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June 4, 2019

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: COPA Assessment, Project No. P181200

Dear Acting Secretary Tabor:

Kaufman, Hall & Associates, LLC, appreciates the opportunity to comment on the issues that will be discussed at the Commission's June 18, 2019, workshop on Certificates of Public Advantage (COPAs). For more than 30 years, Kaufman Hall has provided objective, independent insights on strategy, financial planning, and performance improvement to hospitals and health systems of all sizes across the United States.

These comments specifically address the Commission's question whether competition is more effective than regulation in lowering prices, costs, and expenditures; improving quality and access; promoting efficient resource allocation; and fostering innovation in delivery models. The Commission has made known its preference for competition over regulation—this preference has driven the Commission's opposition to COPA laws and COPA applications in West Virginia, Tennessee, Virginia, and elsewhere. The Commission's preference for competition over regulation presupposes competition is possible. But changing dynamics in the healthcare marketplace are contributing to a continued decline in demand for inpatient services. An increasing number of markets cannot support two or more inpatient, acute-care hospitals. In these markets competition is not an option and insistence on competition until one hospital fails may place patients and communities at risk. COPA laws provide communities that face a transition to one hospital a way to navigate the transition in an orderly way, under the supervision of state authorities with a statutory mandate to serve the public interest.

This letter comments first on the rapidly changing competitive dynamics in the healthcare marketplace. It then comments on how these dynamics are making competition-based approaches an inappropriate response to the allocation of inpatient services in many markets, including those in which COPAs have been approved in recent years.

Competitive Dynamics in Healthcare Are Shifting Away from Inpatient Care

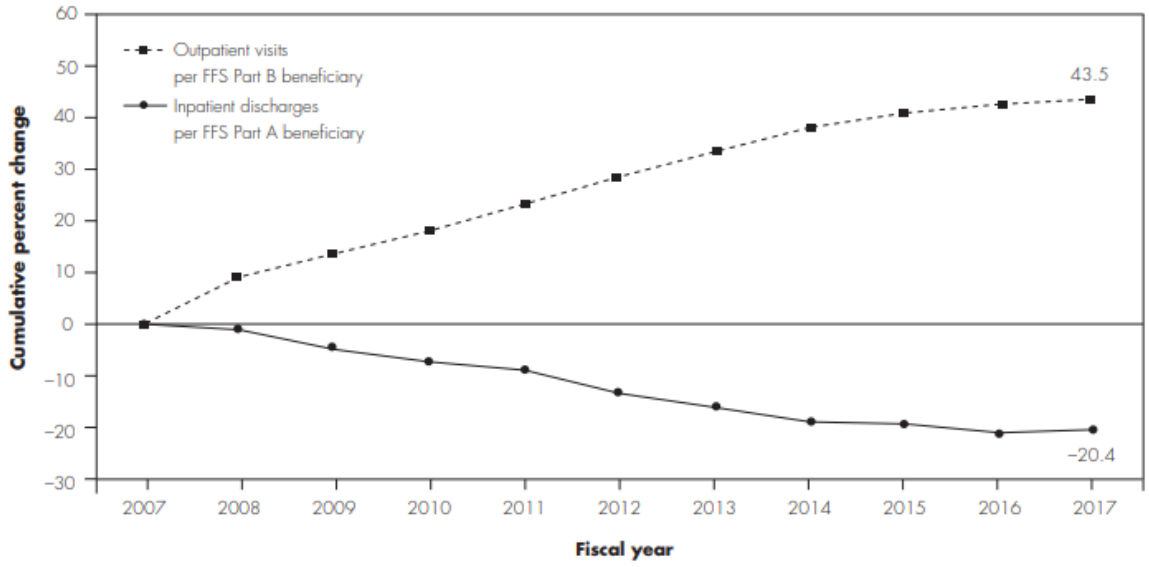
The changing dynamics in healthcare are evident from the data shown in Exhibit 1, which illustrates the significant decline in inpatient discharges, and significant increase in outpatient visits, for Medicare beneficiaries from 2007 through 2017.[1] As care has shifted from inpatient to outpatient settings, so has the focus of competition in the healthcare marketplace. Acute inpatient

[1] Medicare Payment Advisory Commission: *Medicare Payment Policy: Report to the Congress*. March 2019.

10 S. Wacker, Suite 3375, Chicago, Illinois 60606
847.441.8780 phone • 847.965.3511 fax • www.kaufmanhall.com

healthcare will not disappear anytime in the near future, but it will continue to decline as an overall percentage of healthcare services provided.

Exhibit 1: Medicare Inpatient Discharges and Outpatient Visits per Beneficiary, 2007 - 2017

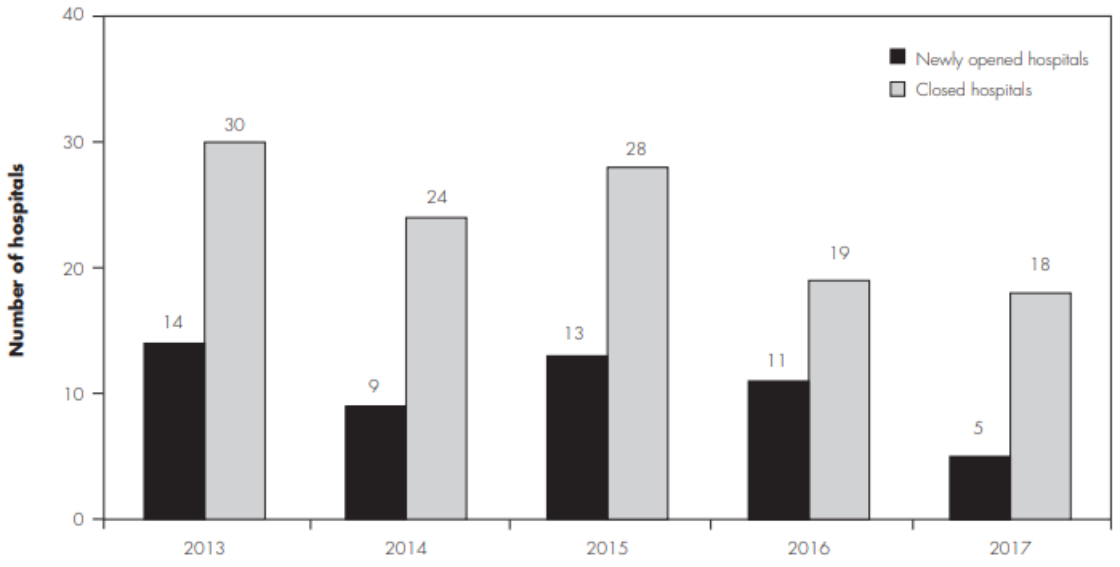


Note: FFS (fee-for-service). Data include general and surgical, critical access, and children's hospitals.

Source: MedPAC analysis of CMS's inpatient and outpatient claims and enrollment data.

The shifting competitive dynamic can be seen in the very different patterns in openings and closures for inpatient hospitals, on the one hand, and ambulatory surgery centers, on the other. As shown in Exhibit 2, the number of hospital closures has been consistently and significantly outpacing the number of hospital openings in recent years.

Exhibit 2: Openings and Closures of Hospital Facilities, 2013 - 2017



Source: MedPAC analysis of the CMS Provider of Services file, internet searches, and personal communication with the Department of Health and Human Services Office of Rural Health Policy.

In contrast, the number of openings for ambulatory surgery centers (ASCs) has been significantly outpacing those lost to closure or merger over a similar time period, as shown in Exhibit 3.

Exhibit 3: Growth in Number of Ambulatory Surgery Centers, 2012 – 2017

				Average annual percent change	
Type of ASC	**2012**	**2016**	**2017**	**2012–2016**	**2016–2017**
Total	5,216	5,474	5,603	1.0%	2.4%
New	176	159	189	N/A	N/A
Closed or merged	114	90	60	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable). The average annual percentage change data for the "new" and "closed or merged" categories are shown as "N/A" because they are outside the purpose of this table, which is to show the growth in the total number of ASCs.

Source: MedPAC analysis of Provider of Services file from CMS, 2018.

ASCs are only one example of growth in outpatient services; in other sectors of the outpatient market, growth has been even more rapid and dramatic. From 2016 to 2017, national utilization of telehealth services increased 53 percent, urgent care center utilization increased 14 percent, retail clinic utilization increased 7 percent, and ASC utilization increased 6 percent. In contrast,

emergency room (ER) utilization—a traditional source of admissions for acute inpatient hospitals—decreased 2 percent.[2]

With lower barriers to entry, high growth rates, and the potential to offer new pathways into the healthcare system, the outpatient market is drawing the attention of both traditional and non-traditional market participants, and is creating powerful new partnerships and combinations. For example, CVS Health has merged with health insurer Aetna, and is now transforming some of its stores and existing retail clinics into "health hubs" that offer an expanded range of healthcare services and products. Initially focused on markets with high numbers of Aetna members, the goal of the stores is to divert members away from ERs.[3] United HealthGroup's Optum unit has targeted 75 markets across the country for expansion of primary care services and is positioning Rally Health, its digital health platform, to serve as its "digital front door for the consumer."[4] Again, the intent is to disrupt traditional referral paths for acute inpatient services.

National employers are also starting to make significant moves to disrupt the healthcare system and reduce utilization of expensive acute inpatient procedures. For example, Walmart has established a program, now in its sixth year, in which it contracts directly with selected "center of excellence" (COE) hospitals across the country for a range of common inpatient surgical procedures. The program bypasses local community hospitals to send its associates to COEs for evaluation and, if needed, surgery. Many of the program's savings have come from avoiding surgeries that were recommended by non-COE providers in favor of less expensive and more appropriate treatments.[5]

The combined force of these dynamics will contribute to further declines in the market for acute inpatient services and the likely consolidation of these services into a smaller number of hospitals.

Rationalizing Acute Inpatient Care Reduces Costs, Increases Efficiencies, and Improves Patient Outcomes

Efforts to maintain competition within a shrinking inpatient services sector face strong headwinds. While competition remains possible in larger urban markets, efforts to maintain

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[2] FAIR Health: *FH Healthcare Indicators® and FH Medical Price Index® 2019: An Annual View of Place of Service Trends and Medical Pricing*. April 2019.
[3] NPR: "CVS Looks to Make Its Drugstores a Destination for Health Care." Feb. 21, 2019 https://www.npr.org/sections/health-shots/2019/02/21/695216345/cvs-looks-to-make-its-drugstores-a-destination-for-health-care
[4] "United Health Group Inc. (UNH) CEO David Wichmann on Q2 2018 Results – Earnings Call Transcript." *Seeking Alpha*, July 17, 2018.
[5] Woods, L., Slotkin, J., Coleman, M.R.: "The Big Idea: How Employers Are Fixing Health Care." *Harvard Business Review*, March 13, 2019.

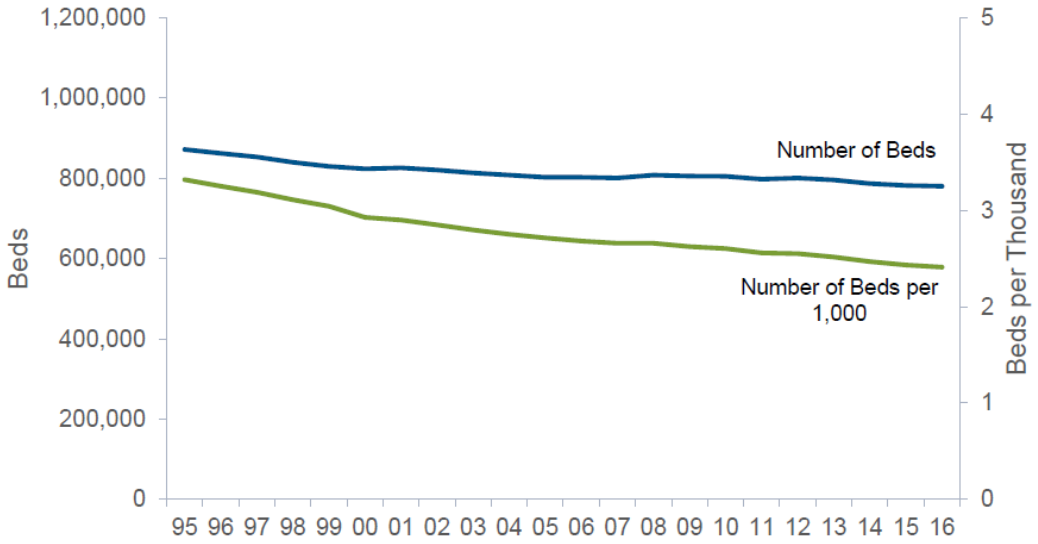
competition are likely to be futile in the many markets where significant excess capacity already exists. At worst, a competition-based approach in markets with excess capacity could undermine efforts to improve patient outcomes, reduce costs, and create efficiencies that are required to ensure the sustainability of the U.S. healthcare system.

Even as hospitals have closed, the U.S. still faces a significant excess capacity issue for inpatient care. Consider these facts:

- From 1995 to 2019, the U.S. population has grown from approximately 262 million to approximately 329 million.[6] Over a similar period, the total number of available inpatient hospital beds has declined from almost 872,000 to just over 780,000, with the ratio of beds per 1,000 persons falling from 3.32 beds per 1,000 in 1995 to 2.41 beds per 1,000 in 2016 (see Exhibit 4).[7]
- In its most recent report to Congress, the Medicare Payment Advisory Commission (MedPAC) notes that, "despite some closures, existing hospitals often still have excess capacity." MedPAC cites a 65.9 percent average occupancy rate nationwide for urban hospitals in 2017, and a 40.2 percent average occupancy rate for rural hospitals.
- Excess capacity can be an even more significant issue at the state level. In 2016, 13 states had occupancy rates below 60 percent for urban acute hospitals, and 27 states had occupancy rates below 40 percent for rural acute care hospitals.[8]

[6] U.S. Census Bureau data at www.census.gov, accessed on May 8, 2019.
[7] American Hospital Association: *Trendwatch Chartbook 2018*. Table 2.2 https://www.aha.org/system/files/2018-06/201806-chartbook-table-2-2.pdf
[8] Healthcare Financial Management Association: "Acute Care and Critical Access Hospital Occupancy Rate Variability by Location." *Healthcare Financial Management*, July 2018.

Exhibit 4: Number of Beds and Number of Beds per 1,000 Persons, 1995 - 2016



Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.

Given existing excess capacity issues, the current ratio of 2.41 beds per 1,000 persons likely will decline further. But even using that generous ratio as a benchmark, it is easy to see how difficult it will be to sustain competition for inpatient hospital services in many markets. A 25-bed critical access hospital would need a population of more than 10,400 to justify its capacity, while a 100-bed acute-care hospital would need a population of almost 42,000.

Consider Norton, Va., which the Commission used as an example in its November 21, 2016, public comments challenging the proposed COPA between Mountain States Health Alliance and Wellmont Health System in Tennessee and Virginia (the COPA was ultimately approved, and the systems combined to form Ballad Health).[9] Norton was one of two communities the Commission cited in which Mountain States and Wellmont directly competed with each other, with acute-care hospitals located two miles apart.

Norton is a city of fewer than 4,000 people. It is located in Wise County, Va., which has seen a decline in population of more than 8 percent since 2010, to a current estimate of just over 38,000 people. The two Norton hospitals today have a combined capacity of 171 beds; another hospital in Big Stone Gap, also in Wise County, has additional capacity of 78 beds, bringing the total

[9] Federal Trade Commission: *FTC Staff Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System*. November 2016. https://www.ftc.gov/policy/advocacy/advocacy-filings/2016/11/ftc-staff-submission-tennessee-department-health-regarding

capacity for the county to 249 beds. Using the national average ratio of 2.41 beds per 1,000 persons, Wise County's population should be able to support just over 90 beds. The county's inpatient bed capacity is more than 2.5 times that number. If Norton kept only the larger of the two hospitals, the 129-bed Norton Community Hospital, it still would have significantly more capacity than needed to serve the county as a whole, without including the additional capacity of the hospital in Big Stone Gap.

What Norton needs is a right-sizing of facilities to reduce the fixed costs necessary to maintain capacity that exceeds both Norton's and Wise County's needs. This could be the result of a rational planning process, or the result of competition. A competition-based approach likely would prolong the inefficiencies associated with excess capacity, while potentially jeopardizing patient outcomes.

Competing hospitals cannot agree to rationalize the services they offer without running afoul of antitrust laws prohibiting market division or allocation between competitors.[10] Instead, they must compete for enough patients to make their services financially sustainable. As an example, consider a two-hospital market, with both hospitals offering general surgery and obstetrics (both are services commonly offered at smaller hospitals). To compete, each hospital would need to recruit sufficient medical staff. Both general surgery and obstetrics require call coverage to handle emergency cases, so each hospital would need to hire four to five physicians for each service line. If, as in Norton, Va., the hospitals are in a rural area, they would be challenged to recruit and retain these hires. Of the approximately 7,000 designated Health Professional Shortage Areas (HPSAs) in the U.S., more than 4,600—just over 65 percent—are in rural or partially rural areas.[11]

To ensure the quality and safety of patient care, the clinicians at the competing hospitals would need to maintain a sufficient volume of cases. The association between volume and patient outcomes has been well documented.[12] If, as is the desired outcome of competition, one hospital out-competes the other and diminishes the volume of cases going to its competitor, patients that remain loyal to the competitor might risk worse outcomes as a result. If neither hospital attracts sufficient volume, the quality of patient care could suffer at both. Moreover, hospitals that are struggling financially are unlikely to have the resources to invest in innovation.

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[10] Department of Justice: *Price Fixing, Bid Rigging, and Market Allocation Schemes: What They Are and What to Look For* https://www.justice.gov/atr/price-fixing-bid-rigging-and-market-allocation-schemes

[11] Bureau of Health Workforce, Health Resources and Services Administration: *Designated Health Professional Shortage Areas Statistics*. March 4, 2019.

[12] See, for example, Institute of Medicine: *Interpreting the Volume-Outcome Relationship in the Context of Health Care Quality: Workshop Summary*. The National Academies Press, 2000.

These issues do not necessarily go away in larger metropolitan areas. Another recent COPA challenged by the Commission ultimately was approved and allowed: the 2018 merger of Cabell Huntington Hospital and St. Mary's Medical Center in Huntington, W.Va. In a scenario common in two-hospital markets, one of the hospitals is faith-based (St. Mary's) and the other is not, reflecting the historic ethnography of the community. Each has a capacity of more than 300 beds.

The city of Huntington has a population of less than 50,000. It is situated in the larger Huntington/Ashland metropolitan statistical area (MSA), which includes portions of West Virginia, Kentucky, and Ohio. As of July 1, 2018, the MSA had an estimated population of 352,823. The population of both Huntington and its surrounding MSA is slowly declining. The MSA has lost an estimated 3.3 percent of its population since 2010.[13]

Huntington and Ashland, Ky., are separated by the Ohio River, which, as the Commission noted in its April 18, 2016, letter to the West Virginia Health Care Authority, acts as a "natural and psychological barrier to travel for health care."[14] But there is little reason for Ashland residents to cross the river, as Ashland also is served by two hospitals, Our Lady of Bellafonte Hospital and King's Daughters Medical Center, which have combined capacity of more than 600 beds.

In other words, an MSA with a total population of just under 353,000 is served by hospitals with a combined inpatient bed capacity in excess of 1,350 beds. Using the national average ratio of 2.41 beds per 1,000 persons, a more sustainable capacity would be just over 850 beds. The excess capacity of approximately 500 beds exceeds the size of any one of the four hospitals in the two cities.

We understand that under the "failing company" doctrine, recognized by the antitrust enforcement agencies in their Horizontal Merger Guidelines, the Commission would not oppose an acquisition by one hospital in a community of a second, failing hospital if, without the acquisition, the second hospital would close.[15] But the Merger Guidelines make clear that failure must be imminent to be credited. The reality, however, is that failure does not happen overnight; it is the last step in what is often an inexorable process, driven by the trends described above. While on the road to failure, quality and innovation at the affected hospital may well suffer. It is in the interest of patients and their communities that, when these trends begin, an orderly process

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[13] U.S. Census Bureau: *American FactFinder* https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk, accessed May 9, 2019.
[14] Federal Trade Commission: *Bureau of Competition Staff Submission to the West Virginia Health Care Authority Regarding Cooperative Agreement Application of Cabell Huntington Hospital*. April 18, 2016. https://www.ftc.gov/system/files/documents/public_statements/945863/160418virginiahealthcare.pdf
[15] United States Department of Justice and Federal Trade Commission: *Horizontal Merger Guidelines*, Sec. 11. April 19, 2010. https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf

be available by which the services at the failing hospital can be transitioned to another hospital in the community without major disruptions in care.[16]

Finally, the Commission should recognize that in some communities, a competition-at-any-cost paradigm is doing little to preserve access to care. To that end, the Commission should ensure that state officials are not discouraged from taking steps to preserve access to care for fear of running afoul of the Commission's enforcement of antitrust laws. For example, so-called "care deserts" are emerging in places such as southeastern Missouri. The closure of 116-bed Twin Rivers Regional Medical Center, the only hospital in Dunklin County, Mo. (with a declining population that now is around 30,000), meant that access to obstetric care for expectant mothers was an hour or more away. Demand was there—approximately 400 babies were delivered annually at the hospital before it closed. But with 95 percent of the patients on Medicare, Medicaid, or uninsured, the margin needed to support the hospital's services was insufficient. In July 2018, when the *New York Times* reported on the story, state officials were working with area doctors on a plan to restore services. It would have been better for the patients and the community if the state had intervened earlier to address the community's care needs in a more orderly fashion.[17]

To insist that competition be allowed to proceed in areas where population growth is stagnant or declining, excess bed capacity already exists, and inpatient utilization continues its downward trend, is simply to sustain an inefficient healthcare system, possibly at the risk of patient outcomes and safety. The markets for which COPAs have been approved in recent years—including those for Mountain States Health Alliance/Wellmont Health System and Cabell Huntington Hospital/St. Mary's Medical Center—have these characteristics. Issuance of a COPA

[16]An example of a hospital failure that caused significant disruption in its community is Walla Walla, Washington. Walla Walla General Hospital, with a licensed capacity in 2016 of 72 beds, and Providence St. Mary Medical Center, with a licensed capacity of 142 beds, both served the community for many years. But by 2016, Walla Walla General's average daily census was under ten patients a day, almost all of whom were patients covered by Medicare or Medicaid (Washington State Department of Health: Comprehensive Hospital Abstract Reporting System (CHARS) Database. https://www.doh.wa.gov/DataandStatisticalReports/HealthcareinWashington/HospitalandPatientData/HospitalDischargeDataCHARS). With almost no commercial patients, Walla Walla General and Providence St. Mary's negotiated an orderly process by which Providence would absorb Walla Walla General (Needham, R.: "Walla Walla: A One Hospital Town." *Whitman Wire*, Sept. 19, 2017. https://whitmanwire.com/news/2017/09/19/hospital-closure/). But when "unexpected regulatory challenges" arose, the deal was called off and Walla Walla General announced it would close within weeks. The announcement caught the community off guard, forcing physicians to decide quickly whether to stay in the area or leave, and causing a rapid transition of patient care from one institution to the other (Hagar, S.: "Updated: Walla Walla General Hospital to Close." *Walla Walla Union-Bulletin*, June 20, 2017. https://www.union-bulletin.com/news/business/updated-walla-walla-general-hospital-to-close/article_95c9a174-553d-11e7-ab6e-fb67ab28a92b.html).

[17] Healy, J.: "It's 4 A.M. The Baby's Coming. But the Hospital Is 100 Miles Away." *New York Times*, July 17, 2018.

is a valid effort to address the inefficiencies of an over-bedded inpatient market rationally and safely.

Conclusion

Competition-based approaches are unlikely to prove effective in lowering costs, promoting efficient resource allocation, and improving quality and access in markets where acute inpatient capacity significantly exceeds the needs of the population. Attempts to maintain competition in this environment likely will result in one of two scenarios. Either no competitor will be able to secure sufficient volumes, or one competitor will take a dominant position and the others will face a period of gradual decline. If competition weakens a hospital, it weakens that hospital's ability to recruit clinicians, invest in innovation, and maintain the volumes necessary to ensure high-quality patient outcomes. In the meantime, the fixed costs associated with excess capacity and duplicative services will be maintained for much longer than justified by market needs.

Healthcare is different from other industries in one important respect: Individual lives are at stake. Competition is not an appropriate solution in healthcare markets where there is excess capacity and insufficient demand. Approaches that can rationally and safely align capacity to demand are required.

Thank you again for the opportunity to comment on these issues. If you have any questions, please do not hesitate to contact me at (847) 441-8780.

Sincerely,

Kenneth Kaufman, Chair
Kaufman, Hall & Associates, LLC