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May 4, 2016

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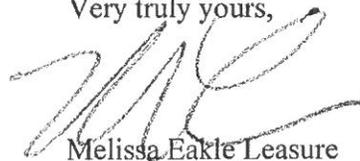
Re: Cabell Huntington Hospital, Inc.  
Cooperative Agreement File No. 16-2/3-001

Dear Mr. Davis and Ms. Dellinger:

Please find enclosed Cabell Huntington Hospital's Response to Public Comments. The Response contains proprietary information that is required to remain confidential and therefore pursuant to West Virginia Code §16-29B-26(e)(1), we are submitting duplicate Responses, one with full information for the Authority's and General's use and one redacted Response available for the public.

If you have any questions or require additional information, please give me a call.

Very truly yours,



Melissa Eakle Leasure

MEL/ke  
Enclosure

**BEFORE THE WEST VIRGINIA HEALTH CARE AUTHORITY**

Re: CABELL HUNTINGTON HOSPITAL, INC.  
Cooperative Agreement File No. 16-2/3-001

**Cabell Huntington Hospital, Inc.'s  
Response to Public Comments**

Cabell Huntington Hospital, Inc. (“Cabell”), the applicant in this application for approval of a cooperative agreement pursuant to sections 26, 28, and 29 of Chapter 16-29B of the West Virginia Code (the “Cooperative Agreement Law”), herein responds to the public comments submitted regarding the application. It is intended that this response and its attachments shall supplement Cabell’s application under the Cooperative Agreement Law, and that they be incorporated by reference into said application.

None of the public comments provides any ground for denying the application. To the contrary, the two longest submissions — those of certain employees of the FTC Bureau of Competition (“Staff”) and Steel of West Virginia Inc. (“Steel”) — simply argue the merits of the very antitrust claims that the Cooperative Agreement Law was designed to supplant and misunderstand the competitive and other effects of the proposed transaction.<sup>1</sup>

**A. Staff and Steel Misconstrue The Legislation And Seek To Litigate An Antitrust Claim.**

The Cooperative Agreement Law 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. *See* W. Va. Code § 16-29B-26, 28(c). Writing on behalf of a group of employees of the Federal Trade Commission Bureau of Competition (but expressly not the Commission itself, and with the proviso that the Commission and the Commissioners may disagree with him/them), Staff asserts that the transaction could violate the antitrust laws, and assumes that if the transaction is unlawful under the federal antitrust laws, the Authority must then deny the application. Staff claims that “the types of benefits and disadvantages” listed in the statute “are similar to” those considered in an antitrust case, Staff Submission at 7, and from this vague generality proceeds to argue the matter on traditional antitrust grounds. Steel’s comments are, if anything, even more direct in their effort to argue that the law changes nothing; not only does Steel continue to make competition arguments, but it openly attacks the wisdom of the law, complaining that its passage was unwise, Steel Submission at 2, and impugning the West Virginia Legislature’s sovereign decision to entrust supervisory oversight to the Authority and the Attorney General, *id.* at 2, 7. Steel even states that this review under the Cooperative Agreement Law by the Authority and the Attorney General “will be both incomplete and absurd.” *Id.* at 3.

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<sup>1</sup> Cabell concurrently files an opposition to the request by Staff to be afforded affected party status. Cabell also files proposed findings of fact and conclusions of law.

Staff's and Steel's arguments are incorrect. The Cooperative Agreement Law does not call upon the Authority to resolve the very antitrust issues it was designed to displace. It sets out a fundamentally different standard for approval that Staff and Steel do not either meaningfully or thoughtfully apply. The federal antitrust laws focus on a lessening of competition, a showing of which tends to be dispositive. 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.*, Horizontal 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 that 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"). The Cooperative Agreement Law, by contrast, 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 wide variety of benefits, not just benefits that would promote competition.

The question for the Authority, therefore, is not whether approval of the cooperative agreement will contravene federal antitrust laws, as Staff and Steel assume, but whether the benefits of the transaction outweigh any disadvantages. *See* W. Va. Code § 16-29B-28(f)(3). 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>2</sup>, and may be approved as a cooperative agreement 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). The law is express and unambiguous on this point: "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. (The 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." *Id.* § 16-29B-28(c).) If in the exercise of these statutory duties the Authority approves the cooperative agreement, then the antitrust laws are "supplant[ed]." Thus, even if Staff and Steel were correct in their antitrust arguments (and, as shown below, they are wrong), these arguments would do nothing to warrant denial of the application.

This is not to say that the Cooperative Agreement Law is blind to potential effects on competition that may result from approved cooperative agreements. To the contrary, the Cooperative Agreement Law not only looks to competitive effects as part of the Authority's approval analysis, but addresses such effects after approval by establishing comprehensive, mandatory State oversight and control over pricing, healthcare quality goals, and other conduct

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<sup>2</sup> *See* W. Va. Code § 16-29B-28(b)-(c).

of approved cooperative agreements. *See, e.g.*, W. Va. Code § 16-29B-28(f)(6)(B)(i), (iii); *id.* § 16-29B-28(i)(1)(B). However, as discussed in more detail below, there is no reason to believe that the transaction here would have an anticompetitive effect.

Staff and Steel also argue that the Authority and the Attorney General are incapable of supervising the conduct of cooperative agreements. Staff Submission at 44-47; Steel Submission at 2, 7. Not only are these contentions entirely baseless and unsupported, but the adequacy of the Authority's and the Attorney General's supervision has been decided by the Legislature, and this legislative determination is binding on the Authority. W. Va. Code § 16-29B-26; *id.* § 16-29B-28(c). Indeed, if the Authority were to ignore the Assurance of Voluntary Compliance entered into by the Attorney General and the hospitals (the "AVC") as Staff and Steel urge, then it would be acting in direct contravention of the statute. *See id.* § 16-29B-28(i)(1)(A). Moreover, the Legislature enacted this regulatory regime in full awareness of the objection of Staff's employer, the Federal Trade Commission, which made a written submission to the Legislature urging it not to pass the Cooperative Agreement Law on these very grounds. In passing the statute, the Legislature obviously rejected the Commission's point of view. The Legislature determined that 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," W. Va. Code § 16-29B-1 — and the West Virginia Attorney General are appropriate and effective agencies to implement this State policy and to serve as stewards of the public interest under the Cooperative Agreement Law.

In a similar vein, Staff and Steel invite the Authority to ignore the AVC. Staff Submission at 41-43; Steel Submission at 7-8, 11. But the Cooperative Agreement Law specifically directs the Authority to consider agreements with the Attorney General in evaluating cooperative agreements, such as the AVC, and reaffirms their "validity" and "enforceab[ility]" under the Cooperative Agreement Law. W. Va. Code § 16-29B-28(i)(1)(A). Regardless of Staff's or Steel's opinions about these so-called "behavioral remedies" in the context of federal antitrust claims, the West Virginia Legislature has determined that regulation stemming from agreements such as the AVC is directly relevant to the Authority's decision whether to approve a cooperative agreement. In any event, 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 prices at the merging hospitals for three years after the proposed merger and to limit price increases for the following four years "besp[oke] a serious commitment by defendants . . . to refrain from exercising market power in ways injurious to the consuming public"), *aff'd*, 121 F.3d 708 (6th Cir. 1997).

When considered under the approval framework set out by the Legislature, the express undertakings set forth in Cabell's application and the statutory requirements, the application plainly satisfies the weighing required by the statute. The application squarely meets each of the statutory goals set out as governing the Authority's analysis in section 28(d). *See* W. Va. Code § 16-29B-28(d)(1)-(2). Many of these same goals were previously identified and addressed by the Authority in its Certificate of Need ("CON") Decision favorable to Cabell.

- Improve access to care. W. Va. Code § 16-29B-28(d)(2)(A). The hospitals have made commitments, in both the AVC and the Application for Approval of Cooperative Agreement (the “Application”), that will improve access to health care. Among other things, the hospitals will implement community wellness programs to connect with medically underserved communities, AVC at 10, accept Medicaid patients residing in Ohio and Kentucky at the rates established by those states for in-state providers, *id.*, and assess community health needs and implement programs and outreach initiatives, Application at 8. Notably, the Authority has already concluded in its CON Decision that the proposed cooperative agreement will improve 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. The Authority specifically concluded that “patients will experience serious problems obtaining complex, specialized health care locally” in the absence of the cooperative agreement. CON Decision at 40; *see also id.* at 26; 37; 39. Currently, local residents must travel to Columbus, Cincinnati, or other larger metropolitan areas in order to access such services.
- Advance health status. W. Va. Code § 16-29B-28(d)(2)(B). The Cooperative Agreement Law establishes 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). Should performance scores 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 supervised and enforced by the Authority. *Id.* § 16-29B-28(g)(1)(C). In addition, the hospitals have made other commitments, such as adopting uniform protocols and best practices. Application at 8-10. Again, the Authority’s CON Decision has 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.” CON Decision at 35. The Authority specifically granted credence to the substantial body of literature which finds that higher patient volumes generally result in increases in the quality of care delivered, *id.* at 35, and as such, concluded that the cooperative agreement will increase the quality and coordination of care to local residents. *Id.* at 26; 35; 37.
- Target regional health issues. W. Va. Code § 16-29B-28(d)(2)(C). Among other commitments, the hospitals will develop quality and population health goals; AVC at 9-10; implement community needs plans and conduct community health assessments; and integrate the hospitals’ electronic records systems and other healthcare data, thereby allowing the hospitals to prioritize and address unique health problems facing the community, Application at 7. The issue of population health was a major focus of the evidence considered by the Authority in the CON matter, wherein it concluded that the cooperative agreement would allow the hospitals to promote “more effective management of population health.” CON Decision at 26.
- Promote technological advancement. W. Va. Code § 16-29B-28(d)(2)(D). To promote technological advancement, the hospitals have committed to capital expenditures, have committed to preparing St. Mary’s for healthcare reform, and have committed to implementing a fully integrated and interactive electronic medical record system, among

other commitments. *See* AVC at 10; *see* also Definitive Agreement (“DA”) Art. IV, ¶ 7. Also, as stated above, 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 the hospitals. CON Decision at 26; 37; 39; 40.

- Ensure accountability of cost of care. W. Va. Code § 16-29B-28(d)(2)(E). Accountability for the cost of care 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 Cooperative Agreement Law requires disclosure of any reimbursement agreement with a commercial health plan or insurer. *Id.* § 16-29B-28(g)(1)(A)(iv). Neither of these regulatory oversight mechanisms is time-limited. And, among other protections, for ten years following closing, rate increases cannot exceed benchmark rates established using the methodology formerly employed by the Authority in its rate review process. AVC at 7.
- Enhance academic engagement in regional health. W. Va. Code § 16-29B-28(d)(2)(F). 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. Application at 11-12. 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 26.
- Preserve and improve medical education opportunities. W. Va. Code § 16-29B-28(d)(2)(G). Among other commitments, the hospitals will expand their relationship with MUSOM; maintain St. Mary’s Schools of Nursing, Radiology, and Respiratory Care; and support St. Mary’s Clinical Pastoral Education Program. Application at 11; DA Art. IV, ¶ 15.
- Strengthen the workforce for health-related careers. W. Va. Code § 16-29B-28(d)(2)(H). 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. *See* AVC at 6-7; DA Art. IV, ¶ 12. The CON Decision specifically concluded that the cooperative agreement will “allow for greater recruitment of professionals” to the area. CON Decision at 26.
- Improve health entity collaboration and regional integration, where appropriate. W. Va. Code § 16-29B-28(d)(2)(I). 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 Aeromedical Services. AVC at 6; Application at 13. In addition, regional integration was a goal identified by the Authority in the CON matter wherein it concluded that the cooperative agreement “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. CON Decision at 21.

The application easily satisfies the standard for approval in light of all of these benefits. The public comments do not seriously address these considerations, and ignore the CON Decision's findings and conclusions about them. Staff and Steel mostly argue, in contravention of the governing Cooperative Agreement Law, that the Authority should simply ignore them or subordinate them to their flawed allegations about competitive harm.

**B. Staff's and Steel's Competitive Effects Arguments Are Factually Incorrect.**

In their submissions, Staff and Steel not only apply the wrong legal standard, but they also make invalid arguments that the cooperative agreement will result in adverse effects on competition. They ignore the realities of the competitive framework within which Cabell and St. Mary's operate, and dismiss without reason multiple pricing constraints and pressures to maintain and improve quality of care that will continue after the cooperative agreement is granted. Because these errors miss the point of the Cooperative Agreement Law, they are summarized only briefly in this submission. A more detailed showing why Staff's and Steel's arguments fail is set forth in the Expert Report of Gautam Gowrisankaran ("Gowrisankaran Rpt."), which is attached as Exhibit A for the Authority's reference.

**1. Staff and Steel Incorrectly Define The Relevant Geographic Market.**

Staff and Steel both incorrectly define the relevant geographic market and thus significantly overstate the parties' purported market shares.

Staff attempts to attribute unduly high market shares to Cabell and St. Mary's by arguing that the relevant geographic market is "no larger than Cabell, Wayne, and Lincoln counties in West Virginia and Lawrence County in Ohio (the 'Four-County Huntington Area')." Staff Submission at 12. Steel agrees with this overly narrow definition. Steel Submission at 4-5. The Authority has already considered and rejected this alleged "Four-County Huntington Area" proposed market as too narrow. CON Decision at 18. Neither Staff nor Steel addresses this determination and they provide no basis to revisit it. As shown in the application for approval of the cooperative agreement, the four-county area does not include many of the patients Cabell and St. Mary's serve, or the numerous other hospitals against which Cabell and St. Mary's must compete for those patients. The geographic service area from which Cabell and, separately, St. Mary's draw and compete for potential patients is much larger than the four-county area, and extends into other parts of West Virginia, Ohio and Kentucky. Drawing patients from such a broad area brings Cabell and St. Mary's into competition with hospitals in those communities. This rivalry will continue after the cooperative agreement is granted – spurring improvement of services and health-care quality.

**2. Staff and Steel Misunderstand The Applicable Competitive Framework.**

Staff's and Steel's analyses of the potential antitrust implications of the proposed cooperative agreement are wrong and based on an incorrect understanding of the competitive situation in which the Huntington hospitals operate.

As Staff and the expert it cites, Dr. Cory Capps, acknowledge, competition occurs in a two-stage process. Staff Submission at 8-9. In stage one, payors negotiate with hospitals over

prices. Gowrisankaran Rpt. ¶ 153; *see also* Report of Dr. Cory Capps (“Capps Rpt.”) ¶ 178. Payors’ bargaining power is based on the number of their enrollees, and hospitals’ bargaining power is based on attractiveness to enrollees. Gowrisankaran Rpt. ¶¶ 155-57.

During stage two, hospitals compete with each other for patients. Gowrisankaran Rpt. ¶ 158. Strong patient demand for a hospital enhances that hospital’s bargaining power at the first stage. Price does not play a substantial role at this second stage because prices are typically paid by payors rather than patients. Gowrisankaran Rpt. ¶ 159. Rather, patients choose among hospitals based on services, quality, and amenities. *Id.* ¶¶ 158-61; Capps Rpt. ¶ 175.

Contrary to Staff’s and Steel’s contentions, Cabell and St. Mary’s are highly complementary in their services, and hence are independently viewed as essential by payors in the markets in which they compete. Gowrisankaran Rpt. ¶¶ 13, 54. Steel argues that “health plans and other third-party payors have repeatedly used [Cabell-St. Mary’s] competition to gain more favorable terms when negotiating discount contracts with the hospitals.” Steel Submission at 3. But Steel provides no support for this statement. When a payor constructs a hospital network, that payor does not choose between having two critical services, like open-heart surgery and pediatric intensive care; it needs both. Gowrisankaran Rpt. ¶ 13. This is true even if the hospitals offer overlapping services as well. *Id.* Because the two hospitals specialize in different services, and neither of them provides the full suite of services necessary to payors and their participants, payors building a provider network in Huntington already view Cabell’s and St. Mary’s complementary services as essential, and thus need both hospitals in their networks. *Id.* ¶ 185. A combined Cabell-St. Mary’s hospital will therefore not have market power to increase prices to payors, which is why so many payors support the transaction.

The so-called diversion ratio model touted by Staff’s expert, Dr. Capps, actually confirms this analysis when properly viewed by separate service line. *See* Gowrisankaran Rpt. ¶¶ 353-57, 367. 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. Staff Submission at 19-20, 27. In the service lines where one of the Huntington hospitals is much stronger than the other, like Cabell’s pediatric care, or St. Mary’s cardiac care, the diversion from the stronger hospital to the other hospital is lower than it is to hospitals outside of Huntington. In other words, patients know each hospital’s strengths and actively seek out each hospital for those strengths. Gowrisankaran Rpt. ¶¶ 353-57, 367. 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 choices across all service areas are simply aggregated, masking their highly differentiated service focuses.

Staff treats a service as “overlapping” if both hospitals offer it, even if patients overwhelmingly prefer one hospital over the other in the service line. Staff Submission at 28-29. Staff’s own discussion of geographic markets, however, would indicate that this “very strong preference” for one hospital means that the other is not an “adequate alternative[.]” for the service line; that the hospitals are not “meaningful competitors” in the service line; and that a network without the preferred hospital for the service line would be “very unattractive.” *Id.* at 16, 21. Because this is true for very significant service lines like pediatric care and cardiac care (not just isolated services offered by only one hospital), the hospitals are complements for payors with respect to Huntington network coverage.

Staff ignores that, in this dual-bargaining context, Herfindahl-Hirschman Index (“HHI”) values are of limited utility to determining any pricing impact of a transaction. Staff Submission at 23-24; Gowrisankaran Rpt. ¶ 329. At the stage where prices are determined, the payor-hospital negotiation, most or all hospitals in a market typically have contracts with most or all payors. Gowrisankaran Rpt. ¶ 329. Hence, hospitals are commonly in-network for nearly 100% of relevant enrollees. *Id.* It is therefore impossible to assign meaningful market shares at this stage. Moreover, hospitals’ shares of patients at the second stage are not a meaningful proxy for ability to exercise market power at the first stage, because highly complementary hospitals like Cabell and St. Mary’s can be viewed as essential to payors wholly apart from patient distributions between them. *Id.* ¶ 330.

**3. A Variety Of Independent Pricing Constraints Remove Any Remaining Risk Of Pricing Effects.**

A number of additional protections are in place to ensure that approval of the application for a cooperative agreement will not create adverse pricing effects.

As an initial matter, the Attorney General will have a veto power on any price increases, W. Va. Code § 16-29B-28(i)(1)(B), and the AVC will impose additional benchmarking constraints on pricing. In addition, Cabell and St. Mary’s serve many patients who receive their health insurance from government sources, which set rates themselves or are subject to federal regulations that prevent improper price increases for government payors. Likewise, long-term contracts, the AVC, and government regulation combine to ensure appropriate pricing for payors that negotiate reimbursement rates. And continued competition from other hospitals in the truly relevant geographic market will ensure robust price and quality competition.

**4. The Mere Possibility Of Anticompetitive Effects Would Not Compel Denial Of The Application Even If It Did Exist.**

The systemic flaws in Staff’s and Steel’s economic analyses are reason enough to reject their conclusions. But even had their analyses been correct, they still would not justify a denial of the application. Rather, as shown above, the Cooperative Agreement Law provides that even agreements that *would* violate the federal antitrust laws can be approved based on benefits to West Virginia as recognized by the Authority. The Cooperative Agreement Law expressly emphasizes that when a “cooperative agreement . . . might be anticompetitive within the meaning and intent of state and federal antitrust laws,” there is nonetheless a legislative determination that “it is in the state’s best interest to supplant such laws with regulatory approval and oversight by the . . . Authority.” W. Va. Code § 16-29B-28(c). Thus, the statute expressly contemplates situations where arguments like those made by Staff and Steel have merit, and even in those cases, unlike here, it makes clear that approval can nonetheless be warranted based upon a wide variety of potential benefits.

**C. Approval Of The Cooperative Agreement Application Will Confer Numerous Benefits On The Communities Served By Cabell And St. Mary’s.**

Staff and Steel offer no valid justification for their sweeping request to dismiss all of the benefits of the proposed cooperative agreement. As explained in greater detail in the attached

expert report, *see* Expert Report of Lisa N. Ahern (attached as Exhibit B), the benefits of the transaction are substantial and well-supported.

The transaction will generate significant efficiencies that cannot be achieved by either hospital independently, or through an alternative transaction, and that would be credited even under the federal antitrust laws. Among other benefits, the transaction will result in \$16 million in annual recurring cost savings three years after closing. Ahern Rpt. ¶ 228. These savings will result from operating efficiencies, including third-party vendor agreements, consolidation, and staffing efficiencies. *See generally id.*

In addition, 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. Ahern Rpt. ¶¶ 34, 129, 144, 191. This integration will include an integrated, community-wide electronic health records system and the fostering of community health programs under the AVC, AVC at 10.

In light of these benefits and the widely supported community goal of retaining local control of the governance of Huntington's hospitals, the transaction is overwhelmingly supported by the communities which the hospitals serve. Area health plans which provide over 75% of the hospitals' commercial revenues have submitted letters of support to the FTC over the course of its investigation (Letters attached as Exhibit C). Thirty-eight (38) local businesses which employ 12,460 area employees have also submitted letters of support. (*Id.*, 25 Example Letters Attached). The three (3) County Commissions located in closest physical proximity to the hospitals all unanimously voted to pass resolutions of support. (*Id.* 3 Resolutions Attached). Eight (8) economic development and quasi-governmental groups wrote of their support to the FTC. (*Id.*, 8 Example Letters Attached). Staff, by contrast, refers the Authority to a small number of declarations from third parties that, in the face of the vast discovery and subpoena power of the Federal Trade Commission, were signed after being drafted and edited by FTC staff. Many of those declarations have been undermined during discovery, and the FTC's tactics in this regard have come under sharp criticism recently. *See, e.g.,* Brent Kendall, *Court Document Sheds Light on FTC Tactics in Staples-Office Depot Case*, Wall Street Journal, available at <http://www.wsj.com/articles/judge-finds-ftc-actions-in-staples-office-depot-case-very-disturbing-1458848889> (March 24, 2016) (noting that a federal judge "chastised the FTC for asking Amazon to sign a document that contained . . . assessments with which the company disagreed").<sup>3</sup>

#### **D. The Authority Should Approve Cabell's Application.**

Staff believes that the underlying transaction would violate the federal antitrust laws. This is hardly surprising — Staff has been charged with prosecuting an antitrust challenge to the

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<sup>3</sup> In addition to FTC Staff and Steel, some 14 individuals submitted written comments generally opposing the transaction. Several expressed the view that the transaction created a monopoly and were opposed for that reason. Some simply expressed a preference for care at St. Mary's. A number of these individuals displayed a misunderstanding of the transaction. Thus, one commentator voiced a fear that he could no longer receive care at St. Mary's. Another suggested that St. Mary's did not accept Medicaid but relied on its own charitable policy.

transaction.<sup>4</sup> Likewise, Steel objects to the proposed transaction and to the wisdom of the Cooperative Agreement Law as a policy matter.<sup>5</sup>

Cabell vigorously disagrees with Staff's and Steel's antitrust arguments, but this legal disagreement is irrelevant to the Authority's task. The Legislature did not task the Authority with the role of determining whether the transaction would violate the federal antitrust laws. The Authority has an entirely different statutory duty here—to evaluate the proposed transaction under a statutory analysis defined by the Legislature in place of the antitrust laws, and in light of the Legislature's determination that the cooperative agreement regime it established will confer benefits on West Virginia and its citizens. There is no question that the transaction at issue here easily satisfies the standards for approval as a cooperative agreement.

The Authority should therefore approve the proposed cooperative agreement.

Respectfully submitted,



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Of Counsel, Cabell Huntington Hospital, Inc.

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<sup>4</sup> Staff also states that it is “aware that the Applicant has filed a motion for expedited review of its application with the Authority,” and urges the Authority to deny that motion. Staff Submission at 3. In fact, Staff itself filed a joint motion with Cabell and St. Mary's to the Federal Trade Commission in which it expressly agreed that Cabell will request an expedited decision as specifically authorized under W.V. Code § 16-29B-28(e)(5). Given that Staff previously joined a representation in advance of Cabell's motion to expedite *requiring* the filing of that motion, Staff's statement of opposition to that motion now is disingenuous at best.

<sup>5</sup> In a second submission, Steel asks the Authority to hold the comment period in abeyance and identifies categories of information, including the identities of St. Mary's other bidders, that it purportedly needs to fully comment on the Application. But as the Authority is well aware, Steel's entitlement to these materials was litigated in the context of its Petition for Writ of Mandamus filed with the West Virginia Supreme Court of Appeals, as well as before the Authority. *See, e.g.*, CON Decision at 34-37. The Authority's denial in that context applies here with equal force, because it specifically found that “superior alternatives [to the transaction] do not exist.” *Id.* at 35. This finding means that there is no alternative arrangement that is “less restrictive to competition,” the relevant question under the Cooperative Agreement Law. W. Va. Code § 16-29B-28(d)(5)(D). Moreover, in the context of section 28(f)(5)(D), the relevant alternative “arrangements” are only those between the parties to the cooperative agreement, so documents pertaining to bids from other parties are simply irrelevant. In any event, this issue is moot now that the public comment period has expired.

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