Southwest Virginia Health Authority
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May 27, 2016

Ms. Barbara Allen
Chairman of the Board
Mountain States Health Alliance
3300 Browns Mill Road
Johnson City, Tennessee 37604

Mr. Roger Leonard
Chairman of the Board
Wellmont Health System
102 Oakview Circle
Bristol, Tennessee 37620

Dear Barbara and Roger:

Your submission to the Southwest Virginia Health Authority (the "Authority") pursuant to Section 15.2-5384.1 of the Code of Virginia (the "Code") of that certain "*Commonwealth of Virginia Application for a Letter Authorizing Cooperative Agreement*" between Mountain States Health Alliance ("MSHA") and Wellmont Health System ("Wellmont") (collectively MSHA and Wellmont, the "Applicants") (the "Application") on February 16, 2016 has now launched a significant effort by the Authority to determine whether the Application is complete. As you know, following a determination of completeness, the actual review of the Application and the public comment process will begin. To undertake review of the Application, the Authority developed five working groups (Competition, Healthcare Access, Healthcare Cost, Healthcare Quality, and Population Health) to review the materials in the Application with a focus on the review process set forth in Section 15.2-5384.1 of the Code and the Authority's adopted Blueprint Goals. The working groups have met several times and have identified several areas where additional information is needed before considering whether the Application is complete.

I write to request additional information for the Board of Directors of the Authority (the "Board") to assist them in their determination of completeness as required by statute. As you consider the Board's requests, please provide additional information on the existing commitments or any new commitments that the Applicants might make, as a comprehensive recitation of the commitments of the Applicants and an understanding of the proposed Cooperative Agreement which will be required before the Authority deems the Application "complete."

Further, please note that the headings under which the questions appear are not meant to restrict or limit your response to that one subject area perspective. The headings are only indicative of the working group where the question originated. All working groups acknowledge that questions should be addressed from multiple perspectives, such as a question from the quality working group should also be considered from access, competition, cost and population health perspectives.

I have compiled the questions of each group and recognize that some duplication may appear to exist, however, as noted, issues have been raised within the perspective of a working group's charge and the unique context of the question should be considered.

Following the initial series of working group meetings, the following questions have been developed by members of the Board.

ACCESS

1. On page 86 the Application refers to eliminating duplication of services. Please provide a table showing where there is duplication or perceived duplication of services.

2. Will any facilities close or any services cease being provided in existing facilities and locations by the Applicants prior to the adoption of the proposed Cooperative Agreement?

3. Recognizing that there may be considerations for the maintenance of facilities and services, how many acute care hospitals will be maintained in Virginia long-term following the merger? What services will continue to be offered during the entire initial five year period?

4. What services will be available at each nonhospital facility in Virginia during the initial five-year period? How long will the Applicants commit to maintaining these services?

5. We have reviewed the New Health System Alignment Policy, but it strikes us as being short on specific metrics for determining when to close facilities or services. The Applicants have come up with an elaborate scoring system at the end of the Application with points assigned to various criteria. The Alignment Policy lacks that specificity and simply recites factors deemed relevant without any indication of the weighing of such factors. We are not saying that a point system is necessary and some flexibility is

necessary to take into account circumstances and factors that cannot be fully anticipated currently. Notwithstanding the need for some flexibility, we seek greater clarity on relevant criteria and how they will be weighed. We also believe that taking into account federal designation of areas as medically underserved areas or health manpower shortage areas is relevant. What role do the Applicants believe should be given to the Authority in reviewing planned closures? How will the New Health System weigh travel time and lack of access to public transportation in making decisions?

6. What long-term commitment will the Applicants make regarding the Virginia hospitals, specifically, which ones are you committed to maintaining and not repurposing? If the Applicants are unwilling to make a commitment with respect to specific facilities, is there a certain number, including specifics on beds and services?

7. We have reviewed the Applicants' current charity care policies. What will be the charity care policy for the New Health System? What commitments will the New Health System make to the dollar level of charity care (or stated as a percentage of another amount such as net revenue)? Please explain whether the metric is cost or forgone charges. To what extent will the Applicants commit to a charity system wherein qualified patients' entitlement to charity care is decided "up front" so that individuals know they have access and know in advance their financial responsibilities and discounts on services versus charity care being largely provided as a result of write-offs after all attempts at collection have been unsuccessful?

8. With respect to charges for medically necessary services for which patients are personally liable, whether by reason of being uninsured or having coverage that does not extend to such charges, will the Applicants commit to not charging more than the amount that they would have collected from Medicare for such services?

9. The Application mentions that the Applicants intend to have charity clinics. Please provide a more specific description of these clinics including services and areas served. How will the clinics integrate with existing charity care clinics in the region?

10. The Applicants have included in their Geographic Service Area Wythe County in Virginia which is closer to Roanoke than to the Tri-Cities area and the Applicants have also included Hamblen County and Cocke County in Tennessee which are closer to Knoxville. Why were these counties included and what is the market share of the Applicants in each of these counties presently?

11. What will be the New Health System's primary and secondary service areas? (See definitions in the Authority's guidance for applications). How, if at all, do the Applicants expect the New Health System's service area to differ from their description of the Applicants' existing service areas?

12. Looking solely at the primary service area as defined in the guidance for the Virginia application, what is the existing combined market share of the two Applicants for: (1) inpatient hospital services; (2) outpatient clinic services (whether provider-based or not provider-based); (3) outpatient radiology services; and (4) outpatient surgery?

13. What further information can be provided regarding the insurance products and plans that the Applicants anticipate will be available in the New Health System? Are the Applicants planning on forming an ACO? For Medicare? Non-Medicare?

14. What are the current number of licensed healthcare professionals by county and facility in Southwest Virginia employed by the Applicants and what is your projection on what that number will be following the adoption of the Cooperative Agreement?

15. It is noted in the Application that the New Health System will maintain three tertiary hospitals in Tennessee. Can the

Applicants give commitments to Virginia on which Virginia hospitals the Applicants will keep open? What is the likelihood a tertiary hospital will open in Virginia in the next ten years? What factors would make opening such a facility more or less likely?

16. The Application references Dickenson County's facility. What does that reference mean for Dickenson County and this facility continuing operation during the five-year period of the Cooperative Agreement or following it?

17. The Authority requests more information on the Level 1 trauma center, such as, where will this be located and how will the decision to locate the center be made?

18. Please address commitments of the New Health System related to the following:

a. Improving access to Ob-Gyn services in Southwest Virginia, including how the New Health System will specifically address those gaps resulting in an increase in the percent of women in the Authority footprint who receive early and adequate prenatal care to achieve state and national benchmarks;

b. Preserving existing primary care Graduate Medical Education ("GME") programs and positions in Southwest Virginia (programs in Norton, Big Stone Gap and Abingdon specifically). Does the merger anticipate moving around residency programs and positions as the only GME referenced in the application are in Tennessee? What commitments will the New Health System make to training residents in Southwest Virginia at Southwest Virginia facilities?

c. Expanding GME's programs and positions, i.e., residency training programs and positions in specialty care including but not limited to psychiatry;

d. Helicopter transport services, which are critical given the distance to major health centers. How will

Southwest Virginia continue to utilize the free service provided by the Virginia State Police helicopter and staffed currently by Wellmont medical providers? Does New Health System commit to providing financial support of Med Flight? Please describe the plan for integration of Wings, Wellmont One and Med-flight to assure access to all affected areas. Describe the land transport back up plan for occasions when flying for level 1 trauma is not possible.

e. Geriatric care.

f. The provision of a broader range of services for substance use disorder (SUD) treatment in Virginia, including but not limited to intensive outpatient (IOP), inpatient detox, and residential treatment located in Virginia? Please discuss decision-drivers in making determination of location of services, assuring access to transportation of clients to facilities and services as well as access to medications as may be indicated for medication assisted treatment ("MAT"). Please include staffing framework of such facilities by professionals trained in SUD treatment and related mental health co-morbidities.

g. Improving access to medical specialty care in Southwest Virginia, including but not limited to gastroenterology, cardiology, pulmonology, oncology, infectious disease/HIV and hepatitis B and C infection treatment? What is the model or are the decision-drivers in determining when a specialty service is provided by telemedicine or "mobile" provider (visiting from a Tri-Cities hub periodically) or having one or more specialists permanently based in a Southwest Virginia locality?

h. Improving access to recommended screening services by the New Health System? What commitment will the New Health System make to take recommended screening including but not limited to colonoscopy services for colon cancer screening, mammography in

particular in counties with no access to mammography services such as (Lee County and Scott County), lung cancer screening and Pap screening to assure access in at least one location in each jurisdiction in the Virginia geographic service area? What specific prevention metrics for the population of Southwest Virginia Health Authority footprint for these procedures will the New Health System commit to achieve so that rates comparable to or better than state and national goals are attained.

i. In addition to other prevention and intervention metrics the New Health System may commit to, what specific metrics and timetable to achievement is the New Health System willing to commit to achieve a reduction of tobacco use in Southwest Virginia to national goals, a reduction in Southwest Virginia obesity rates, an increase in Southwest Virginia physical activity rates and a reduction in Southwest Virginia drug poisoning deaths and NAS.

19. Are any of these facilities Critical Access Hospitals? How does Medicare payment for hospital outpatient services, including clinic services, compare to Medicare payment for nonhospital clinic services under the physician fee schedule? To the extent that Medicare payment is greater for hospital outpatient sites, at least for now, do the additional costs of maintaining a site as a hospital exceed the benefits of receiving Medicare payment as a hospital? Do any of these sites qualify for 340B drug discounts, and if so, same question.

QUALITY

The New Health System created by the combination of MSHA and Wellmont proposes to merge several hospitals over a two state region, essentially creating a "monopoly" for acute hospital care services across the region. For this reason, the Authority believes it is important to accurately address access to quality healthcare and whether the New Health System will lead to an improved quality of care that can be easily accessed by the citizens of Southwest Virginia. The following questions center around how quality of care will be impacted and the measurements used to track and assure quality improvement.

The Application states the Applicants' goals in pursuing the merger are to reduce cost growth, improve the quality of the healthcare services, and access to care, including patient experience of care and to enhance overall community health in the region. The Health Care Quality Working Group questions will focus on access to quality of healthcare services; the assurance of improvement in the quality of healthcare services; and plans to improve the patient experience and community health.

The Health Care Quality Working Group of the Authority asks the following:

20. In the most recent (Spring 2016) version of the Leapfrog safety scorecard, no hospitals in either Applicant system scored an "A" in patient safety metrics and several received "C" grades. Please provide specific details of how the New Health System proposes to improve these current measures and to assure consistent quality and safety performance of not only the system but each hospital and facility. Please include how the "A" level patient safety criteria measurements will be put in place, how they will be tracked, and how often the performance will be reported to the State. Will these be used by the New Health System to determine if the merger has resulted in quality and safety improvement and will the New Health System and the Commonwealth use these as separation criteria if no (or insufficient) improvement is made or there is a decrease in patient safety and quality outcomes.

a. Poor communication is an example of one metric to be addressed where the systems are performing poorly. Using this as an example, please provide an example of how the New Health System would address this issue benefiting from a "system-wide" approach and how the improvements of this and the other safety metrics in the Leapfrog safety scorecard and how and where these would be reported.

b. A 50% improvement system-wide in the measures is listed as the goal, however this may not be an acceptable improvement in some areas. How will the New Health System set individual goals for quality improvement in each area, as many must be individually addressed?

c. The Application states that the New Health System will utilize a rigorous systematic method for evaluating the merits and adverse effects related to quality, access, and service for patients. What additional quality measures will the New Health System use for the rigorous evaluation and reporting to the state? (These would be beyond those currently required for reporting by Medicaid and Medicare and currently used). Such as Triple Aim? Please specify those quality measures that will be utilized to measure success.

21. The Application stresses the importance of an independent medical practice community to the competitive environment in the region. The trend nationally is for increased employment of physicians by hospitals. The value-based payment world of bundled payments, ACOs, etc., integrated systems are focused and require full cooperation to be efficient.

a. How will the New Health System operate as an integrated system utilizing both employed physicians and maintain some predominately non-employed physicians for their ACO and are there other models that exist that have shown this model succeeds?

b. What percent of the physicians of the system are independent practice physicians working in out-patient only practice settings (physicians who do not serve in attending roles for patients who are admitted to acute care facilities or are not employed by the New Health System)? How will quality measures be addressed with these referring independent physicians?

c. How are these independent physicians integrated into the decision making process regarding quality of care?

22. The New Health System suggests that improved clinical information through a common IT platform will lead to higher quality and lower cost delivery of care. The majority of the quality improvement in the document is based on a uniform

technology platform across the New Health System. The following questions remain:

a. What is the projected (reasonable) timetable for implementation of the new IT platform across the system?

b. What will the new common IT platform offer in tracking outcomes greater than the current platforms being used by each system?

c. How will ambulatory practice platforms within the system and independent practices be included in tracking quality outcomes? The application commits to the clinical services network with independent physician groups to share best practices and efforts and to improve outcomes. If the common IT platform does not extend to these groups, how will the outcomes be tracked?

d. As the hospital proposes to work with independent physician's groups, what access will these groups have to the new IT platform and to what extent (under Stark laws) will the New Health System be able to assist independent physician groups in gaining the appropriate equipment for access?

e. As physician communication through medical records is not performing well as a part of the "leap-frog" system how will these criteria be measured in the new common platform? Will they be included in both employed and non-employed practices participating in the system?

f. What outcomes and what measures of improvement are to be reported to the state?

g. The report commits to CMS core measures and benchmarking against CMS data. What other quality measures will be tracked on the IT platform to demonstrate quality and improved quality?

h. If the IT system demonstrates an increase in poor outcomes such as length of stay, mortality rate, readmission, C-sections, infection rates, etc. due to consolidation of services within the New Health System, what is the commitment to and process for unwinding consolidated services or to increase service in the rural area? How will the system address unintended negative consequences to quality as a result of the merger?

23. The Applicants propose common credentialing standards at all hospitals located on page 38 of the Application. The proposal is for new repurposed facilities. Please discuss the following questions:

a. How will physicians on staff of each hospital be involved in determining standards for credentialing and privileges?

b. How will the processes for credentialing differ between rural hospitals and larger facilities including tertiary care?

c. Will independent as well as employed physicians be involved in determining standards in each facility?

d. Will the new credentialing practices differ from current practice?

e. What process will be used for determining credentialing standards for the ambulatory and non-hospital based practices within the health systems? For employed and independent practices?

f. How will the New Health System address the maintenance of separate and independent medical staff functions at each hospital and barriers to the introduction of new initiatives to improve quality?

24. The Application focuses on mostly hospital quality measures which all hospitals are required to track. The New Health System will include additional services, especially in those facilities that

are being repurposed. Who and how will the New Health System determine the quality measures for such areas as nursing facilities, home health, and system owned physician practices? What are some of the models proposed?

25. Quality and Access cannot be separated when in the rural setting. The current application provides assurance for maintaining only the tertiary care hospitals in Tennessee. The remaining facilities, all Virginia hospitals, are open within the next 5 years for "re-purposing" according to the Application. For the purpose of assuring quality, the task force believes the following questions must be answered prior to consideration:

a. Will the majority of rural hospitals with acute care beds that currently have an average census of greater than 30 be maintained as hospitals with acute care beds?

b. In repurposing facilities what is the acceptable distance or usual travel time between acute care hospitals for a hospital to be maintained and not repurposed?

c. Will the rural hospitals with a census of less than 30 beds be repurposed to critical access hospitals or only rehabilitation facilities?

d. How will the communities be involved in determining which services are to be maintained? Will there be a community needs assessment on current services and what the community identifies as essential services? Will the citizens of the community be a part of the comprehensive needs assessment performed for each community served?

e. While the outcomes of some services are of higher quality in larger tertiary care centers (i.e.: trauma), certain services must be maintained for the purpose of patient satisfaction, for patient stabilization, and for quality of care. Specifically, as only the 3 tertiary hospitals are listed to be maintained in Tennessee, how many hospitals will be maintained in Virginia that offer acute care hospital beds beyond critical access?

i. How many emergency rooms will be maintained for stabilization of trauma patients and emergency patients (ie: evaluation for chest pain, shortness of breath, etc.)?

ii. Will cancer care be offered in Virginia?

ii. Will the current level (or improved) of cardiac care be maintained in Virginia?

iii. Will obstetrics and prenatal care be offered in the same facilities in Virginia?

iv. Are there any hospitals who currently have an average greater than 50 inpatients for their census that will be maintained as an acute care hospital with acute care beds).

26. Under the commitments to maintain and build quality healthcare in the system is the commitment by the New Health System to combine the best of both organizations career development programs in order to ensure maximum opportunity for career enhancement and training.

Specifically, the Application states that the hallmark initiative enabled by the "merger is that of an enhanced academic medical center" aligned to bring health care benefits to the community.

The interpretation of the statement could be read as "one academic health center" which is system wide or to moving all residency positions within the tertiary health systems, or sponsored by one facility. While the new Health System states there has been a reduction in graduate medical education positions, there has been a growth of positions in Virginia. Therefore, the following questions must be answered to inform the state of the plans for the current residencies in Virginia. (Note: Virginia has passed recent legislation for the Commonwealth to fund residency positions due to the lack of graduate medical education in Virginia.) Recognizing the current programs are an important vehicle recently established to maintain and improve upon quality healthcare in a rural region:

a. Will the new residency programs and residency positions currently at the Johnson Memorial Hospital be maintained in Virginia?

b. Will the family medicine residency program and positions in the Lonesome Pine hospital be maintained or repurposed as a rural track residency?

c. Will the residency program and positions in the Norton Community Hospital be maintained?

d. If any of the above residency programs will not be maintained, will the residency positions be kept in Virginia where there is a shortage of residency positions as compared to graduates.

e. How much of the $85 million dollars is committed to increase residency, add faculty, and to sustain research in Virginia?

27. The application outlines the provision of "Enhanced Behavioral Health and Substance Abuse Services". Reflecting a continuum of care as outlined, for example, in *ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions (2013)*, which services on the continuum will be added or enhanced and where will the enhanced services be offered in Virginia?

28. The application's process for improved quality relies on new Clinical Pathways developed (over 70 stated in the presentation). Will these outcomes be tracked and reported as a measurement of improvement of quality of the merger? Will these be utilized in determining if removal of duplicated services will in fact lead to not only cost efficiency but improved outcomes?

29. The application states the New Health System will establish annual priorities in quality improvement. What is the process to determine these annual priorities for quality measures?

30. The application refers to AHRQ guidelines, how and what AHRQ measures will be utilized to measure quality?

COST TO PROVIDERS, COSTS TO PAYERS, EMPLOYERS AND PATIENTS, REVENUE ASSUMPTIONS, AND THE ECONOMICS OF THE MERGER

31. Please provide an additional set of financial projections based on the consequences of either Virginia or Tennessee or both agreeing to expand Medicaid as permitted under the ACA.

32. The Authority needs *much more* detailed information for the assumptions underlying the projected financial data post-merger, including without limitation assumptions and conclusions based on other mergers. The spreadsheets of performance before and after the merger provided in Exhibit 9.1 predict improvements but provide virtually no information on the assumptions behind the numbers presented. The Authority needs to understand the basis for the projections in detail. Among the information sought, is information on severity adjusted cost per discharge, labor cost per discharge and other metrics that can support the projections provided. If any of the Applicant hospitals have been penalized by Medicare quality standards regarding readmissions, etc., please indicate how those issues will be specifically addressed.

33. The preliminary efficiencies financial projections include the projected savings from the synergies provided by the merger in addition to the substantial investments to be made by the merging entities. The investments in long-term assets are shown in the projected amounts for PP&E. Where are the investments that are committed to be made in additional personnel to provide new and expanded medical care shown in the projected financial statements? To the extent they are shown in the income statement under salaries, wages and benefits, does the amount shown include both the benefits from synergies and the additional amounts spent for investments in expanded services? Please explain.

34. What process, if any, do the Applicants propose for reporting to the Authority and the involved states how actual budgets depart from the projected financial information, as well as for reporting actual performance in comparison to budget? What

role do the Applicants anticipate the Authority and the states having in reviewing budgets?

35. Given the 19.3 miles separating Bristol Regional Medical Center in Bristol and Wellmont Holston Valley Medical Center in Kingsport and usual travel time of 27 minutes between the two, will creating two pediatric specialty centers be inefficient? Describe the current situation regarding children receiving specialty services?

36. On page 36 of the Application it states that "these practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. This approach to value-based purchasing will truly harness the intent of the changes in federal policy that encourage improved population health." What does this mean?

37. What would be the role of Virginia, Tennessee or the Authority have in any mediation of payer contract negotiations? What assurances can the Applicants offer that such mediation would be concluded timely?

38. There are some predicted savings for payors and patients from reducing admissions and readmissions. This will help the community, patients and payers, but will hurt the hospitals. To what extent, if any, was this reflected in the FTI projected revenue for "out" years?

39. What health care insurance plans and health care insurance products does the New Health System plan to attempt to provide? What specifically will the New Health System do to ensure that the plans and products provided offer a wide range of options to consumers of health care in Virginia costs that see no greater increase than are characteristic of the US market?

COMPETITION

40. As a general public policy in the United States, duplication is a price that we are willing to pay for increased competition. What is unique or unusual about the service area to make operation under state supervision better here than elsewhere? How do the Applicants distinguish this market from any other where consolidation could presumably reduce duplication and result in economies of scale? Is there any data showing the "optimal" size of a health system for purposes of achieving cost efficiency with the least overhead per unit of service? Can that optimal size be realized in larger or more concentrated markets and not here? The Applicants claim that the Southwest Virginia and Northeast Tennessee region is a unique geographic region that requires a unique solution. The solution proposed is one of less competition and increased governmental oversight. Explain why this is the preferred option and provide examples of how such an approach has been successful in other areas.

41. The Applicants claim that the proposed merger will not result in any adverse impact on population health, quality, access, availability or cost to patients or payers. In light of the dramatic reduction in competition within the region, what mechanisms are in place to substantiate these claims? To the extent that the response refers to commitments in the Application (or any additional commitments offered by the Applicants), explain how those commitments mitigate or more than balance the adverse impact from reduced competition.

42. How will the merger impact the private providers?

43. Do the Applicants have any plans to increase materially the percentage of physicians in the community who are employed or affiliated with the New Health System?

44. Do the market share numbers in the Application reflect all discharges for patients living in the area, even if from a hospital outside the area, or just discharges for patients at area hospitals?

45. Which ASC's in the area are single specialty or otherwise limited in the type of surgical services furnished?

46. Notwithstanding outpatient competition, will it not be necessary for a health plan to have the New Health System as a contracting provider? Will that not give the New Health System leverage for outpatient rates? Will the Applicants commit to be willing to contract for inpatient and emergency outpatient hospital services only?

47. What is the share of hospital services furnished by any other hospital (not an applicant) in the primary service area and the secondary service area of the proposed New Health System? What is the share of physician and attending care furnished by independent physician practitioners, not employed by either applicant or affiliated systems, in the primary service area and the secondary service area?

48. Please provide a more thorough description of the competitive environment for the New Health System in the proposed service areas, including:

a. Identification of all services and products likely to be affected, either positively or negatively, by the Cooperative Agreement and the locations of the affected services and products;

b. The Applicants' estimate of their current market shares for services and products and the projected market shares if the Cooperative Agreement is approved; and,

c. A statement of how competition among health care providers or health facilities will be reduced for the services and products included in the Cooperative Agreement.

49. For payer contracts without competition in inpatient service, where would Southwest Virginia patient's access inpatient services if agreements are not made with insurers?

50. What will the impact of the proposed merger be on the independent physician community in Virginia? What commitments will the Applicants make to independent physicians in Virginia?

LABOR FORCE

51. Please provide more detail on the current staffing and the staffing opportunities in Virginia that the Applicants foresee if the Cooperative Agreement is adopted and if the Cooperative Agreement is not adopted?

52. The spreadsheets in Exhibit 9.1 show a reduction of personnel expenses in year one. The text indicates that attrition and other factors will be important drivers for those reductions. Please provide more detail on employee history of voluntary departures and new hires for the two separate systems that would be relevant to the New Health System. Please list opportunities that you have considered in investments for the region that would provide new employment opportunities beyond the direct care services of the New Health System.

53. The projected budget for the New Health System shows $40 million less in labor cost at the end of the 5 year period compared to the existing status projected forward. How many jobs does that represent? How many of those jobs will be at Virginia sites? What steps do the Applicants propose to take to mitigate the effect of job loss on the persons involved and the families and communities affected? We note that one of the problems with the market is low-income and poverty, and the conditions often associated with poverty including, for example, drug abuse. While reducing aggregate jobs may be necessary to achieve savings, it can work at cross purposes to the objectives of the proposed merger which is why we seek your explanation and commitments on how you will mitigate the effects of job loss.

54. To what extent do the Applicants see new jobs being created in Virginia through the committed "investments?" Please be specific.

55. How will decisions be made about the Virginia workforce following the merger? How will decisions be made about the Virginia workforce if the Cooperative Agreement is not approved? This question is not just who will make the decision but what criteria the decision-makers will use.

COMMITMENTS AND METRICS FOR MEASURING SUCCESS

56. A number of commitments provide for reports. Reports will show monitoring by the states but how does reporting show active supervision? As just one example, there could be an "investment" (whatever that means) that reasonable persons could disagree on whether it was for "community health." Or the investment may be for a service or facility that is not viewed by the states as being a very efficient way to get to the goal of community health. More generally, the Authority does not believe that "reporting," by itself, is a sufficient commitment. For all commitments for which there is "reporting," please advise what the Applicants think should occur if the Authority or Commonwealth do not believe that the substance of what is reported is satisfactory?

57. The focus of a number of accountability measures is on inputs and not on outcomes or impact. The Authority is much more interested in having specific outcomes as targets against which performance is measured (just as outcomes in patient care are now the focus rather than the costs and inputs). As just one example, moving where local counties rank in drug abuse compared to the state and the nation would be an objective outcome measure.

58. Will there be a greater commitment than that of achieving 50% of a proposed metric toward a goal? How will achievement be counted across the geographic service area, primary service area, secondary service area, county by county and Tennessee versus Virginia? In the aggregate?

59. What commitments are the Applicants willing to make to give representation to one or more appointees from the Authority on the New Health System's Board?

60. The Authority notes that the Application has a five-year limit to make sure those duties laid out in the Application are put into action; what will happen following the five-year period? What commitment will the Applicants make to the Authority following the five-year period, for example in years six to ten?

OTHER

61. The economy of the catchment area of the New Health System is not strong. There are many studies that link poverty to poor health. The Applicants have made a commitment to improving the health status of the region. Please be more specific about how that commitment will be translated into the reduction of poverty in the community and therefore improvement in health maintenance and prevention.

62. Will the New Health System be a closed system?

63. What is meant by "investment"? Are investments capital expenditures, start-up expenses of the type that would be amortized, covering operating losses, or simply operating expenses of the new activities? However, defined, using the same definition, how does that compare to present levels of "investment"?

64. What do Medicaid managed care plans think of the proposed transaction?

65. What is the plan to add residency slots in light of the CMS GME caps? Will GME programs be instituted at hospitals which presently do not have such programs? Are you confident that you will be able to obtain Medicare GME funding? How many residents and in which specialties are you considering, overall and in Virginia?

66. If the proposed new services are expected to be profitable, then would not investment be called for now if capital were available? Is capital available--and if the answer is "no," what is the basis for that answer, i.e., advice from investment bankers, debt ratios, or another explanation? If proposed services are not expected to be profitable, that may indicate that there is insufficient demand,

although there could be many other reasons for a lack of profitability. Explain why contemplated non-profitable services, if any, would be added, e.g., meet needs for charity care, improve the community's health status, etc.

67. There are examples of education programs such as nonprofit charter schools housed in health facilities that have improved the academic performance and therefore the opportunity for improved job opportunities for disadvantaged children. You will presumably be redeploying some of the existing infrastructure of the New Health System. Please comment on whether the potential use of those facilities for community needs is being considered? Specifically would you provide comments on any possible plans for early childhood as well as K-8 or K-12 program intervention in the communities you serve?

68. When closing rural hospitals there is often a loss of rural healthcare workers including physicians, nurses, and others whose employment or level of income is dependent upon the presence of an acute care facility. How will the New Health System evaluate the potential loss of health care workers from the repurposing of hospitals and what measures will be made to assure a physician workforce for that rural region without the presence of an acute care facility? Will the community be actively involved in making this decision including local, county, and city administration?

As the working groups continue their work, additional questions may arise. Please contact

the Authority with a proposed timeline for addressing these issues, as meetings of many of the working groups are on hold until they receive the information. Please contact me if you need any clarifications on any of the questions listed above.

Sincerely,

SOUTHWEST VIRGINIA HEALTH AUTHORITY

Terry G. Kilgore

The Honorable Terry G. Kilgore, Chairman

cc: Board of Directors, Southwest Virginia Health Authority
Dr. Marissa Levine, Commissioner of Health Virginia Department of Health
Mr. Bart Hove
Mr. Alan Levine
Tim Belisle, Esq.
Richard G. Cowart, Esq.
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