they are “substantial enough to act as a counterbalance against any loss of competition that otherwise would occur.” See, e.g. Merger Guidelines § 10 (“To make the requisite determination [of whether the proposed merger is likely to be anticompetitive in the relevant market], the Agencies consider whether cognizable efficiencies likely would be sufficient to reverse the merger’s potential to harm customers in the relevant market, e.g. by preventing price increases in the market.”; see also Id. (stating that “efficiencies are most likely to make a difference in merger analysis when the likely adverse competitive effects, absent the efficiencies, are not great.”). CHH contrasts that the WVCAL provides that an application can be approved even if it would produce a loss of completion, so long as any likely adverse impact from that loss of competition is outweighed by a wide variety of benefits, not just benefits that would promote competition.

CHH argues that the question for the Authority, therefore, is not whether approval of the cooperative agreement will contravene federal antitrust laws, but whether benefits of the transaction outweigh the disadvantages. If the benefits of the transaction outweigh the disadvantages, then the West Virginia Legislature has determined that the transaction serves a substantial State policy,<sup>92</sup> and may be approved as a cooperative agreement

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<sup>92</sup>See W.Va. Code § 16-29B-28(b)-(c)

even if it would violate the antitrust laws apart from the immunity conferred by the statute. See Id. §§ 16-29B-26,28(c), see also *Cal Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97,105 (1980)(state action immunity applies (1) where the state clearly articulates a policy authorizing the conduct at issue; and (2) the state actively supervises the relevant behavior.) (Id. at p. 2)

CHH argues that the WVCAL is express and unambiguous and states the following: "When a cooperative agreement ...might be anticompetitive within the meaning and intent of state and federal antitrust laws the Legislature believes it is in the state's best interest to supplant such laws with regulatory approval and oversight by the Health Care Authority as set out in this article. W.Va. Code § 16-29B-26." (Id. at p. 2) CHH notes that this same provision grants the Authority the "power to review, approve or deny cooperative agreements" and "ascertain that they are beneficial to citizens of the state and to medical education" without regard to lawfulness under "state and federal antitrust laws." W.Va. Code 16-29B-28(c). If in the exercise of these statutory duties the Authority approves the cooperative agreement, then the antitrust laws are supplanted. Thus, CHH argues that even if FTC and SWVA were correct in their antitrust arguments, these arguments would do nothing to warrant a denial of the application. CHH argues that the WVCAL is not blind to potential effects on competition that may result from approved cooperative agreements. Rather, CHH argues that it looks to competitive effects as part of the Authority's approval analysis but also addresses such effects after approval by establishing comprehensive mandatory State oversight and control over pricing, health care quality, and other conduct of approved cooperative agreements. CHH contends that there is no reason to believe that the transaction would have an anticompetitive effect.

CHH notes that FTC and SWVA both argue that the Authority and the Attorney General are incapable of supervising the conduct of the cooperative agreements. CHH argues that these arguments are unsupported and the adequacy of the Authority and the Attorney General's supervision has been decided by the Legislature. In addition, if the Authority were to ignore the AVC as FTC and SWVA urge then it would be acting in direct contravention of the statute. See, W.Va. Code § 16-29B-28(i)(1)(A). Moreover, CHH contends that the Legislature enacted this regulatory regime in full awareness of FTC's objections which made a written submission to it urging it not to pass the WVCAL. CHH argues that by passing the law, despite the objections of the FTC, that the Legislature rejected the FTC's point of view. (Id. at p. 3) Rather, the Legislature chose to empower the Authority, the body created to "protect the health and well-being of the citizens of [West Virginia] by guarding against unreasonable loss of economic resources as well as to ensure the continuation of appropriate access to cost-effective, high quality health care services," and the West Virginia Attorney General to implement to WVCAL. (W.Va. Code § 16-29B-1)(Id.). Accordingly, CHH argues regardless of FTC's or SWVA's opinions about "so-called 'behavioral remedies' in the context of federal antitrust claims, the West Virginia Legislature has determined that regulations stemming from agreements such as the AVC are directly relevant to the Authority's decision whether to approve a cooperative agreement." (Id.). In any event, CHH argues that "even in the context of antitrust claims, these forms of regulation are valid and appropriate means to deal with any concerns about competitive effects." See, e.g., *FTC v. Butterworth Health Corp.*, 946 F. Supp 1285, 1298 (W.D. Mich. 1996)(finding that a commitment to freeze price increases for the following four years "besp[oke] a serious commitment by defendants... to refrain from exercising

market power in ways injurious to consuming public"). CHH argues that its application meets the statutory requirements.

On May 16, 2016, the Authority received SWVA's Response to CHH's Response to Public Comments. SWVA states that it "certainly believes that the proposed cooperative agreement will violate federal antitrust laws, Cabell is incorrect when it states that SWVA's public comments 'call[s] upon the Authority to resolve the very antitrust issues it [the WVCAL] was designed to displace.'" (SWVA Response to CHH's Response to Public Comments at p. 4). SWVA states that SB 597 "directs the WVHCA to weigh a variety of potential benefits against a variety of potential anti-competitive harms that might result from an acquisition and make a determination as to whether those potential benefits outweigh the anti-competitive harms." (Id.) SWVA argues the Authority must perform a full competitive analysis of the acquisition-merger on Huntington-area consumers so as to weigh the impact of the harms against the impact of the benefits and make a determination as to whether the benefits outweigh the harms. (Id.)

SWVA argues that it did not make antitrust arguments. Instead, SWVA argues that the alleged benefits claimed by CHH are "non-specific, vague, non-quantifiable, and - in general -not merger specific" and are clearly outweighed by the anti-competitive harm the merger-acquisition of SMMC will cause. (Id.) SWVA argues that it is not urging the Authority to ignore the AVC but rather that the AVC will not protect consumers from the anti-competitive harms of the merger-acquisition. SWVA argues that W.Va. Code § 16-29B-28(d)(4)(C) states that: "[i]n reviewing an application for cooperative agreement, the authority shall give deference to the policy statements of the Federal Trade Commission." (Id. at p. 12). SWVA argues that giving deference to the policy statements of the FTC

“certainly includes reviewing and considering FTC Staff’s advisory opinion on the impact of the loss of competition between St. Mary’s and Cabell on Huntington consumers as the WVHCA works to make the determination it is tasked with making: namely, whether the claimed benefits of the merger-acquisition outweigh the anti-competitive harms.” (Id. at p. 12).

FTC argues that the WVCAL explicitly requires the Authority to conduct an analysis of the proposed cooperative agreement’s likely effects on competition, and to weigh those competitive effects against the proposed cooperative agreement’s likely benefits. (FTC’s Response to CHH’s Response to Public Comments dated May 16, 2016, at p. 2) Thus, FTC argues it was entirely appropriate for FTC Staff to refer to that analysis set out in the Merger Guidelines in its submission. (Id.) FTC argues that it followed the analytical framework set out by the WVCAL for approval of a cooperative agreement by weighing the proposed cooperative agreement’s likely competitive harm against its potential benefits. FTC concludes that any benefits from the proposed acquisition are likely to be modest in scope, could be achieved without the proposed merger, and certainly do not outweigh the substantial competitive harm the proposed acquisition is likely to cause. (Id. at p. 3). In addition, FTC contends that it is not questioning the competence of the Attorney General but rather has concerns that the WVCAL’s rate and quality regulation provisions are flawed. (Id.) FTC argues that it is not contending that the Authority “ignore” the AVC but rather points out that the AVC’s price and quality provisions are highly unlikely to prevent or substantially mitigate the competitive harm likely to result from the proposed cooperative agreement. (Id.)



This is not a federal antitrust case. While it is true, that the Authority is directed to give deference to the policy guidelines of the FTC, the West Virginia Legislature specifically provided an exemption from state and federal antitrust laws for “[a]ny actions of hospitals and health care providers under the board’s jurisdiction when made in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the board.”<sup>93</sup> The Legislature further stated it shall “immunize cooperative agreements approved and subject to supervision by the authority and activities conducted pursuant thereto from challenge or scrutiny under both state and federal antitrust law.”<sup>94</sup> In addition, the WVCAL sets forth a different standard for approval than that advocated by either SWVA or FTC. The WVCAL provides that an application can be approved even if it would produce a loss of competition, so long as any likely adverse impact from that loss of competition is outweighed by a variety of benefits. In contrast, the “federal antitrust laws focus on lessening of competition, a showing which tends to be dispositive.” (CHH Response to Public Comments dated May 4, 2016, at p. 2) While a consideration of efficiencies is permitted, it is limited to whether they are substantial enough to act as a counterbalance against any loss of competition that otherwise would occur. Accordingly, the Authority will not apply a standard reserved for an antitrust action to a state law matter. The only criteria that CHH must meet are the criteria set forth in the WVCAL. Accordingly, if CHH can satisfy the balancing test set forth in the WVCAL it can be approved for a cooperative agreement. Accordingly, the Authority, will set forth its analysis of the criteria for the harms of the proposed cooperative agreement.

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<sup>93</sup>W. Va. Code § 16-29B-26

<sup>94</sup>Id.

A. The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers

To properly analyze the competitive effects of a hospital merger, it is necessary first to define both the relevant product market, the relevant geographic market in which the hospitals compete for patients, and how payor's perspective impacts market competition.

Product Market

It is the position of CHH that the relevant product market here consists of the bundle of inpatient hospital services as well as the bundle of outpatient services offered by CHH and SMMC collectively. Both CHH and SMMC are considered full service acute care hospitals and each provides basic hospital services such as general surgery, primary acute care services, imaging services, emergency departments and select tertiary services. Certain important services, however, are provided only at one of the two hospitals. Such services are complementary and not substitute services. To the extent that such services are complementary and not substitutes for each other, there currently exists little or no competition between the hospitals with respect thereto and, therefore, the proposed transaction can have no anti-competitive effect with respect to them. For example, CHH argues that cardiology services are provided largely at SMMC with no equivalent services at CHH. SMMC offers 33 cardiac DRGs that CHH does not. CHH is not authorized to perform open heart surgery and, therefore, is not permitted to provide elective interventional therapy and may perform only a narrowly defined category of emergency PCI intervention. Analysis of discharge data for the year 2013 for West

Virginia, Kentucky and Ohio discloses that only 6% of the discharges at CHH consisted of cardiac patients while the number at SMMC was 24.5%.<sup>95</sup> SMMC regularly has triple or quadruple the number of cardiac discharges from CHH. Additionally, the severity of cardiac patients treated by both hospitals is evident by comparing case mix indices; the cardiac CMI at SMMC is approximately 70 percent higher than that at CHH. Basically, CHH and SMMC simply do not compete for cardiac services. SMMC is generally recognized as the heart center in the area with its primary competitor being King's Daughters Medical Center in Boyd County, Kentucky; not CHH.

Conversely, pediatric care and obstetrical services are performed almost exclusively at CHH. CHH has both a pediatric intensive care unit and a neonatal intensive care unit. SMMC has neither. CHH also has the Hoops Family Children's Hospital, a "children's hospital within a hospital." CHH notes that 2,789 babies were delivered there during fiscal year 2014 compared to only 399 at SMMC. The two hospitals effectively do not compete with respect to pediatric care or high risk obstetrical care.

CHH has the only burn unit in the area while SMMC provides inpatient behavioral health service and CHH does not. Clearly, services with respect to which there is no meaningful competition represent a very important portion of the operations of the two hospitals. Cardiology and circulatory treatment account for nearly a quarter of SMMC total inpatient revenue. Pediatric and obstetrical services at CHH represent nearly one half of its operating revenue.

The fact that major segments of inpatient services offered by the two hospitals represent complementary services rather than substitute services is highly relevant in

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<sup>95</sup>West Virginia Inpatient Discharge Data, 2012-2013; Kentucky Inpatient Discharge Data, 2013; Ohio Inpatient Discharge Data, 2013

judging the impact which the transaction may have in negotiations with health maintenance organizations, preferred provider organizations and other health care payors. The core, non-overlapping services make the hospitals compliments and not substitutes when they are included in payors' hospital networks. To the extent that a payor needs Huntington hospital coverage in its network, the payor needs both of the Huntington hospitals to provide the full range of core services and, therefore, the proposed transaction would not increase the hospitals' leverage in negotiating prices with payors.

SWVA states that CHH essentially "claims that a few differences in specialty services offered by the two hospitals mean that Third-Party Payors gain no benefit from competition when the time comes to negotiate new discount contracts." (SWVA Public Comment at dated April 18, 2016, p. 3). SWVA argues that this is not true and that both hospitals "compete vigorously for patients for most services, and health plans and other third-party payors have repeatedly used that competition to gain more favorable terms when negotiating discount contracts with the hospitals." (Id.)

FTC argues that the proposed cooperative agreement will significantly harm competition and consumers in the relevant product markets for inpatient and general acute care services and outpatient surgical services. The FTC argues that the "relevant product or service market identifies the product[s] and services with which the [merging parties'] products compete." (FTC Public Comment dated April 18, 2016, at p. 9). FTC states that the Merger Guidelines explain that a relevant product market is determined by assessing whether a hypothetical monopolist that is the only seller of the product at issue could profitably impose a small but significant and non-transitory increase in price

("SSNIP")."<sup>96</sup> If so, FTC states that product (or group of products) constitutes the relevant product market; if not, then the product market should be expanded to include other products (or services) to which consumers would switch in the face of the hypothetical SSNIP.

FTC argues that the first relevant market that the Authority should examine is inpatient general acute care (GAC) services sold to commercial health plans and provided to their insured members.<sup>97</sup> The inpatient GAC services market includes a broad "cluster" of medical and surgical diagnostic and treatment services offered by both Cabell and St. Mary's that typically require an overnight hospital stay.<sup>98</sup> FTC argues that the second relevant market for the Authority to focus on is the outpatient surgical services sold to commercial health plans and provided to their insured members. The outpatient is a cluster of outpatient general surgery procedures offered by both CHH and St. Mary's that do not require an overnight hospital stay.

FTC argues that CHH and St. Mary's are not just close competitors--they are each other's closest competitor. FTC states that CHH "incorrectly argues that health plans view Cabell and St. Mary's as complements, rather than substitutes." (Id. at p. 27). FTC states that this argument is at odds with how the hospitals view one another which has been as competitors. (Id. at p. 28). Further, according to Dr. Cory Capps, Ph.D., an economic expert at Bates White Economic Consulting, quantitative analysis shows that CHH's and St. Mary's services largely overlap rather than complement one another. Dr. Capps opines that 92% of commercially insured patients at either CHH or SMMC receive

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<sup>96</sup>Merger Guidelines § 4.1.1

<sup>97</sup>FTC Public Comment dated April 18, 2016, at p. 10

<sup>98</sup>Id.

a service that both hospitals offer. Even in those specialties where the hospitals have some unique services, cardiac for SMMC and obstetrics and neonatal for CHH, most discharges at either hospital were for services that both hospitals offer. For example, 80% of labor and delivery discharges at both hospitals and 78% of newborn discharges at both hospitals, were in services that both hospitals offer. (Id. at p. 28). FTC further argues that CHH's argument that health plans view them as complements is contradicted by declarations describing CHH and SMMC as competitors.<sup>99</sup> Further, FTC argues that CHH's argument simply makes no sense from a competition perspective because the argument implies that unless the two merging hospitals overlap in every service line they offer, a merger can never result in harm to competition.

CHH argues that Dr. Capps's calculation erroneously focuses on the patient's choice in selecting a hospital rather than the payor's needs in bargaining for rates. CHH argues that in the service lines where one of the Huntington hospitals is much stronger than the other, like Cabell's pediatric care or SMMC's cardiac care, the diversion from the stronger hospital to the other hospital is lower than it is to the hospitals outside of Huntington. In rebuttal, CHH submitted the full report of Dr. Gautam Gowrisankaran, which states, "[i]n other words, patients know each hospital's strength and actively seek out each hospital for those strengths."<sup>100</sup> CHH argues that this evidence shows that, from the patient perspective, the hospitals are not substitutes and do not closely compete in their specialty services. (Id.) Rather, the hospitals are complements, even if the diversion ratios are higher when patient's choices across all services areas are simply aggregated, masking their highly differentiated service focuses. CHH argues that FTC treats services

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<sup>99</sup>Aetna (June 4) Decl. ¶ 14; Cigna Decl. ¶¶ 16, 22

<sup>100</sup>Gowrisankaran Rpt. ¶¶ 353-57, 367

as overlapping if both hospitals offer it, even if patients overwhelmingly prefer one hospital over the other.

FTC argues that CHH is merely repeating failed arguments. (FTC Response to CHH's Public Comment dated May 16, 2016, at p. 8). FTC contends that Dr. Gowrisankaran's analysis rests on a faulty foundation that "draws on an overly sharp distinction between the first stage of hospital competition (where healthcare providers compete to be included in the health plan's networks) and the second stage (where providers compete for patients)." (Id. at p. 9). FTC also contends that Dr. Gowrisankaran's analysis ignores the perspective of patients and that taken to the logical extreme only a merger of hospitals that perfectly overlap in services can be anticompetitive. (Id.) FTC further contends that his arguments are inconsistent and selective. (Id. at p. 10).

The Authority finds that CHH and SMMC are complements and not substitutes. First, it is important to note that CHH produced the entire report of Dr. Gowrisankaran, subject to redaction in the public file and non-redacted full report. However, FTC failed to produce Dr. Capps's entire report even when given the opportunity to do so, subject to protective order. Rather, FTC only submitted the portion of two reports entitled "summary of opinions." Accordingly, the Authority was unable to review the entire report of FTC's witness report for consideration. Based upon the information in the record, the Authority is persuaded by the common sense opinions of Dr. Gowrisankaran. First, he reviewed Dr. Capp's full report and determined that there were errors. Dr. Gowrisankaran explains that "Dr. Capps tries to deny that the hospitals are complements, by emphasizing the

many service lines provided by both of them.”<sup>101</sup> Additionally, Dr. Gowrisankaran took issue with Dr. Capps’s “cluster market model” by stating that it did not reflect the “reality of payor competition for enrollees and hospital competition for patients.”<sup>102</sup> For example, Dr. Gowrisankaran explained that Dr. Capps defined the product market as “[g]eneral<sup>103</sup> acute care inpatient hospital services sold by both hospitals to commercial health insurance insurers.”<sup>104</sup> Dr. Gowrisankaran notes that Dr. Capps explicitly eliminates services that one or the other hospital does not provide. Dr. Gowrisankaran argues that by excluding specialty services from the market for GAC inpatient services, Dr. Capps makes his proposed product market “useless” for understanding pricing currently and in the future with and without a merger.<sup>105</sup>

Dr. Gowrisankaran further explains that hospitals, like CHH and SMMC, are complements from the perspective of payors based on important services that only one of them provide. For example, Dr. Gowrisankaran explained that “[w]hen a payor is assembling a hospital network...it needs to have all of the services that are required to make a health plan marketable. This includes critical services like open-heart surgery, high-risk obstetrics, and pediatric intensive care, even though most enrollees will never need those services. From the payors’ perspective, hospitals are not substitutes if only one of them has sufficient services in key areas. That is true regardless of whether the hospitals offer many services for which they are substitutes in the eyes of patients that seek those types of care.”<sup>106</sup> Dr. Gowrisankaran contrasts the payors perspective with

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<sup>101</sup>Id. at ¶ 15

<sup>102</sup>Id. at ¶ 282

<sup>103</sup>Id.

<sup>104</sup>Id.

<sup>105</sup>Id. at ¶ 283

<sup>106</sup>Id. at ¶ 13



that of the patient who may view CHH and SMMC as substitutes when seeking a specific service in an area where the two hospitals are fairly comparable. However, Dr. Gowrisankaran states since it is the payors' perspective that "determines bargaining leverage and, therefore, prices." Dr. Capps' failure to distinguish between the "payor's perspective in bargaining and the patient's perspective in seeking care is the most fundamental flaw in his analysis."<sup>107</sup> Dr. Gowrisankaran notes that "this dispositive defect appears throughout his report."<sup>108</sup>

Second, Dr. Gowrisankaran notes that Dr. Capps's "definition of the relevant product or service market...each hospital service line is its own market and might be 'clustered' with others merely for analytical convenience."<sup>109</sup> Dr. Gowrisankaran argues that "[i]n this way, he [Dr. Capps] seeks to exclude the service lines that make the hospitals complementary. However, Dr. Gowrisankaran argues that Dr. Capps's rationale for this approach—that, for example, cardiac surgical care at one hospital is not a substitute for stroke care at the other—is based on the patient's perspective when she has a heart attack or a stroke<sup>110</sup>. He argues that from a payors' perspective, all inpatient services at a hospital are viewed together because it would be impractical, and unattractive to enrollees, if a hospital were in the payor's network for some of its services but not others. Accordingly, for purposes of assessing the merger's effect on prices set through payor bargaining, all inpatient services are a single market."<sup>111</sup>

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<sup>107</sup>Id. at ¶14

<sup>108</sup>Id.

<sup>109</sup>Id. at ¶ 16

<sup>110</sup>Id.

<sup>111</sup>Id.

Dr. Gowrisankaran argues that Dr. Capps's "diversion" analysis is "based on a model of patient choice at the time care is sought."<sup>112</sup> Dr. Gowrisankaran argues that "substitution and competition from the perspective of patients does not show substitution or competition from the perspective of payors, where, as here, the hospitals have critical service lines that are complementary."<sup>113</sup> Dr. Gowrisankaran opines that Dr. Capps's own "patient choice model, when separated by service line, highlights this complementarity."<sup>114</sup> A diversion ratio is the percentage of a hospital's patients that, if the hospital were not available for the care being sought, would go to a specific other hospital. Dr. Gowrisankaran opines that "[i]n the service lines where one of the Huntington hospitals is much stronger than the other, like cardiac and pediatric care, the diversion from the strong Huntington hospital to the other Huntington hospital is lower than it is to hospitals outside of Huntington."<sup>115</sup> Dr. Gowrisankaran opines that "even from the patient perspective, the Huntington hospitals are not substitutes and do not closely compete in these areas."<sup>116</sup> Dr. Gowrisankaran ultimately opines that "[a]s a result, the Huntington hospitals are complements from the payor perspective, even though the diversion ratios are higher when patient choices across all services are aggregated."<sup>117</sup>

Accordingly, the Authority determines that the relevant product market consists of the bundles of inpatient hospital services as well as the bundles of outpatient services offered by both CHH and SMMC collectively. FTC and SWVA's argument that CHH and SMMC are substitutes does not reflect commercial realities in the market and fails to

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<sup>112</sup>Id. at ¶ 18

<sup>113</sup>Id.

<sup>114</sup>Id.

<sup>115</sup>Id.

<sup>116</sup>Id.

<sup>117</sup>Id.

recognize the important specialty services offered by CHH and SMMC. The Authority rejects FTC's and SWVA's arguments that CHH and SMMC are substitutes because based upon the specialty services offered by each hospital, they are compliments at the payor level. The Authority believes that this view of the product market is more aligned with the commercial reality in the market and believes that this is a reasonable product market definition.

### **Geographic Market**

It is the position of CHH that the relevant geographic market consists of those areas from which the hospital regularly draws at least 80% of its patients. In a leading antitrust case, the United States Supreme Court explained that the relevant geographic market should correspond to the commercial realities of the industry.<sup>118</sup> A decision by the United States District Court for the Western District of Virginia which was affirmed by the Court of Appeals for the Fourth Circuit, the controlling jurisdiction for West Virginia, *United States v. Carilion Health System & Community Hospital of Roanoke, Virginia*, 707 F.Supp. 840 (1989), is particularly instructive in defining the relevant market here. In the *Carilion* case, the District Court noted that the two merging hospitals drew more than one-half of their patients from outside the Roanoke metropolitan area. It explained that "Defendants rely on their financial health on filling their beds with various patients who, even after the Defendants' merger, could turn to one or more other providers for care." It held that counties from which the hospitals received annually at least 100 patients were part of the relevant geographic market.

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<sup>118</sup>*Brown Shoe Co. v. United States*, 370 U.S. 294 (1962)

CHH argues that since at least 2012 it had defined its service area for marketing and planning purposes as the area delineated by zip codes from which it receives 80% of its patients.<sup>119</sup> This geographic market includes 61 zip codes, 18 counties, and 3 states. (CHH, Application, Exhibit J-1).

CHH argues that the 80% primary market delineation used by it is consistent with the definitions used by a majority of the hospitals across the country.<sup>120</sup> In the American Bar Association's Health Care Merger and Acquisitions Handbook it states that "a PSA [Primary Service Area] is usually defined as the smallest set of zip codes from which the hospitals in questions draw 90% of their patients. It is supposed to approximate where the hospitals compete for and draw patients from on a regular basis."<sup>121</sup> CHH argues that a nationally recognized health care consulting firm, HFS Consultants, recommends the use of the concept of the total service area as the relevant geographic market for a hospital and defines the total service area as the area which "provides 85%, plus or minus 3% of total discharges."<sup>122</sup> CHH argues that another consulting firm, Arnett, Foster & Toothman, conducted studies for four West Virginia hospitals, Davis Memorial, Grafton City, Highland Clarksburg and Montgomery General. This firm defined the service area for a hospital "as the geographic area from which a significant number of patients utilizing hospital services reside."<sup>123</sup> This definition resulted in the inclusion of contiguous groups

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<sup>119</sup>In its application for CON File No. 14-2-10375-A, CHH utilized the standard CON study of "25/10". However, CHH noted in its application that CHH and SMMC draw a significant number of patients from contiguous counties outside the study area and within the area considered by the hospitals as their primary and secondary service areas. The methodology used by CHH utilizes zip codes to define the relevant geographic market area. This zip code methodology was utilized by CHH in its Application.

<sup>120</sup>"Data by Region," The Dartmouth Atlas of Health Care

<sup>121</sup>*Health Care Mergers and Acquisitions Handbook*, (American Bar Association, 2003) pp. 31-84 at p. 47

<sup>122</sup>Gomes, Jim, "What to Consider When Defining a Hospital's Service Area". *HFS Blog*.

<sup>123</sup>Davis Memorial Hospital – Community Health Needs Assessment, 2013

of zip codes which together represented 84 percent, 91 percent, and 74 percent of discharges for Davis Memorial, Grafton City and Montgomery General, respectively, and approximately 72% of patients for Highland Clarksburg Hospital.<sup>124</sup>

CHH states that within the CHH and SMMC 80% service area, there are seven hospitals in addition to CHH and SMMC – King's Daughters Medical Center, Our Lady of Bellefonte, CAMC – Teays Valley, Pleasant Valley Hospital, Holzer Health System, Williamson Memorial Hospital and Lifepoint Systems in Logan, West Virginia. CHH further states that a number of other hospitals located adjacent to this area aggressively compete with it and SMMC for patients residing within the 80% market area. These hospitals include Charleston Area Medical Center, the Thomas Health System and Southern Ohio Medical Center. Thus, there are a minimum of 12 hospitals which compete for patients residing within the 80% service area. CHH notes that following the merger there will be 11.

CHH argues that both Charleston Area Medical Center and King's Daughters Medical Center draw a larger percentage of patients from the relevant geographic market than do either CHH or SMMC. CHH argues that it is abundantly clear that the majority of patients residing inside the CHH – SMMC service area can conveniently seek services at hospitals other than CHH and SMMC should their prices be increased beyond competitive levels or quality is diminished.

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<sup>124</sup>"Davis Memorial Hospital Community Health Needs Assessment, 2013," *Davis Health System* 12/13; "Community Health Needs Assessment, 2013," *Grafton City Hospital*, 12/13; "Community Health Needs Assessment 2013," *Montgomery General Hospital*, 12/13; "Community Health Needs Assessment 2014," *Highland Clarksburg Hospital*, updated.

CHH argues that undoubtedly, there are people who live in very close proximity to CHH or SMMC who would be less likely to seek services at another hospital because of a price increase, i.e., persons residing within the city limits of Huntington. Huntington residents, however, account for less than 25% of the admissions to CHH and SMMC. Hospitals cannot discriminate in prices based upon a patient's residence. Thus, even if residents of Huntington were willing to pay increased prices rather than travel to a competing hospital, the loss of patients residing outside of Huntington likely would render any non-competitive price increase unprofitable to the two hospitals. CHH submits that the Cooperative Agreement can have no adverse impact on the price of hospital services.

CHH argues that in some cases, the departure of a competitor from the market may increase the bargaining power of surviving entities in their dealings with customers and others. CHH argues that here, however, when the proposed transaction is viewed in the context of the product market and the relevant geographic market, it is clear that the transaction will have a *de minimis* impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and services arrangements with the hospitals.

CHH argues that in order for an insurer successfully to market a health plan, it is necessary that the plan be able to offer a full array of hospital services. As noted above, neither CHH nor SMMC provides that full range of services. Thus, both hospitals are necessary for payors to be able to successfully market a health plan. They are, in essence, "must have hospitals." Since that will not change post-merger, there will be no significant increase in bargaining power.

While commercial payors insure only roughly 30% of the patients of CHH and SMMC, it is only with respect to such payors that bargaining power or market power is relevant. Virtually all of the remaining 70% of patients are covered by government or quasi government payors such as Medicare, Medicaid, PEIA or Military Tri-care. These payors do not negotiate with hospitals but instead establish rates unilaterally.

While it is the position of CHH that robust competition between the combined entity and other hospitals will continue following CHH's acquisition of SMMC, in the circumstances present here, such competition is not necessary to provide consumer protection. In this case, there are three separate instrumentalities in place to ensure that consumers will not be harmed by the transaction. The first such instrumentality is the AVC entered into between the two hospitals and the Attorney General.

The AVC has several terms designed to assure that the transaction does not result in noncompetitive rate or price increases. Thus, the AVC provides that for a period of ten years, neither CHH nor SMMC will seek an increase in hospital rates beyond those rates which would be established using the benchmarking methodology previously used by the Authority.

In addition, under the AVC, neither CHH nor SMMC may terminate any existing payor contracts that are set to automatically renew in the absence of termination by either party. All of the current commercial contracts for both CHH and SMMC, other than the Highmark contract, fall into this category and all provide for reimbursement based upon a discount off charges. The payor is still able to terminate the contact, but because the hospitals cannot, the payor is guaranteed the same terms negotiated prior to the proposed merger. The hospitals also agree "for a period of five (5) years following

consummation of the Transaction not to negotiate for a reduction in the amount of the discount off charges contained in the third party payor [contract]" for any payor that terminates an existing contract.<sup>125</sup> After five years, the parties agree for another three years to negotiate terms of payor contracts "in good faith" and to be bound by arbitration if they cannot agree with payors on prices and terms.

CHH and SMMC also agree under the terms of the AVC that if the combined operating margin of the hospitals exceed an average of 4 percent during any three-year period, the hospitals' rates will be reduced by the amount of the excess for the following three years.<sup>126</sup>

The second important instrumentality which provides protection to consumers is the LOA entered into between CHH and Highmark in November of 2014. Highmark is by far the largest commercial insurer in the State of West Virginia. Its insured account for approximately 74% of the commercially insured patients at CHH and 72% at SMMC.<sup>127</sup>

The third, and most important instrumentality which provides protection to consumers, is the recently enacted W.Va. Code § 16-29B-28. With respect to prices, the statute prevents a hospital party to a cooperative agreement involving a combination of hospitals from increasing inpatient prices as well as outpatient prices by an amount which exceeds the respective consumer price indices for all urban consumers by more than two percent without justifying such increases to the Authority. The Authority may require the rebate to the payors of any unjustified price increase. Additionally, the Act gives the Attorney General, with respect to hospital parties to an approved cooperative agreement

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<sup>125</sup>See AVC ¶ 2(d)

<sup>126</sup>Id.

<sup>127</sup>CHH Discharge and Visit Data, 2014; SMMC Discharge and Visit Data, 2014



involving a merger of hospitals, the authority to reject any non-competitive price increases as well as contracts with payors with reimbursement rates above competitive levels.

Given the combined effect of the AVC, the Highmark Blue Cross LOA and the recently enacted legislation, the combination of CHH and SMMC simply cannot have an adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with CHH and SMMC.

SWVA argues that CHH attempts to “define and redefine its geographic market as broadly as possible...to claim that institutions as diverse as Pleasant Valley Hospital (which it manages) and Williamson Memorial Hospital are ‘competitors’ for patients.” (SWVA Public Comment dated April 18, 2016, at p. 4) SWVA argues that CHH “willfully and deliberately chooses to misunderstand the unique aspects of the health care market in a rural state like West Virginia.” (*Id.*) SWVA argues that CHH and SMMC offer a “vast array” of services that are not available at rural acute care hospitals. (*Id.*) Thus, they are able to draw patients from many outlying counties in West Virginia, Kentucky, and Ohio where other hospitals serve as the primary provider. SWVA argues that this does not mean that these outlying hospitals can be considered competitors for the population in CHH's primary service area. With respect to market impact, SWVA notes that the AVC and LOA between Highmark are limited time documents and that if CHH is permitted to acquire SMMC the loss of competition in the acute care market in Huntington, West Virginia will be permanent.

FTC argues that the relevant geographic market is the “arena of competition affected by the merger.”<sup>128</sup> FTC states that under the case law and Merger Guidelines, the relevant question in defining the geographic market is whether a hypothetical monopolist controlling all of the relevant services in the proposed geographic market could profitably impose a SSNIP.<sup>129</sup> If so, then the area is the relevant geographic market; if not then the geographic market should be expanded to include a broader geographic area to which consumers will turn. FTC argues that a “geographic market need not include the area from which all or even nearly all of the merging parties’ (or a hypothetical monopolist’s) customers come from; it only needs to consist of the smallest area in which a hypothetical monopolist could profitably impose a SSNIP.”<sup>130</sup> Therefore, FTC argues that CHH’s “overly broad proposed geographic market is inconsistent with the Merger Guidelines and applicable case law.” (FTC Public Comments dated April 19, 2016, at p. 12).

FTC argues that for both GAC services and outpatient surgical services, the Authority’s analysis should focus on a relevant geographic market no larger than Cabell, Wayne, and Lincoln counties in West Virginia and Lawrence County in Ohio (the Four-County Huntington Area). Dr. Capps conducted quantitative analysis of patients’ travel patterns in this case and determined that 76% of the commercially insured patients residing in the Four-County Huntington Area stay in that area for inpatient GAC services. Dr. Capps also performed a diversion analysis between CHH and St. Mary’s<sup>131</sup>. This

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<sup>128</sup>FTC Public Comments dated April 18, 2016; citing Merger Guidelines § 4.2

<sup>129</sup>Merger Guidelines § 4.2.1

<sup>130</sup>Merger Guidelines § 4.1.1

<sup>131</sup>See Merger Guidelines § 6.1 (Diversion ratios between products sold by one merging firm and products sold by the other merging firm can be very informative for assessing unilateral price effects, with higher diversion ratios indicating a greater likelihood of such effects.)

analysis looks at quantifying the degree of competition between merging hospitals by considering, hypothetically, what would happen if one of the merging hospitals dropped from a health plans network and so was no longer an option for that plan's patient members. The patients who would have used the dropped hospital must now use another hospital instead. If a large fraction of those "diverted" patients from merging Hospital A would choose merging Hospital B (and vice versa) then the two merging hospitals can be said to be close competitors. Dr. Capps determined that if CHH became unavailable, 48.5% of its parties would go to St. Mary's. Likewise, if St. Mary's became unavailable, 54% of its patients would go to CHH. FTC argues that based upon these low diversion ratios, hospitals in outlying areas are not close substitutes for CHH or SMMC and are not properly considered in the geographic market.

FTC further argues that the cooperative agreement is presumptively anticompetitive due to its extraordinary high market shares, market concentration and increase in concentration. FTC argues that CHH and St. Mary's are the only two significant competitors providing inpatient GAC services in the Four County Huntington Area. Based upon patient discharges, CHH has a 41.3% market share in inpatient GAC in the Four-County Huntington Area, while St. Mary's hold a 34.9% share, resulting in a combined 76.2% combined market share. Based upon patient days, CHH has a 35.7% market share in the inpatient GAC services market in the Four-County Huntington Area, while St. Mary's holds a 40.2% market share, resulting in a combined 75.9% combined market share. FTC argues that market shares of this level far exceed those presumed unlawful by the Supreme Court. The typical measure for determining market concentration is the Herfindahl-Hirschman Index ("HHI") which is calculated by summing

the squares of individual firms' market shares. Under the Merger Guidelines and applicable case law, mergers and acquisitions resulting in post-merger HHI above 2,500 and increase in HHI of more than 200 points are presumed likely to be anticompetitive and thus unlawful. FTC argues that the proposed cooperative agreement far exceeds these thresholds.

FTC further argues that CHH's reliance on *United States v. Carilion Health System* is in error. (FTC Public Comment at p. 21). FTC notes that this is a thirty year old case which "has been discredited and is inconsistent with the current approach of antitrust law." (Id.) FTC further states that commentators have remarked that "the geographic market analysis of the *Carilion* decision lacks 'economic' or legal logic' and obviously did not adhere to the ...principles mandated by case law and the Merger Guidelines.'" (Id.)

FTC argues that for commercially insured patients living in the Four-County Huntington Area, prices for inpatient GAC services and outpatient services are determined in bilateral negotiations between their health plans and hospitals. (FTC Public Comment at p. 30). The prices that emerge from these negotiations will depend on the relative bargaining power of the hospital versus that of the health plan. (Id.) FTC argues that the health plan's bargaining power comes from the fact that the hospital desires to access the health plan's members. The hospital's bargaining power comes from the fact that its absence from the health plan's network makes that network less attractive to potential members. FTC argues that the "critical determinant of a hospital's bargaining leverage in these negotiations is the availability of substitute hospitals that the health plan can turn to in the event that no agreement is reached with that particular hospital." (Id. at p. 30). FTC argues that a merger of two closely related substitutable hospitals will

increase the combined entity's leverage. (Id.) FTC argues that after the merger, failure to reach an agreement with the merged system means that the health plan's network will lack both hospitals. This "increase in bargaining leverage enhances the merged entity's ability to demand and extract, higher reimbursement rates from health plans." (Id. at p. 31). FTC argues that CHH and St. Mary's are each other's closest substitutes. They compete closely on pricing terms and reimbursement. FTC argues that CHH will end this competition by acquiring St. Mary's and substantially increase its bargaining leverage. FTC argues that this increased leverage will, in turn, enhance the combined entity's ability to command higher reimbursement rates from health plans. FTC argues that higher increases in rates will be passed on to employers and ultimately to the community at large in the form of higher health insurance premiums, higher deductibles, higher co-payments, potentially reduced insurance coverage, and even lower wages.<sup>132</sup>

CHH argues that the FTC "attempts to attribute unduly high market shares to Cabell and St. Mary's." (CHH Response to Public Comments at p. 6) However, CHH takes issue with FTC's overly narrow market definition. FTC argues that the Authority has "already considered and rejected this "alleged 'Four-County Huntington Area' proposed market as too narrow." (Id.; CON Decision at p. 18). CHH argues that the four-county area does not "include many of the patients Cabell and SMMC's serve, or the numerous other hospitals against which Cabell and, SMMC's must compete for those patients. The geographic service area from which Cabell, and separately, SMMC draw

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<sup>132</sup>See Martin Gaynor, Kate Ho, & Robert J. Town, *The Industrial Organization of Health Care Markets*, 53 J. Econ. Literature, no. 2, 2015, at 235, 236 ([hereinafter "Gaynor, Ho, & Town, Industrial Organization"] ("Employers pass through higher health-care costs dollar for dollar to workers, either by reducing wages or fringe benefits, or even dropping health insurance coverage entirely."))

and compete for potential patients is much larger than the four-county area and extends into other parts of West Virginia, Ohio and Kentucky.

CHH notes that competition occurs in two stages. In stage one payors negotiate with hospitals over prices.<sup>133</sup> Payors' bargaining power is based on the number of their enrollees, and the hospital's bargaining power is based on attractiveness to enrollees.<sup>134</sup> During stage two, hospitals compete with each other for patients.<sup>135</sup> Price does not play a substantial role at this second stage because prices are typically paid by payors rather than patients.<sup>136</sup> Rather, patients choose among hospitals based on services, quality, and amenities.<sup>137</sup> CHH argues that contrary to FTC and SWVA's contentions, it and SMMC are highly complementary in their services and are independently viewed as essential by payors in the markets in which they compete.<sup>138</sup> CHH argues that SWVA provides no support for its argument that payors repeatedly use competition between the hospitals when negotiating discount contracts. (CHH Response to Public Comments dated May 4, 2016, at p. 7). CHH argues that when a payor constructs a hospital network, it does not choose between having two critical services like open-heart surgery and pediatric intensive care. CHH argues that it needs both. CHH argues that a combined Cabell-SMMC hospital will not have market power to increase prices to payors which is why payors support the transaction. Further, CHH argues that FTC ignores that, in the

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<sup>133</sup>Gowrisankaran Rpt. ¶ 153

<sup>134</sup>Gowrisankaran Rpt. ¶ 155-157

<sup>135</sup>Gowrisankaran Rpt. ¶ 158

<sup>136</sup>Gowrisankaran Rpt. ¶ 159

<sup>137</sup>Gowrisankaran Rpt. ¶ 158-161; Capps Rpt, ¶ 175

<sup>138</sup>Gowrisankaran Rpt. ¶¶ 13, 54

dual-bargaining context, the HHI values are of limited utility to determining any pricing impact of a transaction.<sup>139</sup>

SWVA argues that CHH fails to respond to SWVA's comments regarding the relevant geographic market and simply "asserts that SWVA and the FTC are incorrect, and that Cabell draws patients from a wider geographic area than the four-county region defined by the FTC as the relevant geographic market." (SWVA Response to CHH's Response to Public Comments at p. 12). SWVA again argues that the WVCAL mandates that the Authority give deference to the policy statements of the FTC. SWVA argues that this deference is "especially applicable when it comes to the methods by which the WVHCA measures and assesses the applicable competitive framework." (SWVA Response to CHH's Public Comment at p. 13). SWVA argues that "it is clear that health plans use competition between hospitals as leverage in their negotiations." (*Id.* at p. 14). SWVA argues that CHH attempts to dismiss the HHI index as having limited utility based on its erroneous dual bargaining arguments. SWVA argues that since the Authority has been directed to give deference to the FTC policy statements such as the Merger Guidelines. The Merger Guidelines utilize the HHI to determine when a potential acquisition is presumptively illegal under federal anti-trust law.

FTC argues that the Authority's determination of the study area in the CON Decision was not a determination of the relevant market guided by antitrust principles for the purposes of calculating the hospitals' market shares or evaluating the proposed cooperative agreement's competitive effects under the WVCAL. (FTC Response to CHH's Response to Public Comments at p. 4). Rather, the CON matter used a traditional

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<sup>139</sup>Gowrisankaran Rpt. ¶ 329

health planning 25/10 service area. FTC argues that this is not a method for determining a relevant market for purposes of analyzing the competitive effects of a proposed cooperative agreement. (Id.) Further, FTC argues that the CON Decision does not support CHH's claim that the Authority specifically considered the Four-County Huntington Area. FTC argues that this issue was not in dispute during the CON process.

FTC argues that even assuming for the sake of argument that the seven-county study area used in the CON Decision was relevant to the cooperative agreement application process, it still would not change the fact that the combined entity would face little post-merger competition. The seven-county study area includes four other facilities besides CHH and SMMC-- Three Gables Surgery Center, Pleasant Valley Hospital, CAMC Teays Valley and Williamson Memorial Hospital. FTC argues that Three Gables has a close business relationship with SMMC which reduces competitive incentives. Pleasant Valley Hospital entered into a joint management agreement with CHH which likely reduces its incentives to compete with CHH. FTC argues that CAMC-Teays Valley "lacks the depth of services" provided by CHH and SMMC. FTC further argues that Williamson Memorial Hospital is not considered a competitor of either hospital. FTC notes that the geographic market utilized by CHH in the cooperative agreement application is different from the CON application. FTC argues that based upon the Merger Guidelines a relevant geographic market is the "arena of competition affected by the merger."<sup>140</sup>

The Authority finds that the geographic market is the 80% market as defined by CHH. CHH supported the definition of its geographic market with physician testimony and reference to expert reports and papers. First, Dr. Yingling supports this geographic

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<sup>140</sup>Merger Guidelines § 4.2



market wherein he testified regarding the two tiers of the service area and that the secondary tier extends to the southern counties of West Virginia and “lots of counties deeper” into Ohio and “lots of counties deeper” into Kentucky based upon where patients reside.<sup>141</sup> Second, CHH in the American Bar Association’s Health Care Merger and Acquisitions Handbook states that a primary service area is usually defined as the smallest set of zip codes from the hospitals in question draw 90% of their patients. It is supposed to approximate where the hospitals compete for and draw patients from on a regular basis. Third, CHH submitted a community needs assessment conducted by Arnett, Foster and Toothman that defined the service area for the Davis Memorial Hospital as the “geographic area from which a significant number of patients utilizing hospital services reside.” Fourth, Dr. Gowrisankaran states that “[i]ndustry practice for examining competition at the patient level is to examine areas that encompass a larger share of a hospital’s patients and a wider driving distance than Dr. Capps considers.”<sup>142</sup> He states that “[a]cademics, regulators, and industry practitioners, in economic policy, or strategy analyses, consider Hospital Service Area—generally defined as “local health care markets for hospital care”—to be regions that include well beyond 60 percent and up to 90 percent of patient discharges, and are based on a reasonable approximation of the set of locations for the choices that patients face.”<sup>143</sup>

Dr. Gowrisankaran states that the “SSNIP test based on competition at the patient level confirms that the Four County Huntington Area is too narrow...” For a market definition to be appropriate under the hypothetical monopolist test, the market cannot be

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<sup>141</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. pp. 207-208

<sup>142</sup>Gowrisankaran Rpt. at ¶ 56

<sup>143</sup>Id.

drawn in such a way that too many of the hypothetical seller's patients reside outside of the market, where the hypothetical monopolist faces competition to which those patients could switch in response to a SSNIP. Dr. Gowrisankaran notes that Dr. Capps's proposed market definition fails for this reason.<sup>144</sup>

In addition, Dr. Gowrisankaran opined that "[t]he product and geographic market proposed by the FTC and its expert Dr. Capps are incorrect."<sup>145</sup> Dr. Gowrisankaran states that while FTC "recognizes that '[c]ompetition between hospitals occurs in two distinct but related stages' with prices set at the stage of hospital negotiations with payors. Dr. Capps employs this framework in his analysis of this merger, but he ignores several key implications for market definition and the change in bargaining power that the FTC claims the proposed merger would generate."<sup>146</sup> Dr. Gowrisankaran notes that in "his [Dr. Capps] identification and analysis of a product market for GAC inpatient services sold to members of commercial health plans, Dr. Capps examines just those services which he claims are overlapping based on a DRG-by-DRG analysis of CHH and SMMC discharges."<sup>147</sup> Dr. Gowrisankaran notes that Dr. Capps states that it is "analytically straightforward to analyze competition across the 'full cluster' of inpatient CAC services."<sup>148</sup> Dr. Gowrisankaran states the Dr. Capps' "cluster market view of product definition is wrong... [because] both patients and payors recognize significant complementarities between the services offered by the two hospitals despite Dr. Capps's finding that the hospitals overlap in 90 percent of their services."<sup>149</sup> Dr. Gowrisankaran

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<sup>144</sup>Gowrisankaran Rpt at ¶ 324

<sup>145</sup>Gowrisankaran Rpt. at ¶ 271

<sup>146</sup>*Id.*

<sup>147</sup>Gowrisankaran Rpt. at ¶ 272, citing Capps' Rpt. at 236

<sup>148</sup>Gowrisankaran Rpt at ¶ 141

<sup>149</sup> Gowrisankaran Rpt at ¶ 272

states that Dr. Capps considers patient substitution between products but ignores the connection across series that is created by competition at the payor stage.<sup>150</sup> Dr. Gowrisankaran notes that in examining geographic markets, Dr. Capps shifts to look at competition at the payor level instead of at the patient level as he did in examining product markets.<sup>151</sup> Dr. Gowrisankaran opines that if competition is “examined consistently at the payor level, however, the complementaries...indicate that the two hospitals are not substitutes and are not used to negotiate lower prices—and thus the merger would not increase their bargaining leverage.<sup>152</sup> Dr. Gowrisankaran opines that if “competition is examined at the patient level...the 4-County market proposed by Dr. Capps excludes over one-third of 2014 GAC inpatient discharges and over a quarter of 2014 outpatient surgical episodes.<sup>153</sup> Finally, Dr. Gowrisankaran concluded that Dr. Capps’s approach to product market and geographic market definition lead him to overstate the increase in concentration that would result from the proposed merger and the import of increased concentration measures for competition and pricing. While the FTC submitted a summary response by Dr. Capps in response to Dr. Gowrisankaran’s report, this submission was not a full report and a review did not allow the Authority to conduct a full comparison of the opinion of both experts. Accordingly, the Authority gave more deference to the opinions of Dr. Gowrisankaran, whose report was available for complete review. Additionally, the Authority finds that the FTC’s Four County Huntington geographic market definition is too narrow because too many of the market resides outside of area defined by the FTC and could switch to a competitor in response to a SSNIP. In addition, Dr.

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<sup>150</sup>Id.

<sup>151</sup>Gowrisankaran Rpt. ¶ 273

<sup>152</sup>Id.

<sup>153</sup>Id.

Capps excludes over one-third of 2014 GAC inpatient discharges and over a quarter of 2014 outpatient surgical episodes. This market definition is not reasonable.

The Authority finds the proposed cooperative agreement will likely have no impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers. Based upon the testimony of Dr. Gowrisankaran he opined that it was unlikely that the merger will result in higher hospital prices and that their pre-merger bargaining leverage is comparably high. To the extent that there is any likely impact, the impact will be ameliorated by the enforceable conditions in the AVC which contain a commitment to open staff,<sup>154</sup> release of the covenant not to compete for any physician or health care provider employed and non-physician employee with privileges,<sup>155</sup> CHH and SMMC agreed it will not seek a rate beyond a benchmark rate,<sup>156</sup> CHH agreed to if the combined operating margins of CHH and SMMC exceed an average of 4% during any three year period, rates at the hospitals will be reduced by the amount of such excess during the following three years in an amount approved by the Attorney General.<sup>157</sup> CHH and SMMC agrees not to bargain for or insist on a "Most Favored Nations Clause" in contracts with third party payors.<sup>158</sup> CHH and SMMC agree not to bargain for or insist upon restrictions on their vendors preventing or impairing vendors from doing business with entities competing with CHH and SMMC.<sup>159</sup> If the

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<sup>154</sup>AVC ¶ 1(c) & (d)

<sup>155</sup>AVC ¶ 1(b) & (e)

<sup>156</sup>AVC ¶ 2(a)

<sup>157</sup>AVC ¶ 2(b)

<sup>158</sup>AVC ¶ 2((g)

<sup>159</sup>AVC ¶ 2(i)

contract is terminated, CHH and SMMC agree to commercial mediation rules of the American Arbitration Association.<sup>160</sup>

(B) **The extent of any reduction in competition among physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement**

CHH states that that it is aware of nothing in the Cooperative Agreement that will result in a reduction in competition among physicians, allied health professionals, other health care providers or those furnishing goods or services in competition with the hospitals. On the contrary, if the agreement is consummated, it argues that provisions of the AVC will promote competition between such persons or entities and the hospitals. Thus, CHH argues that the AVC increases competition by protecting physicians and other health care providers seeking to participate in competing facilities by releasing them from obligations not to compete with the hospitals upon termination of their employment. It also protects non-physician employees seeking to participate in a competing facility by releasing them from their obligation not to compete.

CHH states that the AVC includes several additional provisions that would tend to increase competition by making it easier for other providers to offer new services. In particular, the hospitals agree that they will not oppose "the award of a certificate of need by the West Virginia Health Care Authority to any health care provider seeking to provide inpatient services similar to or competitive with services provided by either or both hospitals in the geographic area identified by CHH and SMMC as being the 90% Market

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<sup>160</sup>AVC ¶ 2(d)

Service Area unless the applicant for the certificate of need is a hospital which does not accept inpatient Medicaid patients and uninsured patients.”<sup>161</sup>

A similar provision applies to outpatient services. For a period of ten years, neither of the hospitals “will oppose the award of a certificate of need by the West Virginia Health Care Authority to any Healthcare Provider seeking to provide outpatient services similar to or competitive with services provided by either or both hospitals in the geographic area identified by CHH and SMMC as being their 90% Market Service area.”<sup>162</sup>

CHH states that other pro-competitive provisions of the AVC include the hospitals’ commitment not to bargain for or insist upon clauses that could potentially hinder the entry or expansion of competing facilities. Thus, the AVC provides that the hospitals will not bargain for or insist on “most favored nations” clauses or anti-tiering or anti-steering clauses in contracts with third party payors.<sup>163</sup>

SWVA argues that CHH “asserts that because the time limited provisions of the AVC require that Cabell release certain professionals from their non-compete agreements the newly created health care monopoly will actually increase competition among other health care providers.” (SWVA Public Comments at p. 8). SWVA argues that this “strains credulity.” (*Id.*) SWVA argues that both CHH and St. Mary’s have been aggressive in purchasing and expanding their medical practices and the current competition between these practice groups will end on consummation of the merger-acquisition.

FTC argues that currently both hospitals seek and compete for referrals from independent physicians and physicians groups such as Huntington Internal Medicine

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<sup>161</sup>See AVC at ¶ 1(a)

<sup>162</sup>*Id.*

<sup>163</sup>*Id.* at ¶ 2

Group. The cooperative agreement will eliminate competition between CHH and St. Mary's for the provision of outpatient surgical services.

The Authority finds the proposed cooperative agreement will likely have no impact on physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement. As stated above, the proposed merger will not impact the bargaining leverage of the two hospitals as it currently exists and therefore will not change the existing landscape. To the extent that there is any likely impact, the impact will be ameliorated by the enforceable conditions in the AVC discussed in Section A above.

(C) **The extent of any likely adverse impact on patients in the quality, availability and price of health care services**

As previously discussed, it is the position of CHH that the transaction will enhance the quality of care in numerous and important ways as CHH detailed earlier in the Decision. CHH argues that opponents of the transaction have argued that the loss of competition from SMMC will diminish the quality of care provided by the two hospitals. This contention belies an understanding of the factors which motivate hospital quality. They involve far more than competition from an across town hospital. An important driver of health care quality is the philosophy and culture of a hospital's governing board and management. The boards of CHH and SMMC are composed of local community and consumer representatives and in the case of SMMC, Catholic sisters. As noted by Dr. Yingling in his testimony in the CON proceedings, the Board meetings at each institution begin with a review of quality. Dr. Yingling further explained "there's a presentation of what the quality outcomes are for that hospital. That's . . . you would refer to that as

dashboard. A dashboard of some sort is provided to the individuals sitting at that board meeting to define exactly where quality is in that hospital. Those are reviewed at every meeting. Those are, in my view. . .culture is not a business model. Culture is a practice culture... And I think both hospitals have made it clear that the practice culture of their hospital is first and foremost about quality. I think that's from the leadership, from the board to the CEO, to the senior management, to the staff, to the patients who receive that benefit."<sup>164</sup> The Boards of CHH and SMMC and their management are totally committed to quality improvement.

As explained above, CHH argues that robust competition with CHH and SMMC for inpatient hospital services will continue from at least eleven other hospitals following consummation of the transaction. Each of these competitors offers outpatient services competitive with CHH and SMMC. Equally important to local competition, however, are the penalties and incentives implemented by governmental and commercial payors. Quality performance by CHH and SMMC is not judged by comparisons to the performance of each other but by how each compares to national, regional and statewide quality performance levels.<sup>165</sup> Quality penalties which may be imposed by CMS through a reduction in payments made to CHH can amount to as much as \$4,500,000 per year. A 5% meaningful use incentive could add an additional \$2,500,000 to the reimbursement at risk. Additionally, \$3,000,000 in payments from Highmark Blue Cross is dependent on achieving quality scores set by Highmark each year. Thus, for CHH up to \$10,000,000 annually can be dependent on meeting quality goals. Comparable amounts can be at risk for SMMC. In addition, there are several independent entities such as Healthgrades,

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<sup>164</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, pp. 184 – 185

<sup>165</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. pp. 251-152 and pp. 184-191



Leap Frog and CareChex that publish quality scores of hospitals throughout the country. These reports are available to consumers and provide powerful incentives for quality improvement.

Assurance of enhanced quality and improved access is also provided by the AVC. In this document, CHH and SMMC agree that within six months following the closing of the transaction they will develop population health goals including centers of excellence with quantitative benchmarks and a proposed timeline to be provided to the Attorney General.<sup>166</sup> The hospitals agree that they will implement community wellness programs reaching out to medically underserved areas and will communicate the details to the Attorney General.<sup>167</sup> The hospitals commit in the AVC to establish a fully integrated and interactive medical records system at both hospitals so that patient encounters at both hospitals will be readily available in real time to treating physicians at both hospitals.<sup>168</sup> The hospitals agree to provide to the Attorney General 90 days written notice of any proposed addition or deletion of a service line and commit to continue to accept Medicaid patients residing in Ohio and Kentucky at payment rates established by such states for in-state providers.<sup>169</sup> The AVC further requires the two hospitals to apprise the Attorney General in detail of the steps they propose in order to achieve projected efficiencies and quality enhancements from the transaction.<sup>170</sup>

Finally, the recently enacted W. Va. Code §16-29B-28 requires an annual report to the Authority submitted by the parties to the cooperative agreement setting forth,

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<sup>166</sup>AVC at ¶ 3(a)

<sup>167</sup>*Id.* at ¶ 3(b)

<sup>168</sup>*Id.* at ¶ 3(c)

<sup>169</sup>*Id.* at ¶ 3(d)

<sup>170</sup>*Id.* at ¶ 4

among other things, a corrective action plan in those instances in which the average performance score of the hospitals in any calendar year is below the 50<sup>th</sup> percentile for all United States hospitals with respect to certain quality metrics selected by the Authority. The report must also provide for a significant rebate to commercial health plans if, in any two consecutive year period, the average performance score is below the 50<sup>th</sup> percentile.

SWVA argues that CHH and St. Mary's have very different cultures, at least when it comes to collections. SWVA argues that CHH is "very aggressive regarding debt collection, and routinely sues patients and garnishes wages for outstanding debts." (SWVA Public Comment at p. 10). SWVA argues that by contrast St. Mary's is always willing to work with its patients and has traditionally offered patients discounts of at least 10% and often more, when individuals are able to pay their outstanding bills in full. SWVA argues that although CHH cites to monetary penalties imposed by CMS, these penalties may ensure a "minimum quality threshold" but they do not "incentivize the monopolistic hospital to invest in new advanced treatments or to provide better service." (SWVA Public Comment dated April 18, 2016 at p. 10). Additionally, SWVA argues that correcting for all other factors, a recent extensive study found that "hospital prices in monopoly markets are 15.3 percent higher than those in markets with four or more hospitals."<sup>171</sup>

FTC argues that the Merger Guidelines recognize that a "merger can lead to a substantial lessening of "non-price" (e.g., quality) competition." (FTC Public Comment at p. 34) FTC argues that a merger that enhances market power may harm consumers through "reduced product quality, reduced product variety, reduced service or diminished

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<sup>171</sup>Cooper, Z. Craig, S., Gaynor, M. Van Reenen, J. (2015). "The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured." Retrieved from: [http://www.healthcarepricingproject.org/sites/default/files/pricing\\_variation\\_manuscript\\_0.pdf](http://www.healthcarepricingproject.org/sites/default/files/pricing_variation_manuscript_0.pdf)

innovation."<sup>172</sup> FTC argues that the proposed cooperative agreement would eliminate CHH and St. Mary's incentives to add services and improve quality in order to attract patients.

The Authority finds the proposed cooperative agreement will likely have no impact on patients in the quality, availability and price of health care services. Based upon the combined testimony of Dr. Burdick and Dr. Yingling, the combined entity will enhance the quality of care. Dr. Yingling testified that a "unified system" will bring efficiencies and improvement of quality of care and unification of protocols and practice. Dr. Yingling further testified that "there's gross inefficiencies within the health record. I think that there's great advantages for having a unified system."<sup>173</sup> Dr. Yingling further testified that "[b]oth hospitals understood that quality meant that you need to use evidence-based medicine to have a sepsis protocol in both hospitals....[t]he problem was they were different...so...in a unified system there will be a unification of a lot of protocols and practice protocols that will bring efficiency and quality of care." (Id.) In addition the statute provides for national benchmarks for quality measures.<sup>174</sup> The Acquisition will also bring subspecialists to the area and thus will not impact the availability of services.<sup>175</sup> To the extent that there is any likely impact, the impact will be ameliorated by the enforceable conditions in the AVC discussed in Section A above.

(D) **The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement**

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<sup>172</sup>Merger Guidelines § 1

<sup>173</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 190

<sup>174</sup>W.Va. Code §§1619B-28(g)(1)(B) & (C)

<sup>175</sup>In re: Cabell Huntington Hospital, CON File No. 14-2-10375-A, Ex 82, Tr. I. p. 29

CHH is aware of no alternative arrangements which would achieve the same level of benefits which the Cooperative Agreement provides. As explained above, this transaction will have at most a minimal impact upon competition in the relevant geographic market. It creates an opportunity for savings which are specific to this transaction and could not be achieved by another purchaser of SMMC. It enables a fully integrated and interactive medical records system which will have far more importance for hospitals in close proximity to each other than could be achieved were SMMC to be acquired by a remotely located purchaser. It permits system wide coordination of community health initiatives. It assures local control of SMMC and continued support by SMMC for the Joan C. Edwards School of Medicine. It makes possible the implementation of common protocols and establishment of the centers of excellence through a single hospital system serving the region. It enhances the ability of the hospitals to recruit highly trained physicians. It makes possible the expansion of services locally so that the requirement for burdensome patient travel to other areas will be reduced.

CHH notes that it is important to remember that SMMC will be sold. The benefits listed above as well as many other benefits from the transaction could be lost to the community if SMMC is sold to another purchaser.

SWVA argues that according to the FTC complaint, numerous other entities submitted bids for St. Mary's, including both non-profits and a Catholic Health System. SWVA argues that without disclosure of the names and identities of the other bidders, the Authority cannot perform the analysis it is required to do by statute and determine whether or not there are actual alternative arrangements that would provide a "better balance" of benefits while being less restrictive to competition.

FTC argues that there are a number of other hospital systems that submitted bids to acquire SMMC such as LifePoint Health, Bon Secours, and Charleston Area Medical Center that remain interested in acquiring SMMC if not acquired by CHH. FTC argues that most of the benefits the merging entities claim they will achieve through the proposed cooperative agreement can be obtained other ways, either through alternative acquisitions, through the hospital's individual efforts, and with a more favorable balance of benefits over disadvantages.

The Authority finds that the availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement do not exist and are not pending before this agency. SMMC is the party that elected to sell to CHH. This is the transaction pending before the Authority not a transaction with another buyer that SMMC rejected. FTC and SWVA argue that the Authority should consider that the benefits of this merger can be obtained in other ways. Specifically, SWVA urged the Authority to obtain the rejected bid documents from SMMC. The rejected bids are not relevant because they have been rejected and SMMC elected not to go forward and sell to any of those proposed purchasers under any terms. In addition, Ms. Ahern evaluated the transaction pending before the Authority and she determined that this transaction resulted in \$16 million in annual recurring cost savings three years after closing.<sup>176</sup> She noted that the geographic proximity of the two hospitals allows for a high degree of integration, otherwise not obtainable by a consolidation between more distant hospitals.<sup>177</sup> . The Acquisition will

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<sup>176</sup>Ahern Rpt. at ¶ 228

<sup>177</sup>d. at ¶ 129

result in cost saving not otherwise obtainable by other hospitals previously rejected by SMMC. To the extent that there is any anticompetitive impact, the impact will be ameliorated by the enforceable conditions in the AVC discussed in Section A above.

### VIII. CONCLUSIONS OF LAW

The following benefits are likely to result from the cooperative agreement:

- A. Enhancement and preservation of existing academic and clinical educational programs;
- B. Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse provided to citizens served by the authority;
- C. Enhancement of population health status consistent with health goals established by the Authority;
- D. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
- E. Gains in the cost-efficiency of services provided by the hospitals involved;
- F. Improvements in the utilization of hospital resources and equipment;
- G. Avoidance of duplication of hospital resources;
- H. Participation in the state Medicaid program; and
- I. Constraints on increases in the total cost of care.

The Authority finds that the proposed cooperative agreement will likely have no impact on:

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

To the extent that there is any likely impact on any of these four items, the Authority finds that they are ameliorated by terms contained in the AVC as specified above.

The Authority **FINDS** that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from the cooperative agreement.

## IX. DECISION

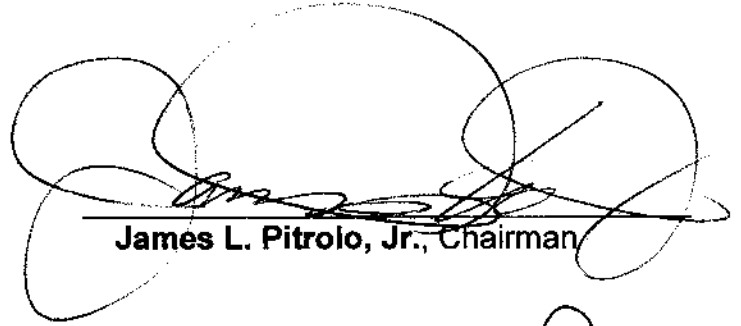
Based on the foregoing findings of fact and conclusions of law, the Authority **APPROVES** the Cooperative Agreement and **GRANTS** to Cabell Huntington Hospital, Inc., a Certificate of Approval relating to the proposed acquisition of St. Mary's Medical Center by Cabell Huntington Hospital in CON File No. 14-2-10375-A, subject to the following **CONDITIONS**:

1. Cabell Huntington Hospital must submit annual reporting in conformity with W.Va. Code § 16-29B-28 et seq. subject to the West Virginia Health Care Authority's ongoing active supervision; and,

2. Additionally, Cabell Huntington Hospital is required to submit to the Attorney General's rate regulatory powers set forth in W.Va. Code § 16-29B-28, et. seq., and any terms that it agreed to in the Assurance of Voluntary Compliance.



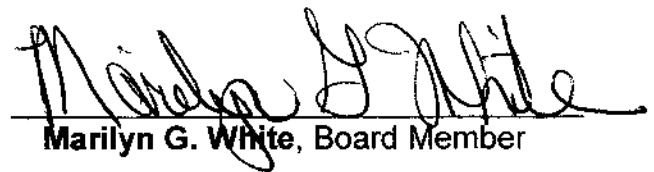
Done this 22<sup>nd</sup> day of June, 2016.



**James L. Pitrolo, Jr., Chairman**



**Sonia D. Chambers, Board Member**



**Marilyn G. White, Board Member**

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Cooperative Agreement No. 16-2/3-001