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Re: Request for Review, Comment and Oversight of Antitrust Concerns Related to New York's Delivery System Reform Incentive Payment ("DSRIP") Program Performing Provider Systems ("PPS") and Use of Proposed Certificate of Public Advantage ("COPA") Process

Dear Ms. Koslov and Mr. Mucchetti:

On behalf of the undersigned health plans and business organizations, thank you for meeting to discuss our request for review of the decisions by New York State to: 1) encourage and incentivize the creation of large networks of healthcare and other service providers, known as Performing Provider Systems ("PPSs"), as part of the implementation of New York's Delivery System Reform Incentive Payment ("DSRIP") program, whereby unrelated health care providers will be authorized to collaboratively negotiate health plan reimbursement as a single provider, and 2) the use of New York's proposed Certificate of Public Advantage ("COPA") process to allow providers participating in DSRIP to secure state action immunity under federal and state antitrust laws.

As discussed, while we support the policy goals of reimbursement reform and promoting integrated systems of healthcare to facilitate improvements in the quality of patient care and cost savings to New York's healthcare delivery system, the manner in which providers are permitted

or required to affiliate for purposes of negotiating reimbursement will inevitably lead to monopolistic or oligopolistic market practices. These practices will, perversely, result in higher healthcare costs and harm to consumers. The State's plan to require PPSs to become a single entity for provider reimbursement purposes has been articulated by the New York State Department of Health ("DOH") as both a long term goal and a critical component of the State's vision for reform. Indeed, most recently, the DOH released its Guidance for PPS Governance in which it references a "Fully Integrated Model" which is the PPS governance model consisting of a single legal entity, operating under a single, integrated management team, with full ownership of the care delivery system which will ultimately survive the DSRIP program.[1] DOH, in its guidance, suggests that PPSs will ultimately evolve into a more integrative system, such as the Fully Integrated model.[2] For your convenience, please find attached the PPS Governance Guidance recently released by the DOH.

This single entity bargaining structure -- which is most likely to occur in upstate New York regions -- will create disproportionate negotiating leverage for providers and systems over Medicaid plans whose rates are determined by DOH and over commercial insurers who, while negotiating Medicaid rates, will be forced to reveal pricing and cost data to various competing hospitals (and other providers). The resultant impact will be increased costs for commercial insurers (to be passed on to policyholders in the form of increased premiums) and Medicare Advantage plans and the threatening of financial solvency of Medicaid plans whose rates are predetermined by the State. As explained in greater detail below, the laudable goals of the DSRIP can be accomplished without compromising the state and federal antitrust laws or the need to allow virtually every provider in a given region to negotiate reimbursement (Medicaid, Medicare Advantage or commercial coverage) as if they were a single entity.

Set forth below are the details of each of these initiatives as well as specific anticompetitive concerns.

## I. The Performing Provider Systems ("PPSs") Being Created through New York's Delivery System Reform Incentive Payment ("DSRIP") Program Will Inevitably Lead to Anticompetitive Effects

On April 1, 2014, New York State finalized the terms and conditions with the Centers for Medicare and Medicaid Services ("CMS") for New York's Partnership Plan 1115 Medicaid Redesign Team Waiver Amendment ("MRT Waiver Amendment") that will allow New York State to draw down $6.42 billion in federal funding over the next five to six years through the Delivery System Reform Incentive Payment ("DSRIP") program.[3] The goal of the DSRIP program is to reduce avoidable hospital admissions in New York State by 25% by the end of the

[1] *See* N.Y. DEP'T OF HEALTH, *New York Delivery System Reform Incentive Payment Program 'How To' – Governance Version 1.2, Sept. 22, 2014* (prepared by KPMG with support of the JHD Group), https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_governance_how_to_guide_v1_2.pdf (last visited Oct. 2, 2014).
[2] *Id*.
[3] *See* N.Y. DEP'T OF HEALTH, NEW YORK PARTNERSHIP PLAN 1115: MRT WAIVER AMENDMENT/DSRIP SPECIAL TERMS AND CONDITIONS (STCS) (2014) [hereinafter DSRIP STCS], *available at:* https://www.health.ny.gov/health_care/medicaid/redesign/docs/special_terms_and_conditions.pdf (as amended Apr. 14, 2014).

demonstration period. However, the state's ultimate, overarching goal for the DSRIP program is to fundamentally change the healthcare delivery and payment system for Medicaid services in New York.[4] DSRIP requires healthcare and service providers to form provider systems that will apply for DSRIP funding as a single Performing Provider System ("PPS") in December of this year.[5]

As part of DSRIP, the state is requesting that all providers of healthcare and support services serving any portion of New York's Medicaid population in a given region of the state, including but not limited to hospitals, physicians, clinics, home care agencies, and nursing homes, work together to form a single PPS. Importantly, this single-entity framework being proposed by New York is unlike any other DSRIP program approved by CMS and operational in other states.

The PPS will be required to implement projects over the five to six year waiver period designed to transform New York's health care financing and delivery system.[6] In most instances, it appears PPSs will include hundreds of providers (including numerous hospitals) within a single system.[7] In exchange for meeting project metrics and milestones, the PPS will receive incentive payments that will be distributed among the participating providers.[8] In addition, the State is required to work with managed care contractors and the providers within a PPS to develop alternatives to fee for service reimbursement (such as shared savings, capitation, pay for performance, etc.).[9]

As highlighted in both DSRIP publications issued by the State as well as numerous public webinars and hearings since April of this year, the stated policy goal is for the PPSs developed through the DSRIP process to be **permanent** (extending beyond the duration of DSRIP) and the PPSs are ultimately expected to contract as a **single entity** with New York's Medicaid Managed Care plans.[10] Contracting as a single entity for Medicaid reimbursement naturally will impact

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[4] *See* N.Y. DEP'T OF HEALTH, *MRT Waiver Amendment Presentation*, HEALTH.NY.GOV (April 2014), https://www.health.ny.gov/health_care/medicaid/redesign/docs/waiver_amendment_update_present.pdf. (last visited September 23, 2014) (webinar and slide presentation). This goal has also been referenced at numerous public meetings throughout the state since April 2014, including at the "MRT Waiver Extension Public Hearing" on April 16, 2014 in Albany, New York.

[5] *See* N.Y. DEP'T OF HEALTH, *Tentative MRT Waiver/DSRIP Key Dates Year 0*, https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_timeline.pdf (last visited September 23, 2014).

[6] *See* DSRIP STCs, *supra* note 3, at § 45.

[7] *See* N.Y. DEP'T OF HEALTH, *Emerging Performing Provider Systems*, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip_loi_received/emerging_pps/ (last visited September 23, 2014).

[8] *See* N.Y. DEP'T OF HEALTH, *DSRIP Program Funding and Mechanics Protocol – Attachment I*, https://www.health.ny.gov/health_care/medicaid/redesign/docs/program_funding_and_mechanics.pdf (last visited September 23, 2014).

[9] See DSRIP STCs, supra note 3, at § 39.

[10] *See* N.Y. DEP'T OF HEALTH, *New York's MRT Waiver Amendment Delivery System Reform Incentive Payment (DSRIP) Plan Frequently Asked Questions (FAQs)*, https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_faq.pdf, 40 (last visited September 23, 2014); Jason Helgerson, N.Y. DEP'T OF HEALTH, *NYS DSRIP White Board - Five Years in the Future*, YOUTUBE (May 28, 2014), http://www.youtube.com/watch?v=BqZGE3q6hHY&feature=youtu.be; Jason Helgerson, N.Y. DEP'T OF HEALTH, *DSRIP: What You Need to Know!*, HEALTH.NY.GOV, https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_what_you_need_to_know.pdf (last visited

commercial health insurance and Medicare Advantage reimbursement, if not lead to single entity negotiation for such reimbursement.

This intentional creation of regional monopolies or oligopolies of healthcare and service providers, particularly for reimbursement purposes, without considerable government oversight and a compilation of detailed guarantees ensuring the protection of consumers, will inevitably result in anticompetitive market conduct and disproportionate pricing power in the Medicaid, Medicare Advantage and commercial marketplace. While the State's policy vision is limited to the provision of healthcare services and support to the State's Medicaid population, without significant restrictions and oversight of the commercial activities of providers, there will also be an impact on the commercial and Medicare Advantage markets, with resulting harm to consumers.

This level of provider collaboration is not necessary to accomplish the goals of the DSRIP; rather, this component of the State's plan runs counter to the State's desire to reduce cost and enhance affordability. Specifically, the stated policy goal of the PPS emerging as a single reimbursement negotiating entity is beyond the scope of what is required to achieve the goals of DSRIP, and, if realized, has the potential to result in anticompetitive behavior in violation of state and federal antitrust laws. Furthermore, without sufficient oversight and restriction on marketplace activities of the participating providers, this construct could have the unintended consequence of raising prices and reducing access for healthcare services in New York's broader healthcare marketplace, akin to the concerning impact of hospital mergers.

This concern is magnified by growing discourse regarding the anticompetitive impact of healthcare provider collaboration and consolidation, including hospital mergers.[11] Indeed, a recent study released by the *Catalyst for Payment Reform* catalogues legislative, regulatory and policy efforts being pursued nationwide by states that have recognized the need to address the contracting practices of healthcare providers and plans that have led to reduced competition and higher prices, at a detriment to consumers.[12]

As a result of the desire to limit the number of PPSs created through DSRIP, the state is seeking widespread alignment of the healthcare providers serving a single geographic region. Even without the formal merging of providers, this de facto development of regional healthcare systems throughout New York State has the potential to afford partnering providers with the ability to exert significant bargaining power to the detriment of New York's consumers. While economies of scale with respect to technology and administration, as well as pooled resources may certainly play a role in the success of a DSRIP PPS, the stated goal of limiting the number of PPSs to one to three per region (outside of New York City) should be reconsidered and the participation between the providers within a PPS should be confined to specific collaborative efforts with clearly defined boundaries governed by a number of factors, including but not

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September 23, 2014) (webinar and slide presentation). Additional webinars and presentations discussing this goal are also available at: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip_webinars_presentations.htm.

[11] *See* Pear, Robert, *F.T.C. Wary of Mergers by Hospitals*, N.Y. TIMES, September 18, 2014, at B1.

[12] *See* Suzanne Delbanco & Shaudi Bazzaz, *Catalyst for Payment Reform (CPR), State Policies on Provider Market Power* 3-9, 14-47 (July 2014), *available at:* *http://www.nasi.org/sites/default/files/research/State_Policies_Provider_Market_Power.pdf*

limited to: 1) current marketplace dynamics, 2) regional geographic barriers to access, and 3) consumer choice. Moreover, alternative models for "value-based" reimbursement to the PPS that preserve direct participating provider agreements with and competition among individual providers in the PPS should be built into the DSRIP model. Without the need for designation of the PPS as a single contracting entity, value-based reimbursement can instead be accomplished through normal negotiations between the individual providers within the PPS and health plans.

Significantly, many hospitals also oppose the effort to force them to negotiate with their competitors. While the hospitals are prepared to work on efforts to improve population health and to reduce unnecessary admissions, hospital groups have publicly stated that hospital competitors should not be forced to negotiate on a collective basis.

As the timeline for the creation of regional PPSs is extremely aggressive, with proposed PPS collaborations required to be submitted with DSRIP applications by December 16th of this year, and DSRIP funding that will require these entities to begin to collaborate by April 2015, we urge the FTC and DOJ to engage in oversight of the DSRIP process in New York.[13]

## II. The Proposed Certificate of Public Advantage ("COPA") Process for Providers Participating in DSRIP Is Inadequate to Confer State Action Immunity Because It is Beyond the Scope Contemplated by the New York State Legislature and Does Not Currently Include Sufficient Protections to Guard against Anticompetitive Behavior

Notwithstanding the significant antitrust concerns associated with the creation of PPSs throughout the state and the single-entity providers envisioned in the New York's "future state" of healthcare delivery discussed above, New York is seeking to use its proposed Certificate of Public Advantage ("COPA") process, described below, to allow providers collaborating as part of the DSRIP program to seek state action immunity under federal and state antitrust laws.

As a threshold matter, the proposed use of the COPA by DSRIP PPSs is beyond the scope contemplated by New York's Legislature upon the passage of New York's "Improved Integration of Health Care and Financing" law.[14] In addition, while the proposed COPA regulatory text mirrors a state action immunity oversight process that has been adopted in several states (e.g., North Carolina, Maine, Wisconsin), the actual implementation plan for New York's COPA will vary considerably from what other States have implemented, and involve far less active supervision and scrutiny despite the fact that New York proposes to use the COPA to permit unprecedented types of provider aggregations.

<u>As a result, we request that the FTC and DOJ review the use of the COPA process for providers participating in the DSRIP program, and, at minimum, support modifications to the use of the COPA for DSRIP to guard against anti-competitive consequences</u>.

[13] *See Tentative MRT Waiver/DSRIP Key Dates Year 0*, *supra* note 5.
[14] N.Y. PUB. HEALTH LAW §§ 2999aa–2999bb (McKinney 2014).

### a. COPA – Statutory History, Proposed Regulation and Use in DSRIP

Statutory History

In 2011, Article 29-F of New York's Public Health law was enacted authorizing the state to encourage appropriate collaborative arrangements among healthcare providers who might "otherwise be competitors."[15] The legislation cites the need for integration of services and coordination among providers based on: (i) the numerous health system demonstration and pilot projects authorized by federal healthcare reform which are intended to promote and assess delivery system and payment reform, and (ii) the need to preserve access to essential services, improve the quality of services provided and efficiency of operations, and minimize the unnecessary increases in the cost of care.[16]

To the extent such arrangements may be anticompetitive within the meaning of state and federal antitrust laws, the legislative intent is to supplant competition with such arrangements under the "active supervision" and related administrative actions of the Commissioner of the New York State Department of Health as necessary to accomplish the state's policy goals, and to provide immunity under the state and federal antitrust laws.[17]

In order to accomplish these goals, the legislature authorized a regulatory program to permit and oversee merger, acquisition, integration, consolidation, collaboration, and coordination among providers, where necessary, to assure access to essential healthcare services, to improve healthcare quality and outcomes, to enhance efficiency, or to minimize the cost of healthcare.[18] Importantly, Article 29-F provides for State action immunity under state and federal antitrust laws with respect to planning, negotiating and executing cooperative, collaborative and integrative arrangements where the benefits of collaboration resulting from activities undertaken by healthcare providers (and others) outweigh the disadvantages resulting from a reduction in competition.[19]

The statute requires the New York State Department of Health to promulgate regulations to implement the law, which are required to provide standards for determining which proposed collaborations, integrations, mergers or acquisitions shall be covered by the law and the manner by which the legislative intent shall be advanced through regulatory oversight.[20]

Proposed Regulation

On September 18, 2013, DOH published a notice of proposed rulemaking that would establish a COPA process for healthcare providers seeking to enter collaborative arrangements with other healthcare providers to obtain immunity from federal and partial immunity from state antitrust liability.[21] Subsequently, on August 27, 2014, DOH issued a revised rulemaking with comments

[15] *Id*.
[16] *See* S.B. 2809-D, § 50, 2011 Leg., 237th Legis. Sess. (N.Y. 2011).
[17] §§ 2999aa–2999bb.
[18] S.B. 2809-D, § 50.
[19] *Id.*
[20] §§ 2999aa–2999bb.
[21] Certificate of Public Advantage, 38 N.Y. Reg 7 (proposed Sept. 18, 2013).

and responses to the original version of the proposed rule.[22] Along with the issuance of the revised regulations, the Department also provided notification that "DSRIP Project Plan applications to be submitted by Performing Provider Systems will include the opportunity to apply for a COPA, and the DSRIP Independent Assessor will review those requests."[23] Pursuant to statute, no COPAs may be granted after December 31, 2016, and the State is seeking to complete COPA reviews for DSRIP by February 2, 2015.[24]

The regulatory impact statement included in the initial proposed regulation provided that the filing for a COPA would be optional, and "[t]he review of certificate of public advantage applications will require the commitment of staff resources. However, the number of applications was expected to be small and the reviews conducted largely by consultants paid for by the applicants" (emphasis added).[25]

Even before the proposed use of the COPA to provide antitrust immunity from providers participating in the DSRIP process, in response to the initial proposed rulemaking, both the health plans and the business community raised concerns with the proposed framework, and urged the state to require, at a minimum:

(1) Due process that allows all interested and/or potentially impacted parties to be notified of a COPA application and provided a meaningful opportunity for written and verbal input into both the approval decision and, if approved, the conditions under which the entity must operate;
(2) Specific approval conditions that constrain the exercise of pricing power;
(3) A regulatory scheme that provides ongoing, specific and enforceable "active supervision" of the operation of any entity granted a COPA certificate; indicating that a mere "promises" and "annual reporting" scheme as currently proposed is clearly not sufficient; and
(4) Specific and timely remedies for anticompetitive behavior.

As indicated, on August 27, 2014, DOH issued a revised rulemaking along with its responses to public comments on the original version of the proposed rule. Significantly, DOH declined to address any of the key concerns raised by the insurers and business community in the revised rule and did not materially address the requested protections against anticompetitive behavior.[26]

[22] Certificate of Public Advantage, 36 N.Y. Reg. 13 (proposed Aug. 27, 2014).
[23] E-mail from Medicaid Redesign Team Update List on behalf of Scott, Kalin, N.Y. DEP'T OF HEALTH, to MRT Listserv, *DSRIP Update: Certificate of Public Advantage (COPA) Revised Regulations – Now Available* (Aug. 26, 2014). *See also* N.Y. DEP'T OF HEALTH , FUNDING AVAILABILITY SOLICITATION (FAS) DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM INDEPENDENT ASSESSOR 3–4 (2014) [hereinafter DSRIP FAS] *available at:* https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_assessor_fas.pdf.
[24] DSRIP FAS, *supra* note 23, at 28.
[25] Certificate of Public Advantage, 38 N.Y. Reg. 7 (proposed Sept. 18, 2013).
[26] *See* 36 N.Y. Reg. 13.

### b. Proposed Use of COPA for DSRIP PPSs is Beyond the Scope Contemplated by Legislature and Proposes Insufficient State Supervision, Failing Both Prongs of the State Action Doctrine

The state's proposed use of the COPA process for DSRIP PPSs fails both prongs of the "State Action Doctrine"[27] in that it is both beyond the legislative scope contemplated by the state legislature, and the proposed process for "active state supervision" is illusory and inadequate to guard against the anticompetitive effects of PPS provider collaboration. Moreover, even assuming that the proposed COPA process is lawful State Action, the State's anticompetitive regulatory scheme would result in substantial interstate spillover, causing negative economic and political consequences to the citizens of neighboring states.

The Special Terms and Conditions for the DSRIP program provide that coalitions of providers must ". . . establish a clear business relationship between the component providers, including a joint budget and funding distribution plan that specifies in advance the methodology for distributing funding to participating providers . . . [and] comply with all applicable laws and regulations. . . "[28] In light of the necessary provider compliance with all applicable laws and regulations, including Federal antitrust laws including the Sherman Act,[29] the Clayton Act,[30] and the Federal Trade Commission Act[31] and New York's own antitrust law, known as the Donnelly Act,[32] New York is seeking to use its proposed COPA process to allow providers collaborating as part of the DSRIP program to seek state action immunity under federal and state antitrust laws.

However, as the Supreme Court recently held in *FTC v. Phoebe*, the State Action Doctrine only applies when the anticompetitive conduct complained of is the ". . . inherent, logical, or ordinary result of the exercise of authority delegated by the state legislature,"[33] and the State has "affirmatively contemplated the displacement of competition." [34]

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[27] "The State Action Doctrine shields certain anticompetitive conduct from federal antitrust scrutiny when the conduct is: (1) in furtherance of a clearly articulated state policy, and (2) actively supervised by the state." Office of Policy Planning, Federal Trade Commission, *Report of the State Action Task Force* 1 (September 2003) [hereinafter FTC STAFF REPORT], *available at* http://www.ftc.gov/os/2003/09/stateactionreport.pdf.

[28] *See* DSRIP STCs, *supra* note 3, at § 5b.

[29] Section 1 of the Sherman Act, 15 U.S.C. §§ 1-7, provides that "[e]very contract, combination . . . or conspiracy, in restraint of trade or commerce . . . is declared to be illegal." The Supreme Court interprets the statute to prohibit only *unreasonable* restraints. *See*, e.g., State Oil Co. v. Khan, 522 U.S. 3, 10 (1997).

[30] Section 7 of the Clayton Act, 15 U.S.C. §§12-27, 29 U.S.C. §§52-53 prohibits mergers if, "in any line of commerce or in any activity affecting commerce in any section of the country, the effect of such acquisition may be substantially to lessen competition, or to tend to create a monopoly."

[31] Section 5 of the Federal Trade Commission Act, 15. U.S.C. §§ 41-51, provides that "[u]nfair methods of competition in or affecting commerce, and unfair or deceptive acts or practices in or affecting commerce, are hereby declared unlawful."

[32] N.Y. GEN. BUS. LAW §§ 340–347 (McKinney 2014).

[33] Federal Trade Commission v. Phoebe Putney Health System, Inc., 133 S. Ct. 1003, 1013 (U.S. Feb. 19, 2013).

[34] *See id.* at 1012.

Legislative and Regulatory Intent

In New York, the use of the COPA process for providers participating in DSRIP was not contemplated by the New York State legislature, as the enactment of the COPA enabling legislation occurred three years prior to the DSRIP and without any contemplation of its eventual creation. Both at the time the COPA legislation was passed in 2011, as well as during the duration of the public comment period for the initial proposed COPA regulations, the use of the COPA process for DSRIP PPS purposes was not considered, nor was the public given opportunity to comment on this proposal. The revised regulations were subject to a new comment period, which expired on September 26, 2014, and we expect that the Department will receive additional feedback given the proposed use of COPA as part of the DSRIP process. However, in view of DOH's position to date, it is unlikely that the concerns set forth in this letter will be adequately addressed prior to December of this year when DOH intends to begin accepting COPA applications.

In addition, prior to enactment of the statute, the COPA process was envisioned to be utilized in isolated instances where warranted and would not be utilized by a large number of providers.[35] With the heightened interrelationship between the DSRIP and COPA, the state is now seeking to utilize this process on a wide-spread, state-wide and provider-wide basis that was clearly not contemplated when COPA was enacted by the Legislature in 2011. Thus, the state action relied upon by the Department is tenuous at best.

Active Supervision

In addition, there is significant concern regarding the ability of the State to meet the second prong of the test that requires "active supervision" of the policy by the State itself. Due to the state-wide participation of providers, the anticipated number of applications is much greater than originally anticipated, and if the use of the COPA by PPS providers is ultimately permitted, at a minimum, a regulatory scheme that provides ongoing, specific and enforceable "active supervision" of the operation of any entity granted a COPA is required.

Pursuant to the regulatory impact statement, the New York State Department of Health indicated that the review of COPA applications will "require the commitment of staff resources . . . [h]owever the number of applications is expected to be small, and the reviews will be conducted largely by consultants paid for by the applicants."[36] In the context of DSRIP, as indicated, the State now proposes to use an "Independent Assessor," rather than the State itself, to both review initial COPA applications from PPS providers and also engage in the "active supervision" of COPAs awarded.[37]

The role of the Independent Assessor in the DSRIP Project Plan process is to score all submitted plans and provide a recommendation on whether the plan satisfies the requirements for DSRIP imposed by CMS. While the assessor will conduct a COPA review, the COPA application and

[35] Certificate of Public Advantage, 38 N.Y. Reg. 7 (proposed Sept. 18, 2013).
[36] *Id*.
[37] *See* DSRIP FAS, *supra* note 23.

subsequent "supervision" is ancillary to the main purpose of the Independent Assessor review, and inadequate to appropriately monitor the marketplace.

Furthermore, it is important to note that, in the limited number of states that have enacted COPA laws, the use of the COPA has never been applied in the manner anticipated by DSRIP. In most states, only one COPA has been issued. North Carolina, for example, enacted COPA laws in 1993, but has only granted a single COPA. This COPA was required as a condition of approving the merger of two acute care hospitals in the western part of the State in 1995.[38] The COPA included specific restrictions and requirements related to reporting information, contracting with or employing physicians, controlling costs, and contracting with insurance plans.[39] The North Carolina COPA renewal was subject to stringent standards, including a five-year compliance assessment performed by an independent entity to determine whether any modifications to the COPA were necessary to better protect consumers from the loss of competition that arose under the 1995 merger. Thus, even though the scale of North Carolina's COPA implementation pales in comparison to New York's, the supervision requirements appear to have been far more comprehensive than what New York has proposed.

While the review process for the New York COPA application was intended to be rigorous, it now appears that the Department of Health will be seeking to process a large number of these applications on an expedited basis to grant providers immunity to begin collaborating as early as February 2015.[40] The regulations as currently proposed provide that the Department "shall not issue a Certificate of Public Advantage without first consulting with the Attorney General and, as appropriate, the mental hygiene agencies, and consulting with, and receiving a recommendation from, the Public Health and Health Planning Council."[41] In addition, in response to comments submitted on the original proposed regulation, the Department stated "there will be opportunity for public comment on a COPA application, either in writing or in person, at a meeting of a designated PHHPC committee."[42] However, in light of the Department's proposed timeline for the processing of COPA applications submitted through DSRIP, the opportunity for a thorough review by the Department and the public appears illusory at best.

Under the current timeline presented by the Department, DSRIP Project Plan applications, which will include the opportunity to apply for a COPA, are to be submitted by Performing Provider Systems by December 16, 2014. The "Independent Assessor" is scheduled to complete the COPA review by February 2, 2015. Final decisions on all DSRIP applications, including the application for a COPA, are due by February 27, 2015. Thus, during a one and a half month span, a single private third party vendor (Public Consulting Group Inc.) will complete a COPA review for up to 42 separate COPA applications, in addition to conducting a review of the DSRIP components of the submitted project plans. Following such analysis, the Attorney

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[38] GREGORY S. VISTNES, PH.D., AN ECONOMIC ANALYSIS OF THE CERTIFICATE OF PUBLIC ADVANTAGE BETWEEN THE STATE OF NORTH CAROLINA AND MISSION HEALTH, (2011), *available at* http://www.mountainx.com/files/copareport.pdf; *see also* Press Release, Mission Health, Mission Hospital Pleased with Final Report on Certificate of Need (Dec. 6, 2012), *available at* http://www.mission-health.org/news/article/mission-hospital-pleased-final-report-certificate-need#sthash.hOuuOTJY.dpuf

[39] *Id.*

[40] *See* DSRIP FAS, *supra* note 23, at 28.

[41] 36 N.Y. Reg. 13.

[42] *Id.*

General and the Public Health and Health Planning Council will be provided with less than one month to review all of the COPA applications, with the PHHPC providing a recommendation of approval or disapproval for each application. The public will be provided with the opportunity to comment on each application when the PHHPC meets to review each application. The nature of the initial review of each application and the subsequent opportunity for public comment are so constricted as to prevent a meaningful and complete review of each application.

Interstate Spillover

Finally, it bears noting that the proposed use of the COPA will result in substantial anticompetitive "spillover" into surrounding states.[43] The establishment of multi-facility PPSs in the New York City region will invariably impact healthcare purchasing for New Jersey and Connecticut citizens who access services in New York. In addition, Vermont and Pennsylvania residents who live along the State's eastern and southern borders, where there is substantial overlap in healthcare purchasing and service delivery, will also be similarly negatively affected by New York's anticompetitive regulatory scheme.

In light of all of the forgoing, as well as the State's policy goal for the PPSs formed as part of the DSRIP process to become permanent provider entities, capable of contracting as a single entity, the need for oversight of provider activities and a regulatory COPA framework to govern the activities of DSRIP providers is critical. The current COPA process proposed by the State lacks sufficient State Action authority following the Supreme Court's holding in *Phoebe* to proceed as proposed without appropriate safeguards and modifications. As PPS formations continue to form in the model of Accountable Care Organizations ("ACOs"), safeguards similar to those articulated under Federal antitrust policy governing ACOs should be applied, including but not limited to, showings of sufficient clinical and financial integration to withstand scrutiny, to ensure that the State's COPA does not create an expansive safe harbor that allows ACO-like collaborations that reduce competition and harm consumers.

## III. Recommendations

We urge the FTC and DOJ to review each of these initiatives and provide comment as to the permissibility of New York's stated DSRIP PPS policy goals and proposals in light of federal antitrust laws.

Due to the potential for "emerging PPSs" to exert pricing powers to the detriment of consumers in New York and its sister states, including Medicaid, Medicare Advantage and commercial health plans, as well as businesses and individuals who purchase coverage, we request that the FTC and DOJ require the State to implement appropriate marketplace safeguards and alternatives. These should include, at a minimum: 1) reconsideration of the policy goal of the creation of a permanent "single entity" PPS provider to negotiate provider reimbursement (e.g., through alternative models for "value-based" reimbursements to PPSs that preserve direct par-

[43] *See* FTC STAFF REPORT, *supra* note 27, Recommendation #4, P. 56-57 (discussing that the economic efficiency and political participation goals of federalism are impaired where a State's anticompetitive regulatory action negatively affects other states).

provider agreements with individual providers in the PPS), and 2) reconsideration of the State's desired degree of consolidation of PPSs.

Finally, to the extent the use of the COPA construct is allowed to proceed for providers participating in DSRIP, we request that the FTC and DOJ support significant modifications to the COPA process to guard against antitrust concerns and to engage in strict state oversight of provider affiliations going forward. Without expressed collaboration with, and support from, impacted health plans, a PPS should not be permitted to evolve to the future state of a single network entity that contracts with any payor (including Medicaid, Managed Care Plans). As a result, the COPA process should be revised to include, at a minimum, the following protections against anti-competitive conduct:

- Any COPA issued to a PPS should expressly prohibit the PPS from contracting with any payor as a single network entity for healthcare services, unless a payor voluntarily agrees to negotiate with a PPS as a single entity.

- A PPS may not act as the exclusive bargaining entity for entities that are part of the PPS and the COPA should expressly prohibit the PPS from blocking or otherwise obstructing negotiations between payors and providers within the PPS.

- A COPA may not be issued unless the PPS can clearly demonstrate that it will provide price reductions and, under no circumstances should the PPS be permitted to impose price increases in excess of medical trend.

- A COPA approval of a PPS should require DSRIP-related cost savings to be passed on to consumers in the form of price reductions to payors and consumers.

- A PPS shall give DOH and payors prior notice of any future transactions involving hospitals and other healthcare providers (including inpatient and outpatient facilities and physician practice groups) in the surrounding geographic area.

- A PPS shall demonstrate to regulatory bodies that it has implemented promised efficiencies. This should be done not less than semi-annually.

As discussed, please find attached for your reference comments on the proposed COPA rule submitted by both the New York State Health Plan Association as well as the New York State Conference of Blue Cross and Blue Shield Plans.

Please do not hesitate to contact us if you have any additional questions or would like to discuss this matter further. We appreciate your consideration of these concerns.

Respectfully submitted,

**New York State Conference of Blue Cross and Blue Shield Plans**

Empire BlueCross BlueShield
Excellus BlueCross BlueShield

**The National Federation of Independent Businesses**
Michael P. Durant, New York State Director

**The Business Council of New York State**
Heather C. Briccetti, Esq., President & CEO

**Unshackle Upstate**
Brian Sampson, Executive Director

**New York State Health Plan Association**

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HealthPlus, an Amerigroup Company
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WellCare

Enclosures