July 13, 2016

Southwest Virginia Health Authority
c/o The Honorable Terry G. Kilgore, Chairman
851 French Moore Jr. Boulevard, Suite 178
Abingdon, VA 24210

Dear Authority Members:

We are pleased to respond to your May 27th, 2016 letter on behalf of the Board Chairs and Boards of Directors of Mountain States Health Alliance and Wellmont Health System. Please find attached the additional information you requested, which we hope will assist you in the process of deeming complete our application for a Cooperative Agreement. We believe the benefits of the proposed cooperative agreement are substantial, and given the increasingly difficult environment rural hospitals are operating in, we believe there is an urgency to completing this process.

We point to an article this week published in *Governing* Magazine[1], which asked the very question, "with hospitals in critical condition, can rural America survive?" The article states that rural hospitals "*are very much an endangered species. Nearly 30 percent of the nation's 2,000 or so rural hospitals are likely to close in the next two years. Rural hospitals have faced closure crises before, particularly in the late 1980s. This time around, however, the threats run deeper and are more challenging. While some states are taking steps to save hospitals operating in rural areas, there are growing barriers to the financial sustainability of these institutions. The decline and possible fall of rural hospitals mirror an existential question: Can rural areas themselves survive?*" The article goes on to highlight that more than 1/3 of rural hospitals were operating in a deficit in 2013, the last year the full data is available. This data along with Sheps Center data that 76 rural hospitals have closed since 2010 is compelling.

Despite several hundred millions of dollars of capital investment in Southwest Virginia, more than 1/3 of the rural hospitals operated by Wellmont and Mountain States in Southwest Virginia have operating losses, and as further detailed in this letter, those losses are supported by other hospitals within each of our systems that are increasingly unlikely to be able to continue to do so in the status quo environment. While we would certainly welcome financial support from the state, we believe we have proposed an innovative solution that permits our own region to sustain access to health care in these communities. In fact, *the only plan which guarantees continued access is the proposal we have made.* Given the ongoing losses, and expected continued increasing challenges, we believe time is of the essence.

As members of the Authority, and residents of Southwest Virginia and Northeast Tennessee, we share the Authority's vision "to achieve continuous improvement in the health and prosperity of the region". As we revel in Southwest Virginia's rich natural resources and traditions, home to generations of families who connect their roots back to pioneer days and celebrate the area's heritage in country music, farming, and coal mining, we also believe there is an alternative to the future painted by the *Governing* article. To the degree our health care economy contributes to the well-being of our communities, we believe this part of our future is in our hands if we choose for it to be.
While there is much to celebrate about our heritage and our culture, we also understand with the Authority that we stand at a crossroads. As the area's traditional major industries are suffering, losses

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[1] Mattie Quinn, *Governing States and Localities,* July 2016.

of well-paying jobs are escalating. The population is aging and population growth decreases further as more of the region's young people seek new opportunities elsewhere. In fact, in some Southwest Virginia communities, the population has declined as much as 9 percent in the last five years. This negative demographic trend has led to despair in some communities, leading to rates of substance abuse and opioid induced deaths among the highest in the nation. Poor health habits which have persisted for generations have led to higher rates of diabetes, cardiovascular disease, and cancer and are stubbornly resistant to change.

Health care in general, and especially rural health care in America, is also at a crossroads. Previous federal policies and economic prosperity led to the construction and operation of hundreds of small rural hospitals across the United States, including those in Southwest Virginia. Hospitalization in the past was the default medical option of the day, and the region benefited not only from more hospital beds, but also the competition between Wellmont and Mountain States to control these resources and the revenue they generated from inpatient and surgical referrals.

The competition for bricks and mortar and the human resources associated with them were deemed essential to create spokes for the tertiary hubs that are at the center of each health system. But this era of acquisition and new construction resulted in a business model and duplicated capacity ineffectively aligned with recent and accelerating changes in reimbursement policies, along with the accumulation of significant levels of debt by both health systems. Our heavily-bedded infrastructure, largely established during stronger economic times where hospitals received reimbursements well in excess of their costs, now creates harsh realities.

The reality is simple. Robust competition has led to overcapacity, higher debt, and as you evidence in your letter, several indicators that the competition and cost resulting from it did not result in better quality.

What has happened to change this landscape from one where our systems preferred the competitive model to one where we believe the only option is a collaborative one? After 2008, when the federal government began to finally face the harsh fact that the cost of American health care was spiraling out of control, reimbursements began a fast pace of reduction further fueled by the nation's own budget crisis. The Affordable Care Act created a trade-off of payment cuts in exchange for expanded coverage. *Our region only got the cuts*. And these cuts were applied to payment rates which federal policy dictates are the third lowest payment rates in the United States among the hundreds of regions as identified by the federal government.

Businesses also began to grapple with the implications of the Affordable Care Act and started enacting high deductible plans to stave off dramatic cost increases. Hospitals could no longer rely on commercial payers to offset the losses from Medicare and Medicaid. All payers began implementing value-based purchasing models placing payment at risk – a payment model which incentivizes physicians to reduce cost and reduce the use of hospitals. This began a reversal of the payment model for hospitals which had previously incentivized payments based on procedure volumes in expensive buildings full of expensive equipment.

The changing reimbursement landscape has led to several consequences for hospitals:

- Hospital admissions have fallen nationally as outpatient services and medical/pharmaceutical treatments replace the need for hospitalization,
- Physicians are increasingly using "observation" status rather than admitting patients to hospitals. With this status, the patient remains in the hospital, often receiving the same treatment they would receive if they were admitted as inpatients, but the payment is significantly lower notwithstanding the fact the costs remain the same for the hospital, and
- Physicians are more assertively trying to keep patients from being admitted to the hospital, in large part because federal policy and commercial insurance companies are incentivizing them to do so.

Admission rates in our region generally range from 127 admissions per 1,000 population to 150 admissions per 1,000 population. Nationally, the range is closer to 90 admissions per 1,000 population to 110 admissions per 1,000 population. Recent trends indicate that our region's use rates are falling, and will continue to fall to more mirror the national trends. As high managed care penetration and risk based arrangements for physicians began more than a decade ago in suburban and urban areas of the nation, these models, combined with the new government payment policies, are now emerging in rural and non-urban areas. We estimate, based on these models, that admissions in our region will decline by somewhere between 14,000 admissions and 30,000 admissions. Plainly, this represents hundreds of millions of dollars of lost revenue to the hospitals, and an indisputable mortal challenge to each system's ability to sustain operations in the same manner the region has become accustomed to.

As we have highlighted, population stagnation is a significant headwind for our region's hospitals. And it is not projected to improve. Looking specifically at the pediatric population of the entire region, for instance, it is clear the counties in our service area in Southwest Virginia and Upper East Tennessee face a crisis. In the last five years, the population of children ages 0-17 in Southwest Virginia has declined in almost every county by a rate ranging from 3.4 percent to as much as 17 percent. In the counties representing Upper East Tennessee, the pediatric population has declined by rates ranging from 1.5 percent to as much as 8 percent. Throughout the service area, the pediatric population has declined by an average 5.3 percent over the past 5 years and is projected to decline by 3.3 percent over the next 5 years. This decline in pediatric population, when combined with the 10 percent decline in pediatric inpatient use rates, creates a serious challenge which is not helped by fragmented efforts of two separate systems. We believe the best chance for providing an organized delivery system for children which has a chance to sustain itself will depend upon the combined efforts of both health systems achieving operating synergy and making the proper targeted investments.

The New Health System has set forth significant commitments to expanded children's resources in our region. These new specialty resources and new access points are needed regardless of this population decline. But, supporting these resources is not possible in a status quo environment where the two health systems are unable to effectively align resources and manage pediatric needs in a fully collaborative model. Without the merger, challenges such as the declining pediatric population further jeopardize the region's ability to develop and sustain these highly specialized, expensive, but needed, services.

In other, more urban and suburban markets, hospital systems have been buffered from admissions (and revenue) decline because their populations continue to experience considerable growth. There has been no population growth in our region in the last five years, and as stated previously, most of the Southwest Virginia counties our mutual hospitals operate in had population declines during this time period, with the decline being as high as 9 percent. The projection for growth in our region is a mere 1% in the next five years, and remains negative in a number of Southwest Virginia counties. In addition to the population stagnation we are experiencing, the federal policy leading to the unfair Area Wage Index methodology used to help determine local Medicare rates results in our region experiencing the 3rd lowest payment rates in the nation. Our region has seen annual declines in our Wage Index adjustment for over a decade while California, Massachusetts and other high cost areas continue to see theirs climb. Combine these factors with the fact that we continue to experience high rates of uninsured individuals and increasing bad debt as patients cannot afford to pay their increasingly high deductibles, and it is clear Southwest Virginia's hospitals are at a national disadvantage.

Even as those regions have higher payment rates and population growth, their hospital systems are also consolidating. In the last month, the California Attorney General entered into a consent agreement permitting a merger creating the 3rd largest non-profit health system in America. The only two hospital systems in Huntington, West Virginia were last week approved by their state to merge interestingly using as a model the same statute Virginia passed one year earlier which would permit the merger we have proposed. In Illinois, the courts ruled in favor of a merger of hospitals there, and in Pennsylvania, the court ruled in favor of a merger there. In each of these cases, which have occurred in the last two months, the hospital systems made commitments similar to the commitments our proposal makes with respect to the elimination of competition, but *none of these other mergers comes close to making the commitments we are making in terms of investment back into our region*. In the Hershey, Pennsylvania case, the court said that the federal government has "created a climate that virtually compels institutions to seek alliances such as the hospitals intended here." We agree with the court's statement, and believe it applies directly in this case.

In reality, rural Southwest Virginia hospitals have been struggling for some time. This was never clearer than when Lee Regional Medical Center closed in 2013—among 76 rural hospital closures across the country in recent years. Today, the rural hospitals operated by the two health systems have operating losses of at least $19.5 million annually (not including capital investment) and must be subsidized to stay open, and $11 million of this is directly related to the Southwest Virginia facilities. These losses are expected to increase. The competitive model existing to date in the region has resulted in seven hospitals operated by Mountain States and Wellmont operating over eleven Southwest Virginia counties with an average daily census of only 173—an average occupancy of 33% percent and about the typical census of a single hospital. So, the same census that would normally occur in one hospital is divided among our 7 hospitals, each with substantial fixed cost to support the low volumes. As low volumes become lower, the fixed administrative cost of sustaining the two systems independently will increase as a percent of the total cost of the systems, since the administrative cost is duplicative and fixed.

The pressures identified in this letter do not only apply to the Virginia hospitals. They also apply to the Tennessee hospitals operated by Mountain States and Wellmont. And while, historically, the larger tertiary hospitals in Tennessee have helped offset these losses, and have helped subsidize the capital funding of the Virginia hospitals, these pressures increasingly challenge each system's ability to continue this model. Independently, both Wellmont and Mountain States have come to the long-studied conclusion that it is not possible to thrive in the status quo environment. In this specific market, competition for market share between the two systems has focused system resources on duplicating revenue-producing services and has not generated funds sufficient to supply the needed sub-specialty services, mental health services, or substance abuse services. It has certainly not produced investments in population health management or community health improvement, which are desperately needed based on the health status of the population. Under the growing pressures outlined above, it will only get worse.

Though both organizations are currently financially stable, remaining independent or seeking to sustain the current levels of competition, would jeopardize rural facilities, rural access, and risk substantial job loss. In the best interests of the region, the options before the two health systems are to merge/be acquired by systems from outside the market or to set aside years of status-quo producing competition and merge with one another.

After significant deliberation, the boards of the two health systems determined the best solution for our unique challenges is the innovative solution of a local merger. Our analysis concludes any out of market system seeking to acquire Wellmont or Mountain States would seek to gain efficiency by reducing unprofitable services without the promise of reinvestment in community health, academics and research, specialized services, or mental health and substance abuse initiatives.

To be clear, any system acquiring Wellmont or Mountain States will likely do three things:

- They will seek to leverage the relative size of their system to seek higher pricing from payers. At least one study has shown this type of merger "allowed hospitals to increase average prices by around 17 percent, with some specifications suggesting even larger increases."[2]
- In an effort to seek synergies for their system, they will likely eliminate local corporate and administrative jobs, which we believe will result in a loss of 600-1,000 high wage jobs in our region.
- They will close unprofitable services and facilities, which is standard procedure for an out of region system seeking to mitigate losses.

In the alternative model where an out of market acquisition occurs, there will be millions of dollars of annual synergies through the deployment of these three strategies, and all the synergies will inure to the benefit of the balance sheet of the system which acquires Wellmont and/or Mountain States.

Conversely, while there will, indeed, be synergies between Mountain States and Wellmont, most of which occur in Tennessee, the benefit of the synergies results in the dollars being reinvested as

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[2] Lewis and Pflum, October 26, 2015, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*

described in the Application. Because of those commitments alone, pricing will increase more if our proposed merger is not approved.

Fortunately, the Southwest Virginia legislative delegation worked to establish the Cooperative Agreement mechanism to allow the two health systems to create an innovative model of regional health care and community health improvement with any potential negative consequences of reduced competition under active supervision from the Commonwealth. The model the delegation created was so effective, the Legislature in West Virginia used it as a model, passed it and applied it to what is now approved by West Virginia as the most recent merger of two local health systems. Additionally, we will add that we are not aware of any case where state or federal agencies have brought legal action against a hospital system operating under a cooperative agreement for increasing pricing unreasonably or taking any anti-competitive action harmful to consumers. In fact, in the case of Mission Health in Asheville, which operated under a similar agreement for 20 years, pricing was lower than its peers in North Carolina. Mission has been named a top 100 hospital in America for 7 consecutive years, and a top 15 health system for 3 consecutive years. In an interesting development, the Department of Justice recently filed a lawsuit alleging anti-competitive behavior, but not against Mission. Instead, they alleged Carolinas Health System behaved anti-competitively by using steering provisions in its contracts with every major payer. While we don't know if Carolinas did what was alleged, we do know that the alleged behavior would be prohibited by a Cooperative Agreement. We also know that no such allegation, or any allegation by the government, was ever made against Mission, a system with significantly higher market concentration than Carolinas, but which operated under a regulated COPA.

Because of all the challenges mentioned, it is difficult to envision an effective business model for the health care system in Southwest Virginia either under the status quo of competition or with the risks presented by an out-of-market merger or acquisition. The New Health System, however, envisions a business model that truly lives up to its not-for-profit tax status by delivering community benefit defined in an enforceable Cooperative Agreement under active supervision by the Commonwealth. The New Health System has committed to measurable price reductions, discrete dollar investments in new services and standards of conduct to not disadvantage payers or other providers in the region. And unlike the relatively weak link between community health needs and community benefit spending that is now required under IRS rules, the New Health System is committed under the terms of the Cooperative Agreement to working collaboratively with the Commonwealth, the Authority and local stakeholders to invest more than twice the current level of community benefit spending on mutually agreed upon community health improvement goals.

We believe that the enclosed answers will help to further illustrate our commitment to this effort. Thank you for the Authority's continued time and attention to our application which we believe is truly an important step forward for the health and prosperity of Southwest Virginia.

Sincerely,

Alan Levine, President and CEO
Mountain States Health Alliance

Bart Hove, President and CEO
Wellmont Health System

# RESPONSES TO QUESTIONS

# SUBMITTED MAY 27, 2016

# BY

# SOUTHWEST VIRGINIA HEALTH AUTHORITY

# IN CONNECTION WITH

# APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1
and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

| | |
|---|---|
| Submitted by: | Mountain States Health Alliance<br>Wellmont Health System |
| Date: | July 13, 2016 |

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## APPLICANTS AND DEFINITIONS

The responses ("Responses") in this document are submitted by the applicants listed below ("Applicants") in answer to questions ("Questions") received by letter dated May 27, 2016 from the Southwest Virginia Health Authority ("Authority"). The Questions request additional information in connection with the Authority's review of the Application for a Letter Authorizing Cooperative Agreement (the "Application"), which was submitted by the Applicants to the Authority on February 16, 2016 pursuant to Section 15.2-5384.1 of the Code of Virginia.

Applicants:

**Mountain States Health Alliance**
Address of Principal Business Office
Alan Levine, President & CEO
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

**Wellmont Health System**
Address of Principal Business Office
Bart Hove, President & CEO
1905 American Way
Kingsport, Tennessee 37660

Throughout the Responses, Mountain States Health Alliance is referred to as "Mountain States," and Wellmont Health System is referred to as "Wellmont." Mountain States and Wellmont are also referred to individually as a "Party" or "Applicant" and collectively as the "Parties" or "Applicants." Capitalized terms used in the Responses and not otherwise defined shall have the meanings given to them in the Application.

## 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.**

**RESPONSE:** As demonstrated in **Exhibit 1A** to these Responses,[1] there is limited duplication or overlap of the Applicants' services in the Virginia portion of the Geographic Service Area, which is due in large part to the fact that several of the Applicants' hospitals in Virginia are very small hospitals with limited sets of inpatient services. The material duplication exists primarily in Wise County where the Parties collectively have three hospitals. The Southwest Virginia region will retain competition from hospitals not associated with the New Health System.

Thus, while the Applicants have committed to keep all hospitals open as clinical and health care facilities for at least five years, Wise County is the one area in Virginia that is most likely to see services aligned across the three existing facilities in that county. The Applicants believe that service alignment in Wise County is likely to inure to the community benefit by using current capacity and locations to provide other health care services needed by its residents. There are also factors outside of the Applicants' control that affect Southwest Virginia and drive the need for service changes there, including in Wise County. The communities and hospitals throughout Southwest Virginia have generally experienced declining population, declining inpatient admissions, and also declining admissions per capita over the last several years.[2] In Wise County, these declines make it even more difficult to sustain three standalone hospitals each attempting to serve a broad range of inpatient services. With re-purposing, however, Wise County is likely to see new services added that do not currently exist in the community, such as expanded outpatient or physician services and make better use of capacity—minimizing any potential negative economic impact. An assessment of need will take place in Wise County utilizing the process and policy outlined in the Application, which will involve local physicians and members of the community.

The New Health System hopes that by implementing a more efficient system of operations – through more efficient use of existing infrastructure and more patient-focused, need-based care – financial losses in the Virginia hospitals can be curtailed or eliminated. However, the New Health System commits to continue funding any levels of operating loss in the Virginia hospitals for at least five years as it keeps those facilities open and works to have them productively meet the needs of people in the region through a better, more effectively aligned system of care.

**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?**

**RESPONSE:** The Applicants have no plans to close any facilities or services prior to the approval of the proposed Cooperative Agreement and the closing of the transaction. In fact, the Applicants do not anticipate any facility closures and have committed to continue operating all

[1] **Exhibit 1A** includes duplication of services in Virginia and Tennessee and shows discharges by hospital for each Wellmont and Mountain States hospital. A threshold of 25 or more discharges was used to represent a hospital having a specific service line (e.g., cardiac surgery); service lines were defined by groups of DRGs. Many of the smaller Mountain States and Wellmont hospitals offer only limited range of inpatient services. .

[2] **Exhibit 1B** includes data for each of several recent years about inpatient admissions, population and inpatient use rates in each of the Southwest Virginia counties of the Geographic Service Area.

hospitals as clinical and health care facilities for at least five years if the Cooperative Agreement is approved. This commitment will not occur without the merger. It is important to note that, withouth the merger, it is likely each system will require cost reductions in order to sustain cash flow. This will be necessary to offset reductions in inpatient use rates, which in conjunction with declining population trends in the Virginia counties creates serious challenges for these hospitals.

In regard to services, frequent evaluation is critical to maintain the highest quality services. Service offerings are often dependent on physician availability, which is sometimes out of the Applicants' control. If circumstances indicate that any major service offerings must change in Southwest Virginia prior to the adoption of the proposed Cooperative Agreement, the Applicants will advise the Authority.

**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?**

**RESPONSE:** The Parties do not anticipate closing any hospitals in Southwest Virginia following the merger and have committed to the ongoing operation of all the Parties' facilities as clinical and health care institutions for at least five years if the merger is approved. Over the long term (which the Authority has defined as 6-10 years), the New Health System may determine the need to repurpose beds in a market where beds and space are underutilized or there is unnecessary duplication of services. In such a situation, alternative uses of the beds will be considered based on the health care needs that exist in the affected community. In the changing environment of health care, it is impossible to predict what the health care landscape will look like beyond a five-year horizon — which is the rationale for the committed time period set forth in the Application. That said, the Applicants' stated commitment in the Application to continue access to needed health care services in each community of the Geographic Service Area beyond the initial 5-year period includes retaining essential inpatient and outpatient services in geographic proximity to the populations currently receiving care from the Applicants.

The commitment to maintain access in these communities does not exist without the merger, as the Parties' existing rural facilities continue to become more financially constrained. The Applicants are not alone in this trend of financial pressure facing rural hospitals and difficulties in sustaining inpatient services. In fact, more than 70 rural hospitals have closed since 2010, and more than 600 could be vulnerable going forward.[3] According to the University of North Carolina Sheps Center, 76 rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia.[4] The current system of health care in the United States was built upon a

[3] *See* iVantage's 2016 Rural Relevance: Vulnerability to Value Study, which assesses rural and Critical Access Hospital performance; Ellison, A. (2016, February). The rural hospital closure crisis: 15 key findings and trends. Becker's Hospital CFO. Retrieved from http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html; Rural Hospital Closures: 2010-Present (2016); and Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, and Pink GH. 2016. The rising rate of rural hospital closures. Journal of Rural Health 32(1):35-43.

[4] *See 76 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at*: https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/ (accessed July 13, 2016). Ten rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.

hospital-centric model. Today, the model of care is shifting away from hospitals to preventative and outpatient services. In rural markets, declining inpatient use rates and negative population trends are creating enormous financial strain on hospitals. Without the investments Mountain States and Wellmont have made in the Southwest Virginia hospitals, for instance, it is unlikely all of these hospitals would remain open. The financial headwinds are also impacting the larger hospitals within the two systems. Without the merger, it is likely that Mountain States and Wellmont will need to reduce non-core expenses in order to sustain the major access points in each system. Thus, in a status quo environment, the rural hospitals are likely to experience reduced financial support and increasing vulnerability. The current financial support that Mountain States and Wellmont provide for the Virginia hospitals can only be maintained in the future through the overall efficiencies gained through the merger as set forth in the Application. Without the merger, no such commitment exists, and Mountain States and Wellmont cannot guarantee that services, or even hospitals, will remain open in these communities. Moreover, the Applicants are making affirmative commitments to provide continued care access in its communities that extends beyond maintaining facilities for specified time periods after the merger is closed, and these commitments will better meet the needs of patients in the region and improve access to cost-effective care for them.

**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?**

**RESPONSE:** The commitment set forth in the Application to maintain operation of all the Applicants' hospitals as clinical and health care institutions for at least five years specifically addresses hospital facilities. However, the Applicants' broader commitment is to regularly assess community needs and to seek to meet those needs through an effective regional system of prevention, physician, inpatient, outpatient, and post-acute services. For example, the Applicants have committed to conduct ongoing physician needs assessments in each community. Through ongoing efforts to recruit physicians, the Applicants target the ultimate variable to ensuring services remain available. Physician services and ambulatory access points will be created or maintained based on the needs of the population in specific geographic locations, but without unnecessary duplication, and in some cases, through competition with unaffiliated entities. Avoidance or reduction of duplication will allow for a more effective allocation of regional resources and will position the New Health System to add services that may not be justified under the lower, divided volumes that exist today.

**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?**

**RESPONSE:** Decisions about regional service alignment are complex and involve many factors, including demonstrated community need for a service; availability of qualified, experienced personnel; unnecessary duplication of services that are readily available but not being utilized to capacity; impact on patient travel times for services; resource requirements to provide the service; balancing the commitment of resources among all needed services; and obligations of the New Health System under the State Agreements. In each case, the weighting of factors will depend upon the circumstances in that community. These decisions will not be conducive to the use of a scoring system because of the complexity involved in the decision-making, but a matrix including the factors listed above and others would be used by the New Health System leaders, physician leaders, the Board, and other involved stakeholders when making these decisions. This process must provide the flexibility to consider all relevant factors of the affected community, including the perspective of the local physicians and stakeholders.

Importantly, the Applicants have committed that no major service will be discontinued within the first two years without a super-majority vote of the New Health System Board if the discontinuation would render the service unavailable in the affected community. Proper management of this decision-making process is a fiduciary responsibility of the independent, public benefit, not-for-profit New Health System Board and cannot be shared or delegated. However, the Parties are committed to the effective communication of these decisions to the community and the Authority as they relate to Virginia facilities and services.

**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?**

**RESPONSE:** As stated in Response #3 above, it is not possible for the Applicants to forecast health care needs beyond five years due to the dramatically changing climate of health care nationally, particularly in regard to inpatient versus outpatient utilization. For this reason, the Applicants have made a clear commitment to keep all current hospitals open as clinical and health care facilities for at least five years if the merger is approved. No such commitment by Mountain States or Wellmont exists today. In fact, the financial environment in which Mountain States and Wellmont currently operate is expected to become more and more difficult, particularly for rural facilities that are currently operating significantly under capacity and inefficiently in areas where populations are declining. This is substantiated by the average daily census of each rural facility compared to the staffed capacity as set forth in the Application.[5] The assurance to maintain current hospitals for five years will be funded through an effective re-alignment of regional resources and will provide the best long-term solution for regional health care, particularly in the rural areas served by the Applicants. Further, the savings from elimination of duplicative services will enable the investments in the development of new, needed services which are not currently available in certain communities along with the preservation of more jobs and advancement of more economic opportunity.

**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**

[5] *See* Application Section 5, Tables 5.2 and 5.3 (pages 18-19).

**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?**

**RESPONSE:** The New Health System will continue to treat all patients with dignity, compassion, and high-quality care standards regardless of their social status or ability to pay. The New Health System's charity care policy will comply with all state and federal regulations in regard to charity care and essential hospital access and will be consistent with the New Health System's role as a public benefit, not-for-profit, tax-exempt corporation. The policy will be published, and all patients will be advised of their ability to access services under the policy. The policy will apply at the time of service delivery rather than after collection attempts have been made. Patients will have no barriers to receiving needed care. The New Health System will place no dollar limits on the amount of charity care it will provide and commits to providing a charity care policy that incorporates the best elements of the current policies of each Applicant. In fact, the New Health System's charity care policy will increase the benefit for charity care above and beyond what either of the Applicants currently provide. The new policy will provide a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level. In addition, all patients may apply for financial assistance and/or payment plans based on their ability to pay. Currently, the highest threshold used by the Applicants for a 100% discount for these services is 200% of the Federal Poverty Level, with a sliding scale applying to certain patients.

The New Health System will take other steps to benefit needy patients. One of the New Health System's stated goals is to reduce unnecessary utilization of high cost emergency department and inpatient services by uninsured individuals. So-called "super-utilizers" of health care consume a disproportionate level of health care resources and often have co-existing medical conditions coupled with addiction and mental health issues and social resource needs.

The New Health System will design an effective case management model for this "super-utilizer" population, once identified, that is proactive. Elements of the program will include social needs screening and assessment (transportation, food and housing insecurity, high risk behaviors or environments, etc.), connection to primary care preferably in a patient-centered medical home model for disease management, connection to health care and social resource navigators and community health workers, and connection to medication assistance. The New Health System will also provide resources for individuals who are ready to receive intervention for unhealthy behaviors that contribute to poor health. Findings from previously conducted model programs will be used to inform and create the overall plan. Partnerships with regional Federally Qualified Health Centers, Rural Health Centers, Health Departments, and charity clinics will be essential.

For individuals who agree to comply with certain requirements such as following physician prescriptions and orders, keeping scheduled appointments, participating in appropriate screenings, and participating in education related to chronic conditions or healthy lifestyles, the New Health System will provide guaranteed access to program services and medical care and the discount for services will be increased substantially.

This model can be a precursor to other population health models which can apply to other high-utilizer populations and may even be a source for translational research studies to result in best practice program development—especially in rural environments.

**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?**

**RESPONSE:** Uninsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section, governing not-for-profit organizations,[6] and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible. It is the goal of the New Health System to provide services to members of the community in a manner that is compassionate, fair, and reasonable and that does not result in an undue financial burden.

**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?**

**RESPONSE:** As detailed in the Application, the New Health System intends to partner with, or support, existing community based charity clinics along with rural health clinics and Federally Qualified Health Centers ("FQHCs") to help people access the care they need rather than creating new charity clinics. There are many effective charity care clinics and programs already operating in the region, and the New Health System believes that partnering with or supporting these established programs will be the best use of community resources. An established network of care options will be especially important as the New Health System seeks to enroll indigent or uninsured high-use, high need individuals in the "super-utilizer" accountability model mentioned in Response #7. Under this program and the regional network of primary care providers, the New Health System will encourage individuals to participate more actively in their health and to employ prevention and disease management strategies so that high cost health care utilization can be avoided. Effective management of the health of this population in partnership with charity care clinics and FQHCs along with social agencies and others will reduce the cost of health care in the region overall and allow the New Health System to keep costs lower for everyone.

**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?**

**RESPONSE:** All of the Wellmont and Mountain States physical facilities and provider locations are located in Virginia or Tennessee and are subject to state regulations in these two states. While the Applicants recognize that "geographic service area" may be defined in different ways,

[6] 26 CFR § 1.501(r) (6).

the Applicants have defined the "Geographic Service Area" in the Application as the twenty-one counties in Virginia and Tennessee where the Applicants propose to conduct business as the New Health System. This twenty-one county area is inclusive of the Virginia and Tennessee counties in which the Applicants have locations and facilities and serve residents, and all locations and providers that will be under the control of the Applicants and subject to any regulation under the Cooperative Agreement in Virginia and the COPA in Tennessee. This 21-county area is inclusive of the vast majority of the population served by the Applicants, whether commercial, Medicare, Medicaid, or uninsured. In fact, ninety-eight percent (98%) of the combined patient discharges come from the Geographic Service Area – the 21 counties in Virginia and Tennessee.[7]

Even though Wythe, Hamblen and Cocke Counties are located between metro areas in Virginia (Roanoke/Tri-Cities) and Tennessee (Knoxville/Tri-Cities), the hospitals located in Wythe, Hamblen, and Cocke serve patients not only from their own counties but from other counties located in the Applicants' Geographic Service Area. In other words, there is meaningful outmigration from the counties in which Mountain States and Wellmont have facilities to Wythe, Hamblen and Cocke Counties. As shown in **Exhibit 10A** attached to these Responses, the Wythe, Hamblen and Cocke hospitals attract between 11% to 34% of their patients from within the Geographic Service Area, indicating that these hospitals are in competition with the Applicants' facilities and other competing facilities located within the Geographic Service Area. In addition, the Mountain States and Wellmont attract patients from Wythe, Hamblen and Cocke Counties to their facilities (ranging from 2% to 12% as shown in **Exhibit 10B**), also indicating overlap and competition with the Applicants. There is little relevance to the county lines in this region; the needs of patients from these counties are aligned with those of all the other Southwest Virginia and Northeast Tennessee communities included in the Geographic Service Area. People from these regions utilize services from each of the Applicants—particularly for tertiary level needs. In combination, the tables in **Exhibits 10A and 10B** to these Responses include data and information on the residents of each of Wythe County, VA, Cocke County, TN and Hamblen County, TN – total volumes of inpatient services used and the locations of care used – and on the hospitals located in these counties – and the meaningful levels of patients drawn from the Geographic Service Area to these independent hospitals. As requested, the tables in **Exhibits 10A and 10B** show the share for inpatient services attributable to the Applicants in these counties (between 2-12%), as well as the use by the Geographic Service Area's residents of the hospitals in these counties.

**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?**

**RESPONSE:** The Parties believe that the Geographic Service Area encompassing the 21-county area in Southwest Virginia and Northeast Tennessee outlined in the Application accurately reflects the Applicants' current and predicted future service areas. The Geographic Service Area reflects the service area over which the Applicants intend to develop a fully integrated health care delivery system with supporting infrastructure, and is the area currently served by the

[7] *See* Application Section 5 (pages 14-21) and the accompanying Exhibits 5.1 and 5.2 for a more detailed description of the Geographic Service Area and the hospitals and other facilities that serve residents of the area.

Applicants. As noted above in Response #10, ninety-eight percent (98%) of the combined patient discharges come from the Geographic Service Area - the 21 counties in Virginia and Tennessee. The Applicants do not expect the New Health System's service area to differ from this 21-county area.

In response to the specific request for definition of a primary and secondary service area using the 75% and 90% methodology, as defined by the Authority's guidance, **Exhibit 11A** to these Responses uses the New Health System's discharge data for CY2014 to identify the zip codes that constitute both the 75% and 90% service areas for the New Health System based on the combined discharges of Mountain States and Wellmont. These zip codes are presented in table format and in a map in **Exhibit 11A**.

**Exhibits 11B and 11C** include maps of the Mountain States and Wellmont discharges, respectively, for the zip codes that constitute each of their 75% and 90% service areas defined using the Authority's guidance. As the maps in **Exhibits 11B and 11C** illustrate, the 75% areas for Mountain States and Wellmont are somewhat different in geographic scope, yet collectively include most of the counties in the 21-county area; the 90% areas also include the vast amount of the area, with some counties included for Wellmont (and not for Mountain States) and the reverse. We note that the 75%/90% areas include many zip codes that are served by hospitals located physically within the areas and others just outside. This is not evident on the maps because the 75%/90% areas by definition are based only on Applicants' data and do not show overlap with other health systems.

The Parties note that the 75% and 90% service areas requested do not represent to them an accurate depiction of their service area. The Parties believe that the 21-county Geographic Service Area (defined in the Application) most accurately represents their service area for the reasons outlined in Response #10: the meaningful outmigration of residents within the 75%-90% area to competitors in Wythe, Cocke and Hamblen counties as well as to hospitals elsewhere including preeminent academic medical centers in nearby Virginia and Tennessee; the numbers of residents within these three counties who seek care within the 21-county area; the alignment of the needs of patients from these three counties with all of the other patients in other parts of the 21-county area; and the location of the Parties' facilities across the area. The Parties have included data in the Application showing the range of service offerings provided by the Parties and the inpatient services offered to residents of the Geographic Service Area by numerous other hospitals. A listing of these hospitals was provided in Application Exhibit 5.1.

Finally, we note that Application Exhibit 5.1 presents maps of the 75% and 90% service areas of each of the Applicants' individual hospitals. The Applicants include as a supplement to the maps in Application Exhibit 5.1 a table showing the zip codes that constitute the 75% and 90% service areas for each of the Applicants' individual hospitals, attached as **Exhibit 11D** to these Responses. As noted in the Application, many of the hospitals are very small and rural with service areas of just a few zip codes, and with very limited overlap with other hospitals. This demonstrates that some of the scope of the Applicants' combined service area is affected by the fact that the outlying hospitals are small with limited discharge volumes.

**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?**

**RESPONSE:** The Parties attempted to calculate the information requested, but the limitations on available data make the estimates inaccurate or incapable of precise calculation, particularly for any service other than inpatient services. In responding to this request, we used inpatient discharge data for CY2014 and derived services areas based on the Authority's guidance. We used the 75% service area based on Wellmont's and Mountain States' combined discharges as the basis for share calculations for inpatient services. For outpatient services, without discharge data, we were not able to re-define service areas. We approximated a service area for outpatient services by excluding entire counties from the 21-county service area if they did not appear to be in the service area; this was done by visual inspection and review of the 75%/90% area map in **Exhibit 11A** to these Responses.[8]

Inpatient Services. **Exhibit 12A** to these Responses presents estimated market shares for the 75% area of the Applicants for inpatient services.[9] We note that the resulting share substantially overstates the combined share of the Applicants and the competitive pressures on the Applicants because it excludes many relevant competitors, including some of the most prominent tertiary and academic medical centers as well as community hospitals located outside the 75% area but that compete for patients inside the 75% area. We respectfully submit that data and information using the full Geographic Service Area and all of the relevant hospitals should be included as part of the record for review of this merger. We do not believe the 75% volume area represents a relevant, accurate geographic market for assessment of the merger. **Exhibit 12C** to these Responses is included to show the New Health System's share of inpatient services for the Geographic Service Area.

Outpatient Services. With respect to calculation of outpatient services, it is important to note that the data is limited. The data that VHHA reports to the Commonwealth (and thus is publicly available) is incomplete: (i) the data do not include Emergency Departments, and (ii) the data only include six outpatient, ambulatory surgery groups (facial plastic surgery, breast surgery, colonoscopy, laparoscopic surgery, knee arthroscopy, and hernia repair). If facilities perform other outpatient surgeries/procedures, VHHA includes them in the outpatient data for VHHA members, but this data is not reported to the Commonwealth and therefore is not publicly available.

No publicly reported data exist for Virginia outpatient services that allows for accurate volume comparison or market share calculation across independent as well as hospital-based services. From time to time, organizations may use purchased claims data or other sources of information to approximate outpatient data. However, these methods are based on proxy calculations or algorithms and are therefore unreliable estimations for purposes of inclusion in the Application.

In an effort to respond to this request, we provide data and information for the outpatient services in the 75% area separately for imaging, surgery, and clinic services as well as other

[8] For example, to define the 90% area, we excluded Wythe, Hamblen, and Cocke Counties.

[9] Shares are reported in the far right column of **Exhibit 12A** based solely on hospitals located in the 75% area; the first column shows shares for all hospitals. For symmetry, we include **Exhibit 12B** to these Responses, which includes shares based on the 90% service area.

outpatient services in **Exhibit 12D** and provide shares based on counts of facilities. In an effort to be responsive to the request for service area analyses, we excluded outpatient facilities located in counties that appear to be wholly outside of the 75% service area defined using the Authority's guidance. While we believe that these adjacent facilities are competitive alternatives, we present shares in **Exhibit 12D** excluding some of these competitive facilities. We present the comparison of the 75% area data with the full set of outpatient facilities in **Exhibit 12E**.[10]

**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?**

**RESPONSE:** The New Health System does not plan to offer any insurance products and, instead, plans to partner with existing insurance providers and self-insured employers in the market to provide value-based, shared savings, and, in certain situations, shared risk payment arrangements. The Cooperative Agreement provides the opportunity for the Applicants to move forward more promptly and effectively to align care and develop models and metrics that address these new types of contracts. Both Applicants have some experience in these areas that will enable them combined to work together more effectively. Mountain States currently operates an accountable care organization ("ACO") in Virginia, AnewCare, which participates in the Medicare Shared Savings Program ("MSSP"). It is likely that the New Health System will continue to operate this ACO in Virginia after the merger closes. Both Wellmont and Mountain States currently participate in some value-based, shared savings, and risk-sharing payment arrangements with their existing insurance providers for non-Medicare business, and the Parties anticipate that all of those arrangements will continue through the New Health System after the merger closes. The Applicants further anticipate that the New Health System will engage more extensively with payers in value-based, shared savings, and risk-sharing arrangements and may partner with independent physicians and providers in the formation of a clinical network that will support the goals of various models developed by the payers. Commitments and investments with regard to IT, infrastucture and population health all serve to align incentives and promote the capacity of the New Health System to be more effective in these forms of contracting and to achieve benefits.

**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?**

**RESPONSE:** The Parties are compiling the information requested and will provide this to the Authority in a subsequent response as soon as possible.

**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?**

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[10] **Exhibit 12E** excludes 5 facilities located in the Geographic Service Area that are single speciality or specific urgent care facilities.

**RESPONSE:** As noted in the Application, all existing Virginia hospitals will remain open as clinical and health care facilities for at least five years.

Tertiary hospitals are noted for high volume and the availability of highly specialized services, which require enough volume to support the ongoing skill development of staff. In a tertiary hospital, there must be sufficient physicians in each specialty, and highly-trained and specialized staff to support them. In order to attract and justify these specialized physician and staff resources for a tertiary hospital, there must be sufficient critical mass of patient population to support the investment. Because Southwest Virginia is geographically large, topographically divided and sparsely populated, the region does not have the ability to support such a tertiary hospital on its own. Travel patterns also vary from the Highway 23/Interstate 26 corridor and the Interstate 81 corridor, making effective placement of one tertiary center difficult and inconsistent with the goal of improving patient access. Finally, hospital use rates are declining in Southwest Virginia and nationally, and the need for more hospitals is in question. The objective of the New Health System will be to keep needed services in close proximity to where people live, to the extent it is practical and appropriate. For these reasons, the Applicants do not foresee a new tertiary hospital opening in Southwest Virginia. Notwithstanding this, the Applicants believe that tertiary services are ones for which patients are willing to travel, and are ones that many patients require only once or infrequently. Tertiary hospitals, including academic medical centers ("AMCs"), have very broad service areas. As such, the population in this region can be and is served both by the Applicants as well as a number of the State's and region's best AMCs. For these services, patients have alternatives, although the Applicants aspire to be the best alternative for local residents.

**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?**

**RESPONSE:** In the Application, Wellmont and Mountain States have committed that all hospitals in operation at the time of the merger, including Dickenson Community Hospital, will remain operational as a clinical and health care institutions for at least five years.[11] Without the savings realized from the proposed merger, there is no similar commitment possible by Mountain States to Dickenson Community Hospital.

It is important to note that the New Health System's Alignment Policy would apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in the affected community. Further, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. The Alignment Policy is attached to the Application as Exhibit 12.1 and is discussed in detail in Section 12.b of the Application (pages 35-36).

The Applicants would like to note that Question 16 includes the wording "during the five-year period of the cooperative agreement." The Applicants expect that the Cooperative Agreement

[11] *See* Application Section 17, page 131: "All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years."

will remain in-place well beyond five years with modifications made from time to time as agreed upon by the Commonwealth and the New Health System; the Cooperative Agreement is not expected to be limited to a five-year period.

**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?**

**RESPONSE:** Currently Mountain States operates one Level I trauma center in Johnson City, Tennessee, and Wellmont operates one Level I trauma center in Kingsport, Tennessee and one Level II trauma center in Bristol, TN. Licensing requirements for Level I and Level II trauma in Tennessee (where each facility is licensed) are very similar.

Throughout Virginia, there are five Level I and four Level II trauma centers. Six Level I trauma centers and one Level II trauma centers operate throughout Tennessee. Best practice trauma care systems are focused on the entire *trauma system*, not simply independent facilities. The effectiveness of a trauma system depends on an integrated system of hospitals, trained care teams, EMS and transport trained to work well within common protocols.

The Applicants have made no decisions regarding the location of Level I trauma care. The decision will be made post-closing in accordance with the New Health System's Alignment Policy described in Section 12.b of the Application (pages 35-36), which requires thorough analysis of the relevant clinical and financial data, and input from physicians and other clinicians relevant to the service. Additionally, any decision to consolidate a service in such a way that results in discontinuation of that service in a community will require a super-majority vote of the Board of the New Health System for two years after the merger.[12]

**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;**

**RESPONSE:** The solution is multi-factorial – while improved access to health care is important, improved inter-conception health of the mother, birth spacing, and actual utilization of effective pre-natal care can be even more important. The Applicants have outlined in the New Health System's Community Health Improvement Plan, attached as **Exhibit 18** to these Responses, the steps that will be necessary to make meaningful positive change in the region's pre-natal care. The Community Health Improvement Plan includes short-term and intermediate-term outcomes for population health improvements, which the New Health System hereby submits for consideration by the Authority and the Commonwealth.[13]

[12] The Alignment Policy (with details of the Alignment Policy's decision-making process) is attached to the Application as Exhibit 12.1.

[13] The Community Health Improvement Plan is the first step in the New Health System's proposal and efforts to improve the population of the region's health over the next decade. The Community Health Improvement Plan

With respect to birth outcomes, there are several evidence-based strategies that lead to improvement, such as nurse family partnership, centering pregnancy programs, smoking cessation programs, and medication assisted treatment during pregnancy for mothers addicted to opioids. The Applicants intend to work collaboratively with the Authority, the Commonwealth and local Departments of Health and Community Service Boards to determine the most effective initiatives for each Southwest Virginia community.

As noted in the Application, improving birth outcomes is a key component of the New Health System's commitment to invest $75 million in population health improvement over the next decade in the Geographic Service Area.[14] The New Health System has committed to performing a physician needs assessment in each community every three years.[15] The New Health System has also committed to spending $27 million over ten years pursuing pediatric sub-specialty services, including recruiting and retaining physicians in the area, preferably by assisting independent physician groups who will identify and employ new physicians. The New Health System intends to employ physicians where independent practices cannot or choose not to employ these needed sub-specialty physicians.

However, money alone will not solve the problem. For example, even when Wellmont and Mountain States have the need, desire and the funds to recruit new physicians, the time to fill these positions often runs in the hundreds or even thousands of days. The Applicants along with the Authority and the communities in the region must be willing to design interventions that recognize the realities and health care patterns of each community and maximize the opportunities for pre-natal care improvement in each community. Changes in health care habits and patterns take time, and are often measured in five and ten year timelines.

**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?**

**RESPONSE:** While specific decisions about GME programs and positions have not yet been made, the Applicants do not anticipate significant movement of residency positions. The New Health System intends to continue training and graduate medical education throughout the system and the entire Geographic Service Area, provided federal and state funding continues. This includes the residency programs in the communities where they are currently offered. It is important to note that, prior to the agreement to merge, both health systems independently had begun implementing plans to reduce the number of residency slots. This reduction was halted, in part, because the health systems were committed to deploying synergies related to the merger toward improving, rather than reducing, residency and training programs.

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was developed in conjunction with the public health resources at ETSU and through results of the Community Health Work Groups, all of which is described in more detail in Application Section 15.a.F, pages 87-91.

[14] *See* Application Section 13.b, pages 48-51.

[15] *See* Application Section 17, page 131.

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

**RESPONSE:** The New Health System is committing to investing $85 million dollars over the next decade in research and academics. Where and how these funds are invested is not yet determined. The Research & Academics Community Health Work Group described in Section 15.a.G of the Application (pages 89-91) has proposed a model for a working relationship between the academic institutions in the region and the New Health System. The decisions regarding the investment in specific research and academic programs will require a collaborative plan to be developed with the academic partners.

**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.**

**RESPONSE:** Medical evacuation ("MEDEVAC") helicopter transport is an important component of the Geographic Service Area's regional trauma system. While the detail regarding how the various MEDEVAC programs may integrate with the New Health System has not been determined, the service levels are expected to continue after the merger. Each of Mountain States and Wellmont currently partner with existing MEDEVAC programs to enable this service.

1. Wings Air Rescue IV

Med-Trans provides MEDEVAC services through the Wings Air Rescue program throughout the Commonwealth and the country. Wings Air Rescue IV is the program that provides MEDEVAC helicopter services to Southwest Virginia along with other parts of Western Virginia. Med-Trans provides the aircraft and aviation management functions for Wings Air Rescue IV, and Mountain States provides a medical director and medical flight crews.

2. WellmontOne Air Transport

WellmontOne is based in Northeast Tennessee, with a primary service area in Tennessee and a secondary service area in Southwest Virginia. Wellmont provides the medical flight crews, the medical director and administrative oversight of the program.

3. MedFlight II

MedFlight II is a program run by the Virginia State Police to provide MEDEVAC services to Southwest Virginia.[16] There are six Virginia State Police helicopters owned by the

[16] The Virginia State Police also runs MedFlight I for MEDEVAC services to Eastern Virginia.

Commonwealth that are available for the program. In addition to the helicopters, the Virginia State Police provides pilots and insurance for the program, and Wellmont provides a medical director and medical flight crews through Bristol Regional Medical Center. Authorization of and general funding for the MedFlight II program is provided to the Virginia State Police by the Virginia General Assembly. MedFlight II service is dependent on the participation by the Virginia State Police and is contingent on continued funding from and authorization by the Commonwealth. The New Health System intends to retain at least the current level of overall medical flight crew service for MedFlight II in the region. The New Health System also will continue to advocate with the Virginia State Police and the Virginia General Assembly for the continued allocation of pilots, helicopters and funding for the MedFlight II program.

**e. Geriatric care.**

**RESPONSE:** Improving chronic disease identification and management is a key component of the New Health System's commitment to invest $75 million in public health in the next decade in the Geographic Service Area.[17] Additionally, the New Health System has committed to performing physician needs assessment in each community every three years[18] and investing in the recruitment and retention of physicians in the area, preferably by assisting independent physician groups in the identification and employment of new physicians, but also by employing physicians where independent practices cannot or choose not to employ these needed physicians. This includes geriatricians, palliative care physicians, psychiatrists and other sub-specialists and clinicians caring for aging adults. In addition, as the mix of services across hospitals is evaluated for efficiencies, gero-psychiatric day programs and inpatient programs are viable alternative uses for unused bed capacity.

Mountain States and Wellmont independently are already pursuing preferred post-acute networks, including skilled nursing and rehabilitation facilities. These efforts focus on improving quality and care management to reduce unnecessary admissions, readmissions and emergency room use. It is expected that these efforts will continue and expand under the New Health System. A Common Clinical IT Platform for health information, which is outlined in the Application, will enable improved performance in the post-acute handoff and management of the patient, and the systems are expected to align efforts to better manage the patients in the post-acute setting upon conclusion of the merger.

**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.**

[17] *See* Application Section 13.b, pages 48-51.
[18] *See* Application Section 17, page 131.

**RESPONSE:** The New Health System has committed to spending at least $140 million over ten years pursuing specialty services, which will include mental health and addiction treatment services.[19] However, specific decisions about the location and staffing of these services have not been made. The Applicants believe that the five broad levels of service intensity described by the American Society of Addiction Medicine (ASAM) Criteria[20] provide an evidence-based model of the continuum of recovery-oriented addiction services for the region. Staffing for these services will be in line with evidence-based best practices and the regulatory and professional practice laws of the Commonwealth.

Even with the New Health System's large investment, it is not expected that all the substance use disorder needs of the region can be met. For this reason, in Virginia the New Health System plans to work closely with the Community Service Boards to determine where gaps exist in the continuum of SUD care and where to prioritize services in the region's communities. The New Health System expects that its investments will leverage existing capacity and infrastructure to expand existing services in the region beyond their current reach and to provide critical missing services.

**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?**

**RESPONSE:** Ultimately, decisions related to providing services through local employment or subsidization of an independent physician, community rotation or telemedicine are made by balancing demand against need.

The New Health System has committed to performing physician needs assessment in each community in the Geographic Service Area every three years[21] and investing in the recruitment and retention of physicians in the area, preferably by assisting independent physician groups to identify and employ new physicians, but also by employing physicians where independent practices cannot or choose not to employ these needed physicians. The physician needs assessments will help identify health care gaps in each community and will influence specialty care service offerings.

Additionally, part of the New Health System's commitment to spending at least $140 million over ten years pursuing additional specialty services will be invested in expanding telemedicine, particularly pediatric telemedicine, in the region.[22] The New Health System plans to utilize both approaches (the recruitment of specialists and the provision of specialty services via telemedicine) to improve access to care. However, no

[19] *See* Application Section 15.a.H, page 94.
[20] *See* http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria.
[21] *See* Application Section 17, page 131.
[22] *See* Application Section 17, page 130.

specific decisions about the establishment of permanent services or the expansion of services via telemedicine have been made.

**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.**

**RESPONSE:** The New Health System plans to target the earlier detection of heart disease, diabetes, suicide and cancer by increasing population screening rates for these diseases, as outlined in the Community Health Improvement Plan, attached as **Exhibit 18** to these Responses. These plans include evidence based screenings for colon cancer, mammography, lung cancer and cervical cancer. HEDIS or HEDIS like metrics will be used to track screening rates and goals will be negotiated with the Virginia Department of Health. The location of screening services will be based on identified need and these services may be facility-based or provided via mobile unit. Details about the implementation of screening services will be decided once the Applicants and the Commonwealth agree on the specific conditions to target.

**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.**

**RESPONSE:** The New Health System commits to implementing programs and strategies to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and NAS in Southwest Virginia, as outlined in the Community Health Improvement Plan, attached as **Exhibit 18** to these Responses. Suggested short-term and intermediate-term outcome metrics are included in the Community Health Improvement Plan. Because of limitations and lags in current federal and state population health data sources, especially at the county level, the Parties expect that final metrics and targets will be agreed upon with the Virginia Department of Health. In order to make data actionable, new or augmented data collection efforts may be necessary.

The New Health System expects to work collaboratively with the Commonwealth to determine which specific interventions will be implemented where. While many evidence based programs exist to reduce tobacco use, obesity, drug poisoning, etc., it may not be possible to implement these locally without modification due to workforce, transportation or other infrastructure constraints.

**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.**

**RESPONSE:** Mountain States operates two critical access hospitals - Dickenson Community Hospital located in Clintwood, Virginia, and Johnson County Community Hospital located in Mountain City, Tennessee. Wellmont operates one critical access hospital - Hancock County Hospital located in Sneedville, Tennessee.

Medicare payments for the Parties' hospital outpatient services exceed Medicare payment for non-hospital clinic services under the applicable physician fee schedules. This difference partially covers the additional costs that the hospitals bear for much higher percentages of charity and self-pay patients in their payer mix. Pursuant to federal policy, the benefit of ensuring access which occurs through the use of the reimbursement mechanisms to incentivize the placement of providers in underserved areas benefits the region by ensuring access for the uninsured and underinsured. Thus, the incremental cost of maintaining a site as a hospital-based site does not exceed the benefit of the additional reimbursement.

The 340(b) program allows the qualified hospitals to purchase certain drugs at reduced prices. The hospitals below that qualify for 340(b) drug discounts disproportionately treat the majority of the Applicants' charity or uninsured patients. The 340(b) discounts help these hospitals to somewhat offset the losses incurred for the care of the aforementioned patients. None of the Parties' critical access hospitals qualify for 340(b) drug discounts.

The following Mountain States hospitals qualify for 340(b) drug discounts (in alphabetical order):

1. Franklin Woods Community Hospital
2. Indian Path Medical Center
3. Johnson City Medical Center
4. Norton Community Hospital
5. Russell County Medical Center

The following Wellmont hospitals qualify for 340(b) drug discounts (in alphabetical order):

1. Hawkins County Memorial Hospital
2. Holston Valley Medical Center
3. Lonesome Pine Hospital

## QUALITY

**The New Health System created by the combination of Mountain States 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.**

**RESPONSE:** Communication is one of the domains of HCAHPs, and has a high correlation with overall satisfaction. If the Board of the New Health System determines that this metric is one that needs improvement, it will be one of the annual priority metrics for the system. Incentive programs within the system will be based on these measures with incentive compensation based on improved results for the priority metrics.[23] Performance under these measures will be provided publicly in the manner the Applicants outlined in the Application. As with any effort, scale and elimination of variation are two key elements to improvement. Standardization of processes throughout the system will enable improvement in targeted metrics. While Leapfrog is one organization measuring hospitals, there are many different organizations covering more than 500 metrics. Payers have priorities which are driven by the organizations they are selected to cover, the federal government has its priorities, and the many commercial organizations which measure quality are also factors. In each case, the New Health System will focus on priorities which consider the demands of each of these groups, and such priorities will be vetted by and reported to the Board of the New Health System.

**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?**

[23] Currently 20% of Mountain State's company-wide bonus plan is tied to performance on four HCAHP measures of communications: RN communication, MD communication, Communication w/medications, Discharge instructions.

**RESPONSE:** On recommendation of the Quality Committee and the Social Responsibility & Population Health Committee, the Board of the New Health System will approve the individual quality improvement goals for the organization. Value based payments by Medicare, Medicaid and large commercial payers, will drive many of the metrics and performance levels the New Health System will be held responsible for, as will agreements under the Cooperative Agreement. The Applicants plan to actively collaborate with the payers and the Commonwealth as the Applicants determine which metrics to prioritize and where to set performance thresholds and goals. The ultimate goal of the organization will be to perform at the top decile level in the relevant measures. Both performance and improvement are factors to consider, depending upon the measure, and both will be elements of the system incentive program.

**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.**

**RESPONSE:** Mountain States and Wellmont are required to report on hundreds of quality measures under their current contracts with commercial payers, Medicaid and Medicare. Many of these measures are not currently publicly reported. The New Health System plans to participate fully in the Commonwealth's efforts to create a common system performance score recommended by the Lt. Governor's Roundtable on Quality, Payment Reform and HIT and will work to adopt the recommend *Focused Menu of Clinical Quality Measures*. This menu was developed in response to growing concern that Virginia providers are being asked to produce far more CQMs than can be effectively monitored and managed in the provider setting. The Applicants intend for the New Health System to focus on measures which have meaning to patients and which are proven to improve the quality of outcomes. In addition, the Application details other specific quality and other measures that the New Health System will report.[24]

**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?**

**RESPONSE:** Combined, Wellmont and Mountain States employ approximately 30 percent of the physicians in the region – the majority of these employed physicians are traditionally hospital based or are in difficult to recruit sub-specialties or rural areas.[25]

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[24] *See* Application Section 15.a.A.iv "Quality Reporting," pages 75-80.
[25] *See* Application Exhibits 14.2 (Mountain States Physicians) and 14.3 (Wellmont Physicians).

The Applicants have committed to the "development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System."[26] Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.

The New Health System will support this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding. The New Health System will (and both Mountain States and Wellmont currently do) provide recruiting assistance to independent physician practices and in some cases provide income support.

The Applicants agree that federal payment reforms have put significant pressure on independent physicians to move towards employment. But other models exist as an alternative. For example, Mountain States' subsidiary Integrated Solutions Health Network (ISHN) operates an accountable care organization (ACO), AnewCare, with a network of independent and employed physicians governed by a board composed largely of physicians. ISHN provides contracting, credentialing and enrollment, quality improvement, care management and analytics services to the ACO and other entities.

The New Health System intends to collaborate with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region. Successful models such as Clinically Integrated Networks typically have shared governance among members. The New Health System also expects to provide management support services to independent physicians that will allow these physicians to more easily comply with new regulations and financial pressures without the burden of large investment in capital or staffing in areas such as IT, EHR and clinical protocols.

**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?**

**RESPONSE:** The Applicants cannot provide the information requested because there is no data readily available to calculate it. The Applicants do not identify physicians as "outpatient only" within any physician referral or allocation tools or designations. In addition, there are physicians who might be considered "outpatient only" for the majority of their practices but who moonlight on occasion in ERs and other hospital-based departments.

The decision to practice independently without a relationship to either Wellmont or Mountain States is appropriately the decision of each physician. In the case of

[26] *See* Application Section 17, page 131.

independent physicians, the professional practices and payers typically set quality expectations and monitor performance. As payers increasingly move towards alternative payment methodologies, such as MACRA for all physicians accepting Medicare, physicians will be incentivized to improve quality. As indicated in Response #21.a above, the New Health System intends to collaborate with physicians in the region, including independent physician groups, to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region. It is the choice of each physician to participate in these efforts. Approximately 70% of physicians overall in the Geographic Service Area are independent.

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

**RESPONSE:** Each facility in the New Health System will continue to operate its own Medical Executive Committee (MEC), which is comprised of employed and independent physicians elected by the members of the medical staff at each facility. These MECs set the rules and conditions for practice within each hospital. The New Health System has committed to forming a Clinical Council composed of physicians nominated by the local Medical Executive Committees and appointed by the Board. The Clinical Council will provide ongoing guidance on reduction in variation, improved peer review and integration of quality efforts with the organized medical community.[27] Both the Master Affiliation Agreement[28] and the bylaws of the New Health System require the Clinical Council.

Also, as noted above, independent physicians who participate in the ACO AnewCare and future efforts such as a Clinically Integrated Network have input into the quality of care decision-making process through their participation on the boards and board committees that govern these networks.

**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?**

**RESPONSE:** If the cooperative agreement is approved, the Parties expect the New Health System to assess each Party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application. This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a

[27] *See* Application Section 15.a.A.iii, page 75.
[28] Application Exhibit 4.1, Master Affiliation Agreement, Section 9.05.

high-level timeline for implementation of the Common Clinical IT Platform is attached as **Exhibit 22A** to these Responses.

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

**RESPONSE:** **Exhibit 22B** to these Responses contains details about both Parties' plans for the Common Clinical IT Platform, including information about the current system each party is using, plans to convert to the single system, the expected features and benefits of the Common Clinical IT Platform and the expected benefits of the Common Clinical IT Platform to a regional Health Information Exchange ("HIE"). As the Authority notes, the Parties anticipate that the proposed Common Clinical IT Platform will enable the New Health System to provide higher quality and lower cost delivery of care. The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care. Additionally, the Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by the New Health System. The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care. This will enable the New Health System to reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

**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?**

**RESPONSE:** As more fully described in **Exhibit 22B** to these Responses, the Common Clinical IT Platform will extend to all participating providers in the New Health System, whether employed or non-employed at any location, thereby enabling these providers to track quality outcomes and best practices. The Parties anticipate that independent providers will participate in a regional HIE with access to enhanced information from the New Health System's Common Clinical IT Platform. The Applicants have committed in the Application to (i) collaborate with independent physician groups to develop a local, region-wide clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region, and (ii) participate meaningfully in an HIE open to all community providers. The Parties believe a more robust regional HIE will accomplish these goals. **Exhibit 22C** attached to these Responses contains a description of the Parties' use of HIEs.

As health care moves from fee-for-service to value-based care, the sharing of clinical data for outcomes and accountable care will be very important both within the New Health System and across various health care organizations. The New Health System believes that the significant financial investments it is making to adopt a Common Clinical IT Platform will bring significant benefits for all patients seeking care within the New Health System. The New Health System's commitment to meaningfully participate in a robust regional HIE ensures that valuable health care data collected within the New

Health System will be accessible by all participating providers across the region and nation. These two commitments taken together have the potential to significantly improve the quality of care offered across the region.

**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?**

**RESPONSE:** Response #22(c) more fully describes the anticipated relationship between the New Health System's Common Clinical IT Platform and a robust regional HIE. The Parties are not aware that independent physicians would need to change their existing equipment in order to access data under a regional HIE. It has been represented to the Parties that the regional HIE eliminates the need for physicians to acquire any new equipment. To the extent that any regional HIE would require physicians to acquire new equipment to participate, the New Health System would be willing to do its part to enable the acquisitions through any available Stark law safe harbors.

**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?**

**RESPONSE:** The Parties agree with the Authority that establishing a thriving regional HIE is an important goal for the region in order to improve cross-provider communication of information, and patient outcomes[29], and this is the reason behind the New Health System's commitment to participate meaningfully in an HIE open to community providers in the region.[30] The Parties cannot commit to the measurement of non-employed/independent physicians, as they do not expect to control the practices of independent physicians. However, through participation in initiatives, like the ACO or a potential Clinically Integrated Network, communication of key information will be a key requirement for participation.

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

**RESPONSE:** The New Health System anticipates that all of the data it has committed to report publicly on its website will be reported independently to the State, if the State so desires.[31]

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[29] *See* Update to Blueprint for Health Improvement and Health-Enabled Prosperity approved by the Authority January 7, 2016, Aim 5.0, Goal 5.5 "Increase Health Information Exchange (HIE) in regional health systems serving upper east Tennessee and Southwest Virginia... PS: Implement data sharing between regional health systems, including but not limited to, Wellmont Health System, Mountain States Health Alliance, Veterans Administration System, Holston Medical Group, and Tennessee and Virginia Departments of Health."

[30] *See* Application Section 15.a.A., pages 72-73, and Section 17, page 132.

[31] *See* Application Section 15.a.A (pages 76-80).

**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?**

**RESPONSE:** In addition to the CMS core measures, patient satisfaction data, benchmarking data, and high priority measures, the New Health System commits to the extensive public and timely reporting on its website the following[32]:

- Surgical site infection rates for each facility annually
- The 10 most frequent surgical procedures performed (by number of cases) at each ASC in the New Health System annually
- The following information annually by facility, aggregated for the facility across the DRGs that comprise 80% of the discharges from the New Health System facilities:
  - + severity adjusted cost/case,
  - + length of stay,
  - + mortality rate, and
  - + Thirty-day readmission rate.
- The New Health System will select a third-party vendor and provide data for the vendor to analyze the severity adjusted measures and post them on the New Health System's website.
- The quality measures for the top 10 DRGs aggregated across the system annually.

The Parties note that the New Health System's Common Clinical IT Platform will enable it to generate and report more data more quickly than the Parties are currently able to do.

**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?**

**RESPONSE:** Given the correlation between higher volumes and improved quality,[33] and the substantial commitments of the Applicants to develop common protocols, improved

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[32] *See* Application Section 15.a.A, pages 78-80.

[33] *See High-volume trauma centers have better outcomes treating traumatic brain injury*, Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and *see* Acute Care Surgery, January 2013, available at: http://www.ncbi.nlm.nih.gov/pubmed/23271089. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, available at: http://jama.jamanetwork.com/article.aspx?articleid=193615. *See Impact of Volume Change Over Time on Trauma Mortality in the United States*, Annals of Surgery Brown, J. B., Rosengart, M. R., Kahn, J. M., Mohan, D., Zuckerbraun, B. S., Billiar, T. R., ... & Sperry, J. L. (2016).. *See Understanding the volume-outcome effect in cardiovascular surgery: the role of failure to rescue,* JAMA Surgery, 149(2), Gonzalez, A. A., Dimick, J. B., Birkmeyer, J. D., & Ghaferi, A. A. (2014), pages 119-123. *See Hospital volume and operative mortality in the modern era,* Annals of surgery, 260(2), Reames, B. N., Ghaferi, A. A., Birkmeyer, J. D., & Dimick, J. B. (2014), page 244.

care coordination and alignment of services across the full spectrum of care, it is unlikely a consolidation of a service would lead to poorer quality. In the unlikely event that consolidation of services was found to result in poorer metrics and outcomes, the New Health System would address the service appropriately and seek to determine the sources and specific reasons behind the poorer metrics and outcomes. The Common Clinical IT Platform will enable the New Health System to analyze data and respond to quality measures (both negative and positive results) in a much more timely way than is currently possible. Any negative quality measures would be analyzed to determine root cause. Once the cause is identified, steps would be taken to address the cause and modify service accordingly to improve results. Each of Mountain States and Wellmont currently use widely accepted processes for performance improvement, such as LEAN, for identification of process issues and causation. The New Health System will continue to utilize a highly organized approach to planning improvements, implementation, checking results and revising improvements as necessary and will have an enhanced system to align care and best practices across facilities.

**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?**

**RESPONSE:** Each medical staff is governed by a set of bylaws, and privileging is determined as recommended by the local staff. The Applicants' objective is to ensure that a physician, once credentialed within the New Health System, can practice anywhere within the system. It is important, however, to respect the local governance of each medical staff as it relates to privileging for specific procedures and services based on each physician's training, education, and experience. Such privileging will be handled by the local medical staff leadership and recommended to the New Health System's Board.

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

**RESPONSE:** As the New Health System moves toward system-wide credentialing, it will rely upon the Clinical Council to provide guidance. The Clinical Council will be composed of practicing physicians throughout the system, as nominated by each organized medical staff's elected leadership. Credentialing and privileging should be considered two separate issues. Each hospital must grant privileges based on the local medical staff's evaluation of each physician's competencies; including his or her training, education, and experience. The physician may enjoy overall privileges to practice in any hospital, but may only provide at each hospital the specific services each medical staff determines he or she is competent to perform. The process for credentialing and granting privileges would be the same in rural and tertiary hospitals, even though physicians in rural hospitals generally practice more broadly than in a hospital which has

more specialties available. Each hospital must determine which physician privileges will be granted to a physician based on the needs in that hospital and the physician's demonstrated training, education, and experience.

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

**RESPONSE:** Yes. Physicians elect their medical executive committees, and physicians make up the credentials committee of each medical staff.

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

**RESPONSE:** The process for credentialing and granting privileges will continue to follow the standards set forward by the Joint Commission and the Healthcare Facilities Accreditation Program (Osteopathic). The objective will be a single application for the entire New Health System, but privileges will be determined by each hospital based upon each physician's demonstrated training, education, and experience and the needs of the hospital.

**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?**

**RESPONSE:** Credentialing for non-hospital based practices is no different than for hospital-based practices. The standards are also the same for all physicians - regardless of whether they are employed or independent. If a doctor does not generally practice in a hospital, his or her hospital privileges may be more consultative rather than active and will depend upon the physician's demonstrated training, education, and experience as determined by the credentialing guidelines.

**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?**

**RESPONSE:** The charge of the Clinical Council is to work within the medical staff structure to eliminate unwarranted clinical variation in care. This is best conducted through education and use of evidence-based practices. Peer review, privileging, etc., would continue at each hospital. The New Health System will overlay a process for evidence-based practice and will encourage each MEC to evaluate its standards against the evidence-based practices. If a hospital chose not to pursue a particular evidence-based practice, or to hold itself to the system standards, the Clinical Council and the Board of the New Health System will likely inquire as to why, and attempt to collaborate with the organized medical staff to address the issue.

**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?**

**RESPONSE:** Quality and patient experience reporting for Home Health, Hospice and Skilled Nursing Facilities is largely dictated by CMS and the New Health System will make the same commitments regarding the public reporting of this data as it has for hospital services. The New Health System will also publicly report the quality and performance data of its Medicare ACO, AnewCare. Employed physician practices participate in a variety of CMS programs on quality and reporting, which are currently undergoing significant revision under the MACRA. In addition, physician practices report other quality measures under value-based payment arrangements with a variety of commercial payers. On recommendation of its Quality Committee and Social Responsibility & Population Health Committee, the New Health System Board will approve the individual quality improvement goals for the system.

The New Health System plans to participate fully in the Commonwealth's efforts to create a common system performance score recommended by the Lt. Governor's Roundtable on Quality, Payment Reform and Health Information Technology and will work to adopt the recommended Focused Menu of Clinical Quality Measures. This menu was developed in response to growing concern that Virginia providers are being asked to produce far more CQMs than can be effectively monitored and managed in the provider setting.

The Parties also note that the New Health System will be committed to aligning metrics across the integrated system in order to better position itself to participate in value-based contracting with payers.

**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?**

**RESPONSE:** Yes. The Applicants have two hospitals in Virginia that have an average daily census above 30 – Mountain States' Johnston Memorial Hospital and Norton Community Hospital – both of which are acute care hospitals.

**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?**

**RESPONSE:** The Alignment Policy will govern decisions regarding repurposing of facilities.[34] There is no general "best practice" definition regarding travel time between acute care hospitals, and acceptable travel times depend upon the specialty. For example, lower travel times for Emergency Services are a primary objective. Therefore, all Emergency Rooms currently operating will remain operational. It is important to note that the repurposing of a facility does not necessarily mean elimination of services in a community. In fact, it may actually result in new services being brought to a community. For instance, if a facility is repurposed due to an overabundance of acute

[34] *See* Application Section 12.b, pages 35-36. The Alignment Policy is attached to the Application as Exhibit 12.1.

care beds in an area which can be consolidated, it is possible that the use of the capacity may be switched to another needed service, like psychiatry, long-term acute care, rehab or other specialty use. Also, and importantly, the New Health System has committed to ongoing physician needs assessments and recruitment, so it should be clear the intent is to provide the appropriate services based on demand and need.

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

**RESPONSE:** The Alignment Policy will govern decisions regarding service alignment and consolidation, including repurposing of facilities. Service decisions, including repurposing, will be determined based on community need and the factors set forth in Response #5. While no specific decisions have been made at this time, repurposing may occur in full or in part and may result in a variety of services. Rehabilitation is only one example. See also Response #3.

**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?**

**RESPONSE:** Not-for-profit health systems are required to perform ongoing community needs assessments, and it is an Internal Revenue Service requirement that community members have significant input into this process.[35] In addition, each Mountain States and Wellmont hospital maintains a local board (of various compositions) which provides input into these assessments. Each hospital will maintain a local board, and it is expected that each board will continue needs assessments. In addition, the Alignment Policy requires thorough analysis of the relevant clinical and financial data, and input from physicians and other clinicians relevant to the service and the facility in question.[36]

**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?**

**RESPONSE:** As noted in Application Section 15.a.B (page 81) most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins. Last year alone, Mountain States and Wellmont collectively invested more than $19.5 million to ensure that inpatient services would remain available at the following rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Johnson County Community Hospital,

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[35] 26 CFR § 1.501(r)-(3).

[36] As noted in the Alignment Policy, the New Health System Board's Integration Committee will have a key role in evaluating and recommending alignment opportunities. The Integration Committee will consist of 10 members: 6 members shall be non-management Directors, two of whom shall be physicians; and 4 members shall be at-large members who are not Directors and who are not otherwise serving on any committees of the Board, and at least two of whom shall be independently practicing physicians.

Dickenson Community Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center. The New Health System commits that all Virginia hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services or new scope of services or repurposing as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. Currently, Mountain States and Wellmont are unable independently to make any such commitment to keep rural institutions open.

It is important to note that state lines are political subdivisions which have little bearing on patient utilization. Although Bristol Regional Medical Center and Holston Valley Medical Center are located just over the border in Tennessee, the reality of patient traffic patterns is that 57.4% percent of the patients at BRMCC in Bristol and 28.4% percent of the patients at Holston Valley Medical Center in Kingsport are from Virginia.[37] Patients being transferred from the New Health System's Johnson County Community Hospital in Mountain City, Tennessee are farther from the closest New Health System tertiary center (Bristol Regional Medical Center in Bristol, Tennessee) than patients from Russell County Medical Center in Lebanon, Virginia.

**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.)?**

**RESPONSE:** An emergency room will be maintained in each Virginia community where the New Health System currently operates facilities.

**ii. Will cancer care be offered in Virginia?**

**RESPONSE:** Yes.

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

**RESPONSE:** Yes.

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

**RESPONSE:** Yes.

**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).**

[37] Based on FY2015 discharge data.

**RESPONSE:** Yes. The Parties' only Virginia acute care hospital currently meeting the criteria of an average daily census greater than 50 is Johnston Memorial Hospital, which will be maintained as an acute care hospital.

**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:**

**RESPONSE:** To clarify, both Wellmont and Mountain States view themselves as Academic Health Systems and the New Health System will continue to provide training and graduate medical education throughout the system and the entire Geographic Service Area provided federal and state funding continues.

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

**RESPONSE:** Yes, the new residency program and positions at Johnston Memorial Hospital will 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?**

**RESPONSE:** The residency programs will be maintained in each community where they are located, and there is no change expected at Lonesome Pine.

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

**RESPONSE:** The residency programs will be maintained in each community where they are located, and there is no change expected at Norton Community Hospital.

**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.**

**RESPONSE:** Yes, these positions will remain in Virginia.

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

**RESPONSE:** This is not yet determined. The Research & Academics Community Health Work Group described in Section 15.a.G of the Application (pages 89-91) has proposed a model for a working relationship between the academic institutions in the region and the New Health System. The decisions regarding the investment in specific research and academic programs, will require a collaborative plan to be developed with academic partners.

**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?**

**RESPONSE:** The Applicants believe that the five broad levels of service intensity described by the American Society of Addiction Medicine (ASAM) Criteria[38] provide an evidence-based model of the continuum of recovery-oriented addiction services for the region. In Virginia, the New Health System plans to work closely with the Community Service Boards to determine where gaps exist in the continuum of care and where to prioritize services in the region's communities. The New Health System expects that its investments will leverage existing capacity and infrastructure to expand existing services in the region beyond their current reach and to provide critical missing services.

**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?**

**RESPONSE:** The Clinical Council will have responsibility for promoting the use of Clinical Pathways throughout the new health system which will be adopted by the Medical Executive Committee of each hospital. The Clinical Council will report on compliance with, and outcomes resulting from, the adoption of these Pathways. It is not expected that a pre and post-merger test on these pathways will be performed as many will be adopted post-merger across the system. Compliance with Clinical Pathways may be one measure of improved outcomes post-consolidation of services, but other measures will be considered such as mortality, infection rates, readmission rates, and so on. Under the Consolidation Policy, the Board Integration Committee will set individual evaluation measures to be reported on a case-by-case basis.

**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?**

**RESPONSE:** On recommendation of the Quality Committee and the Social Responsibility & Population Health Committee, the New Health System's Board will approve the individual quality improvement goals for the organization. Value-based payments by Medicare, Medicaid and large commercial payers will drive many of the metrics and performance levels for which the New Health System will be accountable, as will the measures agreed to in the State Agreements. The Applicants plan to actively collaborate with the payers and the

[38] *See* http://www.asam.org/quality-practice/guidelines-and-consensus-documents/the-asam-criteria.

Commonwealth as they determine which metrics to prioritize and where to set performance thresholds and goals.

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

**RESPONSE:** AHRQ was cited as one source of evidence based guidelines which exist to guide the New Health System's performance. As stated above, the Clinical Council will serve as the primary clearinghouse to promote adoption of best practices working with the local MECs and under the governance of the Board committees on Quality, and Social Responsibility and Population Health.

**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.**

**RESPONSE:** The New Health System is unable to provide an additional set of financial projections related to the potential expansion of Medicaid as permitted under the ACA. Currently both Virginia and Tennessee have decided not to expand Medicaid, and it is highly uncertain whether either State will ever do so. In addition, there is no information available on how Medicaid might be expanded in Virginia or Tennessee, what the coverages would consist of, what the payment mechanisms and limitations would be, how much providers would be taxed to finance each State's portion of Medicaid funding, and a number of other key assumptions that would be required to model the potential impact. Thus, the Applicants are not able to provide an additional set of financial projections related to Medicaid expansion.

**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.**

**RESPONSE:** As outlined in Exhibit 9.1 of the Application, FTI Consulting provided a description of the baseline financial model and an explanation of the key drivers and/or assumptions used in this baseline model for the preparation of the combined New Health System income statement. The assumptions apply general industry expectations in accordance with historical performance and do not include any known or anticipated changes in operations for the individual hospitals that would be deemed proprietary or confidential such that either Party would be able to identify the other Party's proprietary information. Please find attached as **Exhibit 32** to these Responses updated outputs from the model that now are in the "Year 1," "Year 2," etc., format. Also, this additional representation of the model has been updated to match the baseline assumption that the Parties entities do not make distributions or retain cash.

Hospital reimbursements have been affected by Medicare value-based programs such as (HCAHPS), readmissions, hospital acquired conditions, bundled payments, MSSP, as well as by other services such as skilled nursing facilities (SNFs), home health, and rehabilitation facilities. CMS just recently announced that physicians will be operating under a new value-based system effective January 1, 2019. Wellmont and Mountain States hospitals have performed very well under most of the Medicare value-based programs to date with the exception of readmissions, with most of the Wellmont and Mountain States hospitals being penalized.

Our region historically has had high readmission rates, and reducing readmissions is a priority. Both Wellmont and Mountain States are working to reduce or eliminate avoidable readmissions and are tracking readmissions through their quality departments. Both are actively engaged with post-acute care providers, including home health, long-term care, and rehabilitation facilities, to create best-practice protocols and metrics. These include effective patient transition care procedures and mutual expectations for care and quality standards which have been shown to reduce readmissions. Each health system has metrics associated with readmissions and ongoing process improvement strategies related to this and other quality areas. Both systems participate on a collaborative basis with CMS and most of the principal payers in value-based arrangements that focus on reduction of readmissions.

**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.**

**RESPONSE:** Based on the FTI Consulting analysis, the New Health System is projected to achieve cost savings in the areas of reduced non-labor spend, enhanced labor productivity and clinical program and facility modifications equating to $366M over the first 5 years of its existence as a merged entity, with annual recurring savings of $121M available after year 5 to reinvest in programs to benefit the communities served. As outlined in the Application, the New Health System intends to use these cost savings for initiatives to improve the health of the population in specific areas of identified need (as determined by the Parties and the State), including the recruitment and retention of personnel to provide new and expanded medical care in the Geographic Service Area. Due to antitrust concerns associated with this merger, the Parties are not able at this time to prepare pro-formas for each potential new or expanded service offered by the New Health System; therefore, the investments in additional personnel and other operating costs are not included in the projected income statement. However, to ensure that the Parties are held accountable for their plans, the Parties have proposed in the Application a commitment to the Commonwealth to develop a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. One currently identified area for future additional personnel is pediatric subspecialists. The Parties have committed to recruit and retain pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment to address the region's need for these sub-specialists. See Response #35.

**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?**

**RESPONSE:** Currently, the financial performance of each of Wellmont and Mountain States is reported publicly each quarter with annual reports made available at the end of each system's fiscal year. The New Health System intends to continue the same quarterly and annual reporting of its financial performance if the merger is approved.

The Virginia Rules and Regulations Governing Cooperative Agreements require the Department of Health to establish quantitative measures that will be used to evaluate the proposed and continuing benefits of an approved cooperative agreement.[39] The New Health System will be required to report annually to the Commissioner on the extent of the benefits realized and compliance with any terms and conditions set forth in the Applicant's State Agreement.[40] The Parties have proposed certain measures in the Application to be used to evaluate the proposed and continuing benefits of the Cooperative Agreement and expect to be held accountable for those commitments. The Applicants believe the ongoing annual oversight by the Commissioner will provide more than adequate opportunity to evaluate the New Health System's performance and its satisfaction or its commitments. Neither the Virginia statute and regulations nor the Tennessee statute and regulations provide for a review process of the New Health System's budgets by either state or the Authority. The members of the Authority include representatives from organizations that are expected to compete with the New Health System. Establishing a reporting or approval process for the New Health System that involves competitors and organizations with separate fiduciary duties could unnecessarily disadvantage the New Health System in its new competitive environment.

**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?**

**RESPONSE:** The Parties believe that access to pediatric specialties in geographic proximity to where families live is an essential commitment to improving access to needed health care in the region. Mountain States concluded a community needs assessment for Niswonger Children's Hospital in July, 2015. The Niswonger needs assessment found a demonstrated community need for over a dozen specialties analyzed within the geographic service area served by Niswonger Children's Hospital. While consolidation of some services, like the two Level I trauma centers, may offer improved efficiencies, the efficiency of services must be balanced with access to and need for these services. Based on the Niswonger needs assessment, there is demonstrated need and volume support for two pediatric specialty centers, and the New Health System plans to establish pediatric specialty clinics in both Bristol and Kingsport to address these service gaps.

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[39] 12VAC5-221-100(C).
[40] 12VAC5--221-100(A).

A large number of children in the Geographic Service Area are covered by Medicaid, so it is important to recognize the difficulty many families have with transportation and the impact this has on access to care. Currently, there are very few pediatric specialists available in the rural areas of Southwest Virginia. When pediatric specialists are not available in a local community within the Geographic Service Area, children and their families must currently often travel to Johnson City to seek care. If the type of pediatric specialist the child needs is not available in Johnson City, the child and his or her family frequently must travel more than two hours from Southwest Virginia to the nearest competing children's hospital for treatment. The Applicants believe pediatric centers in Bristol and Kingsport would provide needed central access to these services for the Virginia counties in the Geographic Service Area, with decreased travel time for patients. Based on each location's proximity to Virginia, these access points will be an improvement for residents of Virginia and for those communities in Tennessee in which the specialty centers will be located.

The Parties are committed to enhancing the pediatric specialties available in the Geographic Service Area and have determined that providing pediatric specialty clinics in both Bristol and Kingsport will provide appropriate access for several reasons. First, the Bristol and Kingsport locations are close enough to the Niswonger Children's Hospital (each approximately 25 miles distance) that the pediatricians will be able to more easily access the clinics as they travel to the smaller communities. Second, there are advanced specialists located in Bristol and Kingsport who can provide support and other services to pediatric specialists as needed. Finally, the Parties' goal is to make pediatric specialty care as least disruptive as possible for those children and their families who need it. With easier access, families are more likely to seek care when it is needed. Making the specialty clinics more readily available in Bristol and Kingsport is expected to enhance both timely utilization and access.

**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?**

**RESPONSE:** Payers have access to significant utilization and financial data that can be used to identify high cost services and processes. Payers also have access to the cost drivers that drive up premiums and overall costs. The federal government has recently announced that 80% of Medicare payments will be "value-based" by 2018, including the significant reforms underway with how physicians are compensated. The New Health System must have a scalable strategy to shift more toward these mandated value-based arrangements. The strategy involves efforts that encourage an improvement in the health of the population served by the New Health System. Given the payer's superior access to aggregate data, the New Health System anticipates expanded value-based contracts with the payers, which will prioritize a focus by the New Health System on eliminating unnecessary cost drivers to reduce costs and improve overall patient outcomes. The Applicants believe that the greater number of patients served by the New Health System will better position it to enter into additional risk-based contracts with payers, which will lead to better patient outcomes and reduced costs.

As an example, a payer may identify that few children are receiving well-child screenings. Without the payer information, the New Health System would have no way of knowing which

providers are doing a better job than others, nor would the New Health System know why. Under a different and aligned contracting methodology with payers, the Applicants anticipate that payers would focus on a low rate of well-child screenings as a concern, and choose to incentivize the New Health System to improve this metric. The payers would share data with the New Health System on the variation that exists in the marketplace, and the New Health System would work with the associated physicians to improve that metric.

More complex examples of potential risk-based contracting models are global payments for certain surgical procedures and a full risk arrangement. Under a full risk arrangement, which is difficult for Mountain States and Wellmont independently to do on a major scale, an entire population health approach can be taken. For instance, a payer may choose to provide incentives for better management of all patients with certain cancer diagnoses. Practical data, such as time from diagnosis to treatment, may be utilized and incentivized based on improvement in various metrics in order to improve patient outcomes. The New Health System with an expanded regional patient population, can deploy strategies and care models that can reduce variation and costs and also improve outcomes. This full risk model can be used for a variety of diagnoses or procedures to the cost benefit of payers, providers and health benefit to patients. It would be very difficult for each system to do this individually in Southwest Virginia because neither system can achieve the critical mass of potential population necessary to assume full risk under payer arrangements.

**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?**

**RESPONSE:** In the Application, the New Health System has proposed a mediation process as the means to resolve any and all payer contract negotiations that reach an impasse. Since this is a commitment in the Application and potentially in the State Agreements, the New Health System anticipates that the role of the Commonwealth of Virginia and Tennessee will be to ensure that the New Health System negotiates in good faith. The New Health System is willing to commit to timely resolution of any mediation by committing to complete any such mediation within 180 days. The conduct of the payers is important as well, and the New Health System would expect all payers to negotiate in good faith.

It will be in the best interests of the New Health System to resolve any payer disputes in a timely manner since there are a limited number of payers operating in the Southwest Virginia market and one payer has greater than a 75% commercial market share.

The New Health System's pricing commitments benefit the payers, through both pricing concessions and limits on future pricing growth. The New Health System has proposed that already agreed-upon pricing increases would be decreased by 50% for the first full fiscal year that occurs after one year after closing. This commitment provides a substantial benefit to the payers and consumers, as pricing would go up more if the merger were not approved.

**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?**

**RESPONSE:** The New Health System agrees that reduction in inpatient acute utilization rates will provide a substantial financial benefit to payers and patients, but will result in a significant financial loss to the New Health System.

This issue is one of the core reasons behind the Application and proposed merger, as the inpatient acute care use rates have been declining in the Geographic Service Area and are expected to accelerate their decline. These declining use rates, when combined with negative population trends in Southwest Virginia, signal the need to reduce costs and potentially close hospitals absent the merger. Use rates in the Geographic Service Area are at 124 admissions per 1,000 lives, whereas the national rates in moderately managed markets range from 90-110 admissions per 1,000. If the New Health System experiences the same trends in use rates that are occurring nationally, the additional cost reductions will need to occur. Currently, Wellmont and Mountain States duplicate inpatient acute care services with little or no differentiation in service or value. The merger will allow the New Health System to make diligent, reasoned decisions about unnecessary duplication of capacity, which will result in the New Health System being able to withstand the aforementioned utilization reductions.

The model for the New Health System's financial plan is predicated on some migration of inpatient utilization to outpatient utilization over time.

**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?**

**RESPONSE:** The New Health System does not plan to provide any health insurance plans or products. Mountain States' CrestPoint commercial insurance subsidiary exited the insurance and TPA business as of July 1, 2016. It is the New Health System's intent to contract with all payers in the market as Wellmont and Mountain States do currently. By committing to contract with all payers in the market, the New Health System is making a substantial contribution to ensure choices in both plans and products.

## 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.**

**RESPONSE:** The Virginia General Assembly noted the unique nature of the region when it established the Southwest Virginia Health Authority:

> The General Assembly recognizes that rural communities such as those served by the Authority confront unique challenges in the effort to improve health care outcomes and access to quality health care. It is important to facilitate the provision of quality, cost-efficient medical care to rural patients. The provision of care by local providers is important to enhancing, fostering and creating opportunities that advance health status and provide health-related economic benefits.[41]

Having served the region for many years, Mountain States and Wellmont have observed these unique challenges first-hand. The population of this region lags behind the rest of the State in many health areas with substantial medical, personal and economic costs as a result. The economic opportunities in the region are limited and shrinking, and it becomes even more important to support local economies and industries with healthier workforces. Most of the Parties' hospitals based in Virginia are small, serve as the community's sole provider, and are located a good distance away from other hospitals. With the exception of Wise County, which has three acute care hospitals, there is little duplication of services in the Virginia communities of the Geographic Service Area. Given that the demand for inpatient services is declining and all but one of the Parties' Virginia hospitals have an average daily census of 35 or less,[42] the Parties believe that the majority of the Virginia hospitals are at risk for survival without the proposed merger. Each of Mountain States and Wellmont currently support the majority of their Virginia hospitals in order to keep these hospitals open. Most of the Parties' Virginia hospitals were previously owned by not-for-profit or for-profit systems that, due to the increasing downward pricing pressure and reduced utilization of services, chose to end their ownership or affiliation of the hospital and sold the facility to Mountain States or Wellmont, or simply stopped compensating for the operational losses of the hospitals. Without the commitments contained in the Application by the New Health System to keep these hospitals open, the reality exists that few of the Southwest Virginia hospitals could survive, or if they did, would do so with significantly reduced services.

As described, most of the Parties' rural hospitals are not sustainable on their own. However, under the New Health System, these hospitals will be part of a larger locally-governed and state supervised system with more assets and resources. The savings realized from elimination of duplicated services will be able to better support the Virginia hospitals and ensure their survival and will be deployed in supporting investments, services and programs to the benefit of local communities.

In addition, the consolidation of services and resources will produce synergies and savings that will enable the Parties to offer and expand health care services to meet the unique health care needs of the population of Southwest Virginia, including residential addiction recovery services, mobile health crisis management teams, intensive outpatient treatment and addiction resources, and pediatric specialty centers. The Parties have made specific commitments to achieve these critical goals.

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[41] Virginia Code§ 15.2-5368.B.

[42] Johnston Memorial Hospital is the Parties' only Virginia hospital with an average daily census over 35. *See* Applications Tables 5.2 and 5.3 for average daily census data, pages 18-19.

Wellmont thoroughly analyzed and considered proposals to merge with out of market acquirers as part of its alignment options analysis begun in 2014. As described in the Application, the Parties determined that a merger between Wellmont and Mountain States was the best option to create efficiencies that could generate savings for reinvestment in this region, and, under the oversight by the Commonwealth under a Cooperative Agreement, to assure tangible benefits for the communities through enforceable commitments and to protect the public from any potential loss of competition through restrictions on pricing. The proposed merger between Mountain States and Wellmont also has the advantage of satisfying the General Assembly's important mandate to provide "care by local providers" because the New Health System will continue to be a locally-based system with decisions made by local leadership rather than by remote leaders based in other parts of the country. Moreover, this care will be patient-centered, with metrics and accountability.

The Parties believe quality will not diminish under the Cooperative Agreement and that improved access and care coordination provide assurances of sustained or improved quality of care across the spectrum of care. The Parties point to the experience of Mission Health in Asheville as support for this position. For seven years in a row, Mission has been named a Top 100 hospital, and for three years in a row, has been named a top 15 health system in the nation. Under its COPA, quality at Mission has been sustained and costs are lower relative to their peers. According to data provided by the State of North Carolina, the costs for health care services at Mission have been sustained at a lower level than its peers in the state. In fact, Mission Health has been recognized as one of the best examples in the country of health systems that have successfully achieved higher quality while maintaining low costs.[43]

Competition was reduced in Asheville by the merger, but, because of the implementation of the COPA and state supervision over Mission's commitments, health care costs have remained low and health care quality has improved. The Parties note that the U.S. Department of Justice and the North Carolina Attorney General's Office recently took legal action against another health system in North Carolina (Carolinas HealthCare). The legal action alleges anticompetitive behavior by Carolinas Healthcare which could increase pricing and reduce consumer choice.[44] The claims made against Carolinas Healthcare have never been made by a federal or state agency against Mission Health. The Parties note that the anticompetitive behaviors that Carolinas Healthcare has allegedly engaged in are explicitly prohibited by the COPA regulating Mission Health, and Mission has not engaged in such behaviors. The Parties have proposed commitments in their Application that are similar to the Mission Health commitments. These are intended to prohibit the anticompetitive behaviors that triggered the federal and state action against Carolinas Healthcare. The Parties believe such commitments, when properly supervised, reduce the likelihood of the behavior alleged by the Department of Justice in the Carolinas Healthcare case, and protect high quality and low cost.

**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**

[43] http://www.mission-health.org/sites/default/files/document-library/1292_0.pdf
[44] http://www.charlotteobserver.com/news/local/article82726402.html

**commitments offered by the Applicants), explain how those commitments mitigate or more than balance the adverse impact from reduced competition.**

**RESPONSE:** The proposed merger will result in the consolidation of some services between the Parties, but it also creates the opportunity to achieve significant cost-savings and other benefits for consumers. Among the consumer and community benefits are specific commitments regarding behavioral health, infant and maternal care, cardiac and other health conditions/behaviors. These commitments include common IT systems and information exchanges to improve access to data and information to improve and align care, access to timely information on patients, and investments in specific programs that will be tracked by agreed-upon metrics. All of these align the delivery system around improved care for patients and developing and placing resources in the best locations. The mechanisms to substantiate these claims are the specific accountability mechanisms and metrics proposed in the Application. The Parties note that these benefits accrue not just to commercially insured patients, but also to the broader population, including uninsured, Medicare and Medicaid, and those served in the community other than patients. The benefits of improved health and reduced costs inure generally and to the State.

In addition, active supervision through the Cooperative Agreement can preserve, and hold the New Health System accountable for enhancements in healthcare quality, cost-control, affordability, and access. Additional external pressures are also being placed on the health system to improve quality and reduce cost. For example, the Centers for Medicare and Medicaid Services has announced the imposition of value based purchasing and quality-based incentives and penalties for hospitals, which currently are focused on reduced readmissions, hospital acquired conditions, patient satisfaction and literally dozens of metrics which tie quality to reimbursement. Because the hospitals do not segregate populations as they work to comply with these mandates, all patients, regardless of payer, benefit from these efforts. Commercial, Managed Medicaid, and Medicare Advantage contracts are also significantly invested in pay-for-performance, and the New Health System will be held, through financial incentives and penalties, to achieving the objectives agreed to by the payer and the system. In addition, for the New Health System to achieve the expenditure commitments being made in the Application, pressure will exist to achieve the synergies committed in the Application. Significant competition will remain from large tertiary systems located nearby requiring the New Health System to continue to behave competitively to attract patients. Competition will remain locally in the outpatient marketplace. As a locally governed enterprise, accountability to the community will be an important advantage over the elimination of local governance which would occur if one or both of the Parties were to join out-of-market systems based elsewhere.

Therefore, as courts have now recognized, the major changes occurring in the health care landscape require health systems to behave differently and to be responsive to these payer and government imposed performance standards. The consolidations occurring due to the merger better enable the system to achieve these objectives through improved efficiency, lower cost, and a refocusing of resources on the clinical integration necessary for success.

In order to prevent the New Health System from adversely impacting the population health, quality, access, availability or cost to patients or payers, the Parties have proposed that the following commitments be included in the Cooperative Agreement and be actively supervised by the Commonwealth:

1. *The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in close proximity to where the population lives.*

   How this commitment would prevent the potential disadvantage: In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. This commitment ensures that the three hospitals which have traditionally served as the hubs for high-level services, Johnson City Medical Center, Bristol Regional Medical Center and Holston Valley Medical Center, will remain available as tertiary referral centers to the patient population. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

2. *Maintenance of open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors*

   How this commitment would prevent the potential disadvantage: Under the current competitive system, patient choice is limited by restrictions on employed physicians' ability to practice at competing system's hospitals in the Geographic Service Area. With some exceptions, Wellmont-employed physicians are not allowed medical staff privileges at certain Mountain States hospitals and Mountain States-employed physicians are not allowed medical staff privileges at certain Wellmont hospitals. This is particularly true in highly competitive specialties such as cardiology. This practice exists because of competitive factors and does not support convenient access for patients. Not only will the New Health System maintain open medical staffs at all facilities, which allows patients to choose a physician and hospital based on their preferences and needs, but employed physicians will now be able to practice at all facilities within the New Health System subject to the rules and conditions of the organized medical staff of each facility. A commitment to maintaining an open medical staff at all facilities will ensure availability to all qualified employed, contracted or independent physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This commitment would be actively supervised by requiring the New Health System to file an annual report to the Commonwealth attesting to compliance, and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

3. *For all Principal Payers, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement; and, for subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while*

*New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.*

How this commitment would prevent the potential disadvantage: Without a commitment to cap rate increases, the concern is that the New Health System could potentially use any marketing and bargaining power achieved through the merger to increase rates for payers and consumers. In order to prevent any potential disadvantage that may result for the patients and payers in the price of healthcare services, the Parties have proposed an initial rate reduction followed by a rate cap commitment to be supervised by the State. Reducing existing commercial and Medicare Advantage contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System will lead to a reduction of prices for consumers and payers below that which is currently agreed to in contracts between Wellmont and their payers and Mountain States and their payers. The commitment of not increasing hospital, non-hospital and physician services rates greater than their respective Consumer Price Index minus 0.25% will bend the price curve, acting as a maximum cap on price growth always lower than the national average. To ensure this commitment is implemented, the Commonwealth would actively supervise the rate cap implementation, and the New Health System would be required by the Commonwealth to file an annual report attesting to compliance. The Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

4. *The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.*

   How this commitment would prevent the potential disadvantage: Many of the commitments in the Application will allow the New Health System to achieve success as federal, state and commercial payers increase their use of value-based payment. Among others, these include a common IT platform, more concentrated volumes,

commitments to achieve top decile performance, and a commitment to move toward risk based models. Without the transaction, and with decreasing volumes and use rates (and thus an increasing inability to financially support many of the hospitals), it will simply be more difficult for these hospitals to achieve the objectives of the government and commercial payers.

To ensure that a reduction in competition between facilities does not decrease the incentive for increased quality and value of care, the Parties have committed to seeking out the alignment of reimbursements with quality and value measures. Federal and state governments are increasingly tying reimbursement, and reimbursement growth, to performance by measuring quality, patient experience and utilization/total cost of care. Commercial health plans and managed Medicare and Medicaid plans are following Medicare's lead. Not only will increased value-based payments limit anticompetitive pricing, these payments will drive the New Health System towards improved quality and enhanced patient experience. Since an increasing number of payers with value-based systems reward appropriate utilization, it will be difficult for the New Health System to make up lost revenue from the price controls detailed above in Section C.3 by inappropriately increasing utilization. This commitment ensures that the New Health System will actively pursue quality and value based payments, and the Commonwealth will actively supervise this commitment by requiring the New Health System to report progress toward this goal on an annual basis.

5. *The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.*

   How this commitment would prevent the potential disadvantage: To further ensure that a reduction in competition between facilities does not decrease the quality of care in the region, the Parties have proposed a commitment to report quality measures in a timely and easy to understand manner for use by patients, employers and insurers. Public and proprietary reporting of quality data is increasingly being used by patients, employers and insurers to make decisions about what providers provide the best value. Not only are patients utilizing data on quality to decide what provider to use, employers and insurers are increasingly using similar quality data to decide how to tier or narrow their networks to incentivize the use of high-value providers or to exclude low-value providers all together. This commitment ensures that the New Health System will be held accountable by the Commonwealth and the public for its quality performance. The Commonwealth will actively supervise this commitment by requiring the New Health System to comply with its quality reporting obligations on an annual basis.

   The Cooperative Agreement provides a unique mechanism for Wellmont and Mountain States to merge under active state supervision. This structure allows the Commonwealth to replace any reduced competition with regulatory oversight of the New Health System and its compliance with the mutually agreed enforceable commitments and assures that the benefits to the community will outweigh the competitive disadvantages. Ongoing, active supervision by the Commonwealth ensures that the benefits of the merger continue to outweigh any potential disadvantages and

that the Commonwealth's policies underlying the issuance of the Cooperative Agreement are fulfilled.

**42. How will the merger impact the private providers?**

**RESPONSE:** The Applicants believe that the merger will have little adverse impact on independent providers, and instead, providers will benefit from access to improved IT and health information exchange. **Table 42** below provides analysis of the merger's impact on various categories of independent providers in the Geographic Service Area.

**Table 42 – Impact of Merger on Independent Providers**

| Provider Type | Impact |
|---|---|
| Physician in private practice | There will be little, if any, adverse impact on physicians in private practice. The Clinical Council of the New Health System, which will be composed in part of independent, privately practicing physicians, will become a resource for physicians practicing in the community as the New Health System attempts to address priority health issues.<br><br>The New Health System is committing to conduct physician needs assessments and to conduct recruitment in partnership with existing providers rather than using employment as the "go-to" model. This should reduce the reliance on employment, which is a priority of the independently practicing physician community. |
| Physicians in private practice and who have contracts with hospitals to provide various services | There will be little impact for such physicians. Based on service needs of hospitals, hospitals will continue to contract for needed services. |
| Post-Acute Skilled Nursing Facilities | The New Health System will seek to collaborate with those facilities willing to reduce unnecessary readmissions, reduce variation in clinical care, improve outcomes and reduce overall costs. |
| DME | Will remain competitive. There are multiple DME providers. |
| Pharmacy | Will remain competitive. There are multiple pharmacy providers. |
| Outpatient Surgery Centers | A substantial number of the outpatient surgery centers in the service area are 100% owned and controlled by independent physicians or are majority owned by independent physicians. Thus, this service will remain highly competitive.[45] |

**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?**

[45] *See* Exhibit 14.1D to the Application for additional information about outpatient surgery centers in the Geographic Service Area.

**RESPONSE:** No, the Parties do not have plans to materially increase the percentage of physicians in the community employed or affiliated with the New Health System. Instead, the Parties' objective is to support the independent practice of medicine.

The Parties believe that the physician employment model will be used by the New Health System only to facilitate bringing needed specialties to rural and underserved areas or when private physician groups do not want to expand or do not exist. Under the proposed merger, the Parties intend to use income guarantees and other mechanisms legally available to help private practices recruit and grow. The Parties also plan to implement a Management Services Organization to help these private practices, should they want or require assistance. In addition, as specified in Sections 14 and 17 of the Application, the New Health System has committed to: not engage in exclusive contracting for physician services, except for hospital-based physicians, not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities, and not prohibit independent physicians from participating in health plans and health networks of their choice.

**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?**

**RESPONSE:** Market shares in the Application, except where expressly noted, include all hospitals used by patients living in the Geographic Service Area, even hospitals located outside the area.

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

**RESPONSE:** Exhibit 14.1 (Section D) of the Application lists all Ambulatory Surgical Centers ("ASCs") serving the Geographic Service Area. The term ASC encompasses all ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

Outpatient services in the Geographic Service Area, including ASCs, have many independent alternatives, which are identified in Application Exhibit 14.1 and whose locations are shown on maps in Figures 14.1-14.3 of the Application (pages 61-63).

The New Health System will face competition from numerous independent outpatient facilities, post-acute care facilities and physicians in the Geographic Service Area. These competitors will not be a party to the Cooperative Agreement, and the Parties anticipate that the independent providers will continue to operate independently and competitively if the Letter Authorizing Cooperative Agreement is granted. Most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization. We reference Application Exhibit 14.1 (Section D), which lists each of the ASCs in the Geographic Service Area and identifies those that offer only a single service by their Facility Name (e.g., eye surgery only ASCs, which are all identified by the inclusion of "Eye Surgery Center" in their Facility Names). Most of the ASCs, including the Virginia ASCs, offer multiple services.

**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?**

**RESPONSE:** The New Health System will not acquire anticompetitive leverage from the merger. Large payers are of great importance to the New Health System, and it will be important for it to be included in the payer's network. There are sufficient alternatives that payers will have competitive constraints. Currently, 100% of the principal payers in the New Health System's service area have both Wellmont and Mountain States as contracted providers for inpatient, outpatient, and physician services. Once merged, it is the New Health System's intention to continue to be contracting providers to all principal payers to ensure that all of the region's residents have full access to the New Health System's services. The outpatient and physician market is and will remain highly competitive. In addition, the New Health System's pricing commitments apply to outpatient and physician services rates as well as inpatient rates. Typically, virtually all of the principal payers want to contract for all of Wellmont's and Mountain States' services, and the New Health System assumes that would be the case going forward. If a principal payer wanted to contract for inpatient and emergency hospital services only, and the New Health System was unwilling to do that, that negotiation would be subject to the mediation commitment made as part of the Application.

**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?**

**RESPONSE:** The Parties are compiling the information requested and will provide this to the Authority in a subsequent response as soon as possible.

**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;**

**RESPONSE:** The Parties currently provide inpatient, outpatient, and physician services through a variety of facilities located throughout the service area. Many of these services are provided in rural communities with limited healthcare resources and assets and with substantial healthcare challenges. The communities served are relatively sparsely populated with limited commercial volumes, and substantial shares of government pay and uninsured volumes. The Parties anticipate substantial benefits to the residents of these areas, employers, and payers, including government, from the creation and support of an integrated delivery system with supporting infrastructure and investments, including from the deployment of merger savings and synergies across the areas to the benefit of residents. The Parties will provide under the Cooperative Agreement transparent and clear reporting and accountability for investments and programs, with metrics for tracking. These substantial benefits accrue to the benefit of communities and the Commonwealth. Any negative effects and concerns center on the loss of

current competition between Mountain States' and Wellmont's inpatient services. We believe these are less than might be anticipated for several reasons: (1) the combined system will have incentive to reach agreement with payers to sustain important commercial revenues, which are limited; (2) market shares overstate issues because a large part of market share comes from numerous small hospitals which are not a strong competitive constraint; (3) without the merger, substantial cost pressures will limit the Applicants' ability to lower rates materially; (4) there are numerous benefits unlikely to be accomplished but for the merger, and (5) finally, the specific commitments of the Parties limit adverse outcomes.

**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,**

**RESPONSE:** Please see Application Section 5 (pages 14-21) and the accompany Application Exhibits 5.1 and 5.2 for information previously provided on inpatient market shares, and please see Application Section 14 (pages 54-66) and the accompanying Application Exhibits 14.1 for information previously provided on outpatient market shares.

**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.**

**RESPONSE:** Although the merger will eliminate some competition between the Parties, the cooperative agreement is the mechanism created by the Virginia General Assembly to allow beneficial mergers while ensuring through active state supervision that consumers retain those benefits. Through this statutory authority, the Commonwealth is able to protect its citizens from anticompetitive activity and simultaneously allow the New Health System to address the region's major population health issues and related healthcare challenges.

As discussed in the Application, combined facilities share for outpatient services[46] ranges between 0 percent and 55.6 percent depending on the specialty. Combined, the New Health System will employ approximately 30 percent of the physicians in the proposed Geographic Service Area.[47] The merger of Mountain States and Wellmont will not create a concentrated market involving any physician or outpatient services. We acknowledge that for general acute care inpatient services, the merger creates a relatively concentrated proposed Geographic Service Area.

Without active supervision under the authority of the cooperative agreement law, it is possible the merger would empower the New Health System through exclusionary practices to foreclose market access by physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. There are, however, certain mechanisms that the Parties have proposed that could be adopted by the Commonwealth to actively supervise the merger and ensure that consumers reap the expected benefits of higher-quality, more affordable care from the merger.

In order to prevent the New Health System from reducing competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or

[46] *See* Application Section 14.c (pages 59-66) and the accompany Exhibits 14.1 (Sections A through E).
[47] *See* Application Exhibit 14.1 (Section E).

services to, or in competition with, hospitals in a way that results in disadvantages, the Parties have proposed that the following commitments be included in the Cooperative Agreement and be actively supervised by the Commonwealth:

1. *The New Health System will maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors.*

   How this commitment would prevent the potential disadvantage: A commitment to maintain an open medical staff at all facilities will ensure equal access to all qualified physicians in the proposed Geographic Service Area according to the criteria of the medical staff bylaws. This will ensure that independent physicians who meet the rules and conditions of the organized medical staffs of each facility will not be disadvantaged compared to physicians employed or contracted by the New Health System. This commitment would be actively supervised by requiring the New Health System to file an annual report to the State attesting to compliance and the State would have the ability to enforce this commitment under the Cooperative Agreement.

2. *The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the Board of Directors.*

   How this commitment would prevent the potential disadvantage: Independent physician practices frequently depend on the ability to see patients at multiple facilities to provide services or manage populations for whom they've assumed risk. A commitment to abstain from exclusive contracting for certain non-hospital-based physician services will enable independent physician practices to continue to compete with physicians employed or contracted by the New Health System. The New Health System will restrict any exclusive contracting to certain hospital-based physicians, like hospitalists, radiologists, pathologists, or emergency-room physicians, as approved by the Board of Directors. The best practice in the industry for preserving quality and managing cost in these hospital-based departments is for such services to be managed by a single physician group, with such group being held to standards determined by the leadership of the hospital in collaboration with the group. As an example, it would not be optimal for a hospital to have multiple ER physician groups staffing the ER, laboratory or radiology, as doing so would risk confusion and lack of consistency in processes. This is why exclusive contracts for hospital-based physicians is common in hospital markets of any concentration level. For independent physician groups that provide hospitalist services, the New Health System will continue to allow the independent physicians or their hospitalists to follow their patients in multiple hospitals as long as the independent physicians meet the organized medical staff rules and conditions and the metrics related to performance on which the hospital and independent practice agree. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

3. *Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.*

How this commitment would prevent the potential disadvantage: Exclusive contracting has the potential to reduce competition by requiring physicians to render services only at facilities of the New Health System. Restricting the practice of independent physicians to the New Health System's hospitals and other facilities has the potential to reduce the number of referrals in the proposed Geographic Service Area available to competing providers, and reduce the labor supply of physicians necessary for these providers to operate in the market. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

4. *The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.*

How this commitment would prevent the potential disadvantage: Prohibiting or disincentivizing independent physicians from participating in health plans and provider networks of their choice has the potential to reduce competition and raise prices for insurers contracting to form provider networks. A commitment to not engage in such practices (be they as conditions for obtaining privileges or for other reasons) ensures continued competition among health plans and providers. In order to ensure compliance with this commitment, the Parties have proposed that the commitment be actively supervised by the Commonwealth through annual reports attesting to compliance and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

5. *The New Health System will participate meaningfully in a health information exchange open to community providers.*

How this commitment would prevent the potential disadvantage: A health information exchange built off a Common Clinical IT Platform has the potential to improve coordination of care and quality of health care services across the region. To ensure that independent physicians and other health care providers in the proposed Geographic Services Area will not be disadvantaged by lack of access to patient information necessary for the management of their patients, the New Health System has committed to participating in a health information exchange open to community providers. The New Health System will ensure its Common Clinical IT Platform interfaces appropriately with the exchanges designed to share health information such that data may be shared with physicians. Additionally, the New Health System will utilize the data for its own employed physicians and service locations where the use of this data will enable improvement in the coordination of care. This commitment would be actively supervised by requiring the New Health System to file an annual report to Commonwealth attesting to compliance once the health information exchange is fully established and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

6. *The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.*

How this commitment would prevent the potential disadvantage: A health system that achieves increased market share or bargaining power through a merger could potentially obtain labor at more favorable terms and wage rates than in an otherwise competitive market for the purchase of labor. Such an outcome is not likely for the New Health System due to at least two factors, in addition to this commitment: 1) the low area wage index that the region is currently assigned by the federal government creates competition for labor from outside the Geographic Service Area, and the merger will not reduce this competition 2) the New Health System will not have a dominant share in the outpatient and physician services market which are attractive alternative employment options for hospital staff.

To further ensure that employees are not disadvantaged by the loss of competition between the Parties, the New Health System will commit to honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave. This commitment would be actively supervised by requiring the New Health System to file a report to the Commonwealth attesting to compliance after the first year after formation of the New Health System and the Commonwealth would have the ability to enforce this commitment under the Cooperative Agreement.

The Parties believe that including these commitments in the Cooperative Agreement will prevent the New Health System, were it to obtain market power through the merger, from exercising it to reduce competition among or for physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with, hospitals. To ensure the disadvantage is prevented, the Parties propose that the Commonwealth actively supervise these commitments through annual reporting requirements.

**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?**

**RESPONSE:** The Parties do not anticipate an inability to reach agreement with payers, given the importance of commercial revenues to the Applicants. It will be in the best interests of the New Health System to resolve any payer disputes in a timely manner since there are a limited number of payers operating in the Southwest Virginia market and one payer has greater than a 75% commercial market share. In the unlikely event that the New Health System is unable to reach agreement with payers, there are inpatient hospitals not affiliated with either Wellmont or Mountain States in Wythe, Tazewell, and Buchanan Counties in Southwest Virginia, for example. In addition, there are other third-party hospitals in Roanoke, Asheville, Boone, Pikeville, Winston-Salem, and Knoxville to which patients regularly travel currently for care, as well as academic medical centers in the region and beyond. The marketplace in the region is particularly dynamic, with patients crossing state lines and traveling beyond the Geographic Service Area to seek care. New Health System's intends to contract with all insurers offering health plans in the Geographic Service Area. The New Health System has proposed a commitment requiring it to mediate if unable to reach agreement with any payer. Both Wellmont and Mountain States have enjoyed long-term relationships with all of the principal payers and anticipate the continuation of these relationships under a cooperative agreement.

**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?**

**RESPONSE:** As outlined in Response #42, the Parties do not believe the proposed merger will adversely impact the independent physician community in the Virginia areas of the Geographic Service Area. The New Health System's commitments to foster and support the continuation of an independent physician community in the Geographic Service Area include those outlined in Sections 14 and 17 of the Application:

**Commitments to an independent physician community:**

- The New Health System will maintain open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the New Health System's Board of Directors.
- The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health System's Board of Directors.
- The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.
- The New Health System will collaborate with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.
- The New Health System will commit to participate meaningfully in a health information exchange open to community providers.

## 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?**

**RESPONSE:** The Parties have made no decisions about the workforce after the merger. Antitrust laws prohibit the Parties from sharing information in sufficient detail to enable them to formulate specific staffing plans at this time, but the Parties anticipate that the merger will provide job opportunities.

With the commitments made in the Cooperative Agreement to keep all Virginia hospitals open for at least five years, to reinvest savings achieved through synergies into local, community-based services, and to expand specialty services, the Parties believe there is opportunity to maintain or grow the labor force in Virginia. With the exception of Wise County, which has three acute care hospitals, there is little duplication of services in the Virginia communities of the Geographic Service Area. Even in Wise County, where there could possibly be service alignment, the savings generated from the merger will likely allow new services to be added that do not currently exist in the community – thereby creating job opportunities and minimizing any potential negative impact on staffing in Wise.

As stated, the Parties believe that job opportunities will be created in Virginia through the merger. The savings generated by the merger efficiencies will enable the New Health System to make substantial investments in providing new services, which will create jobs. Shifting physical resources and personnel away from unnecessary inpatient services to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce.

In addition, the New Health System will develop academic and research programs that attract talent throughout the region in Virginia and Tennessee. The New Health System commits to increase residency and training slots, create new specialty fellowship training opportunities, and add faculty. The New Health System intends to attract and retain employees by being competitive with neighboring health systems. The Parties believe that by carrying through on the commitments in the Application, the New Health System will become a nationally recognized model which will attract highly talented team members and physicians who want to be part of a health care solution not necessarily offered elsewhere.

Under the Cooperative Agreement, the New Health System is able to make the following commitments its communities – commitments that are not in place or possible if the Cooperative Agreement is not adopted.

## Commitments to current workforce:

- All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.
- The New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System.

- The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.
- The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.
- The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

**Commitments to workforce development:**

- The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program.
- With its academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.
- The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

The staffing opportunities for the Parties' Virginia facilities are likely to be much less if the Cooperative Agreement is not adopted. The Parties believe that it will be increasingly difficult to continue supplementing the Virginia rural facilities over the long-term without the savings the proposed merger would create, thereby threatening the existence of the facilities and the jobs at these facilities. Most of the Parties' Virginia rural hospitals currently have an average daily census of thirty patients or less.[48] The populations of the Virginia counties in the Geographic Service Area are declining or stagnant and are expected to continue to do so.[49] Wellmont and Mountain States, along with other providers nationwide, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, and higher patient out-of-pocket costs due to increased copayments and deductibles which have led to more hospital bad debt. The challenges are intensified in Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant

[48] *See* Tables 5.2 and 5.3 in the Application, pages 18-19.
[49] *See* **Exhibit 1B** to these Responses.

health care challenges.[50] Currently, most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins, representing challenges to the capitalization and, ultimately, the survival of these hospitals. Last year alone, Mountain States and Wellmont collectively invested more than $19.5 million to support operating losses and to ensure that inpatient services would remain available at the following Virginia rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Dickenson Community Hospital, Lonesome Pine Hospital and Mountain View Regional Medical Center.

The economic strain on the Parties is serious and must be addressed. In addition to the operating losses of their rural hospitals, Wellmont and Mountain States have accumulated nearly $1.5 billion of debt as a result of supporting redundant costs borne by the market and duplicating services and programming as separate health care systems. The significant ongoing duplication of costs and health care services in the region cannot be sustained with the status quo. The impetus behind the proposed merger of Wellmont and Mountain States was the independent decision of the Wellmont Board of Directors that Wellmont must merge with another system or be acquired in order to be successful long-term. This decision led to the search for a strategic-partner. The Board of Directors of Mountain States subsequently recognized that if Wellmont merged with an out-of-market entity, Mountain States would need to do the same in order to stay competitive against a better capitalized competitor. While such a merger with a third-party is not a current alternative, it has been raised by opponents as less restrictive to competition than the merger between Wellmont and Mountain States. However, Historical evidence indicates that a merger with an outside competitor would not yield the commitments to the community and continued job opportunities that the Cooperative Agreement would ensure.

In the current resource-constrained, status-quo environment, the Virginia rural hospitals face an uncertain future and are in peril. The existing threat to these hospitals is substantial, which affects not only patients' access to local care in geographic proximity to their homes, but also affects job opportunities and the economic vitality of these communities. Without the Cooperative Agreement, the peril will continue.

**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.**

**RESPONSE:** Both Wellmont and Mountain States have a labor turnover rate that exceeds 12% annually. This amounts to a combined average of over 1,900 people per year. The Parties believe that attrition will continue to occur under the New Health System. The Parties are committed to their current workforces, and plan to offer all current employees of Mountain States and Wellmont comparable positions within the New Health System. There will be some initial overlap of positions, but continued attrition will result in reduced personnel expenses over time by not having to sustain redundant positions. The New Health System will reduce workforce duplication, overtime and other premium labor costs. Workforce duplication can be

[50] *See* Application Section 3, pages 4-5; and Application Section 15.a.C, pages 82-83.

reduced in many cases by moving employees into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. Shifting physical resources and personnel to needed outpatient services (including mental health and substance abuse services), case management services, and health management services will ultimately result in a healthier population and contribute to economic improvement, including a more sustainable health care workforce and a more employable overall workforce.

The Parties fully anticipate that job opportunities will be available as a result of the commitments under the Cooperative Agreement to invest in continued and new services. However, the Parties are unable to make specific commitments regarding employment opportunities at this time. Antitrust laws prohibit the Parties from sharing information in sufficient detail to enable them to formulate such plans. Based on the commitments made in the Application, however, the Parties anticipate that financial savings resulting from synergies achieved through consolidation and avoiding duplication of services will be available to create alternative or enhanced services and programs that will naturally lead to job opportunities. For example, the New Health System has committed to spend at least $140 million over ten years toward specialty services, such as residential addiction recovery services; mental health services; outpatient treatment and addiction resources for adults, children and adolescents; pediatric sub-specialists and specialty centers and rotating specialty clinics in rural hospitals. These new and expanded services represent opportunities for job growth. In addition, the Parties are committed to maintaining all hospitals as clinical and health care institutions for at least five years. This commitment will help to ensure job retention. Therefore, the Parties believe that the commitments made under the proposed merger will provide for new employment opportunities in the future.

**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.**

**RESPONSE:** The Parties are not able to provide numbers and plans for specific labor saving measures at specific hospitals and facilities at this time because antitrust laws prohibit the Parties from sharing information in sufficient detail to enable them to formulate such plans. As noted in Section 13.c.2 of the Application, to date, the Parties have identified broad areas of potential labor savings, primarily in overlapping corporate support infrastructure, such as administration, finance and accounting, health information management, human resources, and supply. There is less overlap of corporate support in Virginia. With the exception of Wise County, which has three acute care hospitals, there is little duplication of services in Virginia. In Virginia, the Parties anticipate that any negative impact on jobs is minimized under the Cooperative Agreement through: (i) the commitment to maintain all existing hospitals as clinical and health care institutions for at least five years, (ii) the presence of less duplication of jobs and services, (iii) the job opportunities created with new service offerings that the New Health

System will be able to offer under the Cooperative Agreement, and (iv) the natural attrition of the labor force over time.

As the Application outlines, one of the most significant anticipated benefits of the proposed merger is to generate savings through consolidation of duplicated support services as well as duplicated patient services, particularly in areas with lower demand. The resulting savings would provide the necessary financial resources required to create alternative or enhanced services and programs that better meet the current health care needs and demands of the Southwest Virginia region. This reinvestment would help retain existing jobs and even help create new jobs for these new services. The population would benefit from greater access to services that will better meet their health care needs, including more behavioral health and addiction treatment services. The Cooperative Agreement will enable the Parties through savings resulting from combined synergies to expand health care services in a geographic region in which the larger trends are shifting away from expansion.

In addition, the New Health System has committed to make investments in research and academic initiatives that will benefit the region. The New Health System has committed to:

- With academic partners in Virginia and Tennessee, develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.

- Work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest quality and resourced labs and scientists.

The Parties do not believe that the Cooperative Agreement will contribute to the economic decline of the region. Quite the contrary. The overall health and economic well-being of our communities will benefit from the retained jobs made possible by keeping existing facilities open under the Cooperative Agreement along with the health improvement and job opportunities created by expanded and new services and the increased opportunity for third-party investment in the region.

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

**RESPONSE:** As noted in Response #53 above, the proposed merger will allow the Parties to avoid duplication of services and generate important savings. Mountain States and Wellmont have committed to utilize resulting savings from the consolidation to invest in the health care of the region, specifically targeting investment in those health care services that best meet the current health care needs of the population in the region. The Parties have committed to spending at least $140 million over 10 years pursuing specialty services, which otherwise could

not be sustainable in the region without the financial support offered by the New Health System. Specifically, the New Health System will:

- Create new capacity for residential addiction recovery services,
- Develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents,
- Ensure recruitment and retention of pediatric sub-specialists, and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals.

These commitments under the Cooperative Agreement will enable the New Health System to minimize job losses and to better allocate services and resources within the Geographic Service Area to meet the needs of the communities served. The New Health System's investment in these new and expanded services would lead to job opportunity and improved health.

The Parties are not yet able to identify the specific new services and programs that will be offered and supported by the New Health System or to provide any additional detail because (i) antitrust laws prohibit discussion between the Parties of information needed to formulate such detailed plans and (ii) the Parties expect that the Commonwealth will contribute to the Parties' determination of specific services and targeted health care needs of the region's population.

**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.**

**RESPONSE:** The Parties have made no decisions about the Virginia workforce following the merger. The primary consideration for any decision to be made by the New Health System after the merger will be the health care needs of the population served in the Geographic Service Area. As a result, the workforce of the New Health System will be aligned to provide services to best meet these patient needs. In making service decisions, the New Health System will consider all relevant factors of the affected community, including the perspective of the local physicians and stakeholders, and demonstrated community need for a service; availability of qualified, experienced personnel; unnecessary duplication of services that are readily available but not being utilized to capacity; impact on patient travel times for services; resource requirements to provide the service; balancing the commitment of resources among all needed services; and obligations of the New Health System under the State Agreements. In each case, the weighting of factors will depend upon the circumstances in that community.

All decisions relating to changes in services and workforce will be consistent with the Alignment Policy and made by the leadership of the New Health System, which will consist of executives from communities in the region. Although the Alignment Policy is general at this time because of the Parties' constraints under antitrust laws in sharing detailed operational data, the Parties have established the basic principles that will be applied in the Alignment Policy which will result

in decisions about health care services and the attendant effects on the workforce being made by the locally-based leadership of the New Health System.

The Parties believe that the Cooperative Agreement will ensure that decisions about the region's workforce will be made by people who are part of the communities affected. In contrast, if the Cooperative Agreement is not approved, the likely, market-driven result is that the Parties will be forced to merge with larger health systems from outside the region and that decisions that significantly affect the region and its workforce would be made by people who do not live in the affected communities. Through state supervision, the Cooperative Agreement will ensure that the New Health System will achieve the overriding community benefits and the desired efficiencies, cost-savings, and quality enhancement opportunities. The Parties believe that keeping local governance of the region's health care decisions through the Cooperative Agreement is the best way to ensure that the health care needs of the region and its workforce will continue to be key consideration in any health care changes that are made.

## 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?**

**RESPONSE:** Based on Mountain States' and Wellmont's current understanding of the Cooperative Agreement process, the Parties and the Commonwealth will agree on the following, before the State Agreement is finalized:

- The areas of greatest health care need in the region in order to achieve population health improvement where resources (monetary and other) are to be allocated.
- Specific programs and initiatives that will be most effective in meeting these health care needs and achieving the population health improvement goals.
- The specific commitments (monetary and otherwise) to be made to those programs and initiatives.
- The reporting obligations or other evidence of compliance that the New Health System will have in order to show fulfillment of its commitments.
- The performance metrics and criteria that the Commonwealth will use to evaluate the New Health System's satisfaction of its commitments.

Mountain States and Wellmont anticipate that the Commonwealth will have significant involvement and input in determining the specific programs and initiatives that the Parties will undertake, initially and on an ongoing basis. In the Application, the Parties have identified areas

of health care need that, based on the Authority's goals, the Commonwealth's state health plan, hospital community needs assessments and their own experience and expertise, they believe are critical for population health improvement in the region. The Parties have set forth representative examples of some of the specific commitments they believe can meet these health care needs and have noted that reporting on the commitments will be made. The Parties anticipate that the Commonwealth (with input from the Authority and others it seeks to consult) and the New Health System will identify the most pressing health care needs and priorities of the region and the *specific* commitments that can best meet these needs and the population health improvement goals.

Reporting obligations of the New Health System and the Department of Health's oversight of these commitments will be agreed upon by the Commonwealth and the Parties prospectively in sufficient detail to establish expectations from all involved and will be set forth in the State Agreement. The reporting obligations for each specific commitment may vary. The Parties anticipate that the Commonwealth and the Parties will have input into the specific programs and initiatives toward which the specified monetary commitments will go and in the reporting obligations or other evidence of compliance that will sufficiently demonstrate satisfaction of the commitments.

Mountain States and Wellmont believe there is sufficient precedent that reporting and requiring compliance with commitments will be adequate supervision. For the last twenty years, the State of North Carolina has overseen the Mission Health Certificate of Public Advantage by using annual audits to review the commitments made by Mission and to determine compliance. Based on the success of the Mission Health COPA, the Parties believe that reporting is an effective, generally accepted mechanism for monitoring and enforcing cooperative agreements and COPAs.

The Parties note that the Virginia cooperative agreement statute requires reporting:

> The parties...shall report annually to the Commissioner on the extent of the benefits realized and compliance with other terms and conditions of the approval. The report shall describe the activities conducted pursuant to the cooperative agreement, including any actions taken in furtherance of commitments made by the parties or terms imposed by the Commissioner as a condition for approval of the cooperative agreement, and shall include information relating to price, cost, quality, access to care and population health improvement."[51]

The Parties also expect that the State Agreement will set forth the consequences and remedies that will be required in the event the Commonwealth does not believe the substance of the New Health System's reports is satisfactory. The Virginia cooperative agreement statute provides authority and mechanisms for the Commissioner to ensure commitments are met. The Commissioner may seek additional information and investigate as needed to ensure compliance with the cooperative agreement.[52] Additionally, the Commissioner may initiate a proceeding to determine whether compliance with the cooperative agreement continues to meet the

[51] Virginia Code § 15.2-5384.1(G).
[52] Virginia Code § 15.2-5384.1(G).

requirements of the statute and may seek reasonable modifications to the cooperative agreement to ensure compliance, with the consent of the parties to the agreement.[53]

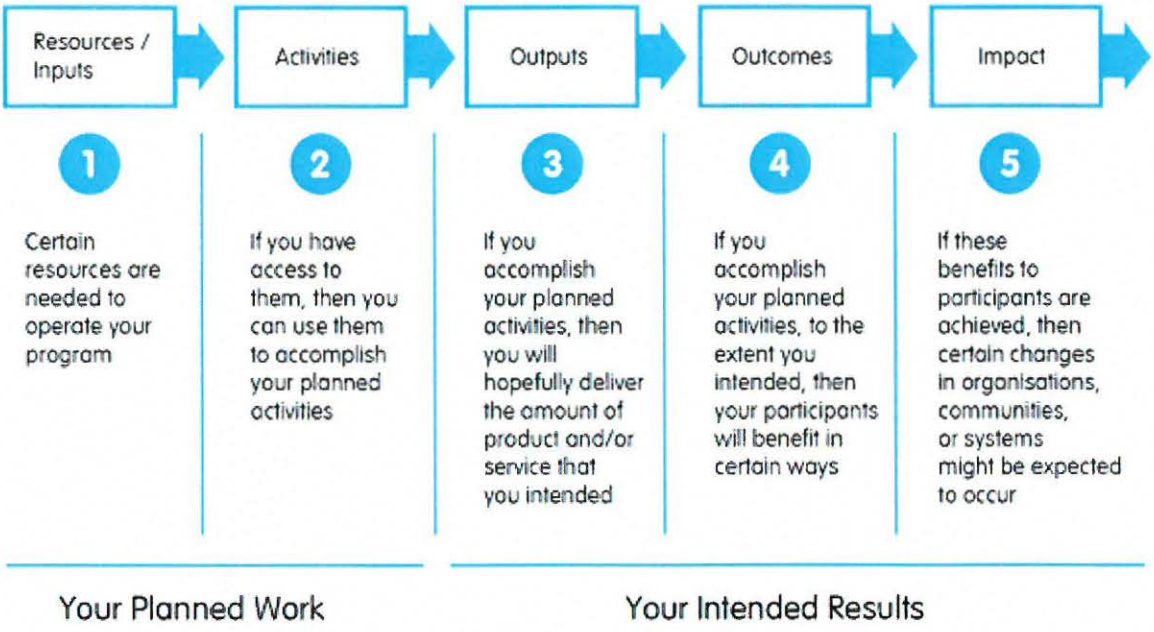
**57. The focus of a number of accountability measures is on inputs and not on outcomes or impact. The Authority is much more interested in having specific outcomes as targets against which performance is measured (just as outcomes in patient care are now the focus rather than the costs and inputs). 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.**

**RESPONSE:** The Community Health Improvement Plan (**Exhibit 18** to these Responses) includes short-term and intermediate-term outcomes for population health improvements, which the New Health System hereby submits for consideration by the Authority and the Commonwealth. The evaluation of improvement in community health is complex and involves many factors, both short-term and long-term. Population health improvement programs can be characterized by their inputs, activities, outputs, outcomes, and impact. *Inputs* are the resources dedicated to or consumed by the program, including the human, financial, organizational, and community resources a program has available to direct toward doing the work. *Activities* are what the program does with its inputs to fulfill its mission. These include the processes, tools, events, technology, and actions that are an intentional part of the program implementation. *Outputs* are the direct products of program activities and may include types, levels and targets of services to be delivered by the program. *Outcomes* are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. *Impact* is the fundamental change occurring in organizations, communities or systems as a result of program activities often with longer term time frames of 7 to 10 years.

Recognizing the complex interplay of inputs and activities in reaching desired population health outcomes, the Parties propose to use the Kellogg Foundation's Logic Model displayed in Figure 15.2 of the Application (and included below) for development of the Commitment to Community Health Annual Report Measures.

**Figure 15.2 – Logic Model for Evaluation**

[53] Virginia Code § 15.2-5384.1(H).




Under this model, the Commonwealth could evaluate progress toward *long-term* community health improvement outcomes under the State Agreement by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The Commonwealth and the New Health System could track participation or service levels related to these programs and performance improvements (Outputs). Over time, the cumulative effect of these efforts is expected to result in the intended population health improvement (short and medium-term Outcomes and long-term Impact).[54]

The root causes of the poor health in the region are many and varied, including many social determinants, so a comprehensive community approach is necessary – no single organization can reverse generational or century long trends that have resulted in one community falling behind another in terms of health, education or the economy. For this reason, the New Health System has committed to provide financial support to develop and sustain an Accountable Care Community,[55] an effort across state lines for the region that will help address these and other issues identified by the Community Health Improvement Plan. The work of the four Community Health Work Groups described in the Application[56] contributed to the development of the New Health System's Community Health Improvement Plan, attached as **Exhibit 18** to these Responses. Establishing a thriving Accountable Care Community is a key component of the Community Health Improvement Plan and will bring together stakeholders from healthcare, public health, education, business, the faith and advocacy communities, government and other sectors to collaboratively and systemically work to achieve long-term health improvement goals for the region.

[54] *See* Application Section 15.d for more detailed description of the proposed accountability measures.
[55] *See* Application Section 15.a.F, page 88.
[56] *See* Application Section 15.a.F, pages 87-91.

**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?**

**RESPONSE:** The Parties will work with the Commonwealth during the Cooperative Agreement review and approval process to determine appropriate metrics for which the New Health System will be held accountable. As noted in Response #56, the Parties anticipate that the final State Agreement will reflect the mutual, prospective understanding of the Commonwealth and the New Health System about the specific commitments the New Health System will make to identified programs and initiatives, the Virginia locations to be affected by such programs and initiatives, the reporting obligations associated with those commitments, and the ways in which the Commonwealth will determine whether the commitments have been satisfied. It is expected that because of current limitations on many state and federal data sources, additional data will need to be collected to report performance metrics at an actionable local level.

Many commitments of the New Health System will encompass the entire Geographic Service Area, while others may focus resources on smaller parts of the Geographic Service Area, which may cross state lines. Different health issues affect different communities in the Geographic Service Area. Part of the Cooperative Agreement review and approval process will be to identify the specific programs and the New Health System's obligations to those programs that the Parties and the Commonwealth believe will most benefit communities. The Virginia and Tennessee State Agreements will set forth reasonable and appropriate metrics for determining satisfaction with the New Health System's progress toward the commitments in the applicable state. The Applicants anticipate that both final State Agreements will reflect a regional approach and commitment from the New Health System befitting the common issues of this geographic area that cross state lines. Although there are similarities with other parts of Virginia and Tennessee, the southern Appalachian mountain region of Southwest Virginia and Northeast Tennessee has a distinct culture, capacity and resource base that results in a unique set of health issues.

In the Application, the Parties have committed to allocate hundreds of millions of dollars over 10 years throughout the Geographic Service Area toward improving the health of this region. The Parties believe this substantial monetary commitment, along with the other commitments set forth in the Application, will be a significant contribution toward the region's and Authority's goal of improving the health of its population.

Without the merger, the Parties will not be able to make these significant contributions to improve the region's health. The merger will generate savings required to allow the New Health System to make meaningful investments toward improving the health of the region's population. These investments could not and would not be made without the merger. As noted in Section 15 of the Application and in Response #55, the likely alternative to the proposed cooperative agreement is a merger by each of the Parties with larger health systems from outside the region. Unlike the proposal by the Parties in the Application with the Cooperative Agreement, a merger with outside health systems would provide no guarantee of investment in the Southwest Virginia region.

In order to evaluate the benefits provided by the New Health System on a continuous basis, the Parties proposed in the Application that the Virginia Department of Health adopt a set of

accountability mechanisms, called "Quantitative Measures," to be used by the Department to evaluate the proposed and continuing benefits of the Cooperative Agreement and the satisfaction by the New Health System of its commitments to the State. The Quantitative Measures proposed were in five major categories:

A. Commitment to Improve Community Health
B. Enhanced Health Care Services
C. Expanding Access and Choice
D. Improving Health Care Value: Managing Quality, Cost and Service
E. Investment in Health Research/Education and Commitment to Workforce[57]

Because the accountability mechanisms for each category of commitment should and will vary, the Parties outlined their detailed accountability proposal for all categories of the New Health System's commitments. For example, the overall commitment to Improve Community Health encompasses many of the Parties' specific investment and initiative commitments that will improve community health. The Parties proposed accountability measures for each type of commitment and investment to that the Commonwealth will be able to measure yearly and over time how the New Health System is performing in all of these areas. Application Section 15.d details all of the varied and specific Quantitative Measures proposed. The Parties believe its proposal is comprehensive and provides a rational, quantifiable way to measure progress that is difficult to assess.

The population of the Geographic Service Area, as a whole, suffers from poorer health than the rest of the state, which is the result of layered socio-economic dynamics. The Parties believe that the metric achievement percentages proposed in the Application are commensurate with the poor health of the region and the recognition that the commitments made by the New Health System alone will not solve the complex problems contributing to the poor health of the region. The Parties are committed to making substantial investments throughout the Geographic Service Area toward improving the health of the population, but the Parties acknowledge that they cannot alter other forces that also contribute to the health of the region. Therefore, the Parties believe the proposed metric percentages are reasonable.

**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?**

**RESPONSE:** The Parties intend for the New Health System to be operated and governed in ways that are consistent with industry best practices. This includes a board of directors composed of individuals possessing the qualifications and competencies necessary to provide the requisite leadership and expertise critical to a comprehensive health system. The New Health System's board of directors will not have members whose seat on the board is based solely on representation of any group or constituency. All board members of the New Health System will be required to follow the duties required of not-for-profit governing boards. The Parties do not believe these duties are consistent with members whose seats are based solely on representing a particular group or constituency. For these reasons, the Parties cannot make a specific commitment to give representation on the New Health System board to appointee(s) from the Authority or any other group.

[57] *See* Application Section 15.d, pages 98 *et seq*.

**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?**

**RESPONSE:** A substantial number of the commitments made by the Parties cover a ten-year period. For example, the New Health System, as specified in the Application, will commit to spending at least $140 million over ten years pursuing specialty services, including residential addiction recovery services, mobile health crisis management teams, intensive outpatient treatment and addiction resources, and pediatric specialty centers. The New Health System also pledges to commit at least $85 million over ten years to build and sustain research infrastructure, increase residency and training slots, add faculty, and create new specialty fellowship training opportunities. The New Health System also committed at least $75 million over ten years in science and evidence-based population health improvement. The implementation of these commitments will be set forth in the State Agreement, which will be subject to ongoing supervision by the Commonwealth.

In addition, the Commonwealth will have the ability, with its ongoing, active supervision of the State Agreement, to ensure that appropriate commitments continue. As specified in the Virginia cooperative agreement statute, circumstances may dictate that some commitments are modified over time or that committed resources should be allocated in different ways. In the Application, the Parties proposed an initial five-year term for the State Agreement, given that attempts to predict the financial and health care environment beyond the five year period would be difficult. However, as evidenced by the numerous commitments made by the Parties beyond the initial five-year term, the Parties anticipate that the obligations of the New Health System will extend beyond this time. Therefore, Mountain States and Wellmont believe sufficient commitments exist well beyond five years and will continue to exist through the active, ongoing supervision of the State Agreement by the Commonwealth.

**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.**

**RESPONSE:** As health care providers, both Parties share a similar mission of delivering superior health care and improving the health of patients and the surrounding communities. [58]In the Application, the Parties have committed to allocate hundreds of millions of dollars over 10 years throughout the Geographic Service Area toward improving the health of this region. The Parties believe this significant monetary commitment, along with the other commitments set forth in the Application, will be a substantial contribution toward and force for achieving the Authority's

[58] The mission of Mountain States is to "identify and respond to the health care needs of individuals and communities in our region and to assist them in attaining their highest possible level of health." The mission of Wellmont is to "deliver superior health care with compassion and a vision to deliver the best health care anywhere."

and the region's goal of improving the health and well-being of its population. The Application identifies several areas that the New Health System would support to promote the well-being of the population, such as ensuring that 3rd graders can read at grade level, reducing the number of low birthweight babies, and confronting the epidemic of addiction, all of which would contribute to greater economic opportunities and well-being for the population.

However, the Parties recognize that the commitments made by the New Health System alone will not solve the "sustained health crises of our region"[59] and that these commitments cannot alter other forces that also contribute to the poor health of the region. The reasons for the poverty and depressed economic condition of the Geographic Service Area are multi-layered and complex. As the Authority noted in the Progress Report 2011 to its Blueprint for Health Improvement and Health-Enabled Prosperity, "...overcoming the substantial health burdens of Southwest Virginia requires a broad, carefully coordinated effort. Importantly, this effort requires an innovative plan that advances educational opportunity and encourages economic development in addition to promoting health."[60] As longtime health care providers in the region, Mountain States and Wellmont have supported this goal and are excited that the proposed merger will allow them to continue to make contributions toward promoting this region's health. The Parties are hopeful that the region's business, education and government sectors, in addition to the health care sector, will also continue to work with the Authority to advance this coordinated effort.

The region's economic stagnation affects the Parties' financial position. The depressed economic conditions of the region and the high percentage of Medicare, Medicaid and uninsured patients mean that the Parties have less money to invest to ensure that inpatient services continue to remain available in the smaller communities of the Geographic Service Area, thereby jeopardizing the sustainability of these services and facilities.

As the Application outlines, one of the most significant anticipated benefits of the proposed merger is to generate savings through consolidation of duplicated services. The resulting savings would provide the financial resources required to reinvest in the region and maintain or expand certain services that would not be economically viable to provide without the benefits of the merger.

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

**RESPONSE:** Both Mountain States and Wellmont currently operate open medical staffs, with exceptions for limited hospital-based services that are customarily excluded from open medical staffs, such as radiology and emergency medicine services. The Parties anticipate that the New Health System would continue to be an open 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"?**

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[59] Southwest Virginia Health Authority Progress Report 2011 to Blueprint for Health Improvement and Health-Enabled Prosperity, page 12.
[60] Progress Report 2011, page 12.

**RESPONSE:** By "investment," the Parties mean capital expenditures or ongoing operating costs. Such investments are intended to be incremental and constitute additions to current spending costs. The investments to which the Parties have committed are only possible with the savings that the Parties can realize through the proposed merger. Without the proposed merger, financial pressure from factors such as reduced Medicare reimbursement amounts and reduced inpatient utilization may force the Parties individually to decrease current spending amounts and scale back or eliminate services and focus solely on core services. The Parties can make no commitments to "investments" without the merger.

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

**RESPONSE:** The Parties are unable to speak on behalf of Medicaid managed care plans.

**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?**

**RESPONSE:** Specific plans for and decisions about GME programs and positions have not yet been made. The New Health System intends to continue training and graduate medical education throughout the system and the entire Geographic Service Area, provided federal and state funding continues. This includes the residency programs in the communities where they are currently offered. It is important to note that, prior to the agreement to merge, both health systems independently had begun implementing plans to reduce the number of residency slots. This reduction was halted, in part, because the health systems were committed to deploying synergies related to the merger toward improving, rather than reducing, residency and training programs.

The Parties currently fund more than 60 residency slots that are above the CMS caps. Through the New Health System, the Parties expect to continue the commitment to create additional residency slots. The New Health System will collaborate with educational partners to determine where the need and opportunity for residency slots exist. The Research & Academics Community Health Work Group described in Section 15.a.G of the Application (pages 89-91) has proposed a model for a working relationship between the academic institutions in the region and the New Health System. The decisions regarding the investment in specific research and academic programs, will require a collaborative plan to be developed with academic partners. Where possible, the New Health System will advocate for and seek to generate federal and state funds to support the needed positions. In the absence of federal and state funds to support needed residency slots, the Parties in the past have had success funding slots through partners. With the merger, the New Health System would also have the ability to continue to support needed residency slots through self-funding if there are inadequate governmental or other funds.

**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.**

**RESPONSE:** The Parties are unable to predict or guarantee whether the proposed new services will be profitable. Several factors will influence whether proposed services will operate profitably. Some services that the New Health System intends to provide are projected to be non-profitable. For example, expanded pediatric specialties are not likely to be profitable, given that a significant number of the pediatric patients in the Geographic Service Area are covered by Medicaid. For the same reason, mental health services and addiction recovery services are generally not profitable due to the high numbers of the patient population that are covered by Medicaid or uninsured.

Both Mountain States and Wellmont believe that, given the bleak economic environment of the region, their debt service requirements, and existing capital commitments for IT maintenance and other fixed costs, neither Party could individually support investment of comparable amounts to provide such services. The majority of the Parties' available growth capital is devoted to efforts to better compete in the markets of the Geographic Service Area. These efforts create redundant expenditures by the Parties, and the elimination of these efforts will be a source of savings under the proposed merger. Through the merger, more capital will be available for additional investments in needed services whether or not those services prove to be profitable.

**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?**

**RESPONSE:** The New Health System has committed to working toward the goal of improving the percentage of 3rd graders reading at grade level and has identified nurse family partnership as an evidence based program for improve birth outcomes and which has the additional benefit of improving high school graduation rates in the long-term. The Applicants have not specifically considered redeploying excess facility infrastructure for non-profit charter schools, however, this is not out of the question. The New Health System has committed to funding an Accountable Care Community infrastructure where a group of multi-sector stakeholders work toward common objectives, and discussion of this type would be appropriate in that forum.

**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?**

**RESPONSE:** Generally, staffing and jobs are based on patient load. Therefore, the threat to health care jobs in the region is not from the merger but from decreased inpatient admissions.

The proposed merger will have little or no effect on this trend. However, the merger will have an impact on the assurance of continued services. The Parties have committed in the Application that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. Without the merger, the Parties are unable to make any guarantee that their hospitals would remain open or any guarantee of continued access to services in the community. The proposed merger provides an enforceable commitment that existing hospitals will remain open for at least five years.

If, after five years, patient need and other factors do not support the continued operation of an existing hospital, the New Health System may decide to repurpose the hospital into another type of facility. Prior to considering potential closures, the most important consideration for the New Health System would be patient need and what is best for patients. However, consideration of the impact on the labor force is something that will be measured. Repurposed hospitals will still require jobs, and many jobs associated with acute care services may still be needed in repurposed facilities. Additionally, as outlined in the Application, the Parties anticipate that savings achieved through the merger will be utilized to create new or expanded services, which will result in additional job opportunities.

All decisions relating to changes in services and workforce will be consistent with the Alignment Policy and made by the leadership of the New Health System, which will consist of executives from communities in the region. In making service decisions, the New Health System will consider all relevant factors of the affected community, including the perspective of the local physicians and stakeholders.

## LIST OF EXHIBITS

| Exhibit Number | Description |
|---|---|
| Exhibit 1A | Duplication of Services |
| Exhibit 1B | Southwest Virginia Counties – Inpatient Volume, Population and Inpatient Use Rates |
| Exhibit 10A | Wythe, Cocke and Hamblen County Hospitals – Utilization by Geographic Service Area Residents |
| Exhibit 10B | Wythe, Cocke and Hamblen County Residents – Utilization of New Health System Hospitals |
| Exhibit 11A | 75% and 90% Service Areas (Map) Based on New Health System Discharges (Mountain States and Wellmont)<br>75% and 90% Service Areas (Zip Codes) Based on New Health System Discharges (Mountain States and Wellmont) |
| Exhibit 11B | 75% and 90% Service Areas (Map) Based on Mountain States Discharges Only |
| Exhibit 11C | 75% and 90% Service Areas (Map) Based Wellmont Discharges Only |
| Exhibit 11D | 75% and 90% Service Areas (Zip Codes) for Individual New Health System Hospitals |
| Exhibit 12A | Inpatient Shares Based on New Health System 75% Service Area |
| Exhibit 12B | Inpatient Shares Based on New Health System 90% Service Area |
| Exhibit 12C | Inpatient Shares Based on New Health System's Geographic Service Area |
| Exhibit 12D | Outpatient Shares Based on New Health System's Estimated 75% Service Area (Excluding Wythe VA, Cocke TN, Hamblen TN, Buchanan VA, Tazewell VA and Hancock TN Counties)<br>Outpatient Shares Based on New Health System's Estimated 90% Service Area (Excluding Wythe VA, Cocke TN and Hamblen TN Counties)<br>Outpatient Shares Based on New Health System's Geographic Service Area |
| Exhibit 14 | Information on Licensed Health Care Professionals (to be provided in a subsequent response) |
| Exhibit 18 | Community Health Improvement Plan |

| Exhibit Number | Description |
|---|---|
| Exhibit 22A | High-Level Timeline for Common Clinical IT Platform |
| Exhibit 22B | Description of Parties Current Electronic Health Records Systems and Plans for Common Clinical IT Platform |
| Exhibit 22C | Description of the Parties' Use of Health Information Exchanges |
| Exhibit 32 | Updated Financial Projections for New Health System |

## Exhibit 1A. Duplication of Services Across Mountain States and Wellmont Hospitals

| NOTE: Volume equals 25 or more discharges | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| System | MSHA | MSHA | MSHA | MSHA | MSHA | MSHA | MSHA | MSHA | MSHA | MSHA |
| Hospital | Dickenson Community Hospital | Franklin Woods Community Hospital | HealthSouth Quillen Rehabilitation Hospital | Indian Path Medical Center | Johnson City Medical Center | Johnson County Community Hospital | Johnston Memorial Hospital | Norton Community Hospital | Russell County Medical Center | Smyth County Community Hospital |
| County | Dickenson, VA | Washington, TN | Washington, TN | Sullivan, TN | Washington, TN | Johnson, TN | Washington, VA | Wise, VA | Russell, VA | Smyth, VA |
| Diagnostic Imaging | X | X | | X | X | X | X | X | X | X |
| Emergency | X | X | | X | X | X | X | X | X | X |
| Inpatient Services | X | X | X | X | X | X | X | X | X | X |
| Cardiac Surgery | | | | | 273 | | | | | |
| Cardiology | | 240 | | 464 | 2,050 | | 627 | 242 | 119 | 167 |
| Cardiology Intervention | | | | 217 | 1,203 | | 150 | | | |
| Endocrinology | | 137 | | 270 | 479 | | 223 | 65 | 67 | 68 |
| ENT Surgery | | | | | | | | | | |
| Gastroenterology | | 479 | | 974 | 1,489 | | 817 | 138 | 102 | 104 |
| General Medicine | | 457 | | 733 | 1,965 | | 1,237 | 280 | 156 | 230 |
| General Surgery | | 356 | | 677 | 1,173 | | 379 | 90 | | 37 |
| Gynecology | | 30 | | 56 | 123 | | 52 | | | |
| Hematology | | 34 | | 112 | 242 | | 88 | | | |
| Neonatology | | 338 | | 194 | 755 | | 165 | 47 | | |
| Nephrology | | 260 | | 234 | 842 | | 485 | 144 | 94 | 99 |
| Neurology | | 82 | | 174 | 1,138 | | 300 | 126 | 29 | 43 |
| Neurosurgery | | | | 81 | 529 | | | | | |
| OB Deliveries Sections | | 326 | | 216 | 330 | | 162 | 54 | | |
| OB Deliveries Vaginal | | 562 | | 358 | 740 | | 378 | 83 | | |
| OB Other | | | | | 179 | | 33 | 26 | | |
| Oncology Medicine | | 39 | | 27 | 331 | | 58 | | | |
| Oncology Surgery | | 46 | | | 59 | | | | | |
| Ophthalmic Medicine | | | | | | | | | | |
| Ophthalmic Surgery | | | | | | | | | | |
| Oral Surgery | | | | | 30 | | | | | |
| Orthopedic Medicine | | 35 | | 25 | 403 | | 87 | | | |
| Orthopedic Surgery | | | | 337 | 1,364 | | 323 | 32 | | 77 |
| Otolaryngology | | 46 | | | 94 | | 29 | | | |
| Plastic Surgery | | | | | | | | | | |
| Psychiatry | | | | | 92 | | | | 478 | |
| Pulmonary | | 572 | | 549 | 2,086 | | 939 | 425 | 312 | 275 |
| Rehabilitation | | | 420 | | | | | 47 | | 164 |
| Rheumatology | | | | | 118 | | | | | |
| Substance Abuse | | 26 | | | 139 | | 34 | | | |
| Thoracic Surgery | | | | 28 | 156 | | | | | |
| Trauma Medical | | | | | 122 | | | | | |
| Urology Medicine | | 104 | | | X | | 31 | 25 | | |
| Urology Surgery | | 170 | | 34 | 50 | | 30 | | | |
| Vascular Surgery | | | | | 456 | | 60 | | | |

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients

## Exhibit 1A. Duplication of Services Across Mountain States and Wellmont Hospitals

| NOTE: Volume equals 25 or more discharges | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| System | MSHA | MSHA | MSHA | Wellmont | Wellmont | Wellmont | Wellmont | Wellmont | Wellmont |
| Hospital | Sycamore Shoals Hospital | Unicoi County Memorial Hospital, Inc. | Woodridge Psychiatric Hospital | Bristol Regional Medical Center | BRMC Ridgeview Pavilion | LPH/MVRMC | Hancock County Hospital | Hawkins County Memorial Hospital | Holston Valley Medical Center |
| County | Carter, TN | Unicoi, TN | Washington, TN | Sullivan, TN | Washington, VA | Wise, VA | Hancock, TN | Hawkins, TN | Sullivan, TN |
| Diagnostic Imaging | X | X | | X | | X | X | X | X |
| Emergency | X | X | | X | | X | X | X | X |
| Inpatient Services | X | X | X | X | X | X | X | X | X |
| Cardiac Surgery | | | | 231 | | | | | 263 |
| Cardiology | 281 | 51 | | 844 | | 219 | | 114 | 1,196 |
| Cardiology Intervention | | | | 257 | | | | | 683 |
| Endocrinology | 153 | | | 270 | | 65 | | | 328 |
| ENT Surgery | | | | | | | | | |
| Gastroenterology | 341 | 79 | | 974 | | 138 | | 56 | 982 |
| General Medicine | 404 | 82 | | 733 | | 280 | 28 | 146 | 1,048 |
| General Surgery | 151 | | | 677 | | 90 | | | 851 |
| Gynecology | | | | 56 | | | | | 141 |
| Hematology | 46 | | | 112 | | | | | 165 |
| Neonatology | | | | 214 | | 48 | | | 207 |
| Nephrology | 272 | 49 | | 504 | | 109 | | 59 | 544 |
| Neurology | 112 | | 28 | 622 | | 36 | | 28 | 610 |
| Neurosurgery | | | | 339 | | | | | 284 |
| OB Deliveries Sections | | | | 222 | | 105 | | | 268 |
| OB Deliveries Vaginal | | | | 427 | | 128 | | | 462 |
| OB Other | | | | 45 | | 28 | | | 45 |
| Oncology Medicine | 30 | | | 114 | | | | | 130 |
| Oncology Surgery | | | | 49 | | | | | 73 |
| Ophthalmic Medicine | | | | | | | | | |
| Ophthalmic Surgery | | | | | | 25 | | | |
| Oral Surgery | | | | | | | | | |
| Orthopedic Medicine | 28 | | | 152 | | | | | 161 |
| Orthopedic Surgery | 97 | | | 740 | | | | | 1,145 |
| Otolaryngology | | | | 26 | | | | | 31 |
| Plastic Surgery | | | | 25 | | | | | 26 |
| Psychiatry | 154 | | 3,385 | 820 | 599 | | | | |
| Pulmonary | 663 | 114 | | 1,291 | | 348 | 57 | 185 | 1,534 |
| Rehabilitation | | | | | | 89 | | 26 | |
| Rheumatology | | | | 25 | | | | | 45 |
| Substance Abuse | | | 106 | 43 | | | | | 26 |
| Thoracic Surgery | | | | 57 | | | | | 106 |
| Trauma Medical | | | | 42 | | | | | 48 |
| Urology Medicine | | | | 45 | | | | | 29 |
| Urology Surgery | | | | 84 | | | | | 70 |
| Vascular Surgery | | | | 131 | | | | | 257 |

Source: Discharge counts from THA and VHHA state databases. Includes discharges from patients

Exhibit 1B. Southwest Virginia Counties – Inpatient Volumes by County and Year

| IP Volume | 2010 | 2011 | 2012 | 2013 | 2014 | FY 2015 |
|---|---|---|---|---|---|---|
| Buchanan County, VA | 3,681 | 3,880 | 3,692 | 3,178 | 3,143 | 3,118 |
| Dickenson County, VA | 2,393 | 2,456 | 2,323 | 1,986 | 1,928 | 2,057 |
| Grayson County, VA | 1,613 | 1,596 | 1,561 | 1,431 | 1,468 | 1,439 |
| Lee County, VA | 4,221 | 4,102 | 3,419 | 3,066 | 2,711 | 2,561 |
| Russell County, VA | 5,075 | 5,056 | 4,858 | 4,434 | 4,538 | 4,589 |
| Scott County, VA | 3,498 | 3,492 | 3,159 | 3,075 | 2,969 | 2,968 |
| Smyth County, VA | 4,596 | 4,849 | 4,800 | 4,761 | 5,122 | 5,313 |
| Tazewell County, VA | 5,317 | 5,658 | 5,929 | 5,284 | 5,149 | 5,119 |
| Washington County & Bristol City, VA | 10,307 | 10,739 | 10,974 | 9,913 | 10,349 | 10,680 |
| Wise County & Norton City, VA | 9,726 | 9,254 | 8,557 | 7,913 | 7,378 | 7,217 |
| Wythe County, VA | 3,965 | 4,026 | 4,351 | 4,137 | 4,276 | 4,252 |

Exhibit 1B. Southwest Virginia Counties - Population by County and Year

| Population | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| Buchanan County, VA | 24,040 | 23,929 | 23,902 | 23,647 | 23,177 | 22,776 |
| Dickenson County, VA | 15,870 | 15,763 | 15,670 | 15,459 | 15,306 | 15,115 |
| Grayson County, VA | 15,496 | 15,406 | 15,225 | 15,221 | 15,999 | 16,012 |
| Lee County, VA | 25,532 | 25,657 | 25,533 | 25,187 | 24,913 | 24,742 |
| Russell County, VA | 28,856 | 28,652 | 28,415 | 28,253 | 28,012 | 27,891 |
| Scott County, VA | 23,133 | 22,960 | 22,790 | 22,612 | 22,360 | 22,126 |
| Smyth County, VA | 32,187 | 32,027 | 31,873 | 31,728 | 31,572 | 31,470 |
| Tazewell County, VA | 45,147 | 44,677 | 44,247 | 44,091 | 43,436 | 42,899 |
| Washington County & Bristol City, VA | 72,746 | 72,559 | 72,867 | 72,259 | 72,002 | 71,732 |
| Wise County & Norton City, VA | 45,585 | 45,442 | 44,935 | 44,678 | 43,975 | 43,657 |
| Wythe County, VA | 29,226 | 29,185 | 29,297 | 29,290 | 29,060 | 29,119 |

Exhibit 1B. Southwest Virginia Counties - Inpatient Use Rates by County and Year

| IP Use Rate per 1,000 | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 |
|---|---|---|---|---|---|---|
| **Buchanan County, VA** | 153.1 | 162.1 | 154.5 | 134.4 | 135.6 | 136.9 |
| **Dickenson County, VA** | 150.8 | 155.8 | 148.2 | 128.5 | 126.0 | 136.1 |
| **Grayson County, VA** | 104.1 | 103.6 | 102.5 | 94.0 | 91.8 | 89.9 |
| **Lee County, VA** | 165.3 | 159.9 | 133.9 | 121.7 | 108.8 | 103.5 |
| **Russell County, VA** | 175.9 | 176.5 | 171.0 | 156.9 | 162.0 | 164.5 |
| **Scott County, VA** | 151.2 | 152.1 | 138.6 | 136.0 | 132.8 | 134.1 |
| **Smyth County, VA** | 142.8 | 151.4 | 150.6 | 150.1 | 162.2 | 168.8 |
| **Tazewell County, VA** | 117.8 | 126.6 | 134.0 | 119.8 | 118.5 | 119.3 |
| **Washington County & Bristol City, VA** | 141.7 | 148.0 | 150.6 | 137.2 | 143.7 | 148.9 |
| **Wise County & Norton City, VA** | 213.4 | 203.6 | 190.4 | 177.1 | 167.8 | 165.3 |
| **Wythe County, VA** | 135.7 | 137.9 | 148.5 | 141.2 | 147.1 | 146.0 |

Exhibit 10A. Wythe, Cocke and Hamblen County Hospitals - Utilization by Geographic Service Area Residents

| Hospital | Hospital County | Hospital State | Total Discharges of hospital | Discharges from patients resident in 3 Counties | Discharges from patients resident in rest of GSA | % of Rest of GSA to hospital on table |
|---|---|---|---|---|---|---|
| **TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER** | COCKE | TN | 2,241 | 2,000 | 241 | 11% |
| **TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL** | HAMBLEN | TN | 2,337 | 1,575 | 762 | 33% |
| **MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM** | HAMBLEN | TN | 6,419 | 4,260 | 2,159 | 34% |
| **WYTHE COUNTY COMMUNITY HOSPITAL** | WYTHE | VA | 2,352 | 1,584 | 768 | 33% |

Source: CY 2014 State Discharge Data
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 10B. Wythe, Cocke and Hamblen County Residents - Utilization of New Health System Hospitals

| Hospital | System | Hospital County | Hospital State | Cocke County, TN | Hamblen County, TN | Wythe County, VA |
|---|---|---|---|---|---|---|
| WELLMONT HOLSTON VALLEY MEDICAL CENTER | WHS | SULLIVAN | TN | 26 | 67 | 20 |
| SYCAMORE SHOALS HOSPITAL | MSHA | CARTER | TN | 1 | 1 | 0 |
| INDIAN PATH MEDICAL CENTER | MSHA | SULLIVAN | TN | 2 | 5 | 4 |
| FRANKLIN WOODS COMMUNITY HOSPITAL | MSHA | WASHINGTON | TN | 2 | 4 | 1 |
| WELLMONT BRISTOL REGIONAL MEDICAL CENTER | WHS | SULLIVAN | TN | 6 | 8 | 169 |
| WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL | WHS | HAWKINS | TN | 1 | 25 | 0 |
| JOHNSON CITY MEDICAL CENTER | MSHA | WASHINGTON | TN | 81 | 66 | 36 |
| WELLMONT LONESOME PINE HOSPITAL | WHS | WISE | VA | 2 | 0 | 0 |
| SMYTH COUNTY COMMUNITY HOSPITAL | MSHA | SMYTH | VA | 0 | 1 | 124 |
| NORTON COMMUNITY HOSPITAL | MSHA | NORTON | VA | 1 | 0 | 1 |
| JOHNSTON MEMORIAL HOSPITAL | MSHA | WASHINGTON | VA | 0 | 0 | 62 |
| NEWCO Share of County Discharges | | | | **2.4%** | **2.2%** | **12.2%** |
| TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL | Other | HAMBLEN | VA | 190 | 1,385 | 0 |
| TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER | Other | COCKE | VA | 1,925 | 75 | 0 |
| MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM | Other | HAMBLEN | VA | 519 | 3,741 | 0 |
| WYTHE COUNTY COMMUNITY HOSPITAL | Other | WYTHE | VA | 0 | 0 | 1,584 |
| OTHER | Other | | | 2,316 | 2,700 | 1,416 |

Source: CY 2014 State Discharge Data
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 11A. 75% and 90% Service Areas (Map) Based on New Health System Discharges (Mountain States + Wellmont)

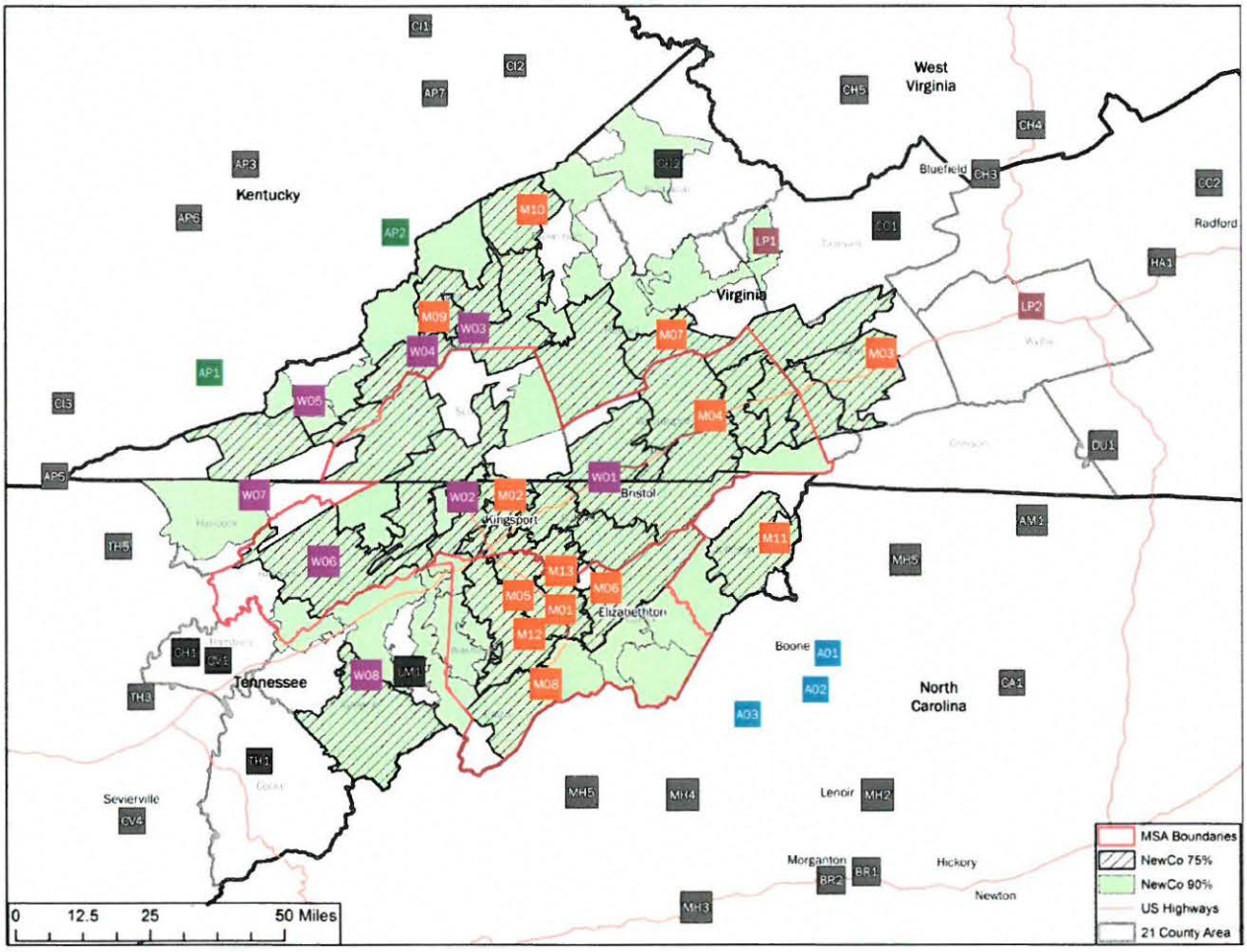

**Exhibit 11A. 75% and 90% Service Areas (Zip Codes) Based on New Health System Discharges (Mountain States + Wellmont)**

| ZIP Code | Discharges | Percentage of Total | Cumulative | 75% Service Area | 9% Service Area |
|---|---|---|---|---|---|
| 37660 | 5,182 | 5.8% | 5.8% | x | x |
| 37601 | 5,138 | 5.8% | 11.6% | x | x |
| 37643 | 4,943 | 5.6% | 17.2% | x | x |
| 37620 | 4,127 | 4.6% | 21.8% | x | x |
| 37604 | 3,947 | 4.4% | 26.3% | x | x |
| 37659 | 3,099 | 3.5% | 29.7% | x | x |
| 37664 | 2,811 | 3.2% | 32.9% | x | x |
| 24210 | 2,333 | 2.6% | 35.5% | x | x |
| 24201 | 2,242 | 2.5% | 38.0% | x | x |
| 37857 | 2,193 | 2.5% | 40.5% | x | x |
| 24354 | 2,170 | 2.4% | 43.0% | x | x |
| 37650 | 1,948 | 2.2% | 45.1% | x | x |
| 37615 | 1,945 | 2.2% | 47.3% | x | x |
| 37642 | 1,660 | 1.9% | 49.2% | x | x |
| 24219 | 1,532 | 1.7% | 50.9% | x | x |
| 37617 | 1,491 | 1.7% | 52.6% | x | x |
| 24293 | 1,390 | 1.6% | 54.2% | x | x |
| 24202 | 1,336 | 1.5% | 55.7% | x | x |
| 37683 | 1,335 | 1.5% | 57.2% | x | x |
| 37618 | 1,335 | 1.5% | 58.7% | x | x |
| 24266 | 1,332 | 1.5% | 60.2% | x | x |
| 24230 | 1,276 | 1.4% | 61.6% | x | x |
| 37663 | 1,251 | 1.4% | 63.0% | x | x |
| 24211 | 1,069 | 1.2% | 64.2% | x | x |
| 24273 | 1,030 | 1.2% | 65.4% | x | x |
| 24251 | 990 | 1.1% | 66.5% | x | x |
| 24319 | 985 | 1.1% | 67.6% | x | x |
| 24228 | 917 | 1.0% | 68.6% | x | x |
| 24370 | 911 | 1.0% | 69.7% | x | x |
| 37743 | 895 | 1.0% | 70.7% | x | x |
| 24340 | 844 | 0.9% | 71.6% | x | x |
| 24244 | 772 | 0.9% | 72.5% | x | x |
| 24224 | 749 | 0.8% | 73.3% | x | x |
| 24263 | 740 | 0.8% | 74.2% | x | x |
| 37686 | 731 | 0.8% | 75.0% | x | x |
| 24361 | 684 | 0.8% | 75.7% | x | x |
| 37665 | 679 | 0.8% | 76.5% | | x |
| 24277 | 675 | 0.8% | 77.3% | | x |
| 37692 | 665 | 0.7% | 78.0% | | x |
| 37745 | 661 | 0.7% | 78.8% | | x |
| 24260 | 660 | 0.7% | 79.5% | | x |
| 24279 | 659 | 0.7% | 80.2% | | x |
| 37681 | 640 | 0.7% | 81.0% | | x |
| 37658 | 613 | 0.7% | 81.7% | | x |
| 37687 | 534 | 0.6% | 82.3% | | x |
| 37641 | 494 | 0.6% | 82.8% | | x |
| 37645 | 491 | 0.6% | 83.4% | | x |
| 24236 | 461 | 0.5% | 83.9% | | x |
| 24283 | 455 | 0.5% | 84.4% | | x |
| 37873 | 449 | 0.5% | 84.9% | | x |
| 37690 | 448 | 0.5% | 85.4% | | x |
| 37640 | 427 | 0.5% | 85.9% | | x |
| 24216 | 411 | 0.5% | 86.3% | | x |
| 37869 | 369 | 0.4% | 86.8% | | x |
| 37656 | 343 | 0.4% | 87.1% | | x |
| 24609 | 322 | 0.4% | 87.5% | | x |
| 24243 | 317 | 0.4% | 87.9% | | x |
| 24237 | 296 | 0.3% | 88.2% | | x |
| 24256 | 277 | 0.3% | 88.5% | | x |
| 24271 | 273 | 0.3% | 88.8% | | x |
| 37711 | 272 | 0.3% | 89.1% | | x |
| 24290 | 245 | 0.3% | 89.4% | | x |
| 24614 | 238 | 0.3% | 89.7% | | x |
| 24641 | 236 | 0.3% | 89.9% | | x |
| 24225 | 230 | 0.3% | 90.2% | | x |

Exhibit 11B. 75% and 90% Service Areas (Map) Based on Mountain States Discharges Only

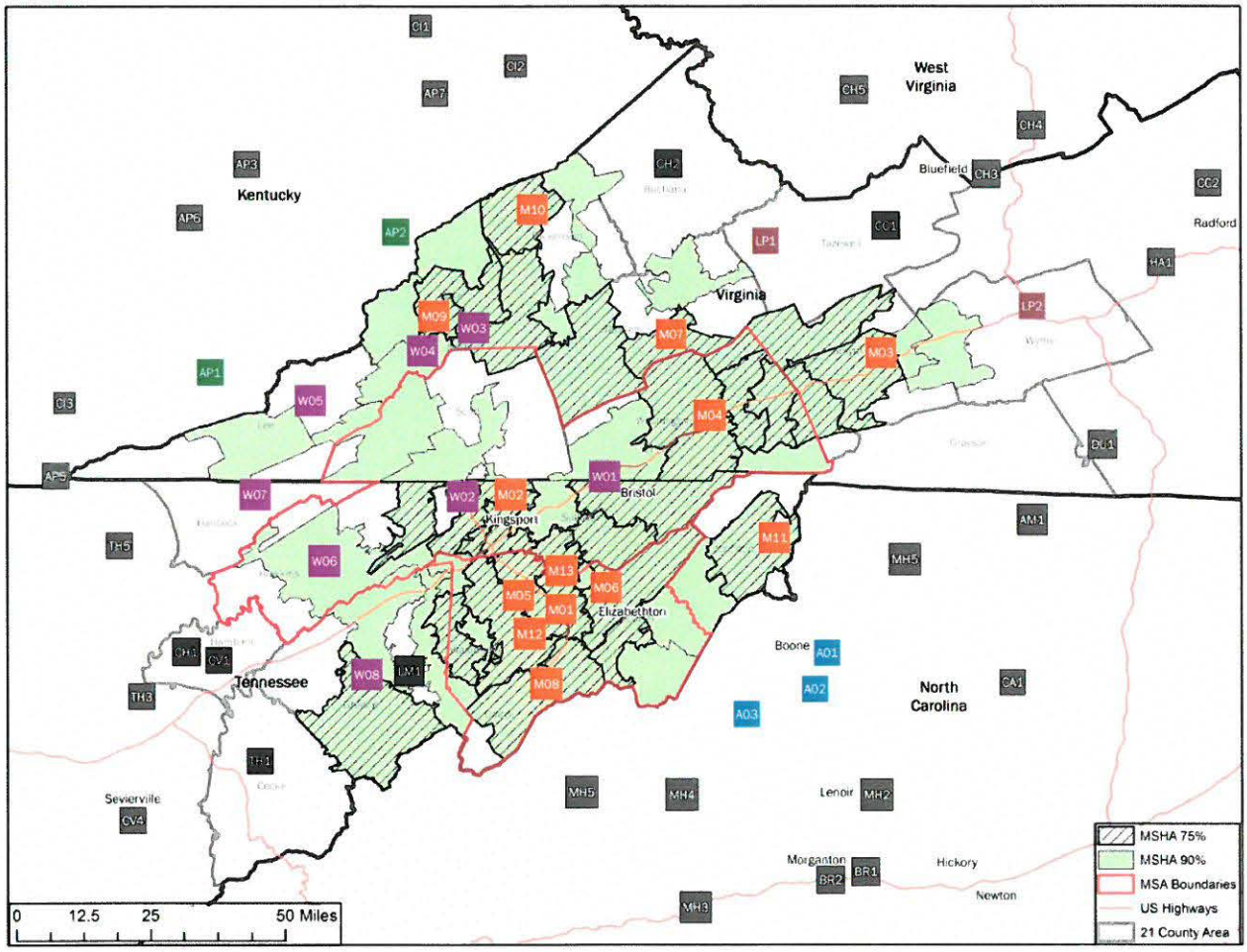

Exhibit 11C. 75% and 90% Service Areas (Map) Based on Wellmont Discharges Only

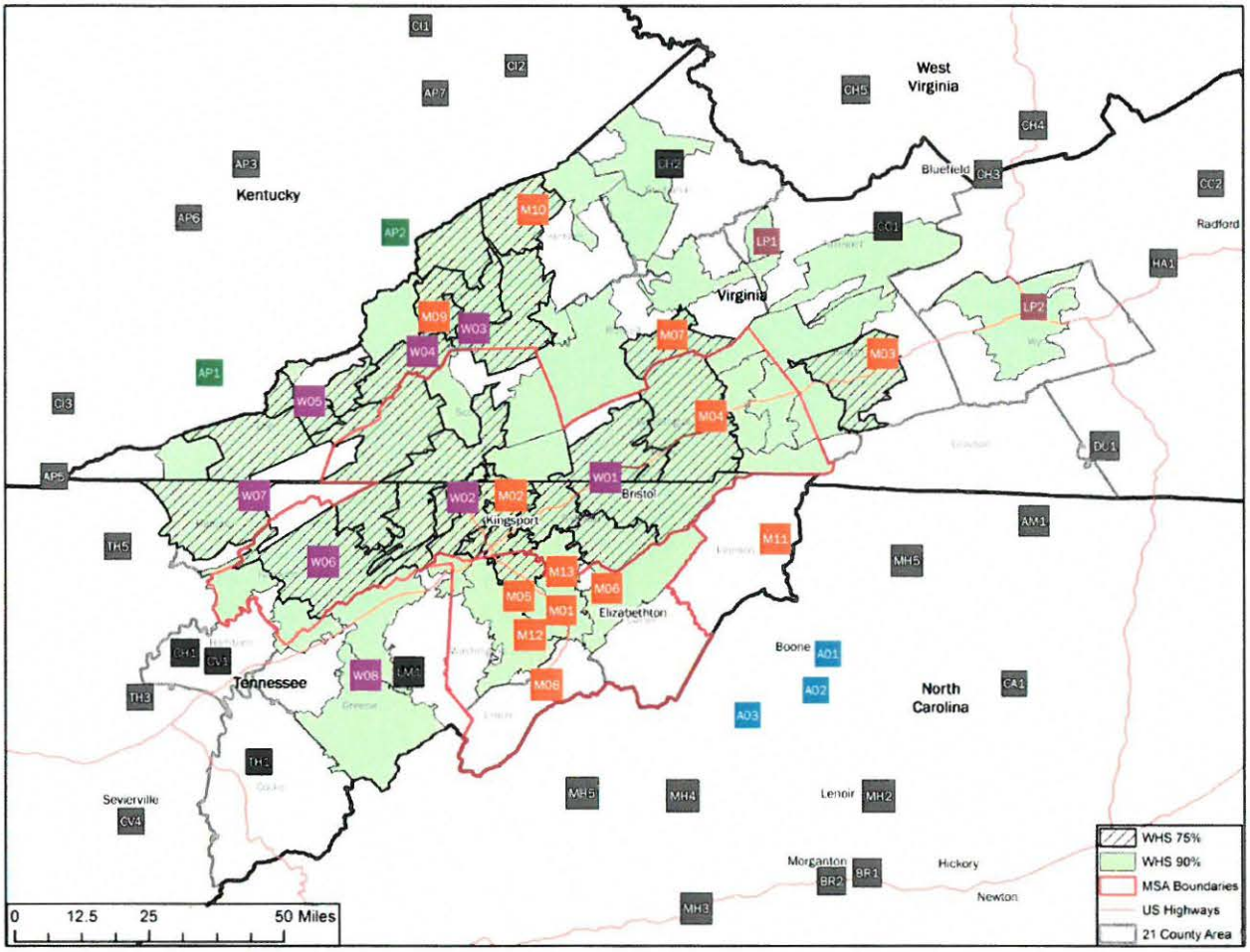

Exhibit 11D. 75% and 90% Service Areas (ZIP Codes) for Individual New Health System Hospitals

| Discharge Area | WELLMONT HOLSTON VALLEY MEDICAL CENTER | WELLMONT BRISTOL REGIONAL MEDICAL CENTER | WELLMONT LONESOME PINE HOSPITAL | MOUNTAIN VIEW REGIONAL MEDICAL CENTER | WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL | WELLMONT HANCOCK COUNTY HOSPITAL |
|---|---|---|---|---|---|---|
| ZIPs that make up the 75% Service Area | 24219 | 24201 | 24216 | 24219 | 37711 | 37869 |
| | 24230 | 24202 | 24219 | 24228 | 37857 | |
| | 24244 | 24210 | 24230 | 24230 | | |
| | 24251 | 24211 | 24243 | 24273 | | |
| | 24263 | 24260 | 24244 | 24279 | | |
| | 24271 | 24266 | 24263 | 24293 | | |
| | 24277 | 24319 | 24277 | | | |
| | 24293 | 24340 | 24279 | | | |
| | 37615 | 24354 | 24293 | | | |
| | 37617 | 24361 | | | | |
| | 37620 | 24370 | | | | |
| | 37642 | 24609 | | | | |
| | 37645 | 24614 | | | | |
| | 37659 | 37617 | | | | |
| | 37660 | 37618 | | | | |
| | 37663 | 37620 | | | | |
| | 37664 | 37686 | | | | |
| | 37665 | | | | | |
| | 37743 | | | | | |
| | 37745 | | | | | |
| | 37857 | | | | | |
| | 37869 | | | | | |
| | 37873 | | | | | |
| ZIPs that make up the 90% Service Area | 24201 | 24212 | 24228 | 24216 | 37731 | 24221 |
| | 24210 | 24219 | 24246 | 24243 | 37811 | 37731 |
| | 24216 | 24224 | 24265 | 24244 | 37873 | 37765 |
| | 24221 | 24225 | 24273 | 24263 | | 37881 |
| | 24224 | 24228 | 24282 | 24277 | | |
| | 24228 | 24230 | | 24283 | | |
| | 24243 | 24236 | | | | |
| | 24245 | 24256 | | | | |
| | 24250 | 24263 | | | | |
| | 24258 | 24273 | | | | |
| | 24266 | 24279 | | | | |
| | 24273 | 24283 | | | | |
| | 24279 | 24293 | | | | |
| | 24281 | 24368 | | | | |
| | 24282 | 24382 | | | | |
| | 24283 | 24620 | | | | |
| | 24290 | 24630 | | | | |
| | 24354 | 24631 | | | | |
| | 24614 | 24637 | | | | |
| | 37601 | 24639 | | | | |
| | 37604 | 24641 | | | | |
| | 37618 | 24649 | | | | |
| | 37641 | 24651 | | | | |
| | 37643 | 24656 | | | | |
| | 37650 | 37615 | | | | |
| | 37656 | 37643 | | | | |
| | 37681 | 37660 | | | | |
| | 37686 | 37663 | | | | |
| | 37711 | 37664 | | | | |
| | 37811 | 37683 | | | | |
| | | 37857 | | | | |

Exhibit 11D. 75% and 90% Service Areas (ZIP Codes) for Individual New Health System Hospitals (Continued)

| Discharge Area | JOHNSON CITY MEDICAL CENTER | INDIAN PATH MEDICAL CENTER | JOHNSTON MEMORIAL HOSPITAL | QUILLEN REHAB HOSPITAL | FRANKLIN WOODS COMMUNITY HOSPITAL | WOODRIDGE PSYCHIATRIC HOSPITAL | NORTON COMMUNITY HOSPITAL |
|---|---|---|---|---|---|---|---|
| ZIPs that make up the 75% Service Area | 37601 | 24228 | 24201 | 37601 | 37601 | 24251 | 24219 |
| | 37604 | 24244 | 24202 | 37604 | 37604 | 37601 | 24228 |
| | 37615 | 24251 | 24210 | 37615 | 37615 | 37604 | 24230 |
| | 37618 | 24263 | 24211 | 37643 | 37643 | 37615 | 24256 |
| | 37620 | 24293 | 24224 | 37650 | 37650 | 37617 | 24273 |
| | 37641 | 37615 | 24236 | 37659 | 37659 | 37643 | 24279 |
| | 37643 | 37617 | 24266 | 37681 | 37686 | 37659 | 24293 |
| | 37650 | 37642 | 24319 | 37683 | 37690 | 37660 | |
| | 37658 | 37645 | 24340 | 37692 | | | |
| | 37659 | 37660 | 24354 | 37743 | | | |
| | 37660 | 37663 | 24361 | 37745 | | | |
| | 37681 | 37664 | 24370 | | | | |
| | 37683 | 37665 | | | | | |
| | 37686 | 37857 | | | | | |
| | 37690 | | | | | | |
| | 37692 | | | | | | |
| | 37743 | | | | | | |
| | 37745 | | | | | | |
| ZIPs that make up the 90% Service Area | 24201 | 24219 | 24212 | 28657 | 37618 | 24266 | 24216 |
| | 24202 | 24221 | 24225 | 28705 | 37620 | 24273 | 24224 |
| | 24210 | 24224 | 24237 | 37605 | 37641 | 37618 | 24226 |
| | 24211 | 24230 | 24260 | 37616 | 37658 | 37641 | 24237 |
| | 24219 | 24245 | 24283 | 37617 | 37663 | 37645 | 24244 |
| | 24228 | 24250 | 24292 | 37618 | 37681 | 37663 | 24263 |
| | 24230 | 24258 | 24311 | 37620 | 37683 | 37664 | 24272 |
| | 24251 | 24271 | 24368 | 37640 | 37687 | 37686 | 24277 |
| | 24266 | 24273 | 24375 | 37641 | 37692 | | 24283 |
| | 24273 | 24277 | 24609 | 37644 | 37743 | | |
| | 24293 | 24279 | 24614 | 37658 | 37745 | | |
| | 24319 | 24290 | 24641 | 37663 | | | |
| | 24354 | 37620 | 37620 | 37686 | | | |
| | 24370 | 37656 | 37680 | 37687 | | | |
| | 28657 | 37659 | 37683 | 37688 | | | |
| | 28705 | 37873 | | 37690 | | | |
| | 37616 | | | | | | |
| | 37617 | | | | | | |
| | 37640 | | | | | | |
| | 37642 | | | | | | |
| | 37644 | | | | | | |
| | 37656 | | | | | | |
| | 37657 | | | | | | |
| | 37663 | | | | | | |
| | 37664 | | | | | | |
| | 37687 | | | | | | |
| | 37694 | | | | | | |
| | 37818 | | | | | | |
| | 37857 | | | | | | |

Exhibit 11D. 75% and 90% Service Areas (ZIP Codes) for Individual New Health System Hospitals (Continued)

| Discharge Area | RUSSELL COUNTY MEDICAL CENTER | SYCAMORE SHOALS HOSPITAL | SMYTH COUNTY COMMUNITY HOSPITAL | DICKENSON COMMUNITY HOSPITAL | UNICOI COUNTY MEMORIAL HOSPITAL, INC. | JOHNSON COUNTY COMMUNITY HOSPITAL |
|---|---|---|---|---|---|---|
| ZIPs that make up the 75% Service Area | 24224 | 37601 | 24311 | 24220 | 37650 | 37683 |
| | 24225 | 37643 | 24319 | 24228 | 37692 | |
| | 24237 | 37658 | 24354 | 24256 | | |
| | 24260 | 37683 | 24370 | | | |
| | 24266 | | | | | |
| ZIPs that make up the 90% Service Area | 24210 | 37640 | 24368 | | 37657 | |
| | 24239 | 37644 | 24375 | | 37659 | |
| | 24280 | 37687 | | | | |
| | 24283 | 37694 | | | | |
| | 24609 | | | | | |
| | 24646 | | | | | |
| | 24649 | | | | | |

Exhibit 12A. Inpatient Shares Based on New Health System 75% Service Area

| Hospital Name | Hospital Affiliation | Total | Shares of Total Area Discharges | Shares of Wellmont and Mountain States Discharges | Shares of Hospitals in 75% Area |
|---|---|---|---|---|---|
| Total | | 71,881 | 100.0% | | |
| WELLMONT HANCOCK COUNTY HOSPITAL | WHS | 10 | 0.0% | 0.0% | |
| WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL | WHS | 749 | 1.0% | 1.1% | 1.1% |
| MOUNTAIN VIEW REGIONAL MEDICAL CENTER | WHS | 851 | 1.2% | 1.3% | 1.2% |
| WELLMONT LONESOME PINE HOSPITAL | WHS | 1,015 | 1.4% | 1.5% | 1.5% |
| WELLMONT BRISTOL REGIONAL MEDICAL CENTER | WHS | 10,700 | 14.9% | 15.9% | 15.7% |
| WELLMONT HOLSTON VALLEY MEDICAL CENTER | WHS | 12,512 | 17.4% | 18.6% | 18.3% |
| WELLMONT TOTAL | WHS | 25,837 | 35.9% | 38.4% | 37.8% |
| DICKENSON COMMUNITY HOSPITAL | MSHA | 3 | 0.0% | 0.0% | 0.0% |
| JOHNSON COUNTY COMMUNITY HOSPITAL | MSHA | 13 | 0.0% | 0.0% | 0.0% |
| WOODRIDGE PSYCHIATRIC HOSPITAL | MSHA | 30 | 0.0% | 0.0% | 0.0% |
| QUILLEN REHABILITATION HOSPITAL | MSHA | 398 | 0.6% | 0.6% | 0.6% |
| UNICOI COUNTY MEMORIAL HOSPITAL, INC. | MSHA | 606 | 0.8% | 0.9% | 0.9% |
| RUSSELL COUNTY MEDICAL CENTER | MSHA | 686 | 1.0% | 1.0% | 1.0% |
| SMYTH COUNTY COMMUNITY HOSPITAL | MSHA | 1,375 | 1.9% | 2.0% | 2.0% |
| NORTON COMMUNITY HOSPITAL | MSHA | 2,161 | 3.0% | 3.2% | 3.2% |
| SYCAMORE SHOALS HOSPITAL | MSHA | 2,430 | 3.4% | 3.6% | 3.6% |
| FRANKLIN WOODS COMMUNITY HOSPITAL | MSHA | 4,377 | 6.1% | 6.5% | 6.4% |
| INDIAN PATH MEDICAL CENTER | MSHA | 4,855 | 6.8% | 7.2% | 7.1% |
| JOHNSTON MEMORIAL HOSPITAL | MSHA | 6,325 | 8.8% | 9.4% | 9.3% |
| JOHNSON CITY MEDICAL CENTER | MSHA | 18,237 | 25.4% | 27.1% | 26.7% |
| MSHA TOTAL | MSHA | 41,496 | 57.7% | 61.6% | 60.7% |
| LAUGHLIN MEMORIAL HOSPITAL, INC. | Other | 1,139 | 1.6% | | |
| TAKOMA REGIONAL HOSPITAL | Other | 1,003 | 1.4% | | 1.5% |
| VANDERBILT UNIVERSITY HOSPITALS | Other | 537 | 0.7% | | |
| UNIVERSITY OF VIRGINIA MEDICAL CENTER | Other | 432 | 0.6% | | |
| UNIVERSITY OF TENNESSEE MEDICAL CENTER | Other | 281 | 0.4% | | |
| All Other | | 1,156 | 1.6% | | |

Source: CY 2014 State Discharge Data – based on Mountain States and Wellmont Discharges
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 12B. Inpatient Shares Based on New Health System's 90% Service Area

| Hospital Name | Hospital Affiliation | Total | Shares of Total Area Discharges | Shares of Wellmont and Mountain States Discharges | Shares of Hospitals in 90% Area |
|---|---|---|---|---|---|
| Total | | 90,650 | 100.0% | | |
| WELLMONT HANCOCK COUNTY HOSPITAL | WHS | 159 | 0.2% | 0.2% | 0.2% |
| WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL | WHS | 911 | 1.0% | 1.1% | 1.0% |
| MOUNTAIN VIEW REGIONAL MEDICAL CENTER | WHS | 1,101 | 1.2% | 1.4% | 1.3% |
| WELLMONT LONESOME PINE HOSPITAL | WHS | 1,515 | 1.7% | 1.9% | 1.7% |
| WELLMONT BRISTOL REGIONAL MEDICAL CENTER | WHS | 11,735 | 12.9% | 14.6% | 13.5% |
| WELLMONT HOLSTON VALLEY MEDICAL CENTER | WHS | 15,594 | 17.2% | 19.5% | 17.9% |
| WELLMONT TOTAL | WHS | 31,015 | 34.2% | 38.7% | 35.6% |
| DICKENSON COMMUNITY HOSPITAL | MSHA | 4 | 0.0% | 0.0% | 0.0% |
| JOHNSON COUNTY COMMUNITY HOSPITAL | MSHA | 13 | 0.0% | 0.0% | 0.0% |
| WOODRIDGE PSYCHIATRIC HOSPITAL | MSHA | 32 | 0.0% | 0.0% | 0.0% |
| QUILLEN REHABILITATION HOSPITAL | MSHA | 466 | 0.5% | 0.6% | 0.5% |
| UNICOI COUNTY MEMORIAL HOSPITAL, INC. | MSHA | 714 | 0.8% | 0.9% | 0.8% |
| RUSSELL COUNTY MEDICAL CENTER | MSHA | 1,153 | 1.3% | 1.4% | 1.3% |
| SMYTH COUNTY COMMUNITY HOSPITAL | MSHA | 1,384 | 1.5% | 1.7% | 1.6% |
| NORTON COMMUNITY HOSPITAL | MSHA | 2,873 | 3.2% | 3.6% | 3.3% |
| SYCAMORE SHOALS HOSPITAL | MSHA | 2,982 | 3.3% | 3.7% | 3.4% |
| FRANKLIN WOODS COMMUNITY HOSPITAL | MSHA | 4,985 | 5.5% | 6.2% | 5.7% |
| INDIAN PATH MEDICAL CENTER | MSHA | 5,660 | 6.2% | 7.1% | 6.5% |
| JOHNSTON MEMORIAL HOSPITAL | MSHA | 7,273 | 8.0% | 9.1% | 8.4% |
| JOHNSON CITY MEDICAL CENTER | MSHA | 21,619 | 23.8% | 27.0% | 24.8% |
| MSHA TOTAL | MSHA | 49,158 | 54.2% | 61.3% | 56.5% |
| LAUGHLIN MEMORIAL HOSPITAL, INC. | Other | 2,598 | 2.9% | | 3.0% |
| CLINCH VALLEY MEDICAL CENTER | Other | 1,990 | 2.2% | | 2.3% |
| TAKOMA REGIONAL HOSPITAL | Other | 1,736 | 1.9% | | 2.0% |
| VANDERBILT UNIVERSITY HOSPITALS | Other | 674 | 0.7% | | |
| UNIVERSITY OF VIRGINIA MEDICAL CENTER | Other | 612 | 0.7% | | |
| All Other | | 2,857 | 3.2% | | 0.6% |

Source: CY 2014 State Discharge Data – based on Mountain States and Wellmont Discharges
Notes: Normal newborns and MDCs 19 and 20 excluded

Exhibit 12C. **Inpatient Shares Based on New Health System's Geographic Service Area**

| Hospital Name | Hospital Affiliation | Total | Shares of Total Discharges | Shares of WHS and MSHA Discharges |
|---|---|---|---|---|
| **Total** | | **119,282** | **100.0%** | |
| **Total 21-County Hospitals** | | **108,392** | **90.9%** | |
| **Total Non 21-County Hospitals** | | **10,890** | **9.1%** | |
| **Share Outside 21 County-Area** | | **9.1%** | | |
| WELLMONT HANCOCK COUNTY HOSPITAL | WHS | 179 | 0.2% | 0.2% |
| WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL | WHS | 1,012 | 0.8% | 1.2% |
| MOUNTAIN VIEW REGIONAL MEDICAL CENTER | WHS | 1,160 | 1.0% | 1.3% |
| WELLMONT LONESOME PINE HOSPITAL | WHS | 1,704 | 1.4% | 2.0% |
| WELLMONT BRISTOL REGIONAL MEDICAL CENTER | WHS | 13,000 | 10.9% | 15.0% |
| WELLMONT HOLSTON VALLEY MEDICAL CENTER | WHS | 16,773 | 14.1% | 19.4% |
| DICKENSON COMMUNITY HOSPITAL | MSHA | 5 | 0.0% | 0.0% |
| JOHNSON COUNTY COMMUNITY HOSPITAL | MSHA | 14 | 0.0% | 0.0% |
| WOODRIDGE PSYCHIATRIC HOSPITAL | MSHA | 32 | 0.0% | 0.0% |
| QUILLEN REHABILITATION HOSPITAL | MSHA | 491 | 0.4% | 0.6% |
| UNICOI COUNTY MEMORIAL HOSPITAL, INC. | MSHA | 757 | 0.6% | 0.9% |
| RUSSELL COUNTY MEDICAL CENTER | MSHA | 1,313 | 1.1% | 1.5% |
| SMYTH COUNTY COMMUNITY HOSPITAL | MSHA | 1,753 | 1.5% | 2.0% |
| NORTON COMMUNITY HOSPITAL | MSHA | 3,120 | 2.6% | 3.6% |
| SYCAMORE SHOALS HOSPITAL | MSHA | 3,167 | 2.7% | 3.7% |
| FRANKLIN WOODS COMMUNITY HOSPITAL | MSHA | 5,138 | 4.3% | 5.9% |
| INDIAN PATH MEDICAL CENTER | MSHA | 5,939 | 5.0% | 6.9% |
| JOHNSTON MEMORIAL HOSPITAL | MSHA | 8,123 | 6.8% | 9.4% |
| JOHNSON CITY MEDICAL CENTER | MSHA | 22,983 | 19.3% | 26.5% |
| CARILION TAZEWELL COMMUNITY HOSPITAL | Other | 543 | 0.5% | |
| BUCHANAN GENERAL HOSPITAL | Other | 1,041 | 0.9% | |
| WYTHE COUNTY COMMUNITY HOSPITAL | Other | 1,801 | 1.5% | |
| TENNOVA HEALTHCARE-LAKEWAY REGIONAL HOSPITAL | Other | 1,820 | 1.5% | |
| TENNOVA HEALTHCARE-NEWPORT MEDICAL CENTER | Other | 2,011 | 1.7% | |
| TAKOMA REGIONAL HOSPITAL | Other | 2,270 | 1.9% | |
| LAUGHLIN MEMORIAL HOSPITAL, INC. | Other | 3,225 | 2.7% | |
| CLINCH VALLEY MEDICAL CENTER | Other | 4,102 | 3.4% | |
| MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM | Other | 4,916 | 4.1% | |
| UNIVERSITY OF TENNESSEE MEDICAL CENTER | Other | 1,764 | 1.5% | |
| CARILION MEDICAL CENTER | Other | 1,159 | 1.0% | |
| TENNOVA HEALTHCARE-PHYSICIANS REGIONAL MEDICAL CEN | Other | 1,045 | 0.9% | |
| UNIVERSITY OF VIRGINIA MEDICAL CENTER | Other | 862 | 0.7% | |
| VANDERBILT UNIVERSITY HOSPITALS | Other | 856 | 0.7% | |
| All Other | | 5,204 | 4.4% | |

Exhibit 12D. Outpatient Shares Based on New Health System's Estimated 75% Service Area (Excluding Wythe, Cocke, Hamblen, Buchanan, Tazewell, and Hancock Counties)

| Service Type | WHS & MSHA Combined % | Mountain States | Mountain States-NsCH Affiliate | Wellmont | Non-Managed Joint Venture | All Other* | Total |
|---|---|---|---|---|---|---|---|
| Pharmacy | 2.2% | 5 | 0 | 0 | 0 | 223 | **228** |
| XRAY | 28.3% | 14 | 0 | 12 | 0 | 66 | **92** |
| Fitness Center | 0.0% | 0 | 0 | 0 | 0 | 67 | **67** |
| Nursing Home | 10.9% | 3 | 0 | 2 | 0 | 41 | **46** |
| Physical Therapy | 10.8% | 1 | 0 | 3 | 0 | 33 | **37** |
| Home Health | 28.6% | 8 | 0 | 2 | 0 | 25 | **35** |
| Rehabilitation | 31.4% | 4 | 0 | 7 | 0 | 24 | **35** |
| CT | 78.6% | 12 | 0 | 10 | 0 | 6 | **28** |
| MRI | 72.0% | 11 | 0 | 7 | 0 | 7 | **25** |
| Urgent Care | 72.7% | 8 | 0 | 8 | 0 | 6 | **22** |
| Surgery - Endoscopy | 73.7% | 9 | 0 | 5 | 0 | 5 | **19** |
| Surgery - Hospital-based | 82.4% | 9 | 0 | 5 | 0 | 3 | **17** |
| Dialysis Services | 0.0% | 0 | 0 | 0 | 0 | 15 | **15** |
| Rehabilitation & Physical Therapy | 35.7% | 0 | 0 | 5 | 0 | 9 | **14** |
| Chemotherapy | 76.9% | 4 | 1 | 5 | 0 | 3 | **13** |
| Wellness Center | 23.1% | 2 | 0 | 1 | 0 | 10 | **13** |
| Surgery - ASC | 41.7% | 2 | 0 | 3 | 3 | 4 | **12** |
| Radiation Therapy | 75.0% | 3 | 0 | 3 | 0 | 2 | **8** |
| Cancer Center | 75.0% | 3 | 0 | 3 | 0 | 2 | **8** |
| Weight Loss Center | 14.3% | 0 | 0 | 1 | 0 | 6 | **7** |
| Community Center | 0.0% | 0 | 0 | 0 | 0 | 3 | **3** |
| Women's Cancer Services | 100.0% | 0 | 0 | 1 | 0 | 0 | **1** |
| Cancer Support Services | 0.0% | 0 | 0 | 0 | 0 | 1 | **1** |

*Excluded 3 facilities under ASC and 2 under Urgent Care
ASCs excluded - The Regional Eye Surgery Center, Reeves Eye Surgery Center, and Johnson City Eye Surgery Center; Urgent Care Centers excluded - Patmos EmergiClinic and Doctors Care

Exhibit 12D. Outpatient Shares Based on New Health System's Estimated 90% Service Area (Excluding Wythe, Cocke and Hamblen Counties)

| Service Type | WHS & MSHA Combined % | Mountain States | Mountain States-NsCH Affiliate | WHS | Non-Managed Joint Venture | All Other* | Total |
|---|---|---|---|---|---|---|---|
| Pharmacy | 1.9% | 5 | 0 | 0 | 0 | 253 | 258 |
| Fitness Center | 0.0% | 0 | 0 | 0 | 0 | 72 | 72 |
| XRAY | 28.3% | 14 | 0 | 12 | 0 | 66 | 92 |
| Nursing Home | 10.2% | 3 | 0 | 2 | 0 | 44 | 49 |
| Physical Therapy | 9.8% | 1 | 0 | 3 | 0 | 37 | 41 |
| Home Health | 22.2% | 8 | 0 | 2 | 0 | 35 | 45 |
| Rehabilitation | 30.6% | 4 | 0 | 7 | 0 | 25 | 36 |
| CT | 68.8% | 12 | 0 | 10 | 0 | 10 | 32 |
| MRI | 62.1% | 11 | 0 | 7 | 0 | 11 | 29 |
| Surgery - Endoscopy | 66.7% | 9 | 0 | 5 | 0 | 7 | 21 |
| Urgent Care | 69.6% | 8 | 0 | 8 | 0 | 7 | 23 |
| Surgery - Hospital-based | 70.0% | 9 | 0 | 5 | 0 | 6 | 20 |
| Dialysis Services | 0.0% | 0 | 0 | 0 | 0 | 16 | 16 |
| Wellness Center | 20.0% | 2 | 0 | 1 | 0 | 12 | 15 |
| Surgery - ASC | 41.7% | 2 | 0 | 3 | 4 | 3 | 12 |
| Chemotherapy | 71.4% | 4 | 1 | 5 | 0 | 4 | 14 |
| Rehabilitation & Physical Therapy | 33.3% | 0 | 0 | 5 | 0 | 10 | 15 |
| Radiation Therapy | 66.7% | 3 | 0 | 3 | 0 | 3 | 9 |
| Cancer Center | 66.7% | 3 | 0 | 3 | 0 | 3 | 9 |
| Weight Loss Center | 14.3% | 0 | 0 | 1 | 0 | 6 | 7 |
| Community Center | 0.0% | 0 | 0 | 0 | 0 | 3 | 3 |
| Cancer Support Services | 0.0% | 0 | 0 | 0 | 0 | 1 | 1 |
| Women's Cancer Services | 100.0% | 0 | 0 | 1 | 0 | 0 | 1 |

*Excluded 3 facilities under ASC and 2 under Urgent Care
ASCs excluded - The Regional Eye Surgery Center, Reeves Eye Surgery Center, and Johnson City Eye Surgery Center; Urgent Care Centers excluded - Patmos EmergiClinic and Doctors Care

Exhibit 12D. Outpatient Shares Based on New Health System's Geographic Service Area

| Service Type | WHS & MSHA Combined % | Mountain States | Mountain States-NsCH Affiliate | WHS | Non-Managed Joint Venture | All Other* | Total |
|---|---|---|---|---|---|---|---|
| **Pharmacy** | 1.7% | 5 | 0 | 0 | 0 | 297 | 302 |
| **Fitness Center** | 0.0% | 0 | 0 | 0 | 0 | 82 | 82 |
| **XRAY** | 28.3% | 14 | 0 | 12 | 0 | 66 | 92 |
| **Nursing Home** | 9.1% | 3 | 0 | 2 | 0 | 50 | 55 |
| **Physical Therapy** | 7.8% | 1 | 0 | 3 | 0 | 47 | 51 |
| **Home Health** | 19.6% | 8 | 0 | 2 | 0 | 41 | 51 |
| **Rehabilitation** | 39.5% | 9 | 0 | 8 | 0 | 26 | 43 |
| **CT** | 59.5% | 12 | 0 | 10 | 0 | 15 | 37 |
| **MRI** | 52.9% | 11 | 0 | 7 | 0 | 16 | 34 |
| **Surgery - Endoscopy** | 58.3% | 9 | 0 | 5 | 0 | 10 | 24 |
| **Urgent Care** | 57.1% | 8 | 0 | 8 | 0 | 12 | 28 |
| **Surgery - Hospital-based** | 58.3% | 9 | 0 | 5 | 0 | 10 | 24 |
| **Dialysis Services** | 0.0% | 0 | 0 | 0 | 0 | 20 | 20 |
| **Wellness Center** | 18.8% | 2 | 0 | 1 | 0 | 13 | 16 |
| **Surgery - ASC** | 66.7% | 2 | 0 | 3 | 3 | 4 | 12 |
| **Chemotherapy** | 62.5% | 4 | 1 | 5 | 0 | 6 | 16 |
| **Rehabilitation & Physical Therapy** | 31.3% | 0 | 0 | 5 | 0 | 11 | 16 |
| **Radiation Therapy** | 60.0% | 3 | 0 | 3 | 0 | 4 | 10 |
| **Cancer Center** | 60.0% | 3 | 0 | 3 | 0 | 4 | 10 |
| **Weight Loss Center** | 14.3% | 0 | 0 | 1 | 0 | 6 | 7 |
| **Community Center** | 0.0% | 0 | 0 | 0 | 0 | 3 | 3 |
| **Cancer Support Services** | 0.0% | 0 | 0 | 0 | 0 | 1 | 1 |
| **Women's Cancer Services** | 100.0% | 0 | 0 | 1 | 0 | 0 | 1 |

*Excluded 3 facilities under ASC and 2 under Urgent Care

ASCs excluded - The Regional Eye Surgery Center, Reeves Eye Surgery Center, and Johnson City Eye Surgery Center; Urgent Care Centers excluded - Patmos EmergiClinic and Doctors Care

# Exhibit 14

## Information on Licensed Health Care Professionals

(to be provided in a subsequent response)

**Exhibit 18 - Community Health Improvement Plan**

| Ensure Strong Starts for Children 1/2 | Short-term Outcomes | Intermediate Outcomes | Long-term Expected Health Impact | | | | |
|---|---|---|---|---|---|---|---|
| | | | Heart | Cancer | Diabetes | Behavioral Health | Infant Mortality |
| **Reduce Childhood Obesity** | | Reduction in percent children classified as "overweight" | X | X | X | | |
| • Increase rates of breastfeeding<br>▪ Program Example: *Baby Friendly Hospital Initiative* | Increased rate of breastfeeding at 6 months | | X | X | X | | X |
| • Increase physical activity<br>▪ Program Example: *Morning Mile; Project SPARK* | Increased rate of children achieving the recommend level of weekly physical activity | | X | X | X | | |
| • Increase healthy eating<br>▪ Program Example: *#LiveSugarFreed campaign* | Decreased amount of weekly sugary beverage consumption in children | | X | X | X | | |
| **Decrease Tobacco Use in Youth** | | Decreased rates of "current" use of tobacco | X | X | X | X | X |
| • Expand anti-smoking campaigns<br>▪ Program Example: *#UNSMOKABLE* | Reduced rate of past year smoking initiation or "ever" smoked | | X | X | X | X | X |
| **Decrease Opioid Abuse in Youth** | | Decreased reported past month non-medical use of pain relievers | | | | X | X |
| • Decrease diversion<br>▪ Program Example: *Drug return kiosks* | Milligrams of prescription painkillers removed from circulation | | | | | X | X |
| • Expand anti-opioid campaigns<br>▪ Program Example: *Above the Influence* | Reduced rate of "ever" tried | | | | | X | X |
| **Increase 3rd Graders reading at Grade Level** | | Increased percentage of 3rd graders scoring "pass/proficient" on VA DOE SOL tests | X | X | X | X | X |
| • Increase read aloud opportunities<br>▪ Program Example: *Bear Buddies; Nurse Family Partnership* | Increased percentage of "at-risk" K-2 students paired with a Bear Buddy reading mentor | | X | X | X | X | X |

**Exhibit 18 - Community Health Improvement Plan**

| Ensure Strong Starts for Children 2/2 | Short-term Outcomes | Intermediate Outcomes | Long-term Expected Health Impact | | | | |
|---|---|---|---|---|---|---|---|
| | | | Heart | Cancer | Diabetes | Behavioral Health | Infant Mortality |
| **Decrease Pre-term Births** | | Decreased pre-term birth rate | | | | X | X |
| • Increase effectiveness of pre-natal care<br>▪ Program Example: *Nurse Family Partnership; Centering Pregnancy; 17-P utilization* | Increased percentage high-risk women participating in program | | | | | X | X |
| • Decrease tobacco use among pregnant women<br>▪ Program Example: *ACOG 5 As Behavioral Intervention; Baby and Me* | Increased percentage of pregnant female participants completing nicotine abstinence programs | | | | | X | X |
| • Decrease NAS births<br>▪ Program Example: *Residential treatment for opioid addicted pregnant women* | Decreased percentage of births with NAS | | | | | X | X |
| • Increase birth spacing<br>▪ Program Example: *Post-partum LARC insertion* | Increased average/median months between pregnancy in high-risk women | | | | | X | X |

**Exhibit 18 - Community Health Improvement Plan**

| Help Adult Live Well in the Community | Short-term Outcomes | Intermediate Outcomes | Long-term Expected Health Impact | | | | |
|---|---|---|---|---|---|---|---|
| | | | Heart | Cancer | Diabetes | Behavioral Health | Infant Mortality |
| **Decrease Adult Obesity** | | Decreased adult obesity rate | X | | X | | |
| • Increase Physical Activity<br>▪ Program Example: *YMCA Diabetes Prevention Program* | Decreased percentage of adults reporting no physical activity within past month | | X | X | X | | |
| • Increase Healthy Eating<br>▪ Program Example: *YMCA Diabetes Prevention Program* | Improvement in the Healthy Eating Index measure of dietary quality | | X | X | X | | |
| **Decrease Adult Tobacco Use** | | Decreased rates of "current" tobacco use | X | X | X | X | X |
| • Increase cessation treatment<br>▪ Program Example: *Screening and Physician Counseling* | Improved score on tobacco-related HEDIS measures in the New Health System. | | X | X | X | X | X |
| • Expand successful mass-reach health communication interventions<br>▪ Program Example: *CDC's Tips From Former Smokers* | Increased population awareness in anti-smoking awareness and attitudes over survey baseline | | X | X | X | X | X |
| **Increased Early Detection of Chronic Disease** | | Decreased early mortality from heart disease, diabetes, suicide, cancer, infant mortality | X | X | X | X | X |
| • Increase population screening<br>▪ Program Example: *Screening and Physician Counseling; SBIRT; Mobile Health Unit Deployment* | Improved score on screening-related HEDIS measures in the New Health System. | | X | X | X | X | X |

**Exhibit 18 - Community Health Improvement Plan**

| Promoting a Drug Free Community | Short-term Outcomes | Intermediate Outcomes | Long-term Expected Health Impact | | | | |
|---|---|---|---|---|---|---|---|
| | | | Heart | Cancer | Diabetes | Behavioral Health | Infant Mortality |
| **Decrease Opioids In Circulation** | | Decreased reported past month non-medical use of pain relievers | | | | X | X |
| • Decrease prescriptions written<br>▪ Program Example: *Choosing Wisely, Virginia PMP* | Decreased morphine equivalents prescribed | | | | | X | X |
| **Expand Environmental Prevention Strategies** | | Decreased reported past month non-medical use of pain relievers | | | | X | X |
| • Increase participation and support of multi-sector community collaborations<br>▪ Program Example: OneCare | Increased participation in pursuit of select OneCare goals | | | | | X | X |
| **Expand supportive services** | | Decreased reported past month non-medical use of pain relievers | | | | X | X |
| • Increase supportive housing<br>▪ Program Example*: Oxford House* | Expanded number of units available in drug-free supportive housing. | | | | | X | X |

**Exhibit 18 - Community Health Improvement Plan**

| Decrease Avoidable ED Use for High-Need High-Utilization Uninsured Individuals | Short-term Outcomes | Intermediate Outcomes | Long-term Expected Health Impact | | | | |
|---|---|---|---|---|---|---|---|
| | | | Heart | Cancer | Diabetes | Behavioral Health | Infant Mortality |
| **Increase use of ED alternatives** | | Reduction in avoidable ED and Inpatient Admissions in High-Need High-Use population | X | X | X | X | |
| • Increase use of primary, BH and specialty-care services<br>▪ Program: *Project Access, Free-clinics* | Increased utilization of primary care and specialty services by High-Need High-Risk population | | X | X | X | X | |
| • Increase use of home-based health services<br>▪ Program Example: *Community Paramedics, Community Health Workers* | Increased utilization of home-based health services by High-Need High-Risk population | | X | X | X | X | |
| **Expand supportive services** | | Reduction in avoidable ED and Inpatient Admissions in High-Need High-Use population | X | X | X | X | |
| • Increase use of case management<br>▪ Programs example: *SC Medicaid Healthy Outcomes Program* | Increased percentage of High-Need High Utilizing population in active case management | | X | X | X | X | |
| • Decrease transportation barriers<br>▪ Programs example: *Transportation vouchers* | Decrease "no-show" rate in High-Need High Utilization population | | X | X | X | X | |

**Exhibit 18 - Community Health Improvement Plan**

| Improve Access to Behavioral Health | Short-term Outcomes | Intermediate Outcomes | Long-term Expected Health Impact | | | | |
|---|---|---|---|---|---|---|---|
| | | | Heart | Cancer | Diabetes | Behavioral Health | Infant Mortality |
| **Increased Screening for Depression and Substance Abuse** | | Increased use of behavioral health treatment services | | | | X | X |
| • Increased screening at sites of care<br>▪ Program Example: *SBIRT* | Increase in the rates of SBIRT administration | | | | | X | X |
| **Reduce Unnecessary Psychiatric Admissions** | | Decreased psychiatric ER and inpatient admissions. | | | | X | X |
| • Expand community based outpatient treatment<br>▪ Program Example: *Assertive Community Treatment* | Increased percentage of individuals with SMI/SUD participating in community-based treatment | | | | | X | X |
| • Expand crisis management services<br>▪ Program Example: *Mobile Crisis Teams* | Increased percentage of crisis calls responded to by crisis management teams versus law enforcement | | | | | X | X |
| **Increase number of individuals with SUD in recovery** | | Increased percentage of individuals participating in active recovery | | | | X | X |
| • Expand continuum of treatment options<br>▪ Program Example: *Medically Monitored Detox, Residential Treatment, Outpatient Treatment* | Increased capacity in full continuum of treatment services for individuals living with SUD | | | | | X | X |

Exhibit 22A: High-Level Timeline for Common Clinical IT Platform

| d. Common Clinical IT and Health Information Exchange | Year 1 | | | | Year 2 | | | | Year 3 | | | | Year 4 | | | | Year 5 | | | | Year 6 | | | | Year 7 | | | | Year 8 | | | | Year 9 | | | | Year 10 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| *Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10* | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **i. System Integration 18-24 months** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Assessment of Health Systems including vendor | | X | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| System Implementation with data conversion and 3rd party interfaces | | | | X | X | X | X | X | X | X | X | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Training all Users (employed & non-employed providers) | | | | | | | | | X | X | X | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1. Behavioral Health Capability** | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EMR systems include:<br>- Standardized screening questionnaires & assessment tools<br>- Clear and consistent documentation protocols<br>- Treatment plans, flowsheet & restraint documentation<br>- Suicide intervention tools | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Integration and interoperability follows the standard for an integrated EMR, which is fully integrated and interoperable. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EMR system will have future development for a behavioral health module | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **2. Integration** | | | | | | | | | | | X | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Large EMRs interface with over fifty 3rd party vendors, linking records, integrating lab, medical, diagnostic, referral, and scheduling. Interfaces are inbound and outbound, to and from vendors, providers, government entities, etc. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **3. Migration of Historical Data** | | | | | | | | | | X | X | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Historical data such as medications, allergies and problems lists are generally converted to the new system. The remaining historical data will be accessible through a link inside the EMR to an archiving system such as DataArk (used at Wellmont.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **4. Training of New Users** | | | | | | | | | X | X | X | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All employed and non-employed providers are required to attend a minimum of 8 hours classroom training and pass a test to gain access to the EMR. Surgeons /proceduralists/specialists require additional training time. Training is specialty specific and includes a personalization lab. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **5. Patient Portal Access** | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.1 Medications, allergies, problem list, immunization records, test results, visit/admission summaries, e-visits, billing information with the capability to pay online as well as patient engagement: such as clinical offerings to healthy behavior classes, research studies, patient education are available through a patient portal. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.2The patient portal also links to other vendor enabled health systems. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5.3 Patients have access to reconciled health care data from different health systems. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **6. Collecting, Analyzing and Reporting Quality Outcomes** | | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Data is sent monthly to various analytical companies including Crimson, Comparion and CMS providing statistical analysis for clinical cost, quality, and patient satisfaction for both system and non system providers. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Exhibit 22A: High-Level Timeline for Common Clinical IT Platform

| **d. Common Clinical IT and Health Information Exchange**<br>*Tenn. Comp. R. & Regs. 1200-38-01-02(2)(a)10* | **Year 1** | | | | **Year 2** | | | | **Year 3** | | | | **Year 4** | | | | **Year 5** | | | | **Year 6** | | | | **Year 7** | | | | **Year 8** | | | | **Year 9** | | | | **Year 10** | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| **ii $150 Million Investment** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. Common Clinical IT Platform - $148m *<br>This initiative provides the platform for both the common clinical IT solution and connectivity for health information exchange, population health management and quality measurement reporting. This creates the connected community of hospitals and care givers, providing patients full access to their personal health record. | | X | X | X | X | X | X | X | X | X | X | X | X | | | | | | | | | | | | | | | | | | | | | | | | | |
| a. Health information exchange - Wellmont's health information exchange plan includes, regional, domestic, and international capabilities. Currently Wellmont is exchanging on all three. | | | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | |
| b. Quality reporting capabilities | | | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | |
| c. Population Health Management | | | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | |
| d. Connectivity for non system providers (current state) | | | | | | | | | | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. EHR solution for non-system providers $2m* | | | | | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| *Cost for the Common Clinical IT Platform will include, but not limited to, the following: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Hardware: new and upgrades | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Software: new and upgrades | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -3rd party interfaces | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Licensing fees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Post implementation annual maintenance fees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Vendor implementation fees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Consulting fees | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Labor | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Training/training related materials | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| -Go-live support | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **iii Regional Health Information Exchange** | X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wellmont's participation in OnePartner/HIE will be fully operable June 23, 2016. MSHA is currently participating in OnePartner. It is expected that the New Health System will meaningfully participate in a health information exchange. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Exhibit 22B

- **Description of the Parties' Plans for Electronic Health Records Systems**

A. Wellmont currently uses Epic (2014 version) as its enterprise-wide electronic health record solution. It includes the enterprise system to support the workflows for all clinical areas (acute hospitals and outpatient centers), ambulatory clinics and urgent care centers, as well as the access and revenue system for financial and billing functions. This results in one record for each patient regardless of where he/she is seen within the Wellmont system.

B. Mountain States currently employs multiple Meaningful Use Stage 2 certified technologies to support health care services in the region.

(i) Ambulatory. The ambulatory space is based on the AllScripts Touchworks Electronic Health Record version 11.4.1 hf20 with a planned upgrade to 15.1 scheduled for August 2016. This system supports:

- Problems, Allergy, Medication, and Immunization recoding and communication
- Electronic Medication Prescribing (drug / allergy interaction checking)
- Physician Order Entry
- Physician documentation at point of care
- Electronic lab and radiology resulting
- Electronic document imaging
- Intersystem Communication
- Integrated patient portal supporting scheduling and clinical interaction
- Patient Education

(ii) Acute. Additionally, Mountain States utilizes the Cerner Soarian Version 4.0.15 system for the acute setting. Major functions include:

- Full integrated legal electronic health record
- Problem, allergy, medication, and immunization capture and communication
- Medication administration assurance
- Clinician clinical documentation
- Clinical order entry
- Integration with clinical design and administration (IMRT, Critical Care)
- Digital radiology capture and communication
- Integrated lab result communication
- Intersystem communication

The Ambulatory and Acute systems work as a cohesive unit, supporting all aspects of care across the continuum of Mountain States' integrated healthcare delivery network.

- **Description of plan to convert to a single records system if the New Health System is approved**

  If the Cooperative Agreement is approved, the Parties expect the New Health System to assess each Party's existing electronic health records computer platform(s), including third party systems, hardware, software, computer infrastructure, etc., to determine the roadmap to bring the New Health System onto a Common Clinical IT Platform, as described in the Application.

  This assessment is expected to take at least six months after the New Health System is formed. Until this full assessment is completed, a detailed timeline and cost estimate cannot be determined. However, a high-level timeline for implementation of the Common Clinical IT Platform is included as **Exhibit 22.1** to these Responses. Major categories of the implementation costs would include, but not be limited to, the following:

  (i) Hardware: New and Upgrades
  (ii) Software: New and Upgrades
  (iii) 3rd Party Systems and Interfaces
  (iv) Licensing Fees
  (v) Vendor Implementation Fees
  (vi) Consulting Fees
  (vii) Labor Costs
  (viii) Training/Training Related Materials
  (ix) Go-Live Support
  (x) Post-Implementation Annual Maintenance Fees
  (xi) Any Future Additions of EMR Applications

- **Expected Features and Benefits of the Common Clinical IT Platform.**

  The Common Clinical IT Platform that the New Health System adopts will allow providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care. Specifically, the Common Clinical IT Platform is expected to result in a "One Patient-One Record" platform where all health information will be located on one system. The Parties intend for the Common Clinical IT Platform to include the following features:

  A. Log inpatient visits, emergency department visits, outpatient visits, ambulatory clinic visits, urgent care visits, and any visit within the New Health System.
  B. When a physician views a patient record, he/she will be able to see ALL encounters the patient has had anywhere in the system. This will be available to both employed and non-employed physicians.
  C. The data will include all physician notes, nurses notes, therapy notes, all other clinical specialty notes, history/physical, discharge summaries, lab, radiology and other diagnostic reports, allergies, medications, problem lists, radiology images, photos of wounds and other physical notations as surgical photos, all physician

orders placed, protocols used for treatment, patient data from other locations where the patient may have been treated, links to evidence based literature articles as reference and patient education materials.

D. The physician will also be able to link out to past medical records of the patient in the previous EMR system, so he/she does not need to go back to another system to see the patient's history.
E. Future appointments can be made as well as referrals to specialists.
F. Follow up letters to referring physicians can be generated within the Common Clinical IT Platform and sent directly from the Common Clinical IT Platform.
G. Results from outpatient testing will be delivered to the physician's in-basket to allow review of the results as soon as they are completed.
H. Actual radiology/cardiology images can be viewed by the physician within the EMR without going to another system to see the image or to the Radiology Department to view.
I. Patient results can be graphed or charted so trends can be viewed.
J. Data reports can be generated to determine the quality of the care being delivered, which allows for peer review as required by accrediting agencies.
K. Physicians can document the ICD-10 diagnoses with accompanying details for Meaningful Use purposes as required by CMS.
L. Best practice alerts will notify the physician/clinical staff if the patient is at risk for certain issues, medication interactions, falls risk, and numerous other safety features.
M. The order sets will include all orders that are required by CMS and other regulatory agencies as well as best practice guidelines to assure the patient is receiving the best and safest care.
N. Physician notes can be dictated directly into the EMR, saving transcription and reporting time, so the notes are available immediately to any consulting physician or clinical staff.

The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care. Additionally, the Platform will be used to facilitate the increased adoption of best practices and evidence-based medicine implemented by the New Health System. The New Health System intends to use the Common Clinical IT Platform to provide immediate system-wide alerts and new protocols to improve quality of care. This will enable the New Health System to reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

- **Expected Benefits of the Common Clinical IT Platform to the Regional Health Information Exchange (HIE).**

While the Common Clinical IT Platform will offer many benefits to patient care within the New Health System, not all providers in the region will be on the same IT platform as the New Health System and may not be able to share data with the New Health System. Historically, EHRs built by different vendors lacked transmission standards for exchanging patient data between healthcare entities. This meant that many EHR

systems could not exchange data outside of their own private networks. The HIE is a way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. Both Mountain States and Wellmont currently participate in an existing HIE in the region, as described below, and the Parties believe the functionality of this HIE or another can be significantly improved through the expanded use of the HIE through the region and the more detailed and meaningful data the New Health System will be able to contribute as a result of its Common Clinical IT Platform. Better communication of patient data and best practices via a thriving regional HIE will improve patient care and lower cost of care. The New Health System is committed to participating meaningfully in the enhancement of a regional HIE.

The Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, while the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.

The New Health System desires to support an HIE that will allow the doctors and nurses treating patients in a hospital or doctor's office to access the patient's medical history from any provider connected to the HIE. For example, an independent primary care doctor can review recent lab results whether the test was conducted at an independent specialist's office, at a New Health System hospital, or at a third-party participating lab. Because all authorized doctors and medical personnel will see the same health information through the HIE, this will help to reduce any errors, avoid unneeded duplication of tests and procedures, and consequently, could reduce medical bills.

A key distinction between the Common Clinical IT Platform and HIE is the information available to providers when accessing a medical record. While a provider on the Common Clinical IT Platform will be able to pull up the patient's entire medical history contained in the patient record, the information available within an HIE is typically limited to certain fields that are most commonly used or accessed by providers. This information is typically limited to the following fields:

- Name
- Demographics
- Active Allergies
- Current Medications
- Problem List (Current Problems)
- Problem List (Resolved Problems)
- Recent Visits
- Immunizations
- History (Medical and Surgical)
- History (Family)
- History (Social)
- Last Recorded Vital Signs
- Progress Notes
- Plan of Care

- Functional Status
- Recent Results
- Primary Care Physician
- Custodial/Source Organization

Because the HIE is primarily designed to share information across multiple EHR systems in small and large settings, not all of the Common Clinical IT Platform features are available to providers using the HIE. For example, the Common Clinical IT Platform is expected to include the following features that are not typically included in HIE capabilities:

- Helping providers more effectively diagnose patients, reduce medical errors, and provide safer care through evidence-based tools built into the Common Clinical IT Platform
- Improving patient and provider interaction and communication, as well as health care convenience, by enabling electronic communications between providers and patients (e.g. secure messaging)
- Enabling safer, more reliable prescribing by enabling electronic transmission of prescriptions from provider offices to pharmacies
- Helping promote legible, complete documentation and accurate, streamlined coding and billing
- Reducing costs through decreased paperwork, improved safety, reduced duplication of testing, and improved health
- Enabling providers to improve efficiency and meet their business goals, improve productivity and work-life balance.

As health care moves from fee-for-service to value-based care, the sharing of clinical data for outcomes and accountable care will be very important both within the New Health System and across various health care organizations. The New Health System believes that the significant financial investments it is making to adopt a Common Clinical IT Platform will bring significant benefits for all patients seeking care within the New Health System. The New Health System's commitment to meaningfully participate in an HIE ensures that the health care data collected within the New Health System will be accessible by all participating providers across the region and nation. These two commitments taken together have the potential to drastically improve the quality of care offered across the region.

**Exhibit 22C**

**Description of Parties' Use of Health Information Exchanges**

- **Description of the HIEs Currently Used by Each Party**

A. Wellmont

(i) Wellmont is currently an acute data contributor to OnePartner.

(ii) As an acute data contributor, Wellmont provides the following information to OnePartner:
- Demographics
- Encounters
- Labs
- Diagnoses
- Procedures and
- Radiology.

(iii) The initial cost to set up the interface with OnePartner was $63,500.

(iv) There are annual fees of $9,800.

(v) The cost for each provider to be able to access the information in the HIE is $149 per physician per month.

(vi) As of July, 2016, a group of Wellmont physicians have access to OnePartner as collaborators rather than simple contributors.

(vii) The only patient information currently available within the HIE is the 18 data points identified in Subsection C.(vi) below. The patient information can be viewed and printed when the provider is accessing the HIE.

B. Mountain States

(i) Mountain States is currently an acute data contributor to OnePartner under a five year agreement set to expire on December 31, 2019.

(ii) As an acute data contributor, Mountain States provides the following information to OnePartner:
- Demographics
- Encounters
- Labs
- Diagnoses
- Procedures and
- Radiology.

(iii) Clinical Documents are scheduled to go-live in July 2016. For acute hospitals the clinical documents will include history and physical, progress notes (SOAP), consults, procedure notes, and discharge summaries. For ambulatory surgery centers, the clinical documents will include office visit assessments, post- op visit notes, ER follow up notes, and prenatal visit notes.

(iv) Mountain States Medical Group is currently testing ambulatory data on-boarding with OnePartner, which will be complete by the end of August 2016. Once on-board, Mountain States Medical Group is expected to provide

Demographics, Encounters, Vitals, Labs, Diagnoses, Procedures, Problems, Allergies, Medications, Immunizations, and Clinical Documents to OnePartner for all patients treated by the Group's 375 providers and mid-levels.

(v) Mountain States' current financial commitment to OnePartner is $98,000, which includes initial setup cost of $53,500 and a contract to pay a participation fee of $8,900 per year for five years for access to the OnePartner data.

(vi) In addition to exchanging 11,432,731 data transactions with OnePartner, Mountain States has had a broad range of experiences with data sharing arrangements. Currently, other data sharing partners of Mountain States include:

- State of Franklin Health Associates : 373,673 data transactions
- Inpatients Consultants: 289,760 data transactions
- Medical Practice Management: 162,384 data transactions
- East Tennessee State University: 69,502 data transactions.

(vii) Mountain States also currently send Immunization data, and is in final testing for exchanging Syndromic Surveillance data, to the state of Tennessee. In addition, Mountain States currently sends Immunization and Syndromic Surveillance data to the Virginia Connect HIE.

(viii) Mountain States was a Veterans Administration proof of concept, pilot and demonstration partner in the development of the Direct Messaging platform and has recently undertaken initial conversations with the Veterans Administration for potential inclusion with their Virtual Lifetime Electronic Record (VLER) program.

(ix) Finally, Mountain States is actively working with Tennessee's Healthcare Innovation Initiative to develop a community case management tool.

C. Description of the OnePartner HIE

(i) OnePartner is a for-profit limited liability company owned by physicians in Northeast Tennessee.

(ii) OnePartner is exclusively a physician regional HIE available to providers located in Northeast Tennessee and Southwest Virginia.

(iii) It is operationalized through the use of a product named dbMotion. dbMotion is a context aware computer application that when deployed and integrated with a OnePartner collaborator's EMR, provides access to the OnePartner patient record from the practicing physician's EMR workstation.

(iv) Access to OnePartner is available through an online portal: https://provider.onepartnerhie.com.

(v) Before accessing the OnePartner HIE data, a participating entity must sign a collaborator agreement, meet the criteria in the agreement, pay a subscription fee of approximately $150-$200 per month per provider, and meet the minimum standards for participating providers. They must also sign a Business Associate Agreement and a Data Sharing Agreement.

(vi) The information fields available in the OnePartner HIE are limited to the following:

- Name

- Demographics
- Active Allergies
- Current Medications
- Problem List (Current Problems)
- Problem List (Resolved Problems)
- Recent Visits
- Immunizations
- History (Medical and Surgical)
- History (Family)
- History (Social)
- Last Recorded Vital Signs
- Progress Notes
- Plan of Care
- Functional Status
- Recent Results
- PCP
- Custodial/Source Organization

(vii) These 18 components are sent to the HIE unless a patient affirmatively opts-out and requests that his/her information not be included.

(viii) Once on the system, HIE data can be printed and can be brought into the participating entity's EMR only if they have certain computer capabilities.

(ix) According to OnePartner, over the last four years:

- the number of providers providing data is currently greater than 1,000
- the number of providers viewing data is approximately 400
- there are 654,083 unique patients have been entered into the database.

(x) Based on information provided by OnePartner, the top contributing providers are Mountain States, Holston Medical Group, and State of Franklin Health Associates.

(xi) Again, based on information provided by OnePartner, the top accessors of data are Holston Medical Group, State of Franklin Health Associates, and Qualuable Medical Professionals.

# Exhibit 32 - Updated Financial Projections for New Health System

| Income Statement - NewCo Baseline | Actuals | | | Forecasted | | | | |
|---|---|---|---|---|---|---|---|---|
| $'000s | FYE 6/13 | FYE 6/14 | FYE 6/15 | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Net patient service revenue ("NPSR")** | **$ 1,670,727** | **$ 1,671,050** | **$ 1,813,472** | **$ 1,812,747** | **$ 1,886,737** | **$ 1,924,471** | **$ 1,962,961** | **$ 2,002,220** |
| **Other revenues:** | | | | | | | | |
| Other revenues | 120,585 | 102,581 | 90,756 | 90,756 | 90,756 | 90,756 | 90,756 | 90,756 |
| **Total other revenues** | **120,585** | **102,581** | **90,756** | **90,756** | **90,756** | **90,756** | **90,756** | **90,756** |
| **Total revenue, gains, & support** | **1,791,312** | **1,773,631** | **1,904,228** | **1,903,502** | **1,977,492** | **2,015,227** | **2,053,716** | **2,092,976** |
| **Expenses:** | | | | | | | | |
| Salaries, wages, & benefits | 881,530 | 865,989 | 925,061 | 936,615 | 948,313 | 960,157 | 972,150 | 984,292 |
| Medical supplies & drugs | 325,559 | 330,375 | 344,718 | 346,269 | 362,169 | 371,224 | 380,504 | 390,017 |
| Purchased services | 183,607 | 189,280 | 196,037 | 201,918 | 207,975 | 214,215 | 220,641 | 227,260 |
| Interest & taxes | 63,495 | 62,742 | 61,453 | 59,338 | 57,756 | 56,216 | 54,717 | 53,258 |
| Depreciation & amortization | 130,666 | 121,237 | 127,336 | 126,507 | 126,364 | 126,828 | 127,872 | 129,471 |
| Maintenance & utilities | 53,687 | 54,030 | 56,561 | 58,258 | 60,006 | 61,806 | 63,660 | 65,570 |
| Lease & rental | 17,892 | 15,506 | 15,435 | 15,821 | 16,216 | 16,622 | 17,037 | 17,463 |
| Other | 107,995 | 122,584 | 143,924 | 149,681 | 155,668 | 161,895 | 168,371 | 175,105 |
| **Total expenses & losses** | **1,764,431** | **1,761,743** | **1,870,524** | **1,894,407** | **1,934,468** | **1,968,962** | **2,004,952** | **2,042,436** |
| **Income from operations** | **26,881** | **11,888** | **33,704** | **9,095** | **43,024** | **46,265** | **48,765** | **50,540** |
| **Non-operating gains:** | | | | | | | | |
| Investment income | 60,296 | 65,452 | 4,883 | 23,099 | 23,561 | 24,032 | 24,512 | 25,003 |
| Derivative valuation adjustments | 9,474 | 4,526 | 19,093 | - | - | - | - | - |
| Loss on refinancing | - | (5,755) | (1,389) | - | - | - | - | - |
| Gain on revaluation of equity method investment | - | 14,744 | - | - | - | - | - | - |
| **Non-operating gains, net** | **69,770** | **78,967** | **22,587** | **23,099** | **23,561** | **24,032** | **24,512** | **25,003** |
| **Revenues & gains in excess of expenses & losses** | **96,651** | **90,855** | **56,291** | **32,194** | **66,585** | **70,296** | **73,277** | **75,542** |
| **Other non-operating items:** | | | | | | | | |
| Discontinued operations | (4,484) | (26,639) | (2,720) | - | - | - | - | - |
| Income attributable to non-controlling interest | (7,728) | (9,826) | (15,046) | (14,483) | (14,999) | (15,054) | (15,099) | (15,133) |
| **Total other non-operating operations** | **(12,212)** | **(36,465)** | **(17,765)** | **(14,483)** | **(14,999)** | **(15,054)** | **(15,099)** | **(15,133)** |
| **Revenues & gains in excess of expenses & losses attributable to** | **$ 84,439** | **$ 54,390** | **$ 38,526** | **$ 17,711** | **$ 51,586** | **$ 55,242** | **$ 58,178** | **$ 60,409** |

# Exhibit 32 - Updated Financial Projections for New Health System

| Balance Sheet - NewCo Baseline | Actuals | | | Forecasted | | | | |
|---|---|---|---|---|---|---|---|---|
| $'000s | 6/30/13 | 6/30/14 | 6/30/15 | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Current assets:** | | | | | | | | |
| Cash & cash equivalents | $ 130,860 | $ 89,859 | $ 128,580 | $ 99,994 | $ 90,690 | $ 85,045 | $ 76,870 | $ 65,621 |
| Current portion of investments | 25,447 | 28,262 | 22,904 | 22,904 | 22,904 | 22,904 | 22,904 | 22,904 |
| Patient accounts receivable, net | 271,216 | 278,583 | 274,678 | 273,154 | 284,303 | 289,989 | 295,789 | 301,704 |
| Other receivables, net | 51,463 | 60,187 | 41,588 | 43,667 | 45,851 | 48,143 | 50,551 | 53,078 |
| Inventories & prepaid expenses | 58,383 | 59,859 | 63,930 | 61,664 | 64,496 | 66,108 | 67,761 | 69,455 |
| **Total current assets** | **537,370** | **516,750** | **531,680** | **501,384** | **508,243** | **512,190** | **513,875** | **512,762** |
| **Other non-current assets:** | | | | | | | | |
| Long-term investments | 1,037,563 | 1,124,957 | 1,154,927 | 1,178,026 | 1,201,586 | 1,225,618 | 1,250,131 | 1,275,133 |
| Property, plant, & equipment, net | 1,359,023 | 1,374,010 | 1,331,657 | 1,330,150 | 1,335,035 | 1,346,020 | 1,362,851 | 1,385,318 |
| Goodwill | 169,487 | 208,262 | 208,179 | 208,179 | 208,179 | 208,179 | 208,179 | 208,179 |
| Net deferred financing, acquisition costs & other charges | 33,658 | 30,067 | 28,972 | 27,523 | 26,147 | 24,840 | 23,598 | 22,418 |
| Other assets | 47,091 | 48,870 | 53,567 | 55,174 | 56,830 | 58,534 | 60,290 | 62,099 |
| **Total other non-current assets** | **2,646,822** | **2,786,166** | **2,777,303** | **2,799,052** | **2,827,778** | **2,863,191** | **2,905,049** | **2,953,148** |
| **Total assets** | **3,184,192** | **3,302,916** | **3,308,983** | **3,300,436** | **3,336,021** | **3,375,381** | **3,418,924** | **3,465,910** |
| **Current liabilities:** | | | | | | | | |
| Current portion of debt & liabilities | 75,323 | 73,791 | 84,731 | 84,731 | 84,731 | 84,731 | 84,731 | 84,731 |
| Accounts payable & accrued expenses | 242,267 | 261,554 | 270,782 | 268,682 | 275,199 | 280,683 | 286,301 | 292,056 |
| Estimated third-party payor settlements | 33,932 | 18,888 | 18,471 | 18,841 | 19,217 | 19,602 | 19,994 | 20,394 |
| **Total current liabilities** | **351,523** | **354,233** | **373,985** | **372,254** | **379,148** | **385,017** | **391,027** | **397,181** |
| **Non-current liabilities:** | | | | | | | | |
| Long-term debt & liabilities | 1,566,294 | 1,565,512 | 1,524,098 | 1,483,455 | 1,443,897 | 1,405,393 | 1,367,915 | 1,331,438 |
| Retention bonus liability | - | - | - | - | - | - | - | - |
| Other long-term liabilities | 78,447 | 99,400 | 81,633 | 83,265 | 84,931 | 86,629 | 88,362 | 90,129 |
| **Total non-current liabilities** | **1,644,740** | **1,664,912** | **1,605,731** | **1,566,721** | **1,528,827** | **1,492,022** | **1,456,277** | **1,421,567** |
| **Total liabilities** | **1,996,263** | **2,019,145** | **1,979,715** | **1,938,975** | **1,907,975** | **1,877,038** | **1,847,304** | **1,818,748** |
| **Net assets:** | | | | | | | | |
| Unrestricted | 994,348 | 1,080,586 | 1,112,232 | 1,129,943 | 1,181,529 | 1,236,771 | 1,294,949 | 1,355,358 |
| Temporarily restricted | 19,703 | 20,418 | 20,508 | 20,508 | 20,508 | 20,508 | 20,508 | 20,508 |
| Permanently restricted | 1,438 | 1,446 | 1,450 | 1,450 | 1,450 | 1,450 | 1,450 | 1,450 |
| Noncontrolling interests | 172,439 | 181,321 | 195,078 | 209,560 | 224,559 | 239,614 | 254,713 | 269,846 |
| **Total net assets** | **1,187,929** | **1,283,771** | **1,329,268** | **1,361,462** | **1,428,046** | **1,498,343** | **1,571,620** | **1,647,162** |
| **Total liabilities and net assets** | **$ 3,184,192** | **$ 3,302,916** | **$ 3,308,983** | **$ 3,300,436** | **$ 3,336,021** | **$ 3,375,381** | **$ 3,418,924** | **$ 3,465,910** |

# Exhibit 32 - Updated Financial Projections for New Health System

| Statement of Cash Flows - NewCo Baseline | | Forecasted | | | | |
|---|---|---|---|---|---|---|
| $'000s | Scenario | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Cash flows from operating activities:** | | | | | | |
| Income from operations | | $ 9,095 | $ 43,024 | $ 46,265 | $ 48,765 | $ 50,540 |
| **Adjustments to reconcile change in net assets to net cash provided by operating activities:** | | | | | | |
| Depreciation and amortization | | 126,507 | 126,364 | 126,828 | 127,872 | 129,471 |
| Loss on extinguishment of debt | | - | - | - | - | - |
| Change in estimated fair value of derivatives | | - | - | - | - | - |
| Equity in net income of JVs, net | | - | - | - | - | - |
| Loss/(Gain) on disposal of assets | | - | - | - | - | - |
| Capital Appreciation Bond accretion and other | | - | - | - | - | - |
| Restricted contributions | | - | - | - | - | - |
| Pension and other defined benefit plan adjustments | | - | - | - | - | - |
| **Increase/(Decrease) in cash due to change in:** | | | | | | |
| Patient accounts receivable, net | | 1,524 | (11,149) | (5,686) | (5,800) | (5,916) |
| Other receivables, net | | (2,079) | (2,183) | (2,293) | (2,407) | (2,528) |
| Inventories & prepaid expenses | | 2,266 | (2,832) | (1,612) | (1,653) | (1,694) |
| Net deferred financing, acquisition costs & other charges | | 1,449 | 1,376 | 1,307 | 1,242 | 1,180 |
| Other assets | | (1,607) | (1,655) | (1,705) | (1,756) | (1,809) |
| Current portion of debt & liabilities | | - | - | - | - | - |
| Accounts payable & accrued expenses | | (2,100) | 6,517 | 5,485 | 5,618 | 5,755 |
| Estimated third-party payor settlements | | 369 | 377 | 384 | 392 | 400 |
| Other long-term liabilities | | 1,633 | 1,665 | 1,699 | 1,733 | 1,767 |
| **Total adjustments** | | **127,962** | **118,480** | **124,407** | **125,241** | **126,627** |
| **Net cash provided by operating activities** | | **137,057** | **161,504** | **170,672** | **174,005** | **177,166** |
| **Cash flows from investing activities:** | | | | | | |
| Purchases of property, plant, and equipment | | (125,000) | (131,250) | (137,813) | (144,703) | (151,938) |
| Acquisitions, net of cash acquired | | - | - | - | - | - |
| Non-operating gains, net | | 23,099 | 23,561 | 24,032 | 24,512 | 25,003 |
| Purchases of held-to-maturity securities | | (23,099) | (23,561) | (24,032) | (24,512) | (25,003) |
| Net distribution from JV's and unconsolidated affiliates | | - | - | - | - | - |
| Proceeds from sale of plant, property, and equipment | | - | - | - | - | - |
| **Net cash used in investing activities** | | **(125,000)** | **(131,250)** | **(137,813)** | **(144,703)** | **(151,938)** |
| **Cash flows from financing activities:** | | | | | | |
| Payments on LT debt and liabilities, including escrow deposits | | (40,643) | (39,559) | (38,504) | (37,477) | (36,478) |
| Payment of acquisition and financing costs | | - | - | - | - | - |
| Proceeds from issuance of LT debt & other financings | | - | - | - | - | - |
| Net amounts received on interest rate swaps | | - | - | - | - | - |
| Restricted contributions received | | - | - | - | - | - |
| **Net cash used by financing activities** | | **(40,643)** | **(39,559)** | **(38,504)** | **(37,477)** | **(36,478)** |
| Net increase/(decrease) in cash and cash equivalents | | (28,585) | (9,305) | (5,644) | (8,175) | (11,250) |
| Cash and cash equivalents at beginning of year | | 128,580 | 99,994 | 90,690 | 85,045 | 76,870 |
| **Cash and cash equivalents at end of year** | | **$ 99,994** | **$ 90,690** | **$ 85,045** | **$ 76,870** | **$ 65,621** |

# Exhibit 32 - Updated Financial Projections for New Health System

| Income Statement - NewCo with Preliminary Efficiency Estimates | Actuals | | | Forecasted | | | | |
|---|---|---|---|---|---|---|---|---|
| $'000s | FYE 6/13 | FYE 6/14 | FYE 6/15 | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Net patient service revenue ("NPSR")** | **$ 1,670,727** | **$ 1,671,050** | **$ 1,813,472** | **$ 1,812,747** | **$ 1,886,737** | **$ 1,924,471** | **$ 1,962,961** | **$ 2,002,220** |
| **Other revenues:** | | | | | | | | |
| Other revenues | 120,585 | 102,581 | 90,756 | 90,756 | 90,756 | 90,756 | 90,756 | 90,756 |
| **Total other revenues** | **120,585** | **102,581** | **90,756** | **90,756** | **90,756** | **90,756** | **90,756** | **90,756** |
| **Total revenue, gains, & support** | **1,791,312** | **1,773,631** | **1,904,228** | **1,903,502** | **1,977,492** | **2,015,227** | **2,053,716** | **2,092,976** |
| **Expenses:** | | | | | | | | |
| Salaries, wages, & benefits | 881,530 | 865,989 | 925,061 | 936,615 | 938,313 | 941,691 | 935,264 | 946,416 |
| Medical supplies & drugs | 325,559 | 330,375 | 344,718 | 346,269 | 337,871 | 340,229 | 341,842 | 344,601 |
| Purchased services | 183,607 | 189,280 | 196,037 | 201,918 | 201,785 | 205,929 | 209,434 | 214,233 |
| Interest & taxes | 63,495 | 62,742 | 61,453 | 59,338 | 57,756 | 55,972 | 53,882 | 52,353 |
| Depreciation & amortization | 130,666 | 121,237 | 127,336 | 126,507 | 130,650 | 142,843 | 157,111 | 165,204 |
| Maintenance & utilities | 53,687 | 54,030 | 56,561 | 58,258 | 58,898 | 60,236 | 61,363 | 62,917 |
| Lease & rental | 17,892 | 15,506 | 15,435 | 15,821 | 16,216 | 16,558 | 16,820 | 17,228 |
| Other | 107,995 | 122,584 | 143,924 | 149,681 | 141,334 | 143,766 | 146,245 | 148,940 |
| **Total expenses & losses** | **1,764,431** | **1,761,743** | **1,870,524** | **1,894,407** | **1,882,824** | **1,907,224** | **1,921,961** | **1,951,892** |
| **Income from operations** | **26,881** | **11,888** | **33,704** | **9,095** | **94,669** | **108,003** | **131,755** | **141,083** |
| **Non-operating gains:** | | | | | | | | |
| Investment income | 60,296 | 65,452 | 4,883 | 23,099 | 23,561 | 24,032 | 24,512 | 25,003 |
| Derivative valuation adjustments | 9,474 | 4,526 | 19,093 | - | - | - | - | - |
| Loss on refinancing | - | (5,755) | (1,389) | - | - | - | - | - |
| Gain on revaluation of equity method investment | - | 14,744 | - | - | - | - | - | - |
| **Non-operating gains, net** | **69,770** | **78,967** | **22,587** | **23,099** | **23,561** | **24,032** | **24,512** | **25,003** |
| **Revenues & gains in excess of expenses & losses** | **96,651** | **90,855** | **56,291** | **32,194** | **118,229** | **132,035** | **156,267** | **166,086** |
| **Other non-operating items:** | | | | | | | | |
| Discontinued operations | (4,484) | (26,639) | (2,720) | - | - | - | - | - |
| Income attributable to non-controlling interest | (7,728) | (9,826) | (15,046) | (14,483) | (14,999) | (15,054) | (15,099) | (15,133) |
| **Total other non-operating operations** | **(12,212)** | **(36,465)** | **(17,765)** | **(14,483)** | **(14,999)** | **(15,054)** | **(15,099)** | **(15,133)** |
| **Revenues & gains in excess of expenses & losses attributable to** | **$ 84,439** | **$ 54,390** | **$ 38,526** | **$ 17,711** | **$ 103,230** | **$ 116,980** | **$ 141,168** | **$ 150,953** |
| Uses expense related to COPA, excluding D&A expense | - | - | - | - | (10,750) | (27,250) | (43,500) | (49,000) |
| **Net income, including COPA uses attributable to NewCo.** | **$ 84,439** | **$ 54,390** | **$ 38,526** | **$ 17,711** | **$ 92,480** | **$ 89,730** | **$ 97,668** | **$ 101,953** |

# Exhibit 32 - Updated Financial Projections for New Health System

| Balance Sheet - NewCo with Preliminary Efficiency Estimates | Actuals | | | Forecasted | | | | |
|---|---|---|---|---|---|---|---|---|
| $'000s | 6/30/13 | 6/30/14 | 6/30/15 | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Current assets:** | | | | | | | | |
| Cash & cash equivalents | $ 130,860 | $ 89,859 | $ 128,580 | $ 99,994 | $ 115,197 | $ 91,247 | $ 93,168 | $ 135,397 |
| Current portion of investments | 25,447 | 28,262 | 22,904 | 22,904 | 22,904 | 22,904 | 22,904 | 22,904 |
| Patient accounts receivable, net | 271,216 | 278,583 | 274,678 | 273,154 | 284,303 | 289,989 | 295,789 | 301,704 |
| Other receivables, net | 51,463 | 60,187 | 41,588 | 43,667 | 45,851 | 48,143 | 50,551 | 53,078 |
| Inventories & prepaid expenses | 58,383 | 59,859 | 63,930 | 61,664 | 60,169 | 60,589 | 60,876 | 61,367 |
| **Total current assets** | **537,370** | **516,750** | **531,680** | **501,384** | **528,424** | **512,873** | **523,287** | **574,452** |
| **Other non-current assets:** | | | | | | | | |
| Long-term investments | 1,037,563 | 1,124,957 | 1,154,927 | 1,178,026 | 1,201,586 | 1,225,618 | 1,250,131 | 1,275,133 |
| Property, plant, & equipment, net | 1,359,023 | 1,374,010 | 1,331,657 | 1,330,150 | 1,360,750 | 1,420,720 | 1,468,311 | 1,480,046 |
| Goodwill | 169,487 | 208,262 | 208,179 | 208,179 | 208,179 | 208,179 | 208,179 | 208,179 |
| Net deferred financing, acquisition costs & other charges | 33,658 | 30,067 | 28,972 | 27,523 | 26,147 | 24,840 | 23,598 | 22,418 |
| Other assets | 47,091 | 48,870 | 53,567 | 55,174 | 56,830 | 58,534 | 60,290 | 62,099 |
| **Total other non-current assets** | **2,646,822** | **2,786,166** | **2,777,303** | **2,799,052** | **2,853,492** | **2,937,891** | **3,010,509** | **3,047,875** |
| **Total assets** | **3,184,192** | **3,302,916** | **3,308,983** | **3,300,436** | **3,381,916** | **3,450,764** | **3,533,796** | **3,622,327** |
| **Current liabilities:** | | | | | | | | |
| Current portion of debt & liabilities | 75,323 | 73,791 | 84,731 | 84,731 | 84,731 | 84,731 | 84,731 | 84,731 |
| Accounts payable & accrued expenses | 242,267 | 261,554 | 270,782 | 268,682 | 275,199 | 280,683 | 286,301 | 292,056 |
| Estimated third-party payor settlements | 33,932 | 18,888 | 18,471 | 18,841 | 19,217 | 19,602 | 19,994 | 20,394 |
| **Total current liabilities** | **351,523** | **354,233** | **373,985** | **372,254** | **379,148** | **385,017** | **391,027** | **397,181** |
| **Non-current liabilities:** | | | | | | | | |
| Long-term debt & liabilities | 1,566,294 | 1,565,512 | 1,524,098 | 1,483,455 | 1,443,897 | 1,405,393 | 1,367,915 | 1,331,438 |
| Retention bonus liability | - | - | - | - | 5,000 | - | - | - |
| Other long-term liabilities | 78,447 | 99,400 | 81,633 | 83,265 | 84,931 | 86,629 | 88,362 | 90,129 |
| **Total non-current liabilities** | **1,644,740** | **1,664,912** | **1,605,731** | **1,566,721** | **1,533,827** | **1,492,022** | **1,456,277** | **1,421,567** |
| **Total liabilities** | **1,996,263** | **2,019,145** | **1,979,715** | **1,938,975** | **1,912,975** | **1,877,038** | **1,847,304** | **1,818,748** |
| **Net assets:** | | | | | | | | |
| Unrestricted | 994,348 | 1,080,586 | 1,112,232 | 1,129,943 | 1,222,424 | 1,312,154 | 1,409,822 | 1,511,775 |
| Temporarily restricted | 19,703 | 20,418 | 20,508 | 20,508 | 20,508 | 20,508 | 20,508 | 20,508 |
| Permanently restricted | 1,438 | 1,446 | 1,450 | 1,450 | 1,450 | 1,450 | 1,450 | 1,450 |
| Noncontrolling interests | 172,439 | 181,321 | 195,078 | 209,560 | 224,559 | 239,614 | 254,713 | 269,846 |
| **Total net assets** | **1,187,929** | **1,283,771** | **1,329,268** | **1,361,462** | **1,468,941** | **1,573,725** | **1,686,493** | **1,803,579** |
| **Total liabilities and net assets** | **$3,184,192** | **$3,302,916** | **$3,308,983** | **$ 3,300,436** | **$ 3,381,916** | **$ 3,450,764** | **$ 3,533,796** | **$ 3,622,327** |

# Exhibit 32 - Updated Financial Projections for New Health System

| Statement of Cash Flows - NewCo with Preliminary Estimated Efficiencies | | Forecasted | | | | |
|---|---|---|---|---|---|---|
| $'000s | Scenario | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
| **Cash flows from operating activities:** | | | | | | |
| Income from operations | | $ 9,095 | $ 94,669 | $ 108,003 | $ 131,755 | $ 141,083 |
| Uses expense related to COPA, excluding D&A expense | | - | (10,750) | (27,250) | (43,500) | (49,000) |
| | | **9,095** | **83,919** | **80,753** | **88,255** | **92,083** |
| **Adjustments to reconcile change in net assets to net cash provided by operating activities:** | | | | | | |
| Depreciation and amortization | | 126,507 | 130,650 | 142,843 | 157,111 | 165,204 |
| Loss on extinguishment of debt | | - | - | - | - | - |
| Change in estimated fair value of derivatives | | - | - | - | - | - |
| Equity in net income of JVs, net | | - | - | - | - | - |
| Loss/(Gain) on disposal of assets | | - | - | - | - | - |
| Capital Appreciation Bond accretion and other | | - | - | - | - | - |
| Restricted contributions | | - | - | - | - | - |
| Pension and other defined benefit plan adjustments | | - | - | - | - | - |
| **Increase/(Decrease) in cash due to change in:** | | | | | | |
| Patient accounts receivable, net | | 1,524 | (11,149) | (5,686) | (5,800) | (5,916) |
| Other receivables, net | | (2,079) | (2,183) | (2,293) | (2,407) | (2,528) |
| Inventories & prepaid expenses | | 2,266 | 1,496 | (420) | (287) | (491) |
| Net deferred financing, acquisition costs & other charges | | 1,449 | 1,376 | 1,307 | 1,242 | 1,180 |
| Other assets | | (1,607) | (1,655) | (1,705) | (1,756) | (1,809) |
| Current portion of debt & liabilities | | - | - | - | - | - |
| Accounts payable & accrued expenses | | (2,100) | 6,517 | 5,485 | 5,618 | 5,755 |
| Estimated third-party payor settlements | | 369 | 377 | 384 | 392 | 400 |
| Retention bonus liability | | - | 5,000 | (5,000) | - | - |
| Other long-term liabilities | | 1,633 | 1,665 | 1,699 | 1,733 | 1,767 |
| **Total adjustments** | | **127,962** | **132,093** | **136,614** | **155,846** | **163,562** |
| **Net cash provided by operating activities** | | **137,057** | **216,011** | **217,367** | **244,101** | **255,646** |
| **Cash flows from investing activities:** | | | | | | |
| Purchases of property, plant, and equipment | | (125,000) | (161,250) | (202,813) | (204,703) | (176,938) |
| Acquisitions, net of cash acquired | | - | - | - | - | - |
| Non-operating gains, net | | 23,099 | 23,561 | 24,032 | 24,512 | 25,003 |
| Purchases of held-to-maturity securities | | (23,099) | (23,561) | (24,032) | (24,512) | (25,003) |
| Net distribution from JV's and unconsolidated affiliates | | - | - | - | - | - |
| Proceeds from sale of plant, property, and equipment | | - | - | - | - | - |
| **Net cash used in investing activities** | | **(125,000)** | **(161,250)** | **(202,813)** | **(204,703)** | **(176,938)** |
| **Cash flows from financing activities:** | | | | | | |
| Payments on LT debt and liabilities, including escrow deposits | | (40,643) | (39,559) | (38,504) | (37,477) | (36,478) |
| Payment of acquisition and financing costs | | - | - | - | - | - |
| Proceeds from issuance of LT debt & other financings | | - | - | - | - | - |
| Income attributable to non-controlling interest | | - | - | - | - | - |
| Net amounts received on interest rate swaps | | - | - | - | - | - |
| Restricted contributions received | | - | - | - | - | - |
| **Net cash used by financing activities** | | **(40,643)** | **(39,559)** | **(38,504)** | **(37,477)** | **(36,478)** |
| Net increase/(decrease) in cash and cash equivalents | | (28,585) | 15,202 | (23,949) | 1,920 | 42,230 |
| Cash and cash equivalents at beginning of year | | 128,580 | 99,994 | 115,197 | 91,247 | 93,168 |
| **Cash and cash equivalents at end of year** | | **$ 99,994** | **$ 115,197** | **$ 91,247** | **$ 93,168** | **$ 135,397** |