



UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION  
WASHINGTON, D.C. 20580

Bureau of Competition  
Bureau of Economics  
Office of Policy Planning

January 13, 2017

VIA ELECTRONIC MAIL

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Honorable Mark R. Herring  
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Re: Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System

Dear Dr. Levine and General Herring:

On behalf of the staffs of the FTC's Bureau of Competition, Bureau of Economics, and Office of Policy Planning, and pursuant to the Virginia regulations promulgated at 12VAC5-221, we are providing the attached supplemental written public comment in reply to the October 14, 2016 Response to FTC Staff Submission submitted by Mountain States Health Alliance and Wellmont Health System to the Virginia Department of Health and Southwest Virginia Health Authority, as well as a chart regarding the proposed Cooperative Agreement Commitments put forward in the Southwest Virginia Health Authority's December 22, 2016 Review of the Virginia Cooperative Agreement Application. We can provide copies of any documents referenced in these comments, upon request.

Please direct questions concerning this submission to Goldie V. Walker, Attorney, Bureau of Competition, 202-326-2919, [gwalker@ftc.gov](mailto:gwalker@ftc.gov); and Stephanie A. Wilkinson, Attorney Advisor, Office of Policy Planning, 202-326-2084, [swilkinson@ftc.gov](mailto:swilkinson@ftc.gov).

Respectfully submitted,

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Enclosures



Federal Trade Commission Staff Supplemental Submission  
to the Virginia Department of Health  
Regarding the Cooperative Agreement Application of  
Mountain States Health Alliance  
and Wellmont Health System

Pursuant to Virginia Code § 15.2-5384.1  
and the regulations promulgated thereunder at 12VAC5-221

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## **I. INTRODUCTION<sup>1</sup>**

On October 14, 2016, Mountain States Health Alliance (“Mountain States”) and Wellmont Health System (“Wellmont”) (collectively “the parties” or “the applicants”) submitted responses to the public written comments filed in opposition to their application for a Letter Authorizing a Cooperative Agreement with the Virginia Department of Health (“VDH”) and the Southwest Virginia Health Authority (“the Authority”).<sup>2</sup> This included responding to the public written comment that Federal Trade Commission staff (“FTC staff”) submitted on September 30, 2016. FTC staff submits this supplemental comment to address some of the parties’ most critical errors and misrepresentations. Importantly, we do not attempt to address each and every error or misrepresentation in the parties’ response. Moreover, our initial submission fully addresses most of the issues raised in the parties’ response; therefore, they need not be repeated here.

On December 22, 2016, the Authority transmitted its written recommendation to the VDH Commissioner recommending that VDH approve the parties’ cooperative agreement application, which included proposed cooperative agreement commitments agreed to by the parties.<sup>3</sup> We have also attached to this supplemental comment a chart containing FTC staff’s analysis, questions, and concerns regarding the proposed cooperative agreement commitments. As set forth in the chart, those proposed commitments have significant shortcomings, gaps, and ambiguities. Consequently, the commitments do not remedy the competitive harm likely to result from the merger, and the parties have not come close to carrying their burden to show that the likely benefits of the cooperative agreement exceed the harm.

FTC staff has conducted a detailed investigation into the proposed merger of Mountain States and Wellmont, in which we collected and reviewed a voluminous amount of confidential documents, data, and information from the parties and other market participants.<sup>4</sup> As with our previous written comment, however, this supplement and the attached chart rely on public information only.

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<sup>1</sup> These comments express the views of the FTC’s Bureau of Competition, Bureau of Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to submit these comments.

<sup>2</sup> Mountain States Health Alliance & Wellmont Health System, Response by Applicants to Federal Trade Commission Staff Submission on September 30, 2016 and Supporting Memorandum to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application (Oct. 14, 2016), <https://swvahealthauthority.files.wordpress.com/2016/09/response-to-ftc-comments-submitted-to-swvha.pdf> [hereinafter Mountain States-Wellmont Response to FTC Staff Comment].

<sup>3</sup> The Southwest Virginia Health Authority, A Review of The Commonwealth of Virginia Application for a Letter Authorizing a Cooperative Agreement Filed by Mountain States Health Alliance and Wellmont Health System (Dec. 22, 2016) at 117-51, <https://swvahealthauthority.files.wordpress.com/2016/12/cooperative-agreement-report-december-22-2016.zip> [hereinafter Southwest Virginia Health Authority Report].

<sup>4</sup> The evidence collected by FTC staff was available to its quality of care expert retained in this matter, Dr. Kenneth Kizer, in order for him to prepare his independent assessment of the parties’ quality of care, population health management, and related claims.

## II. THE APPLICANTS BEAR THE BURDEN OF PROOF

Apart from the numerous mischaracterizations in the parties' response, one glaring shortcoming undermines their entire submission: the *parties* bear the burden of proving that the benefits of the cooperative agreement outweigh the harm from the lost competition,<sup>5</sup> not FTC staff or any other commenter. From the outset, the parties suggest that FTC staff's conclusions lack substantiation or supporting evidence.<sup>6</sup> FTC staff's comment, however, included detailed references to sources, data, and analyses supporting our conclusions. Nevertheless, the parties' criticisms miss the point – it is the *parties* that bear the burden of presenting evidence to the VDH that meets the “preponderance of the evidence”<sup>7</sup> standard.

The parties' discussion of the alternative arrangements statutory factor is but one of many examples of how they mischaracterize the framework through which the VDH must evaluate their cooperative agreement application under relevant Virginia law. Under the Virginia Cooperative Agreement Act, it is a *statutory disadvantage* if there are “availab[le] [ ] arrangements that are less restrictive to competition and [that] achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.”<sup>8</sup> The parties failed to provide any analysis of available alternative arrangements, whether through collaborations with each other short of a merger, joint ventures or affiliations, or mergers with other hospitals. Rather than meet their burden, the parties attempt to shift the burden by claiming that FTC staff “provide[d] no detail” about alternative arrangements available to and considered by the parties.<sup>9</sup> Although the cooperative agreement application publicly notes that Wellmont received eight alternative acquisition offers, the parties do not fully compare the details and potential benefits of those offers with the claimed benefits of this merger. Nor do they discuss in any meaningful detail any other affiliations or other arrangements that might provide comparable benefits with the same, less, or even no competitive harm. It is not incumbent on FTC staff to show the superiority of an alternative option; rather, the parties must demonstrate to VDH that other options either are inferior to this one or are not available. They have failed to do so.<sup>10</sup>

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<sup>5</sup> See 32 Va. Reg. Regs. 1897, 1903 (Feb. 8, 2016) (to be codified at 12 Va. Admin. Code §5-221-80.B), 12VAC5-221-10 (“The commissioner is authorized to issue a letter authorizing cooperative agreement if he determines by a preponderance of the evidence that the benefits likely to result from the cooperative agreement outweigh the disadvantages likely to result from a reduction in competition.”), <http://register.dls.virginia.gov/details.aspx?id=5578> [hereinafter Virginia Cooperative Agreement Regulations]. See also Virginia Cooperative Agreement Act, VA. CODE ANN. § 15.2-5384.1. F.2 (“[T]he Commissioner shall approve the proposed cooperative agreement if he finds . . . that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement.”), <http://law.lis.virginia.gov/vacode/title15.2/chapter53.1/section15.2-5384.1/> [hereinafter Virginia Cooperative Agreement Act].

<sup>6</sup> See Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 39.

<sup>7</sup> Virginia Cooperative Agreement Regulations, *supra* note 5, 12VAC5-221-10.

<sup>8</sup> Virginia Cooperative Agreement Act, *supra* note 5, § 15.2-5384.1.E.3.d.

<sup>9</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 24.

<sup>10</sup> The parties claim that none of these eight other bidders “remain as active proposals for consideration today,” but that carefully crafted language fails to address whether certain bidders are today still interested in acquiring Wellmont if the transaction with Mountain States does not proceed. Southwest Virginia Health Authority Report, at 154 (citing Letter from Gary Miller, Wellmont General Counsel, to J. Mitchell, Nov. 4, 2016). In order to avoid revealing whether any of those alternative bids involved better terms than Mountain States is committing to,

If the parties genuinely believe this merger is the best option for residents of Southwest Virginia and Northeast Tennessee, their reticence to discuss alternative arrangements is a surprising and critical omission. Further, because cooperative agreement applicants bear the burden of demonstrating that they could not achieve the benefits they claim would result from this cooperative agreement through a less restrictive alternative, the parties have the burden to undertake a reasonable investigation and provide an explanation of the available alternatives. Instead, they expect VDH to accept at face value their unsubstantiated claims about the dangers of “out-of-market” mergers<sup>11</sup> and the infeasibility of alternative collaborations.<sup>12</sup>

The parties’ discussion of the relevance of the Certificate of Need (“CON”) process in Tennessee, which is analogous to Virginia’s Certificate of Public Need (“COPN”) process, to their claims of “unnecessary duplication” of facilities and services provides another example of their misplaced burden of proof.<sup>13</sup> In response to the parties’ generalized claims that the proposed merger would eliminate “unnecessary duplication,”<sup>14</sup> FTC staff pointed out that both Virginia and Tennessee are COPN states, so the states had already made a determination that their communities needed each of the services Mountain States and Wellmont provide. While the parties correctly note that demand conditions may have changed since the grant of any given COPN, they present no specific analysis to demonstrate changed conditions or indicate that Virginia or Tennessee would not grant a COPN today. The COPN process creates a presumption that the parties’ services are *not* unnecessarily duplicative; thus, they have the burden to show that conditions have changed for particular services.

### **III. THE FACTORS CONSIDERED UNDER THE VIRGINIA COOPERATIVE AGREEMENT ACT AND THE MERGER GUIDELINES ARE SIMILAR**

The parties attempt to dismiss FTC staff’s entire comment by arguing that we applied a *Horizontal Merger Guidelines* (“*Merger Guidelines*”) analysis instead of the analysis prescribed by the Virginia Cooperative Agreement Act. This criticism is not only wrong – it is misleading. The structure of FTC staff’s comment tracks the factors laid out in the Virginia Cooperative Agreement Act. FTC staff’s comment also discusses the similarities between the framework laid out in the Virginia Cooperative Agreement Act and the analysis described in the *Merger Guidelines*, illustrating why our public comment is wholly consistent with the analysis required under the Commonwealth’s statute. In response, the parties again try to distract from the

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including greater financial investments and a commitment to maintain local control of hospitals, the parties claim that they are not at liberty to share the proposals with the public due to confidentiality restrictions, but appear to have made no effort to seek waivers to share such information with the public.

<sup>11</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 25.

<sup>12</sup> *Id.* at 24-25.

<sup>13</sup> See Mountain States Health Alliance & Wellmont Health System, Response by Applicants to Submissions of Federal Trade Commission Staff, Amerigroup Tennessee Inc., Professors and Academic Economists, Kenneth Kizer, M.D., MPH, and Holston Medical Group to the Tennessee Department of Health Regarding Certificate of Public Advantage Application (Dec. 19, 2016), Section III, at 41-42, [https://www.tn.gov/assets/entities/health/attachments/Response\\_to\\_Public\\_Comments\\_Submitted\\_to\\_TN\\_DOH\\_with\\_TOC2.pdf](https://www.tn.gov/assets/entities/health/attachments/Response_to_Public_Comments_Submitted_to_TN_DOH_with_TOC2.pdf) [hereinafter Mountain States-Wellmont Response to Tennessee Public Comments].

<sup>14</sup> Mountain States-Wellmont Response to Tennessee Public Comments, *supra* note 13, Section III, at 41.

substantive issues by arguing that VDH should disregard FTC staff's analysis, stating that "State Policy And Not Antitrust Law Governs Cooperative Agreements,"<sup>15</sup> which we do not contest. The parties ignore the fact that FTC staff conducted its analysis under the Commonwealth's policy laid out in the Virginia Cooperative Agreement Act, which, again, is remarkably similar to the *Merger Guidelines* framework. At their core, both the Virginia Cooperative Agreement Act and the *Merger Guidelines* seek to weigh the harms from a merger against the potential benefits, analyses with which FTC staff has significant experience. Notably, the parties do not point to any Virginia statutory factor ignored by FTC staff's comment.

**IV. THE LEGISLATURE INTENDED TO DISPLACE COMPETITION ONLY WHEN APPLICANTS PROVE THAT THE BENEFITS OUTWEIGH THE HARM; THE APPLICANTS ASK VDH TO IGNORE THIS**

Despite the parties' claims to the contrary, an analysis of a cooperative agreement application under the Virginia Cooperative Agreement Act requires an in-depth analysis of the competitive harm. The applicants must demonstrate that "the likely benefits resulting from the proposed cooperative agreements outweigh any disadvantages attributable to a reduction in competition that may result from the proposed cooperative agreements."<sup>16</sup> The VDH regulations further require applicants to do so "by a preponderance of the evidence."<sup>17</sup> It is not possible to conduct the balancing test required by the Virginia statute without a full analysis of the competitive harm. The parties have either failed to do the competitive harm part of the analysis, or have done so but failed to provide VDH any information on it because it is unfavorable to their cooperative agreement application.

By contrast, consistent with the cooperative agreement law framework, FTC staff's analysis (1) evaluated the competitive impact of the merger and (2) examined whether that harm would be outweighed by the potential benefits or mitigated by the proposed commitments. By encouraging VDH to ignore FTC staff's and other commenters' discussion of the market structure, diversion statistics, and predicted price increases, the parties are refusing to engage in half of the analysis Virginia law requires. The tools FTC staff used to determine the competitive impact of the merger are well established and standard in economics and merger law. Tellingly, the parties baldly assert that these analyses are "[n]ot [i]nformative,"<sup>18</sup> but present no alternative methodology or analysis. VDH can *only* evaluate the sufficiency of the commitments and the benefits if it *also* analyzes and weighs the competitive impact of the merger, which the parties ask VDH to ignore.

Given the overwhelming evidence that the competitive harm from this transaction would be substantial, the parties must prove that the proposed commitments or claimed benefits outweigh this substantial harm. As described in our initial comment and the attached chart, they have done neither.

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<sup>15</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 8.

<sup>16</sup> Virginia Cooperative Agreement Act, *supra* note 5, § 15.2-5384.1. B.

<sup>17</sup> Virginia Cooperative Agreement Regulations, *supra* note 5, 12VAC5-221-10.

<sup>18</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 14.

**A. The Proposed Commitments Do Not Sufficiently Mitigate the Proposed Merger’s Enormous Competitive Harm**

In addition to establishing the degree of competitive harm likely to result from the merger, VDH must assess whether the parties have demonstrated that the commitments meaningfully mitigate and counter that harm. As an initial matter, the parties make clear in their response that the proposed investment commitments are *entirely contingent* on achieving the cost savings they project.<sup>19</sup> Should the parties fail to achieve their projections, these investments likely would not occur or would be materially smaller. According to a significant body of literature, efficiency predictions made in advance of mergers often prove to be inaccurate and are not achieved.<sup>20</sup> Consequently, VDH should be wary of approving this cooperative agreement based on the conditional promise of these investments.

Moreover, the proposed commitments are merely high-level goals and promises without any meaningful details. For example, many commitments offer little more than a timetable to submit a plan or make a vague commitment to improve and report on unspecified quality metrics. For this reason alone, VDH should deny the cooperative agreement. The discussion

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<sup>19</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 14 (“funds are available only through synergies generated by the merger”); at 33 (“The monetary commitments are possible solely based on savings to be realized from merger efficiencies, and cannot be made without the merger.”).

<sup>20</sup> See HEALTH CARE ADVISORY BOARD, *M&A—To What End? Five Characteristics of Intentional Corporate Strategy*, at 4 (2014), <https://www.advisory.com/-/media/Advisory-com/Research/HCAB/Research-Study/2013/MA-To-What-End/HCAB-MA-To-What-End.pdf> (“[E]xecutives ought to view deals that promise significant cost savings, immediately or even over the long haul, with an abundance of skepticism.”), *id.* at 5 (“Few [health system] networks even attempt to pursue full range of cost savings”); Melanie Evans, *Merger Indigestion: Big Hospital Mergers Failing To Deliver Promised Results*, MODERN HEALTHCARE (Apr. 23, 2016), <http://www.modernhealthcare.com/article/20160423/MAGAZINE/304239980> (finding that some of the biggest hospital mergers in recent years have failed to achieve operating efficiencies that would make them more cost-competitive); David Muhlestein, Robert Saunders & Mark McClellan, *Medical Accountable Care Organization Result for 2015: The Journey to Better Quality and Lower Costs Continues*, HEALTH AFFAIRS BLOG (Sept. 9, 2016), <http://healthaffairs.org/blog/2016/09/09/medicare-accountable-care-organization-results-for-2015-the-journey-to-better-quality-and-lower-costs-continues/> (“[C]onsolidation [among health systems] and larger size do not necessarily lead to the functional integration and efficiency needed to succeed under alternative payment models.”); Anil Kaul, K.R. Prabha & Suman Katragadda, *Size Should Matter: Five Ways to Help Healthcare Systems Realize the Benefits of Scale*, PWC STRATEGY& (March 15, 2016), <http://www.strategyand.pwc.com/reports/size-should-matter> (finding that greater size has not led to lower costs or better quality outcomes for consolidated health systems); Marissa J. Noles, Kristin L. Reiter, Jonathan Boortz-Marx & George Pink, *Rural Hospital Mergers and Acquisitions: Which Hospitals Are Being Acquired and How Are They Performing Afterward?*, 60 J. HEALTHCARE MANAGEMENT 395, at 403 (2015), <http://www.whartonwrds.com/wp-content/uploads/2016/05/Levin-research-paper.pdf> (“If rural hospitals solicit merger or acquisition [sic] because they are expecting a rapid influx of capital, a relief of debt burden, or an improvement in bottom-line profitability, evidence from this study suggests that these results may not materialize, at least in the short term. Our results suggest that profitability may actually decline after the transaction.”); Sanjay B. Saxena, Anu Sharma & Anne Wong, *Succeeding in Hospital & Health Systems M&A: Why So Many Deals Have Failed and How To Succeed in the Future*, PWC STRATEGY& , at 4 (originally published by Booz & Company, 2013), [http://www.strategyand.pwc.com/media/file/Strategyand\\_Succeeding-in-Hospital-and-Health-Systems-MA.pdf](http://www.strategyand.pwc.com/media/file/Strategyand_Succeeding-in-Hospital-and-Health-Systems-MA.pdf) (finding that the majority of recent hospital and health system mergers have been financially unsuccessful, and that “only 41 percent of hospitals acquired between 1998 and 2008 outperformed their market peer group”).

## FTC Staff Supplemental Submission - January 13, 2017

below identifies four of the most significant gaps in the proposed commitments; the attached chart provides a more comprehensive critique of each commitment they have proposed.<sup>21</sup>

### 1. Rural Hospitals Are Not Protected

The parties have repeatedly touted the preservation of rural hospitals as a central benefit and motivation for the cooperative agreement. They present little evidence, however, to show that any of their rural facilities would be closed without the cooperative agreement or that any other potential merger partner had plans to close any hospitals.<sup>22</sup> Instead, the parties rely almost entirely on generalized studies about the challenges rural hospitals face across the country,<sup>23</sup> and on a narrow description of the financial state of their current facilities that overlooks the important role those hospitals play in their larger systems.

The parties argue that “[b]ecause of decreasing reimbursements and the other challenges mentioned earlier, it will be increasingly difficult to continue to sustain these [rural] facilities over the long-term without the savings the proposed merger would create.”<sup>24</sup> The parties’ financial reports do not support these general statements. At the system level, both Mountain States and Wellmont have reported financial results that contradict the dire picture they paint.<sup>25</sup> In fiscal year 2015, Mountain States generated approximately \$1 billion in total revenue and \$55 million in net revenue,<sup>26</sup> and Wellmont generated approximately \$813 million in total revenue

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<sup>21</sup> The attached chart contains and analyzes the most recent commitments made by the parties, reflected in the Southwest Virginia Health Authority’s December 22, 2016 recommendation to VDH. Southwest Virginia Health Authority Report, *supra* note 3, at 117-51.

<sup>22</sup> Indeed, a consultant for the Authority acknowledged that the parties’ Virginia hospitals have an added layer of protection from closure because some of the hospitals are joint ventures that would require approval of the local boards prior to closing. *See* Southwest Virginia Health Authority Report, *supra* note 3, at 115 (“Mr. Barry noted that the Virginia hospitals have an additional level of protection with the impact of the joint venture nature of the ownership of the facilities on decision making.”).

<sup>23</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 2.

<sup>24</sup> *Id.* at 25.

<sup>25</sup> Wellmont Health Systems, Financial Report, <http://www.wellmont.org/Our-Mission/Community-Benefit/Financial-Report/>; Tammy Childress, Mountain States Health Alliance Posts Audited Year-End Results, BRISTOL HERALD COURIER (Nov. 5, 2015), [http://www.heraldcourier.com/workittricity/business\\_news/mountain-states-health-alliance-posts-audited-year-end-results/article\\_e1a9b05c-8316-11e5-a8d4-5f3b2b601935.html](http://www.heraldcourier.com/workittricity/business_news/mountain-states-health-alliance-posts-audited-year-end-results/article_e1a9b05c-8316-11e5-a8d4-5f3b2b601935.html) (reporting that for fiscal year 2015, Mountain States substantially reduced its debt as a result of strong volume growth and cost discipline); Nate Morabito, Wellmont Health System, Executives Benefit from Good Financial Year, WJHL (May 18, 2016), <http://wjhl.com/2016/05/18/wellmont-health-system-executives-benefit-from-good-financial-year/> (“Overall, Wellmont Health System is coming off a solid year financially. . . .”); Hank Hayes, Wellmont’s Filing Discloses Compensation, Shows Better Operating Margins, KINGSPORT TIMES-NEWS (May 17, 2016), <http://www.timesnews.net/Business/2016/05/17/Wellmont-s-filing-discloses-old-salaries-and-shows-better-operating-margins>.

<sup>26</sup> In its submission to Tennessee, Mountain States refers to this as “excess of revenue, gains and support over expenses and losses.” Mountain States Health Alliance & Wellmont Health System, Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for A Certificate of Public Advantage, Exhibit 23 at 5 (Audited Financial Statement on MSHA as of June 30, 2015) (July 13, 2016), [http://tn.gov/assets/entities/health/attachments/WHS-MSHA\\_April\\_22\\_2016\\_DOH\\_Response\\_1.pdf](http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22_2016_DOH_Response_1.pdf) [hereinafter Responses to Tennessee Department of Health Questions].

## FTC Staff Supplemental Submission - January 13, 2017

and \$16 million in net revenue.<sup>27</sup> The parties also frequently reference their combined debt of nearly \$1.5 billion, yet fail to mention that at the end of fiscal year 2015, they had a combined \$3.3 billion of total assets, resulting in combined net assets of approximately \$1.33 billion.<sup>28</sup> Moreover, neither system has indicated that it has any issues with making its debt payments. The parties repeatedly mention the \$19.5 million of purported operating losses in their small rural community hospitals, but do not deny that their rural hospitals contribute to the overall profitability of each system by serving as feeder hospitals for admission to the parties' large tertiary hospitals. In short, Mountain States and Wellmont are not financially struggling health systems.

More importantly, even if the parties' rural hospitals were in jeopardy of closing, the commitments do little to improve the status quo. The parties commit only to maintain the existing hospital facilities as "clinical and health care institutions," but make no commitment to maintain these facilities *as hospitals*.<sup>29</sup> While the parties have revised the commitment to agree to maintain certain services at these facilities, the commitment is ambiguous, leaves room for the elimination of many services, and makes no commitment with respect to physician or nurse staffing levels or anything else. Moreover, the parties make this ambiguous commitment for only five years. This commitment should be of little comfort to the residents of rural communities served by Mountain States and Wellmont today, particularly when an alternative purchaser may be willing to make a stronger commitment to maintain these rural hospitals as hospitals.

Finally, the parties pledge to "continue to provide access to health care services" to these rural communities if the communities can "demonstrate[] need."<sup>30</sup> This portion of the commitment is even more equivocal than the five-year commitment described above. The parties provide no details on what they mean by "provide access," nor do they explain what these communities would have to show to persuade the New Health System that they have a "demonstrated need."<sup>31</sup> With no other meaningful hospital option available following the merger, access to healthcare in these communities would be at the New Health System's

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<sup>27</sup> In its submission to Tennessee, Wellmont refers to this as "revenue and gains in excess of expenses and losses." Mountain States Health Alliance & Wellmont Health System, Application for a Certificate of Public Advantage for State of Tennessee (Feb. 16, 2016), Exhibit 11.5, Attachment B (Wellmont Health System and Affiliates Consolidated Financial Statements June 30, 2015 and 2014), at 4, [http://tn.gov/assets/entities/health/attachments/COPA\\_application.pdf](http://tn.gov/assets/entities/health/attachments/COPA_application.pdf) [hereinafter Tennessee COPA Application].

<sup>28</sup> Mountain States had over \$2.1 billion in total assets and net assets of approximately \$787 million at the end of fiscal year 2015. Responses to Tennessee Department of Health Questions, *supra* note 26, Exhibit 23 at 4. Wellmont had total assets of approximately \$1.2 billion and net assets of approximately \$546 million at the end of fiscal year 2015. Tennessee COPA Application, *supra* note 27, Exhibit 11.5, Attachment B (Wellmont Health System and Affiliates Consolidated Financial Statements June 30, 2015 and 2014), at 3.

<sup>29</sup> Southwest Virginia Health Authority Report, *supra* note 3, at 137.

<sup>30</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 26.

<sup>31</sup> In the parties' recent response in Tennessee, they noted that they "will not require after five years a 'showing' by any community 'to persuade the New Health System' to maintain access to healthcare services." Mountain States Health Alliance & Wellmont Health System, Response by Applicants to Submission of Federal Trade Commission Staff to the Tennessee Department of Health Regarding Certificate of Public Advantage Application (Jan. 11, 2017) at 10, <https://mgtvwjhl.files.wordpress.com/2017/01/msha-and-wellmont-response-to-ftc-comments-to-tdh.pdf>.

discretion – the cooperative agreement does not appear to provide a mechanism for the Commonwealth to require the New Health System to maintain any facility or particular service.

**2. The Rate Caps Do Not Clearly Apply to Value-Based or Risk-Based Contracts**

While the parties take issue with the criticism that their proposed rate caps would not apply to new and evolving models of value- and risk-based contracting, their response fails to alleviate the concern.<sup>32</sup> The parties do not describe how the current rate cap commitments would apply to these important new models of contracting. Instead, they suggest that “most” of these types of contracts “commence with fee-for-service pricing.”<sup>33</sup> Rather than explain how they envision the rate cap applying in these circumstances (especially in instances when the contract is not based on fee-for-service), the parties avoid addressing this issue, saying that these “new models ... can be developed in a form that can be reviewed by the Department[.]”<sup>34</sup> In the parties’ Tennessee response, they assert that the cooperative agreement may be modified to account for new types of contracting.<sup>35</sup> It is unclear, however, how such a modification would be developed and implemented. And, in Virginia, the parties would have to consent to any such modifications – thus, they could reject any modifications for any reason.<sup>36</sup> The parties essentially admit in their response that these rate caps could be inapplicable and ineffectual for new models of contracting, leaving the parties free to exercise their substantial market power even as the evolution towards value- and risk-based contracting continues. And, as detailed in our public comment, the proposed rate caps leave many questions and loopholes even for traditional fee-for-service contracts.

**3. The Definition of “Principal Payer” Unjustifiably Excludes a Significant Number of Payers**

The parties defend their exclusion of payers that account for less than two percent of the New Health System’s total net revenue from their rate cap commitment as “[a]ppropriate,” but concede that this exclusion would cut out *200 payers*.<sup>37</sup> They explain the exclusion by citing the potential for “net losses” to the New Health System without any detailed explanation of how

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<sup>32</sup> See Mountain States-Wellmont Response to Tennessee Public Comments, *supra* note 13, Section III, 21-22. See also Response by Applicants to Submissions of Anthem Health Plans of Virginia, Inc., Virginia Association of Health Plans, and America’s Health Insurance Plans and Supporting Memorandum to the Southwest Virginia Health Authority Regarding Cooperative Agreement Application, at 11-12, <https://swvahealthauthority.files.wordpress.com/2016/09/response-to-anthem-ahip-and-vahp-comments-submitted-to-svwaha.pdf>.

<sup>33</sup> Mountain States-Wellmont Response to Tennessee Public Comments, *supra* note 13, Section III, at 21-22.

<sup>34</sup> *Id.* at 22.

<sup>35</sup> *Id.*

<sup>36</sup> VDH’s inability to unilaterally modify the commitments could seriously limit VDH’s ability to enforce the commitments, address flaws in the commitments, and could lead to serious disputes and litigation during the term of any approved cooperative agreement. Relatedly, the parties have the unilateral right to voluntarily withdraw from the cooperative agreement. To the extent there are any concerns about the ability to implement a Plan of Separation, this right gives the New Health System significant bargaining leverage to resist any attempts to modify the cooperative agreement commitments, lest they threaten to simply withdraw from it.

<sup>37</sup> Mountain States-Wellmont Response to Tennessee Public Comments, *supra* note 13, Section III, at 22-23.

such losses would occur.<sup>38</sup> Presumably, however, the parties' current contracts and contract rates with these payers *already* reflect the risk of losses, so it is unclear why applying the rate caps should impose any more risk on the parties. Nor do the parties propose any alternative commitment that would limit the impact of their newfound market power on these small payers. Consequently, these 200 payers and their insured members in Virginia and Tennessee are likely to face significant price increases by the New Health System, which would be unrestrained by any commitment or meaningful competition.

The best the parties offer is a suggestion that the payers would police the New Health System's adherence to the commitments and alert VDH to any infractions.<sup>39</sup> But, it is far from clear that payers would be willing to complain. A payer could decide that complaining to VDH would risk its relationship with the New Health System – which would be the payer's *only* meaningful contracting option for hospital services in the region – and face possible retaliation. Or the payer could conclude that it would be able to pass along higher prices to its members in the form of higher premiums and co-pays. VDH should not rely on payers to report on the New Health System; the responsibility for monitoring and enforcing the commitments falls to VDH under the cooperative agreement statute.

**4. The Plan of Separation Is Unlikely To Serve as an Effective Backstop If the Cooperative Agreement Regime Fails to Yield Benefits for the Community**

FTC staff's comment extensively discussed the deficiencies of the parties' Plan of Separation, as well as the challenges of prying apart an integrated system of 19 hospitals.<sup>40</sup> The parties lodge two objections to FTC staff's criticisms, but neither has merit. First, the parties claim that FTC staff ignored the "ongoing supervision" of the cooperative agreement, but they fail to explain how this supervision would facilitate the disentanglement of the New Health System after years of integration.<sup>41</sup> Second, the parties assert that FTC staff's standard for a successful separation – that it "restore pre-merger competition" – somehow misstates the

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<sup>38</sup> Mountain States-Wellmont Response to Tennessee Public Comments, *supra* note 13, Section III, at 22-23. When asked why some payers were excluded from the Principal Payer definition, the Authority's report quotes Mountain States' CEO Alan Levine to say "a small payer likely does not have many insureds in the region and could generate a situation where the health system loses money on every admission" and that "those payers above the 2% threshold account for 97% of the commercial business." Southwest Virginia Health Authority Report, *supra* note 3, at 103. Even if this equivocal and hypothetical statement is true, it would already be true today, so it still does not justify the exclusion of these small payers.

<sup>39</sup> The parties claim that "[p]ayers have the ability to verify and validate the rate commitments using common models and methods used currently and to provide feedback or express any concerns to the Authority and Commissioner." Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 16.

<sup>40</sup> The number of hospitals would increase to 21 if the announced transactions for Laughlin Memorial Hospital and Takoma Regional Hospital ("Takoma") proceed as planned. In that regard, we understand that Wellmont has completed its acquisition of Takoma, but it is unclear whether Takoma is now included within the scope of the cooperative agreement commitments that the parties are making to VDH and the Tennessee Department of Health. Wellmont Health System, Takoma Regional Hospital Is Now Part of Wellmont, Giving Patients Seamless Access to Advanced Services, <https://www.wellmont.org/News/Our-Facilities/Hospitals-And-Medical-Centers/Community/Takoma-Regional/Takoma-Regional-Hospital-Is-Now-Part-of-Wellmont.aspx> (Jan. 5, 2017).

<sup>41</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 36.

standard in the Virginia regulations, which calls for a Plan of Separation that would return the parties to a “pre[-]consolidation state.”<sup>42</sup> The parties are drawing a distinction without a difference. Currently, Mountain States and Wellmont compete vigorously against each other in a *pre-consolidation state*, and this is precisely what any successful Plan of Separation would need to restore. The Virginia regulations clearly recognize this and that is what our criticism of their Plan of Separation addressed.

Indeed, the parties’ response indirectly admits FTC staff’s point. They suggest that the Plan of Separation would be developed in the future “based on the current reality of the market and the merged system” at that time.<sup>43</sup> As detailed in our comment, FTC staff’s experience demonstrates that the future “current reality” of the New Health System is likely to prevent any meaningful ability to return Mountain States and Wellmont to their pre-consolidation state. The harm from the loss of competition in Virginia and Tennessee would have materialized, but VDH likely would have no meaningful way to rectify it. In addition, because the proposed commitments are intended to remain in effect for only ten years,<sup>44</sup> if the New Health System refuses to extend or amend the cooperative agreement at the conclusion of that period – which appears to be in its sole discretion – the only meaningful recourse Virginia could have is to try to effectuate the Plan of Separation.<sup>45</sup> Terminating the cooperative agreement without an effective Plan of Separation presents the worst possible outcome: an unregulated and dominant hospital system.

## **V. CONCLUSION**

FTC staff’s initial comment contains substantial information and evidence to rebut the parties’ claims in their response. This supplemental submission highlights only a few of these points. It is telling that the parties focus on encouraging VDH to ignore the comments from FTC staff and others that cast doubt on their claims rather than addressing the critical issues the comments raise. The proposed merger would create a dominant hospital system in Southwest Virginia and Northeast Tennessee with tremendous market power. Moreover, the New Health System would have opportunities and strong financial incentives to evade the proffered regulatory commitments. The Virginia Cooperative Agreement Act places a heavy burden on the parties to overcome the likely substantial competitive harm of the proposed transaction by demonstrating significant, measurable benefits and clear and enforceable commitments. Having failed to meet their burden by a wide margin, we respectfully submit that the Virginia Cooperative Agreement Act compels the Virginia Department of Health to deny Mountain States and Wellmont’s cooperative agreement application.

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<sup>42</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 36; Virginia Cooperative Agreement Regulations, *supra* note 5, 12VAC5-221-20 (“‘Plan of Separation’ means the written proposal submitted with an application to return the parties to a pref[-]consolidation state . . .”).

<sup>43</sup> Mountain States-Wellmont Response to FTC Staff Comment, *supra* note 2, at 36.

<sup>44</sup> Southwest Virginia Health Authority Report, *supra* note 3, at 150 (Recommendation A).

<sup>45</sup> According to the Authority’s recommendation, “[i]n the event that an extension of the existing cooperative agreement or negotiation of a new or amended agreement is not achieved, the Commonwealth should withdraw its support for the cooperative agreement.” Southwest Virginia Health Authority Report, *supra* note 3, at 151 (Recommendation B).



**FEDERAL TRADE COMMISSION STAFF COMMENTS  
ON THE MOUNTAIN STATES-WELLMONT COOPERATIVE AGREEMENT COMMITMENTS  
(AS AMENDED FOR THE SOUTHWEST VIRGINIA HEALTH AUTHORITY<sup>1</sup>)**

Commitment 1 – Reduction of Fixed Rate Increase	FTC Staff Comment
<p>In order to ensure pricing is not increased as a result of the elimination of inpatient competition for the majority of consumers covered by third party commercial insurance, pricing will increase by less with the merger than if the merger were not to occur. For all Principal Payers<sup>1</sup>, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date 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 which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement. Applicants represent that the fiscal year for the New Health System will end on June 30, and that the fiscal year will not change until after the second full year commencing after the closing date of the New Health System.<sup>2</sup></p> <p><b>Timing:</b> First full fiscal year following the first contract year after the formation of the New Health System.</p> <p><b>Amount:</b> The estimated annual savings to consumers for the combination of Commitments 1 and 2 are \$10 million in lower health care costs annually.<sup>3</sup></p> <p><sup>1</sup> For purposes of this Application, “Principal Payers” are defined as those commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System’s total net revenue. (All of a payer’s revenue shall be considered in calculating the revenue percentage even if the payer has more than one contract with the New Health System.) The proposed</p>	<p>Generally:</p> <ol style="list-style-type: none"> <li>1. Price commitments are unlikely to replicate the benefits of competition or what pricing would have been with ongoing competition between Mountain States and Wellmont.</li> <li>2. Price commitments are difficult to construct, monitor, and enforce.</li> <li>3. Pricing commitments do not remedy the harm to non-price competition – such as competition to improve quality, access, and invest in healthcare services, facilities, and equipment. In fact, price regulation makes harm to quality even more likely, according to economic literature.</li> </ol> <p>Specifically with respect to Commitment 1:</p> <ol style="list-style-type: none"> <li>4. The commitment appears to apply only to a relatively small portion of the parties’ contracts – only those contracts meeting two conditions: (1) contracts with fixed rate increases, which the parties have indicated represents a small portion of their contracts, and (2) contracts with Principal Payers. We understand that less than 6% of Mountain States’ insurance contracts with <i>all payers</i> (not just Principal Payers) have fixed rate increases as written, and 16% of Wellmont’s insurance contracts with <i>all payers</i> (not just Principal Payers) have fixed rate increases as written.<sup>2</sup></li> <li>5. Even under the revised definition of “Principal Payers,” the price commitment provides no price protection to payers that represent 2% or less of the combined system’s net revenue. The parties admit that this definition would exclude <i>200 payers</i> from the price cap,<sup>3</sup></li> </ol>

<sup>1</sup> The first column of this chart contains the most recent public version of the commitments made by the parties, as reflected in the Southwest Virginia Health Authority’s December 22, 2016 Review of The Commonwealth of Virginia Application for a Letter Authorizing a Cooperative Agreement, <http://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/SWHA-Cooperative-Agreement-Report-December-22-2016.pdf>, at 117-51 [hereinafter Southwest Virginia Health Authority Report], and the second column contains FTC staff’s analysis and comments on those commitments.

<sup>2</sup> Mountain States Health Alliance & Wellmont Health System, Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for A Certificate of Public Advantage (July 13, 2016) at 6, [http://tn.gov/assets/entities/health/attachments/WHS-MSHA\\_April\\_22,\\_2016\\_DOH\\_Response\\_1.pdf](http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_DOH_Response_1.pdf) [hereinafter Response to Tennessee Department of Health Questions].

<sup>3</sup> Mountain States Health Alliance & Wellmont Health System, Response by Applicants to Submissions of Federal Trade Commission Staff, Amerigroup Tennessee Inc., Professors and Academic Economists, Kenneth Kizer, M.D., MPH, and Holston Medical Group to the Tennessee Department of Health Regarding Certificate of Public Advantage Application (Dec. 19, 2016), Section III, at 22-23, [https://www.tn.gov/assets/entities/health/attachments/Response\\_to\\_Public\\_Comments\\_Submitted\\_to\\_TN\\_DOH\\_with\\_TOC2\\_.pdf](https://www.tn.gov/assets/entities/health/attachments/Response_to_Public_Comments_Submitted_to_TN_DOH_with_TOC2_.pdf) [hereinafter Mountain States-Wellmont Response to Tennessee Public Comments].

commitments would not apply to traditional Medicare or any other payers that provide two percent (2%) or less of the New Health System's net revenue. Notwithstanding any provision to the contrary, the limitation on rate increases applicable to insurers providing coverage on behalf of governmental payers (i.e., Medicare Advantage Plans or Medicaid Plans) does not apply if the adjustments are tied to actions made by government entities, including but not limited to, market basket adjustments, adjustments tied to area wage index, or other governmentally imposed rate adjustments. The limitations on pricing committed to by the parties are intended to ensure price increases beyond the limits imposed by the Cooperative Agreement (COPA) do not occur as a result of increased market concentration resulting from the merger transaction. The price limits imposed by the Cooperative Agreement (COPA) are not intended to interfere with government-imposed pricing which would occur with or without the creation of the New Health System. To the degree pricing for insurers providing coverage on behalf of governmental payers is tied contractually to Medicare rates (i.e., a percent of Medicare), the Cooperative Agreement (COPA) is not intended to interfere with such pricing relationships. The intent is to ensure future pricing is not increased as a result of the merger transaction.

<sup>2</sup> For purposes of these commitments, the Commissioner shall not appoint an individual as his or her delegate if such person has a conflict of interest. If the Commissioner appoints an entity as his or her delegate, such as the Southwest Virginia Healthcare Authority, the entity must take steps to assure that no person involved with the entity in its role as the Commissioner's delegate has a conflict of interest. Notwithstanding anything herein to the contrary, the Commissioner shall retain the final authority with respect to conclusions reached by the Commonwealth or actions to be taken by the Commonwealth.

<sup>3</sup> This estimate is nonbinding. To the extent, however, that there is a dispute on the New Health Systems compliance with these rate of increase commitments, the estimate may be used as a tool to interpret what the commitment means.

potentially leaving thousands of these payers' enrollees – residents of Virginia and Tennessee – subject to unrestrained price increases. There is no meaningful reason why the price commitment should exclude *any payers*, including small commercial and governmental payers. The parties' claim that these smaller payers raise a higher "risk profile" is a red herring – the current contract prices that Mountain States and Wellmont have negotiated with these smaller payers already should reflect this risk profile. Post-merger, these smaller payers would have no meaningful ability to resist demands for higher prices from New Health System ("NHS").

6. The preamble to Commitment 1 ("In order to ensure pricing is not increased as a result of the elimination of *inpatient* competition . . .")(emphasis added) suggests this commitment may only apply to inpatient prices. If so, then this price commitment would not reduce prices for NHS's outpatient services, physician services, or any other prices.
7. It is still not clear when the pricing commitment takes effect. In the first paragraph, the text states that NHS would reduce rates "for the second full fiscal year commencing after the closing date of the New Health System." (emphasis added) The "Timing" paragraph, however, states that it would be effective in the "First full fiscal year following the first contract year after the formation of the New Health System." (emphasis added) The parties state in their December 19 response to public comments in Tennessee that the first formulation is the correct one, but the commitment language itself appears inconsistent.<sup>4</sup>
8. The parties provide an unsubstantiated and unexplained estimate of achieving lower healthcare costs, but state that their estimate is "nonbinding."
9. This commitment does not provide any protection if NHS terminates its contract and goes out of network (i.e., become non-par) with any payer – even with Principal Payers.
10. There does not appear to be an enforcement mechanism if the parties do not abide by the commitment. None appears in the commitment itself.
11. The commitment does not restrict NHS with respect to any other negotiated contract provisions, such as outliers

<sup>4</sup> See Mountain States-Wellmont Response to Tennessee Public Comments, Section III, at 17-18.

	<p>and stop-loss provisions, leaving ample room for NHS to exploit its greatly enhanced bargaining leverage to the detriment of consumers.</p> <p>12. There are gaps in the commitments, which open the door for NHS to impose higher prices. For example, what happens if NHS acquires another hospital in the area? What happens if NHS buys another hospital in the area through a 50-50 joint venture with another hospital system? What happens if another entity acquires NHS? The price commitment does not appear to apply in any of these circumstances.</p>
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<b>Commitment 2 – Limit on Pricing Growth</b>	<b>FTC Staff Comment</b>
<p>To ensure the Cooperative Agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, a limit on pricing growth is applied for each year to restrain pricing growth to below the national hospital consumer price index. Effective on the closing date of the merger, the New Health System will commit to not adjust 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 is a ceiling in rate adjustments; nothing herein establishes these adjustments as the floor on rates. To the extent, if any, that the Applicants negotiate contracts with Principal Payers between October 10, 2016 and the closing date of the merger and such contracts include fixed rate increases in excess of the hospital Consumer Price Index for hospital inpatient and outpatient services and the medical care Consumer Price Index for physician and non-hospital outpatient services compared with previous contracts with the same payer, no later than one month following the closing date, New Health System will rollback its rates to what they would have been if the negotiated rates of increase had been no more than the above-referenced Consumer Price Index changes. Applicants represent that their current contracts with Anthem for nongovernmental patients will not expire prior to the now-expected date of the rate increase commitment becoming effective, i.e., July 1, 2018.</p>	<p>Generally:</p> <ol style="list-style-type: none"> <li>1. Price commitments are unlikely to replicate the benefits of competition or what pricing would have been with ongoing competition between Mountain States and Wellmont.</li> <li>2. Price commitments are difficult to construct, monitor, and enforce.</li> <li>3. Pricing commitments do not remedy the harm to non-price competition – such as competition to improve quality, access, and invest in healthcare services, facilities, and equipment. In fact, price regulation is likely to make harm to quality even worse, according to economic literature.</li> </ol> <p>Specifically with respect to Commitment 2:</p> <ol style="list-style-type: none"> <li>4. The price cap may well result in higher prices than with competition. Indeed, because of competition between Mountain States and Wellmont, health plans have obtained significantly lower reimbursement rates on behalf of their members.</li> <li>5. The price cap is likely to represent not just a price ceiling, but a price floor. Because health plans and consumers would not have viable alternatives to NHS, NHS has no reason to agree to prices that are below the price cap.</li> <li>6. Even under the revised definition of “Principal Payers,” the price commitment provides no price protection to payers that represent 2% or less of the combined system’s net revenue. The parties admit that this definition would exclude <i>200 payers</i> from the price cap,<sup>5</sup></li> </ol>

<sup>5</sup> Mountain States-Wellmont Response to Tennessee Public Comments, Section III, at 22-23.

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. The New Health System agrees that contract structures may include rates being tied to a percentage of Medicare, or may establish base rates with annual inflators or quality incentives. The New Health System will not refuse to enter into any of these types of structures on the basis of the structure and will negotiate the rate structure in good faith. 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 result 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, New Health System agrees to mediation<sup>4</sup> as a process to resolve any disputes. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer updates to the Commissioner on the progress of such mediation.

**Timing:** Subsequent contract years.

**Amount:** The estimated annual savings to consumers for the combination of Commitments 1 and 2 are \$10 million in lower health care costs annually.

**Metric:** Easily verifiable.

<sup>4</sup> Nothing herein is intended to override dispute resolution provisions that may be parts of binding contracts between New Health System (in its own name or as a successor to the Applicants) and any payer.

potentially leaving thousands of these payers' enrollees – residents of Virginia and Tennessee – subject to unrestrained price increases. There is no meaningful reason why the price commitment should exclude *any payers*, including small commercial and governmental payers. The parties' claim that these smaller payers raise a higher "risk profile" is a red herring – the current contract prices that Mountain States and Wellmont have negotiated with these smaller payers already should reflect this risk profile. Post-merger, these smaller payers would have no meaningful ability to resist demands for higher prices from NHS.

7. There is no assurance that healthcare costs would be lower and, even if so, passed on to consumers. The parties provide an unsubstantiated and unexplained estimate of achieving lower healthcare costs, but state that their estimate is "nonbinding."
8. This commitment does not provide any price cap if NHS terminates its contract and goes out of network (i.e., become non-par) with any payer – even with Principal Payers.
9. The commitment only applies to negotiated rates for current contracts. As such, we question whether this commitment would provide any protection if NHS has, or demanded in the future, contracts without fixed rates. For example, the commitment may not apply to contracts with risk-based or value-based reimbursement.
10. There does not appear to be an enforcement mechanism if the parties exceed any price caps. None appears in the commitment itself.
11. The commitment does not restrict NHS with respect to any other negotiated contract provisions, such as outliers and stop-loss provisions, leaving ample room for NHS to exploit its greatly enhanced bargaining leverage to the detriment of consumers.
12. At the end of the cooperative agreement period, which could be as soon as 10 years, the price cap expires and there would be no price cap regulation and likely no meaningful competition to restrain NHS's prices.
13. There are gaps in the commitments, which open the door for NHS to impose higher prices. For example, what happens if NHS acquires another hospital in the area? What happens if NHS buys another hospital in the area through a 50-50 joint venture with another hospital system? What happens if another entity acquires NHS?

	Do the price caps apply in any of these circumstances and to which hospitals do they apply?
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<b>Commitment 3 – Negotiations with Principal Payers</b>	<b>FTC Staff Comment</b>
<p>In order to minimize any adverse impact on the ability of insurance companies to contract with the hospitals, and while this Cooperative Agreement ensures open access and choice for all consumers to choose any hospital in the region, it also remains the intent of the Cooperative Agreement that consumers and businesses enjoy a competitive market for insurance. As such, the New Health System will negotiate in good faith with Principal Payers to include the New Health System in health plans offered in the Geographic Service Area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System will not unreasonably refuse to negotiate with potential new entrants to the market or with insurers that do not meet the definition of “Principal Payer”, as long as the payer has demonstrable experience, a reputation for fair-dealing and timely payment and negotiates in good faith. New Health System will resolve through mediation any disputes as to whether this commitment applies to the proposed terms of a health plan contract. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer to the Commissioner updates on the progress of such mediation.</p> <p><b>Timing:</b> Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new payers coming into area, and ongoing.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Complaints from payers and credible report by the New Health System.</p>	<ol style="list-style-type: none"> <li>1. This commitment provides no benefit over the status quo unless the parties are not today negotiating in good faith to reach commercially reasonable terms and rates with health plans.</li> <li>2. The commitment contains multiple undefined terms that likely would be subject to dispute, including, for example, with respect to the requirement to negotiate “in good faith” with payers to include NHS in health plans on “commercially reasonable terms and rates,” and that prohibit NHS from “unreasonably” refusing to negotiate with a potential new entrant.</li> <li>3. The commitment provides for resolution of disputes through mediation, but there are no provisions addressing, for example, how this mediation would occur, how the mediator would be selected, whether the mediation would be binding, which party pays for the costs of mediation, and what happens if mediation is not successful.</li> <li>4. The commitment lacks an enforcement mechanism if NHS breaches this commitment.</li> </ol>

Commitment 4 – Will Not Require Exclusivity	FTC Staff Comment
<p>In order to ensure providers in the region not affiliated with the New Health System may continue to operate competitively, and to ensure new provider entrants to the market are not disadvantaged by the New Health System, the New Health System will not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer. Nothing herein shall be construed as to impede the discretion of the payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System’s service area.</p> <p><b>Timing:</b> Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new payers coming into area, and ongoing.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Easily verifiable.</p>	<ol style="list-style-type: none"> <li>1. New hospital entry (at least on a meaningful scale) is unlikely in the Geographic Service Area even with this commitment. This commitment does not make new hospital entry more likely.</li> </ol>

Commitment 5 – Participation in HIE	FTC Staff Comment
<p>In order to improve quality for patients, ensure seamless access to needed patient information, and to support the efforts of the local physician community to access needed information in order to provide high quality patient care, the New Health System will participate meaningfully in a health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with community-based providers for the purpose of providing seamless patient care.</p> <p><b>Timing:</b> No later than 36 months after closing.</p> <p><b>Amount:</b> Up to \$6 million over 10 years.</p>	<ol style="list-style-type: none"> <li>1. Mountain States and Wellmont already participate in a health information exchange (“HIE”) called OnePartner,<sup>6</sup> so the merger is not needed to do so. OnePartner says the benefits of its HIE include reduced cost, improved efficiency, improved quality, improved patient safety and satisfaction, and reduced duplication of services.<sup>7</sup> OnePartner’s website states that “[e]very electronic medical record system can connect!” and that, including Mountain States and Wellmont, the HIE includes “over 80% of the primary care providers in the Tri-Cities TN/VA market.”<sup>8</sup></li> <li>2. The parties have not sufficiently substantiated what additional benefits they would achieve that they could not achieve independently, with another merger partner, or through the OnePartner HIE.</li> </ol>

<sup>6</sup> See Press Release, OnePartner, Mountain States Health Alliance Announces Participation in the OnePartner Health Information Exchange (Aug. 26, 2014), <http://www.onepartner.com/news/mountain-states-health-alliance-announces-participation-with-onepartner-hie>.

<sup>7</sup> OnePartner, OnePartner HIE, <http://www.onepartner.com/hie>.

<sup>8</sup> *Id.*

<p><b>Metric:</b> The New Health System shall report annually to the Commissioner on mileposts toward meeting this commitment.</p>	<ol style="list-style-type: none"> <li>3. Because the parties already participate in the OnePartner HIE, we respectfully submit that the only benefits from the cooperative agreement that should be credited are those that are incremental – above and beyond – those the parties could achieve without the cooperative agreement. Those incremental benefits likely would be relatively small and must be weighed against the cost to fulfill this commitment.</li> <li>4. There is no requirement that NHS share health information with other providers. The revised commitment was weakened to eliminate the requirement that the HIE be “open to community providers.” Now, the commitment states only that health information “<i>may</i>” be shared with other providers.</li> <li>5. The commitment now states that the parties will <i>either</i> “participate” in an HIE or a so-called “cooperative arrangement” where protected health information can be exchanged with “community-based providers.” The meaning of “participate meaningfully” is undefined, so it is unclear how substantial and meaningful their participation would have to be for this commitment to be deemed fulfilled. The meaning of “cooperative arrangement” is also undefined. If this means that the parties would make arrangements to share protected health information with local physicians, they can already do this without the cooperative agreement.</li> <li>6. If the parties are not participating in an HIE by the end of 36 months, the commitment provides no enforcement mechanism.</li> </ol>
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<b>Commitment 6 – Collaboration with Independent Physician Groups</b>	<b>FTC Staff Comments</b>
<p>In order to enhance quality and decrease the total cost of care, the New Health System will collaborate in good faith 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 to deliver such outcomes at the highest possible value.</p> <p><b>Timing:</b> No later than 36 months after closing.</p> <p><b>Metric:</b> The New Health System shall report to the Commissioner on the mileposts toward meeting this</p>	<ol style="list-style-type: none"> <li>1. The commitment lacks details of what this collaboration would actually entail. For example, the commitment does not say what data would be shared, with how many physicians, what outcomes would be improved, or how substantial and extensive NHS’s collaborations would need to be for this commitment to be fulfilled and meaningful benefits realized.</li> <li>2. The commitment to collaborate with independent physicians to share data, best practices, and improve quality is not a meaningful benefit over what the parties could engage in today without a merger (or through alternative collaborations or mergers) because there is</li> </ol>

commitment.	<p>likely little or no impediments to Mountain States and Wellmont doing so today under the antitrust laws.</p> <p>3. There is no enforcement mechanism if the parties do not fulfill this commitment within 36 months.</p>
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Commitment 7 – Quality Improvement	FTC Staff Comment
<p>In order to enhance quality, improve cost-efficiency and reduce unnecessary utilization of hospital services, 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.</p> <p><b>Timing:</b> Immediately upon closing of the merger and ongoing.</p> <p><b>Amount:</b> No incremental cost.</p> <p><b>Metric:</b> Annual report and complaints, if any, from payers.</p>	<ol style="list-style-type: none"> <li>1. The commitment does not <i>require</i> NHS to include provisions for improved quality or other value-based incentives in contracts with Principal Payers. NHS simply commits to “endeavor” to do so, without any definition or standard for what that means, so NHS need not include any such provisions in any of its contracts. Consequently, this is not a substantial commitment and provides no meaningful benefits over what the parties separately could achieve today without the cooperative agreement.</li> <li>2. Today, Principal Payers can use competition between Mountain States and Wellmont to spur the parties to add quality-related terms or to engage in value-based contracting. Post-merger, there is no meaningful threat that a Principal Payer can drop NHS from its network, and NHS faces little risk that a significant number of patients will turn to other providers as a substitute for NHS. As such, the merger would greatly diminish, if not virtually eliminate, payers’ ability to negotiate for such terms in contracts with NHS, except on NHS’s terms.</li> <li>3. Because the definition of “Principal Payers” excludes payers that represent 2% or less of the combined system’s net revenue – approximately 200 payers<sup>9</sup> – NHS would have no obligation even to endeavor to include quality-improvement or value-based incentives in its contracts with these other payers for the benefit of their Virginia and Tennessee enrollees.</li> <li>4. The commitment states that it is intended to reduce unnecessary utilization, but this is not a meaningful benefit unless the parties are suggesting that they engage in unnecessary medical care today.</li> <li>5. There is no enforcement mechanism if the parties do not include provisions for improved quality or other value-based incentive in <i>any</i> contracts – even if payers complain.</li> </ol>

<sup>9</sup> Mountain States-Wellmont Response to Tennessee Public Comments, Section III, at 22-23.

Commitment 8 – Quality Reporting	FTC Staff Comment
<p>In order to enhance quality of patient care through greater transparency, improve utilization of hospital resources, and to ensure the population health of the region is consistent with goals established by the Authority, 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. Such reporting shall include posting of quality measures and actual performance on New Health System’s website accessible to the public. The New Health System shall report such data timely so the public can easily evaluate the performance of the New Health System as compared to its competitors, and ensure consumers retain the option to seek services where the quality is demonstrably the highest. The New Health System will give notice to the Authority of the metrics the New Health System is prioritizing, and will, in good faith, include input from the Authority in establishing or modifying its priorities.</p> <p><b>Timing:</b> Annually, based upon when the New Health System establishes its annual quality goals.</p> <p><b>Metric:</b> Compliance with commitment as agreed upon and modified subsequently.</p>	<ol style="list-style-type: none"> <li>1. As sophisticated health systems, Mountain States and Wellmont should <i>already</i> have established priorities relating to quality improvement goals. If they do not, that would be remarkable. In any event, the parties could establish such priorities and report quality measures on their own without the cooperative agreement. As such, this is not a substantial commitment and does not provide meaningful benefits over what could be achieved independently or through alternative means.</li> <li>2. The commitment does not indicate which quality measures would be measured and reported, how the metrics would be measured, or which quality measures they would prioritize. The parties have no obligation to accept Virginia’s or Tennessee’s input as to which quality measures to prioritize and report. NHS could selectively pick certain quality metrics to measure and report in order to highlight positive and easily achievable measures, but not negative or difficult-to-achieve—yet important—quality measures.</li> <li>3. The claim that the requirement to publish quality measures would help consumers evaluate NHS’s performance against competitors and ensure that the public retains the option to seek services where quality is highest is flawed for at least two reasons: (1) it assumes that these unidentified competitors are measuring the same metrics in the same way and reporting the same metrics publicly, allowing for such comparisons, which could very well <i>not</i> be the case, and (2) many patients in the Geographic Service Area, would have no meaningful competitors to NHS. Because most patients generally prefer local care and, in this area, seek care at either Mountain States or Wellmont, the reporting of quality measures is unlikely to make significantly more patients travel to hospitals outside their local area.</li> </ol>

Commitment 9 – Charity Care Policy	FTC Staff Comment
<p>In order to ensure low income patients who are uninsured are not adversely impacted due to pricing, the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue</p>	<ol style="list-style-type: none"> <li>1. The commitment requires only that NHS adopt a charity care policy that is substantially similar to what the parties offer today, so this is not a substantial commitment and does not provide meaningful benefits over what could be achieved today or without the cooperative agreement.</li> </ol>

<p>Service’s final 501(r) rule. The New Health System shall furnish a copy of its policies relating to charity care to the Commissioner no later than the end of the third month following the closing of the merger. Thereafter, the New Health System shall furnish to the Commissioner a copy of any revisions to such policies immediately upon the effective date of such revisions. These policies shall provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred percent (200%) of the federal poverty level. The New Health System shall inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site and on the separate web sites for all provider components that are part of the New Health System.</p> <p><b>Timing:</b> Immediately upon closing of the merger and ongoing.</p> <p><b>Amount:</b> Extent of additional cost is unknown but is not immaterial.</p> <p><b>Metric:</b> Charity care costs as measured in cost of care furnished. For hospital services, that number can come from the Medicare cost report S-10 schedule. New Health System’s annual report to the Commissioner shall also include data on the number of individuals receiving uncompensated care and compare that number to prior fiscal years when the New Health System was in operation. The cost for charity care for nonhospital services may be estimated using the cost to charge ratio aggregated for all nonhospital services.</p>	<ol style="list-style-type: none"> <li>2. The commitment appears to be subject to revision at the unilateral discretion of the parties at any time because the charity care policy can be revised at will by NHS – it only needs to notify the Commissioner of any changes.</li> <li>3. The parties provide no estimate of how much incremental charity care would be provided (other than stating it “is not immaterial”); thus, the incremental benefits, if any, cannot be quantified.</li> <li>4. The commitment states that the charity care policy will include a write-off for certain patients, but that write-off is limited to “services,” and does not include a write-off of any products or medications associated with the service.</li> <li>5. Mountain States and Wellmont already inform the public of their charity care and financial assistance policies online,<sup>10</sup> so the commitment to post NHS’s charity care policy provides no incremental benefit.</li> </ol>
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<b>Commitment 10 – Discounts to Low Income Patients</b>	<b>FTC Staff Comment</b>
<p>In order to ensure low income patients are not adversely affected due to pricing, uninsured or underinsured 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</p>	<p>There appears to be gaps in the commitment to uninsured and underinsured individuals who do not qualify for charity care:</p> <ol style="list-style-type: none"> <li>1. The commitment provides for a “discount off hospital charges,” but a hospital’s chargemaster is subject to change (increase) at the complete discretion of the hospital.</li> </ol>

<sup>10</sup> See, e.g., [https://www.mountainstateshealth.com/sites/default/files/documents/MSHA-00042\\_Charity\\_Policy.pdf](https://www.mountainstateshealth.com/sites/default/files/documents/MSHA-00042_Charity_Policy.pdf); <http://www.wellmont.org/Patients-and-Visitors/Financial-Assistance.aspx>.

<p>Section governing not for-profit organizations, 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.</p> <p>“Uninsured” patients are those with no level of insurance or third-party assistance to assist with meeting his/her payment obligations. “Underinsured” patients are those with some level of insurance or third-party assistance but with out-of-pocket expenses that exceed financial abilities. These patients will not be charged more than amounts generally billed (AGB) to individuals who have insurance covering such care in case of Emergency or other Medically Necessary Services.” AGB percentage is determined using the look-back method utilizing the lowest percentage for all facilities per the IRS regulatory guidelines set forth in 501(r). Emergency Services are defined in accordance with the definition of “Emergency Medical Conditions” in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). Medically Necessary Services are defined by Medicare as services of items reasonable and necessary for the diagnosis or treatment of illness or injury and are Services not included in the list of “particular services excluded from coverage” in 42 CFR § 411.15). Financial assistance eligibility will be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Financial assistance determinations are based on National Poverty Guidelines for the applicable year. The New Health System shall adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.</p> <p><b>Timing:</b> Immediately upon closing and ongoing.</p> <p><b>Metric:</b> Credible report.</p>	<p>2. The commitment provides no details about how much the discount would be, other than a reference to not exceeding amounts generally billed to individuals with insurance in the case of Emergency and other Medically Necessary Service.</p>
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<b>Commitment 11 – Default Notices</b>	<b>FTC Staff Comment</b>
<p>In order to demonstrate the New Health System maintains the financial viability to fulfill its commitments of this Cooperative Agreement, and to ensure proper state supervision, any notices of default, technical or otherwise, that the New Health System, or</p>	<p>1. The commitment to provide a notice of default could come too late to put the Commonwealth on notice of potential problems and, in any event, does not give the Commonwealth the right to do anything about the default once notice is received.</p>

<p>an affiliate, receives under bond or other debt documents, must be furnished to the Authority and the Commonwealth.</p> <p><b>Timing:</b> Ongoing.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Credible report.</p>	<p>2. The commitment does not require NHS to cure or otherwise remediate the default.</p>
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<b>Commitment 12 – Material Adverse Event Notification</b>	<b>FTC Staff Comment</b>
<p>In order to demonstrate the New Health System maintains the financial viability to fulfill its commitments of this Cooperative Agreement, and to ensure proper state supervision, If the New Health System records a liability for a Material Adverse Event which may impair the ability of the New Health System to fulfill the commitments, the New Health System will notify the Authority within 30 days of making such a determination.</p> <p><b>Timing:</b> Ongoing.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Credible report and easy to determine.</p>	<ol style="list-style-type: none"> <li>1. The commitment to provide a notice of a Material Adverse Event (“MAE”) to the Commonwealth does not give the Commonwealth the right to do anything about the MAE.</li> <li>2. The commitment does not require NHS to cure or otherwise remediate the MAE.</li> <li>3. The commitment does not provide any time limit for how long NHS’s ability to fulfill a commitment could be impaired due to a MAE before it has to come back into compliance with the cooperative agreement commitments.</li> <li>4. The term “Material Adverse Event” is not defined in the commitment. The precise definition of MAE could significantly affect NHS’s obligations, and if and when the Commonwealth receives notice of any adverse events.</li> </ol>

<b>Commitment 13 – Employee Vesting</b>	<b>FTC Staff Comment</b>
<p>In order to ensure employees are properly recognized for their years of service, and to protect the benefits they have earned over time, 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.</p> <p><b>Timing:</b> First year.</p> <p><b>Metric:</b> Easily verifiable.</p>	<ol style="list-style-type: none"> <li>1. This commitment should not be credited as a benefit of the merger since employees have this benefit today, without the merger.</li> <li>2. The commitment does not clearly state that the “credit for accrued vacation and sick leave” will be <i>full</i> credit. As such, NHS could provide partial credit and still comply with this commitment.</li> <li>3. This commitment is not merger specific because any other acquirer could agree to this same commitment.</li> </ol>

Commitment 15 <sup>11</sup> – Pay Structure Differences	FTC Staff Comment
<p>In order to ensure a uniform system of compensation, and to ensure competitiveness of pay for attracting and retaining employees, the New Health System will work as quickly as practicable after completion of the merger to invest up to \$70 million over 10 years addressing differences in salary/pay rates and employee benefit structures between Wellmont and Mountain States. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.</p> <p><b>Timing:</b> By the end of the first full fiscal year upon closing of the merger.</p> <p><b>Amount:</b> The estimated incremental investment in addressing salary/pay rate differences is approximately \$70 million over 10 years.</p> <p><b>Metric:</b> Credible report which shall be provided confidentially in order to preserve a competitive employment environment. Such report will include if there were grievances filed by employees with respect to pay adjustments related to the merger and how the grievances were addressed.</p>	<ol style="list-style-type: none"> <li>1. Although the commitment would begin by the end of the first full fiscal year after closing the merger and the parties may plan to do so, the commitment itself does not require that the parties invest any specific amounts over any of the first nine years. Thus, NHS would have until year 10 to meaningfully close any salary/pay and benefits gap.</li> <li>2. The commitment does not require that the salary/pay and benefits gap be closed only by raising salary/pay and benefits of the lower-compensated system’s employees. As such, some or even a large portion of this commitment could be satisfied by (a) letting higher-paid employees leave through attrition or otherwise, (b) freezing the salary/pay and benefits of the higher-compensated system’s employees, or (c) slowing the rate of salary/pay and benefits increases at the high-compensated system.</li> <li>3. Depending on any differences in, for example, employee jobs, titles, and responsibilities, there could be significant discretion and room for disagreement about whether a particular employee’s or group of employees’ compensation needs to rise to that of the higher-compensated system.</li> <li>4. The commitment is to spend “up to” \$70 million to address discrepancies, but it is not clear that it needs to approach that amount.</li> <li>5. This commitment is not merger specific because any other acquirer could agree to this same commitment.</li> </ol>

Commitment 16 – Severance Policy	FTC Staff Comment
<p>In order to ensure employees are treated fairly in the event there is a facility closure or termination of services related directly and demonstrably to the merger, the New Health System will provide to the Commissioner, within two (2) months of closing, a severance policy addressing how employees will be compensated if they are not retained by the New Health System or any of its subsidiaries or affiliates. This policy shall not affect termination of employees if the</p>	<ol style="list-style-type: none"> <li>1. The commitment does not commit NHS to any particular severance policy or that the new policy will be better than the parties’ current severance policies. It is merely a commitment to develop a policy in the future.</li> <li>2. The commitment limits application of the new severance policy to employees whose termination is caused by a facility or service closure “related directly and demonstrably to the merger.” There is no definition of how a closure or a termination would be “directly and</li> </ol>

<sup>11</sup> Commitment 14 was deleted from the revised commitments contained in the Southwest Virginia Health Authority Report, but subsequent commitments were not renumbered. For consistency, this chart keeps the commitment numbering that is reflected in the Southwest Virginia Health Authority Report.

termination was for-cause or related to the routine operation of such facility. The severance policy shall consider several factors, including but not limited to, each individual's position within his/her current organization and years of service. The policy will also address outplacement support to be provided to any such employee. Compliance with this commitment in Virginia shall be judged solely by the Commissioner and corrective action required for noncompliance shall be determined solely by the Commissioner. This provision shall not be construed to create a right of action for any individual employee.

**Timing:** 5 years.

**Amount:** Severance cost is estimated to be approximately \$5 million from the closing of the merger to the end of the first full fiscal year after the closing of the merger, attributable mostly to corporate level synergies. Severance cost thereafter is not easily calculable due to unknown variables in the market, including ongoing attrition in the workforce as inpatient hospital use rates continue to decline.

**Metric:** Confidential annual report for the first five full fiscal years after the closing of the merger reporting on the total number of involuntary employee terminations due to merger-related reductions, the number of such terminations for which severance compensation was paid, and the aggregate cost of such severance compensation. Importantly, it is also recognized that there will be new employment created as the New Health System makes the committed investments in research, academics, new specialties and services and population health. The New Health System may also provide as part of the annual report the number of new jobs created due to such investments, and approximate incremental payroll costs resulting.

demonstrably" related to the merger. As such, discretion and disagreements over whether a termination is "directly and demonstrably" related to the merger could well arise. Moreover, the commitment does not indicate whether it would be NHS's, the employee's, or the states' obligation to show or contest whether the termination was "directly and demonstrably" related to the merger and what happens in the event of a dispute.

3. Implicitly, this commitment suggests that NHS plans to terminate employees by closing facilities and/or services.
4. The parties also commit to reporting on the number of new jobs, but there is no requirement – as there is with terminating employees – that NHS specify which, if any, new jobs are "directly and demonstrably" related to the cooperative agreement, as opposed to jobs that Mountain States or Wellmont would have filled without the merger.
5. The commitment provides the Commonwealth with some *undefined* ability to take "corrective action . . . for noncompliance," but this could require the Commonwealth to evaluate any or all terminations related to the merger to see if NHS complied with the new severance policy.
6. The commitment appears to apply only for five years. The parties have committed to keep certain facilities operating as healthcare facilities for five years, but not beyond that. As such, this commitment to provide a severance policy would expire at the very time when NHS would be free to close facilities and eliminate services.

Commitment 17 – Career Development Programs	FTC Staff Comment
<p>In order to invest in the advancement of employees, and to assist employees in achieving growth in their careers, 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.</p> <p><b>Timing:</b> No later than 24 months after closing.</p> <p><b>Metric:</b> Credible report.</p>	<ol style="list-style-type: none"> <li>1. This commitment and what the parties would actually do is undefined and ambiguous.</li> <li>2. To the extent the commitment involves the sharing of best practices, the parties likely could develop career development programs without the merger – either collaborating together, with another merger partner, or with an outside career development consultant.</li> </ol>

Commitment 18 – Post-Graduate Training	FTC Staff Comment
<p>In order to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop, in partnership with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee. The plan will include, but not be limited to, how it will address the Authority’s goals, how training will be deployed in Virginia and Tennessee based on the assessed needs, clinical capacity and availability of programs. Contingent on continued funding for existing programs from federal and state sources, the New Health System will not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area. Notwithstanding the foregoing, minor and temporary decreases in the number of full time equivalent residents working at Virginia hospitals may reflect year-to-year variations in residents applying for such training, dropping out of such training, electing to rotate to other hospitals, or transferring to another residency program, and shall not be deemed to violate this agreement.</p> <p><b>Timing:</b> 10 years.</p> <p><b>Amount:</b> Combination of commitments 17 and 18 total \$85 million.</p>	<ol style="list-style-type: none"> <li>1. The commitment provides that the 10-year training plan must be <i>developed</i> by June 30, 2018 – 18 months after the cooperative agreement could be approved and the merger consummated, well after the time at which the benefits of this commitment can be assessed against the harms stemming from the cooperative agreement.</li> <li>2. The commitment does not clearly identify by when the 10-year plan must be <i>implemented</i>. In fact, the parties deleted prior draft language for this commitment that required the implementation of the 10-year plan, so it is not even specified that the plan must be implemented at all.</li> <li>3. The training commitment has no specific details or training goals. As such, there is no requirement that the number of persons trained or expected expenditures on such training be any higher than the levels today.</li> <li>4. The commitment not to reduce or eliminate medical residence programs or available residency positions is “contingent” on federal and state funding. If that funding is discontinued, NHS seemingly would have no further obligations. As such, it could reduce or eliminate medical residency programs and residency positions.</li> <li>5. The cooperative agreement and this commitment are not necessary to develop such a training plan and maintain residency programs. The parties have not shown that they could not engage in these activities without the merger – either on their own working directly with medical schools, or collaborating with each other, or with another merger partner that could agree to the same commitments.</li> <li>6. Before crediting this commitment, the Commonwealth</li> </ol>

<p><b>Metric:</b> Annually, the New Health System will report to the Commissioner: the number of accredited resident positions for each residency program operated in Virginia and the number of such positions that are filled, and shall furnish copies of the relevant pages of the Medicare cost reports showing the number of full time equivalent residents. An annual report shall also include a description of any affiliation agreements moving resident “slots” from one hospital to another pursuant to Medicare rules, resident programs moved from one hospital to another, and new programs started. No later than June 30, 2018, the New Health System will furnish to the Commissioner a plan for medical residency training programs and other health care professional training. The plan shall set forth the targeted number of persons to be trained by physician specialty or health care professional category, the location(s) of such training, the schedule for starting such training, and the expected gross annual expenditure relating to such training. It is acknowledged that the service area for the New Health System extends across state boundaries and patients, employees, and vendors freely cross those state lines. Accordingly, the Commissioner will not apply a fixed ratio to determine whether each year’s expenditure under commitments number 17 and 18 is appropriately shared in by Virginia. On the other hand, the Commissioner will review expenditures made pursuant to this commitment for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.</p>	<p>should confirm if the parties even had plans to reduce or eliminate training or medical residency programs and positions, the extent to which the parties already had undertaken to maintain or expand training and residency programs, and the availability of alternatives. Otherwise, there is no way to assess the incremental benefit this commitment would provide.</p> <p>7. The commitment appears to expire after 10 years.</p>
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<b>Commitment 19 – Academic Partnerships</b>	<b>FTC Staff Comment</b>
<p>In order to help create opportunities for investment in research in partnership with Virginia’s academic institutions, the New Health System is committed to collaborating with the academic institutions to compete for research opportunities. The New Health System will work closely with current academic partners to develop and implement a 10-year plan for investment in research and growth in the research enterprise in Virginia and Tennessee service area. The plan will include, but not be limited to, how it will address the Authority’s goals, how research will be deployed in Virginia and Tennessee based on the needs and</p>	<ol style="list-style-type: none"> <li>1. The commitment does not require the parties to develop the plan for investment in research until “the end of the first fiscal year after the merger” would be consummated, well after the time at which the benefits of this commitment can be assessed against the harms stemming from the cooperative agreement.</li> <li>2. Although the commitment suggests that NHS would begin making expenditures in the second full fiscal year after the merger closes, this is not clearly required by the commitment, and there is no minimum investment required by year two or any other particular year.</li> </ol>

<p>opportunities, capacity and competitiveness of the proposals.</p> <p><b>Timing:</b> 10 years.</p> <p><b>Amount:</b> Combination of commitments 17 and 18 total \$85 million.</p> <p><b>Metric:</b> Report in year one and dollars spent thereafter. The New Health System will present a plan for research expenditures for full fiscal years two and three starting after the closing of the merger no later than the end of the first fiscal year after the merger. Thereafter, the New Health System must update its plan to address subsequent fiscal years no later than the end of the period for which the prior plan ends up to the end of the ninth full fiscal year after the closing of the merger. The annual report should include a description of research topics, the entities engaged in the research, the principal researcher(s) who is/are responsible for each project, any grant money applied for or expected, and the anticipated expenditures. Annual reports for full fiscal years three and through ten should report on the outcome of previously reported research projects including references to any published results. The Commissioner will review expenditures made pursuant to this commitment for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.</p>	<ol style="list-style-type: none"> <li>3. The commitment contains no specific details or thresholds set out or promised.</li> <li>4. The commitment lacks an enforcement mechanism if the parties fail to develop or implement the investment plan, including if NHS fails to fulfill its commitment.</li> <li>5. The commitment appears to expire after 10 years.</li> <li>6. The cooperative agreement and this commitment are not necessary to invest in research. The parties have not shown that they could not invest in these activities without the merger – either on their own working directly with medical schools, or collaborating with each other, or with another merger partner that could agree to the same commitments. Before crediting this commitment, the Commonwealth should assess these alternatives. Otherwise, there is no way to assess the incremental benefit this commitment could provide.</li> </ol>
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<b>Commitment 20 – Common IT Platform</b>	<b>FTC Staff Comment</b>
<p>In order to enhance hospital quality, improve cost-efficiency, improve the utilization of hospital-related services, and to enhance opportunities in research, the New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. The New Health System will make access to the IT Platform available on reasonable terms to all physicians in the service area. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, and post-acute care and outpatient services and facilitate the move to value-based contracting. Subject to confidentiality laws and rules, the New Health System will grant reasonable access to the data collected in its Common Clinical IT</p>	<p>With respect to the commitment to implement a Common Clinical IT Platform:</p> <ol style="list-style-type: none"> <li>1. The parties have not shown that they could not achieve comparable benefits using an HIE or developing a “bridge” between their existing clinical IT platforms (without merging) as an alternative. To the extent they could achieve some, but not all, of the benefits using an HIE or a clinical IT platform bridge, then the parties have not shown the incremental benefit of implementing a common platform.</li> <li>2. The parties have not shown that they could not implement a common clinical IT platform with another merger partner and achieve comparable benefits. To the extent there could be greater benefits under the</li> </ol>

<p>Platform to researchers with credible credentials who have entered into Business Associate Agreements for the purpose of conducting research in partnership with the New Health System.</p> <p><b>Timing:</b> Implementation No later than 48 months after closing.</p> <p><b>Amount:</b> Up to \$150 million.</p> <p><b>Metric:</b> Implementation of promised system with mileposts along the way. The mileposts shall be proposed by New Health System no later than three months after the closing of the merger or June 30, 2017, whichever is later. The New Health System will report in each annual report its progress toward implementing the Common Clinical IT Platform, and after implementation, any material enhancements or changes. The New Health System will also include in the annual report the researchers (by individual or by group for those working together) who have entered into Business Associate Agreements for purposes of conducting research.</p>	<p>cooperative agreement, they have not shown how much greater the benefits would be than having a common platform with a different merger partner.</p> <ol style="list-style-type: none"> <li>3. The common IT platform would not be implemented for up to four years, so there would be little or no benefit during that interim time period.</li> <li>4. The benefits of the common IT platform should be “netted” against the cost of implementing and maintaining such a platform, both of which can be immense.</li> <li>5. There is no enforcement mechanism if the parties are delayed or fail to implement the common clinical IT platform, or if the platform does not work properly.</li> </ol> <p>With respect to the commitment to make the IT platform available to physicians:</p> <ol style="list-style-type: none"> <li>1. The commitment to make the IT platform available on “reasonable terms” is vague, subject to interpretation, and may preclude widespread physician use.</li> <li>2. The parties could already make their clinical IT systems available to physicians today, without the cooperative agreement or this commitment.</li> <li>3. There is no specified enforcement mechanism if the parties do not make their IT platform available to physicians in the area.</li> </ol>
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<p><b>Commitment 21 – Preservation of Hospital Services</b></p> <p>In order to preserve hospital services in geographical proximity to the communities traditionally served by such facilities, to ensure access to care, and to improve the utilization of hospital resources and equipment, 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. In the event that the New Health System repurposes any hospital, it</p>	<p><b>FTC Staff Comment</b></p> <p>Perhaps in response to our public comment, the parties enhanced their commitment regarding preservation of existing facilities, but it still has significant limitations:</p> <ol style="list-style-type: none"> <li>1. The commitment does not require the parties to keep the vast majority of their hospitals open <i>as hospitals</i> for <i>any</i> period of time. (The parties do commit to keep three tertiary hospitals open in Commitment 22).</li> <li>2. The commitment requires only that the parties keep certain basic “essential services” available for five years. But the parties make no promise to keep a host of other services available at these non-tertiary hospitals, including, but not necessarily limited to: <ol style="list-style-type: none"> <li>a. Secondary care services</li> <li>b. OB services (except “emergent obstetrical care”</li> </ol> </li> </ol>
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will continue to provide essential services in the community. For purposes of this commitment, the following services are considered “essential services”:

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community and based on physician availability;
- Helicopter or high acuity transport to tertiary care centers;
- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;
- Primary care services;
- Access to a behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commonwealth and the Authority.

If the New Health System becomes the primary health service partner of the Lee County Hospital Authority, the New Health System will be responsible for essential services as outlined above.

**Timing:** Ongoing.

**Amount:** The net cost varies depending on annual operating losses. The current annual operating losses for the predecessors of the New Health System for Virginia hospitals that are losing money are approximately \$11 million.

**Metric:** Each year, the operating results for the Virginia hospitals and sites furnishing “essential services” as defined above will be reported to the Commissioner. The annual report to the Commonwealth will also outline services provided in each community by the hospitals or other sites furnishing “essential services” as specified in this commitment.

and “primary care services”)

- c. Outpatient services (except “outpatient diagnostics needed to support emergency stabilization”)
- d. Behavioral health services (only requires “access to a behavioral health network . . .”) (emphasis added)

3. The commitment only applies to hospitals and hospital services. There is no commitment to keep any freestanding outpatient facilities open or not to eliminate services at those outpatient facilities. Further, there is no commitment to maintain current or comparable levels of physicians, nurses, and other staff at *any* hospital or outpatient facility.
4. There is no specified enforcement mechanism if the parties fail to fulfill this commitment. It is unclear how the Commonwealth would require the parties to re-open a facility, re-establish a service, or re-hire a physician.
5. The parties have not shown that they would have closed any hospitals or eliminated “essential services” at these hospitals without the merger. If there was no such plan, then this commitment should not be credited as a benefit of the cooperative agreement.
6. The merger and cooperative agreement are not necessary to preserve the other hospitals or maintain “essential services.” The parties have not shown that they lack the financial resources to maintain these facilities. In any case, another merger partner could make the same commitment as the parties have. Unless the Commonwealth can validate that no other bidder for Wellmont would make this commitment, the Department should attribute little weight to this commitment.
7. Interestingly, the parties deleted the prior draft language that stated that there was no current commitment to keep rural institutions open. If there was such a commitment, then this cooperative agreement commitment provides no benefit over the status quo.
8. The reference to the Virginia hospitals that are losing money fails to acknowledge that both Mountain States and Wellmont are substantial and profitable health *systems*. Indeed, in fiscal year 2015, Mountain States generated total revenues of approximately \$1 billion and approximately \$55 million in excess revenues over expenses and losses, and Wellmont generated total

	<p>revenues of approximately \$813 million and \$16 million in revenue and gains in excess of expenses and losses.<sup>12</sup> While individual hospitals may not be, on a stand-alone basis, particularly profitable, they may contribute to the overall profitability of the health system by serving as feeder hospitals to the tertiary hospitals or otherwise as access points to the health system, which increase the system’s revenues and profits.</p>
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<b>Commitment 22 – Maintain Three Tertiary Hospitals</b>	<b>FTC Staff Comment</b>
<p>In order to ensure preservation of hospital facilities and tertiary services in geographical proximity to the communities traditionally served by those facilities, the New Health System will maintain, for the Virginia and Tennessee service areas, a minimum of the three full-service tertiary referral hospitals located in Johnson City, Kingsport, and Bristol, to ensure higher-level services are available in close proximity to where the population lives.</p> <p><b>Timing:</b> Immediately upon closing of the merger and ongoing.</p> <p><b>Amount:</b> Not applicable.</p> <p><b>Metric:</b> Easily verifiable. The New Health System must report immediately to the Commissioner the closing of any of the above referenced three full-service tertiary referral hospitals and must also report any reduction in the capability of any of the three tertiary referrals hospitals so that they can no longer be credibly viewed as tertiary referral hospitals.</p>	<ol style="list-style-type: none"> <li>1. As with the prior commitment, this commitment only applies to tertiary hospitals. There is no commitment to keep any freestanding outpatient facilities open or not to eliminate services at those outpatient facilities. Further, there is no commitment to maintain current or comparable levels of physicians, nurses, and other staff at <i>any</i> hospital or outpatient facility.</li> <li>2. There is no specified enforcement mechanism if the parties fail to fulfill this commitment. It is unclear how the Commonwealth would require the parties to re-open a tertiary facility, re-establish a service, or re-hire a physician.</li> <li>3. The parties have not shown that they would have closed any tertiary hospitals or other hospitals without the merger. If there was no such plan, then this commitment should not be credited as a benefit of the cooperative agreement.</li> <li>4. The cooperative agreement is not necessary to preserve the three tertiary hospitals. Again, the parties have not put forward evidence that they would have closed these hospitals without the merger. In any case, another merger partner could make the same commitment as the parties have. Unless the Commonwealth can validate that no other bidder for Wellmont would make this commitment, little weight should be attributed to this commitment.</li> <li>5. Although the commitment initially states that the parties will keep open three tertiary facilities, the last provision in this commitment states that NHS must report to the Commissioner if it plans to close a tertiary facility or</li> </ol>

<sup>12</sup> Response to Tennessee Department of Health Questions, Exhibit 23 at 5 (Audited Financial Statement on MSHA as of June 30, 2015); Mountain States Health Alliance & Wellmont Health System, Application for a Certificate of Public Advantage for State of Tennessee (Feb. 16, 2016), Exhibit 11.5, Attachment B (Wellmont Health System and Affiliates Consolidated Financial Statements June 30, 2015 and 2014), at 4, [http://tn.gov/assets/entities/health/attachments/COPA\\_application.pdf](http://tn.gov/assets/entities/health/attachments/COPA_application.pdf).

	eliminate capabilities that would no longer make the hospital a tertiary facility. This makes the commitment much less certain than it appears and potentially the benefits of this commitment less creditable.
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<b>Commitment 23 – Maintain Open Medical Staff</b>	<b>FTC Staff Comment</b>
<p>In order to ensure choice of providers for consumers and to ensure physicians are free to practice medicine without any adverse effect from the merger, the New Health System will maintain an 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 departments or services as determined by the New Health System’s Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.</p> <p><b>Timing:</b> Immediate upon closing of the merger and ongoing, subject to current contractual obligations.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Easily verifiable.</p>	<ol style="list-style-type: none"> <li>1. The parties have revised this commitment, and it may be narrower than the parties’ original commitment. Previously, the parties committed that they would maintain an open medical staff except perhaps for “hospital based physicians.” Now they exclude from the commitment entire “hospital departments or services.” The commitment now gives NHS discretion to “close” any hospital’s departments or services, possibly displacing assigned medical staff, for any reason without apparent limitation or restriction.</li> <li>2. The commitment references a timing caveat – “subject to current contractual obligations,” which may delay the implementation of the commitment by an indeterminate period of time. The scope of this limitation should be understood before it is accepted.</li> </ol>

<b>Commitment 24 – Independent Physician Exclusivity</b>	<b>FTC Staff Comment</b>
<p>In order to ensure physicians and patients maintain their choice of facilities, and to ensure independent physicians can maintain their independent practice of medicine, the New Health System will not require independent physicians to practice exclusively at the New Health System’s hospitals and other facilities.</p> <p><b>Timing:</b> Immediate upon closing of the merger and ongoing.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Easily verifiable.</p>	<ol style="list-style-type: none"> <li>1. If independent physicians in the area do not today regularly practice at hospitals other than Mountain States and Wellmont, this commitment provides little benefit.</li> <li>2. In general, physicians do not like to practice at hospitals far from their offices or homes. As such, the commitment to allow local-area physicians to practice at hospitals that may be quite far from their current office or home is unlikely to be a benefit that most such physicians will take advantage of, which means the commitment provides little benefit.</li> </ol>

<b>Commitment 25 – Independent Physician Health Networks</b>	<b>FTC Staff Comment</b>
<p>The New Health System will not take steps to prohibit independent physicians from participating in health</p>	<ol style="list-style-type: none"> <li>1. Unless the parties are suggesting that they currently take steps to prohibit independent physicians from</li> </ol>

<p>plans and health networks of their choice.</p> <p><b>Timing:</b> Immediate upon closing of the merger and ongoing.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Easily verifiable.</p>	<p>participating in health plans and health networks of their choice, this commitment does not provide any new benefit.</p> <p>2. Otherwise, the commitment appears to concede that, without this commitment, the cooperative agreement would enable the parties to exercise market power by taking steps to prevent even <i>independent</i> physicians from participating in health plans and health networks of their choice.</p>
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<b>Commitment 26 – Physician Needs Assessments</b>	<b>FTC Staff Comment</b>
<p>In order to enhance access to services for patients, and to ensure robust choices remain in the market for physicians in the various specialties needed throughout the region, the New Health System will commit to the development of a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by the New Health System. The New Health System will consult with the Authority in development of the plan. The New Health System will employ physicians and physician extenders 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 promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children’s Hospital physician needs assessment.</p> <p><b>Timing:</b> Every 3 years, starting within the first full fiscal year.</p> <p><b>Amount:</b> Costs of recruitment related to implementation of the recruitment plan shall be part of the \$140 million commitment referenced below in number 26. Expenditures incurred in the development of the community needs assessment and the recruitment plan shall not be credited toward that \$140 million commitment.</p> <p><b>Metric:</b> Credible evidence of recruitment plan, which identifies needs and priorities. The first community needs assessment and physician/physician extender recruitment plan shall be presented to the</p>	<ol style="list-style-type: none"> <li>1. The commitment provides no specific details of the proposed plan or how much of the \$140 million commitment referenced in Commitment 27 would be devoted to this recruitment plan.</li> <li>2. The development of the proposed plan would not need to be completed until the end of the first full fiscal year after closing. As such, the plan’s benefits, if any, cannot be assessed until well after VDH’s decision on the cooperative agreement application and the closing of the merger.</li> <li>3. The commitment to conduct a needs assessment and recruitment plan for physicians and physician extenders is something the parties could do today, without the merger, either independently, with another merger partner, and perhaps even with each other through a collaboration short of a merger. In fact, the penultimate sentence of the commitment specifically refers to “alternatives <i>such as</i> building relationships with centers of excellence.” Therefore, the parties have not shown that the cooperative agreement is necessary to achieve this benefit.</li> <li>4. To the extent that the parties argue that they could not hire as many physicians/physician extenders without the merger, they have not shown the incremental benefit of the cooperative agreement by specifying how many physicians/physician extenders they would employ above what they could do alone or through alternatives.</li> <li>5. Similarly, although the parties commit to hiring physicians and physician extenders “primarily in underserved areas,” there is no specific commitment as to the number of physicians to be hired, what specialties, or where. The parties could arguably satisfy the commitment by hiring a single physician assistant. As</li> </ol>

<p>Commissioner no later than in the annual report submitted after the end of the first full fiscal year after closing of the merger, and thereafter at three (3) year intervals (or more frequently if the plan is amended). In each annual report, the New Health System shall report on progress toward its recruitment goals including the number of recruited physicians by specialty, and related data such as recruitment efforts, interviews conducted, and the number of offers extended. To the extent that physician needs identified in the plan are not met in 600 days or more (measured at the end of each full fiscal year), the New Health System shall include an explanation of the feasibility of meeting the plan for the unfilled position(s), additional steps, if any, that management believes are appropriate to take, and consideration of alternatives such as building relationships with centers of excellence to improve the availability of the missing specialty to patients in the region. In order to preserve competition, this annual reporting requirement will be treated as confidential.</p>	<p>such, the parties have not shown the magnitude of the benefit or that it would be significant.</p> <ol style="list-style-type: none"> <li>6. Based on the specific language in the commitment, the parties do not specifically commit to employing any pediatric sub-specialists, just that they would “<i>promote</i> recruitment and retention of pediatric sub-specialists in accordance with” the Niswonger needs assessment.</li> <li>7. Although there is a reporting requirement, NHS must only explain the feasibility of meeting the plan and explain what steps “<i>if any</i>” it “<i>believes</i> are appropriate to take” if it does not meet its employment plans. There is no specific enforcement mechanism if it falls short of employing a meaningful number of physicians/physician extenders in underserved areas or recruiting and retaining pediatric sub-specialists.</li> </ol>
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<b>Commitment 27 – Enhancement of Healthcare Services</b>	<b>FTC Staff Comment</b>
<p>Enhancing healthcare services:</p> <ol style="list-style-type: none"> <li>a. In an effort to enhance treatment of substance abuse in the region, the New Health System will create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee.</li> <li>b. Because improved mental health services is a priority of the Authority and the law, the New Health System will 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 designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements throughout the Virginia and Tennessee service area.</li> <li>c. As part of the priority of preserving hospital services in geographical proximity to the communities traditionally served by the facilities, and to ensure access to care, the New Health System will develop pediatric specialty centers and Emergency Rooms in Kingsport and Bristol with further deployment of</li> </ol>	<ol style="list-style-type: none"> <li>1. The commitment only requires the parties to develop a plan within 24 months, well after a decision on the cooperative agreement is made, thus preventing an accurate assessment of the benefits of the plan. The commitment lacks any requirement as to when these enhanced services would be available nor does it specify how much of the \$140 million NHS would invest in these services.</li> <li>2. In FTC staff’s public comment to the Virginia Department of Health and Southwest Virginia Health Authority, we addressed the deficiencies in the parties’ claims about developing new substance abuse and mental health resources, but to summarize: <ol style="list-style-type: none"> <li>a. The parties have actively opposed efforts by other providers to begin offering substance abuse services, so they should not be given credit for bringing those same services into the area.</li> <li>b. The parties have not shown that these services could not be offered through alternatives that are less restrictive to competition – either on their own, through a collaboration with each other short of a merger, or with another partner. The Commonwealth should evaluate what plans</li> </ol> </li> </ol>

<p>pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes.</p> <p><b>Timing:</b> The plan will be developed no later than 24 months after closing and will include a time schedule for implementing the plan and expenditures under the plan.</p> <p><b>Amount:</b> \$140 million over 10 years including physician recruitment referenced in number 25 above.</p> <p><b>Metric:</b> The New Health System will include in the annual report for the second full fiscal year the plan for enhancing healthcare services, and in that report and each following, shall include in the annual report progress in implementing the plan and expenditures made.</p>	<p>each party had to enhance existing services before the planned merger and what alternative bidders may have offered Wellmont with respect to enhancing area health services before crediting this commitment.</p> <p>c. To the extent the parties could not offer a new health service independently but only through a collaboration with each other, those are the types of non-merger collaborations that are most likely to be non-problematic under the antitrust laws.</p> <p>d. To the extent that the cooperative agreement would result in some new services that would not be developed through alternative means, the parties have not specifically shown the incremental benefit of the cooperative agreement over available alternatives.</p> <p>3. There is no enforcement mechanism if the parties do not develop these services, delay the development of these services, do not meaningfully develop these services, or primarily develop them in Tennessee rather than Virginia (or vice versa).</p>
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<b>Commitment 28 – Population Health</b>	<b>FTC Staff Comment</b>
<p>In an effort to enhance population health status consistent with the regional health goals established by the Authority, the New Health System will invest not less than \$75 million over ten years in population health improvement for the service area. The New Health System will establish a plan, to be updated annually in collaboration with the Authority, the Commonwealth, and possibly the State of Tennessee, to make investments that are consistent with the plan and to complement resources already being expended. The New Health System also commits to pursuing opportunities to establish Accountable Care Communities in partnership with various local, state and federal agencies, payers, service providers and community groups who wish to partner in such efforts. It is the desire of the New Health System for the Commonwealth and Tennessee to collaborate with the New Health System to establish a regional plan that disregards state boundaries.</p>	<p>With respect to the commitment to invest in population health improvement efforts:</p> <ol style="list-style-type: none"> <li>1. Health systems do not need to merge in order to engage in population health management. Indeed, hospital systems smaller than the parties already engage in population health management on their own.</li> <li>2. The parties have not shown that the cooperative agreement is necessary to engage in population health management. They have not shown that they could not engage in population health management on their own, with each other in a collaboration short of a merger, or with another merger partner. Indeed, this commitment refers to “resources already being expended” and “efforts already underway through community based assets,” suggesting the population health management efforts are proceeding even without the merger.</li> <li>3. To the extent the parties are arguing that the cooperative agreement enables them to engage in aspects of population health management above what they could</li> </ol>

<p><b>Timing:</b> 10 years.</p> <p><b>Amount:</b> \$75 million.</p> <p><b>Metric:</b> The New Health System will establish and track long-term outcome goals similar to those developed in Healthy People 2020 and consistent with the health plans of Virginia and Tennessee, and will be evaluated based on whether expenditures made are consistent with the plan established by the collaborative between the states, including the Authority, and the New Health System.</p> <p><b>Discussion:</b> The expenditures of \$75 million throughout the region have the greatest positive impact only if those dollars are spent in a prioritized way in collaboration with the state health plan and the regional priorities as established by the Authority, and in partnership with efforts already underway through community based assets.</p>	<p>do through these alternatives, they have not shown what those incremental efforts are or the specific benefits from their undefined post-merger efforts. Similarly, the parties have not shown how much they had planned to invest in efforts to enhance population health without the merger. Only the amount by which the \$75 million commitment exceeds their pre-merger investment plans should be credited as a benefit of the cooperative agreement.</p> <p>4. There is no enforcement mechanism if the parties do not implement, invest in, or achieve population health management programs and goals.</p> <p>With respect to the commitment to “pursu[e] opportunities to establish Accountable Care Communities”:</p> <ol style="list-style-type: none"> <li>1. Assuming the “Accountable Care Communities” (“ACCs”) here refers to the approach being developed to partner with counties and private entities to achieve healthy counties, this approach is still under development and the benefits of such an approach are unknown. According to the National Association of Counties: “ACCs are in the early phases of adoption; therefore limited analysis and research are currently available.”<sup>13</sup> The parties have not shown that a merger is required to establish an ACC.</li> <li>2. The commitment language indicates that the parties would “pursu[e]” ACC opportunities, but there is no commitment to <i>actually establish</i> an ACC.</li> <li>3. There is no enforcement mechanism if the parties do not establish an ACC.</li> </ol>
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<b>Commitment 30<sup>14</sup> – Reimbursement of Authority</b>	<b>FTC Staff Comment</b>
<p>In support of the Authority’s role in promoting population health improvement under the Commonwealth’s Cooperative Agreement with the New Health System, the New Health System shall reimburse the Authority for costs associated with the various planning efforts cited above in an amount up to \$75,000 annually, with CPI increases each year. No reimbursable costs shall be paid toward compensation for any member of the Authority’s Board or Directors.</p>	<ol style="list-style-type: none"> <li>1. It is unclear whether this commitment is solely for purposes of supporting the planning related to Commitment 28 or for all the commitments in the cooperative agreement.</li> <li>2. It is unclear whether \$75,000 would be sufficient to engage in the planning efforts related to Commitment 28, but it is likely that \$75,000 per year would be insufficient to supervise the cooperative agreement as a whole.</li> </ol>

<sup>13</sup> <http://www.naco.org/sites/default/files/documents/Accountable-Care-Communities.pdf>, at 3 (emphasis added).

<sup>14</sup> Commitment 29 was deleted from the revised commitments contained in the Southwest Virginia Health Authority Report.

<p><b>Timing:</b> Annual.</p> <p><b>Amount:</b> Up to \$75,000 annually as part of the \$75 million for population health improvement, with annual CPI increases.</p> <p><b>Metric:</b> Reimbursement is made or is not made. All amounts paid to the Authority shall be included in the annual report submitted to the Commissioner.</p>	
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<b>Commitment 31 – Board Membership</b>	<b>FTC Staff Comment</b>
<p>Best practice governance of the New Health System is critical to the success of the efforts outlined in the Cooperative Agreement. As such, the Board of Directors of the New Health System will operate such that each Board member must exercise the Duty of Care, Loyalty and Obedience to the New Health System required by law, and all Board members must adhere to the strict fiduciary policies established by the Board. It is recognized that governance of the New Health System should reflect the region, including both Virginia and Tennessee. As such, the New Health System makes the following commitments related to governance:</p> <ul style="list-style-type: none"> <li>• Currently, one member of the Board of Directors resides in Virginia. No later than 3 months after closing, an additional resident of Virginia will be appointed to serve on the Board of Directors of the New Health System. Such resident shall be appointed through the governance selection process outlined in the bylaws of the New Health System;</li> <li>• The New Health System will ensure membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce;</li> <li>• The New Health System will ensure than not less than 30 percent of the composition of the Community Benefit/Population Health committee will reside in Virginia (committee will be the Board committee responsible for the oversight of the compliance of the Cooperative Agreement); and</li> <li>• Within 5 years, not less than 3 members of the Board of Directors will reside in the Commonwealth of Virginia, and such composition shall be sustained.</li> </ul>	<p>No comments on this commitment.</p>

<p><b>Timing:</b> Ongoing.</p> <p><b>Amount:</b> No dollar cost.</p> <p><b>Metric:</b> Easily verifiable.</p>	
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Commitment 32 – Annual Report	FTC Staff Comment
<p>The New Health System expects that the conditions under which the Cooperative Agreement is granted will be enumerated in a formal enforceable agreement between the New Health System and the Commissioner, and it is expected an annual report will be required. Any report will be attested to by the appropriate leadership of the New Health System, including the Senior Executive.</p> <p><b>Timing:</b> Annual.</p> <p><b>Amount:</b> No material cost.</p> <p><b>Metric:</b> Receipt of compliant report.</p>	<ol style="list-style-type: none"> <li>1. As explained throughout, the commitments, as drafted, leave doubts about the degree to which particular commitments could be enforced. While the Commonwealth may be able to enforce the <i>prohibitions</i> imposed on NHS (which does not necessarily mean the anticompetitive harm would be prevented), it is unclear if the Commonwealth would be able to enforce the <i>affirmative obligations</i> for NHS to engage in any quality- or population-health-enhancing activities; how that enforcement would occur; who would pay the costs of any mediation, arbitration, or court action; and what happens if the Commonwealth does not prevail in an enforcement action.</li> <li>2. The binding commitments should be finalized before VDH decides whether to approve the cooperative agreement and allow the merger to close.</li> </ol>

Commitment 33 – Quarterly Financial Reporting	FTC Staff Comment
<p>The New Health System will provide information on a quarterly basis of the key financial metrics and the balance sheet comparing performance to the similar prior year period and year to date. This information will be provided on the same timetable as what is publicly reported through EMMA (Electronic Municipal Market Access).</p> <p><b>Timing:</b> Annual and quarterly.</p> <p><b>Amount:</b> No material cost.</p> <p><b>Metric:</b> Easily verified.</p>	<ol style="list-style-type: none"> <li>1. The commitment leaves undefined what “key financial metrics” are and which of such metrics would be reported.</li> <li>2. To the extent that these key financial metrics and the parties’ balance sheets are available in what is publicly reported now through EMMA or in the parties’ IRS Form 990s, then this commitment provides no new benefit.</li> </ol>

Commitment 34 – Facility Closings	FTC Staff Comment
<p>The New Health System will adhere to Exhibit 12.1 setting forth relevant considerations and the process for closing a facility should it be necessary. This policy will</p>	<ol style="list-style-type: none"> <li>1. The Exhibit (12.1 of the parties’ Virginia Cooperative Agreement Application) sets forth a policy for “alignment” (i.e., closing clinical facilities and clinical</li> </ol>

<p>remain in effect unless the change is agreed to by the Commissioner.</p> <p><b>Timing:</b> If closing a facility is considered.</p> <p><b>Amount:</b></p> <p><b>Metric:</b> Annual report will provide evidence of compliance with policy.</p>	<p>services), which contains a variety of considerations that NHS would review before closing a facility or service. The policy, however, provides no sense of how NHS would weigh any of these considerations. As such, while the impact on community health status and access are among the considerations, so too is the effect on NHS's finances and its operating margins. Neither the commitment nor the policy indicates whether NHS would give community health or NHS's financial considerations more, less, or equal weight.</p> <p>2. According to the definitions in the policy, "Clinical Facility or Facilities" is defined as any location where "inpatient care is provided." This suggests that the alignment policy would be limited to closing inpatient facilities and services. As such, NHS would not be bound by the same alignment considerations, including the effect on the community when closing and discontinuing outpatient facilities or services, physician medical office buildings and services, and other non-inpatient facilities and services.</p>
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<b>Commitment 35<sup>15</sup> – Joint Task Force</b>	<b>FTC Staff Comment</b>
<p>The New Health System shall create, together with the Southwest Virginia Health Authority, a Joint Task Force comprised of four members, two from the New Health System and two from the Southwest Virginia Health Authority. The Task Force shall meet at least annually to guide the collaboration between the Authority and the New Health System, and to track the progress of the New Health System toward meeting the commitments of the Cooperative Agreement and shall report such progress to the Authority. The Task Force shall be chaired by a member of the Authority. The members appointed by the Authority may not have a conflict of interest.</p> <p><b>Timing:</b> Immediate upon closing of the merger.</p> <p><b>Amount:</b> No cost.</p> <p><b>Metric:</b> Creation of a Joint Task Force.</p>	<p>1. No comments on the creation of the Joint Task Force, other than it currently appears limited to Virginia.</p>

<sup>15</sup> Commitments 36 and 37 appear to have been deleted from the revised commitments contained in the Southwest Virginia Health Authority Report.

Revision of Commitments	FTC Staff Comment
<p data-bbox="77 224 722 289">A. Revision of Commitments – Recommendations by the Authority to the Commissioner</p> <p data-bbox="77 329 743 1810">These commitments have been negotiated and drafted with the intent of them remaining in place for ten (10) years. Nevertheless, there may be changes in circumstances that arise which affect the feasibility or the meaningfulness of the commitments and which are not possible to foresee presently. For example,<sup>5</sup> a major structural change to the federal payment system could, depending on how it is implemented, materially change both the needs of the region and the New Health System’s ability to meet those needs. Other events which may have a material effect include, but are not limited to, substantial and material reductions in federal reimbursement, repeal of Certificate of Public Need, labor shortages causing significant and material increases in labor expense, significant reductions in inpatient hospital use rates which cause a material decrease in revenue (and which may be demonstrated to reduce the total cost of care), or an act of God. It is the interest of the Commonwealth that the region’s hospitals maintain their financial viability, that they are of sound credit worthiness and that they are capable of reinvesting capital. Accordingly, if the New Health System produces clear and convincing evidence that changes in circumstances have materially affected its ability to meet the commitments and that its inability is not affected by deficiencies in management, either the Commissioner or the New Health System may petition the other to amend the commitments to reduce the burden or cost of the commitments to a level that may be more sustainable. In the event that the New Health System petitions the Commissioner for amendment of the Cooperative Agreement, the Commissioner may require the New Health System to engage an independent consultant to prepare a report validating that the changes in circumstances have adversely affected the New Health System, the extent to which this has occurred, and validating that the changes in circumstances are not related to the effectiveness of management. The cost of such an independent consultant engagement shall not exceed \$250,000 (as adjusted by the CPI from the date of the closing of the merger). The amendment process should not be used</p>	<p data-bbox="771 224 1367 254">Provision A raises several questions and concerns:</p> <ol data-bbox="820 275 1546 1774" style="list-style-type: none"> <li data-bbox="820 275 1546 556">1. The first sentence of the provision states that the commitments are intended to be in place for only 10 years. The merger, however, is intended to last in perpetuity. One of the greatest concerns is that the cooperative agreement would allow the parties to merge to a monopoly and later rid itself of any and all limitations on NHS’s market power by terminating the cooperative agreement commitments.</li> <li data-bbox="820 577 1546 1176">2. One of the cooperative agreement’s greatest risks is that it is impossible to foresee all the ways the market could evolve, how the commitments could be deficient, and the gaps in the commitments that would become evident only after the parties integrated their operations. In fact, this provision in the commitments specifically notes that there may be “changes in circumstances” that may arise that are “not possible to foresee,” which could affect the parties’ ability to comply with the conditions of the cooperative agreement (e.g., change in federal healthcare reimbursement, repeal of Certificate of Public Need, etc.). The Southwest Virginia Health Authority Report further states that these are only examples of the changes in circumstances that may justify a commitment amendment and “are not intended to be [sic] exclusive basis for amending the agreement . . .”<sup>16</sup></li> <li data-bbox="820 1197 1546 1512">3. Many aspects of this provision contain terms that are subject to interpretation and disagreement: “<i>major structural change to the federal payment system</i>”; “<i>materially change . . . the needs of the region</i>”; “<i>material reductions in federal reimbursement</i>”; “<i>significant reductions in inpatient hospital use rates</i>”; “<i>clear and convincing evidence that changes in circumstances have materially affected its ability to meet the commitments.</i>” (emphasis added)</li> <li data-bbox="820 1533 1546 1774">4. Provision A says that the amendment process should <i>not</i> be used to “increase the overall burden or cost on the New Health System.” That suggests that, if the cost required to achieve a particular benefit or fulfill a particular commitment exceeds that contemplated by the parties today, the Commonwealth might not be able to require NHS to expend those additional costs.</li> </ol>

<sup>16</sup> Southwest Virginia Health Authority Report, at 150 n.188.

<p>to increase the overall level of burden or cost on the New Health System, although the parties acknowledge that depending on the change in circumstance, measuring the change in the level of burden or cost may be subject to reasonable ranges and disagreement of the impact within a range. If either party petitions for amending the commitments and the parties cannot come to agreement, the parties shall agree on a dispute resolution process in order to reach agreement.</p> <p><sup>5</sup> These are examples only and are not intended to be exclusive basis for amending the agreement, but simply as an illustration of a possible change in circumstances that may have a material impact.</p>	<p>5. Neither Provision A nor the other commitments describe in detail the commitment-amendment process. Provision A does indicate that either NHS or the Commonwealth may petition the other for an amendment to the commitments, but if they cannot reach agreement, they shall then agree on a dispute resolution process. But it provides no details on what the dispute resolution process would entail, whether it would be binding, who would pay the costs of dispute resolution, and what would happen if NHS and the Commonwealth cannot agree to the terms of the dispute resolution process.</p>
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<b>Ten-Year Review</b>	<b>FTC Staff Comment</b>
<p><b>B. Ten-Year Review of Cooperative Agreement – Recommendations by the Authority to the Commissioner</b></p> <p>Before the end of calendar year 2026, the New Health System and the Commissioner shall review how well the formation and operation of the New Health System has served the overall interests of Virginians and Virginia businesses in the area. That review will consider all the elements set forth in Section 15.2-5384.1, Code of Virginia, and will also consider New Health System’s profitability. It is the opinion of the Authority that the citizens of the region and the Commonwealth are well-served when the health system generates the resources necessary to be sustainable, of good credit, and capable of meeting its commitments as a community-based health system in the region. It is the hope of the Authority that the New Health System achieves financial sustainability that exceeds national or regional averages. If, however, it appears the New Health System is generating excessive profits and negotiated payment rates to the New Health System have increased more rapidly than national or regional averages, new or additional commitments may be appropriate. Conversely, if the New Health System is unable to attain sufficient profitability notwithstanding effective management, reducing the burden of the commitments would be appropriate. Likewise, if the New Health System is not maintaining its support of population health,</p>	<ol style="list-style-type: none"> <li>1. Provision B states that “new or additional conditions may be appropriate” if, for example, NHS is generating excessive profits or negotiated payments rates, but does not define “excessive,” specify who defines that term, whether “excessive” is to be judged on a system or stand-alone-hospital basis, and whether the Commonwealth would assess this only for Virginia hospitals or all NHS hospitals. The use of “may” in this provision also makes it uncertain whether the Commonwealth would be able to demand an amendment based on excessive profits or payment rates, or whether some dispute resolution or litigation process would be required.</li> <li>2. Provision B says that if an amended or extended cooperative agreement cannot be reached, the Commonwealth should “withdraw its support” for the cooperative agreement. This suggests that if NHS refused to extend or amend the cooperative agreement – which appears to be in its sole discretion – the Commonwealth could only “withdraw” from the cooperative agreement. It is not clear that the Commonwealth could require NHS to take any action or even to implement the Plan of Separation. Even if the Commonwealth could order NHS to effectuate the Plan of Separation, as we stated in our public comment, staff has concerns that the separation could be too difficult or even impossible after 10 years of integration. Even if separation were feasible, it could very well not restore Mountain States and Wellmont to their pre-consolidation state because their plan includes closing</li> </ol>

<p>subsidizing money-losing services, medical education, research, and physician recruitment, new commitments may be appropriate. In the event that an extension of the existing cooperative agreement or negotiation of a new or amended agreement is not achieved, the Commonwealth should withdraw its support for the cooperative agreement.</p>	<p>facilities and consolidating services.</p>
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Other commitments and provisions	FTC Staff Comment
<p>Several commitments, including the pricing commitment, rely on payers to report complaints about NHS failures to fulfill commitments.</p>	<ol style="list-style-type: none"> <li>1. Payers may not be in a position to monitor NHS's compliance with all commitment terms, due to limitations on resources, lack of incentive, concern about repercussions or retaliation, or lack of information.</li> <li>2. NHS's failure to meet a commitment may not have a material effect on a payer's business, but might violate the commitment and have an effect on the community.</li> <li>3. Because the definition of Principal Payer excludes the smaller payers for which NHS is likely to constitute a relatively more significant portion of the payer's overall business, the commitments exclude those payers who would be more likely to have an incentive to monitor NHS's compliance with the commitments. Whereas, large national Principal Payers for whom NHS may constitute a relatively smaller portion of their overall business, may have a lower incentive to monitor NHS's compliance.</li> </ol>
<p>Revised Plan of Separation (submitted to Tennessee Department of Health on September 9, 2016)<sup>17</sup></p>	<ol style="list-style-type: none"> <li>1. Provision 2.B is unclear whether it would limit the parties <i>each</i> from transferring 10% (or "roughly" \$300 million) of NHS's total assets or whether it would apply to the parties on <i>a combined basis</i>. In any case, this threshold is likely much too high as a threshold for materiality because operationally significant back-office and other expenses would likely fall below this threshold.</li> <li>2. Provision 2.B is also unclear in whether it would limit the parties (individually or combined) from transferring assets that <i>in the aggregate</i> are valued at 10% (or "roughly" \$300 million) of NHS's total assets, or whether it would merely limit the parties (individually or combined) from transferring <i>a single asset</i> whose value is 10% (or "roughly" \$300 million) of NHS's total assets. These differences could have a tremendous effect on the</li> </ol>

<sup>17</sup> We understand that the parties provided this Plan of Separation to the Authority during its review process. See Southwest Virginia Health Authority Report, at 29.

	<p>value of assets that the parties would be permitted to transfer.</p> <ol style="list-style-type: none"> <li>3. Provision 2.B. also does not define the meaning of “Assets used in providing support services,” which leaves the parties with substantial discretion to decide which assets may be transferred without restriction.</li> <li>4. Paragraph 2.C.(3)c) provides no deadline or funding source for appointing new executive officers of the separated hospital systems. Paragraph 2.C.(3) overall likely underestimates the time and resource that would be required to restore the executive management personnel at the separated health systems.</li> <li>5. Paragraph 2.C.(4)a) provides for separation of debt based on debt that each party “brought to the merger,” but this method for allocating debt fails to take into account the actual reasons for the issuance of any NHS debt. Debt may have been issued for the benefit of one or only a few NHS hospitals, so it should not be allocated upon separation based on debt brought into the merger.</li> <li>6. Paragraph 2.C.(4)b) requires cash and marketable securities to be separated in proportion to the parties’ original contribution, but this fails to account for whether (i) one party may have simply had more cash on hand at closing to contribute but whose hospitals may generate lower profits, and thus have contributed less to the available cash reserves at separation, and (ii) the marketable securities being contributed by one party, even if in a smaller amount, may have appreciated at a faster rate than the party contributing more marketable securities at closing.</li> <li>7. Paragraph 2.C.(5) provides that employees would be assigned to their principal place of business/service, but if NHS has closed any hospitals, outpatient facilities, or other medical facilities, then the Plan of Separation does not account for staffing any restored facilities. Further, to the extent a facility provides a service using part-time staff from <i>another</i> NHS facility from the other system, then the first facility could receive no employees to continue to provide these services under this provision.</li> <li>8. Paragraph 2.C.(6) does not make clear whether the credit for service would be full credit or something less.</li> <li>9. Paragraph 2.C.(7) indicates that there would be little clinical consolidation in the Short-Term Period, meaning any cost or quality benefits would be minimal in that</li> </ol>
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	<p>period.</p> <ol style="list-style-type: none"><li>10. Paragraph 2.C.(8) indicates that there would not be full implementation of the Common Clinical IT Platform in the Short-Term Period, meaning the benefits of this system may be limited in that period.</li><li>11. Paragraph 2.C.(9) says that NHS would abide by existing payer contracts and would negotiate in good faith if payers wish to modify or replace existing contracts. If payers wish to do so, however, no provision is made for who would negotiate such contracts on behalf of Mountain States and – separately – Wellmont, since presumably NHS would have only one person leading contracting negotiations with health plans.</li><li>12. The Paragraph 2.C.(10) plan for restoring physicians to the entity that employed them at closing does not account for physician lay-offs or departures that could reduce the number of physicians available to be restored to Mountain States and Wellmont facilities, which could compromise the ability to restore physician services at those facilities.</li><li>13. The Long-Term Plan of Separation is not a real plan, but only a commitment to develop an actual plan of separation. This is not a meaningful commitment or workable proposal.</li><li>14. Paragraphs 3.B.(4) and 3.C. provide that a Proposed Plan shall be submitted within 180 days of notice from the Department that the cooperative agreement has been terminated and that it would be implemented within some indeterminate time after the Final Plan is approved. This means that the actual separation would not occur for well beyond six months after the cooperative agreement is terminated. To the extent that the cooperative agreement commitments would not continue to restrict NHS’s conduct after termination of the cooperative agreement but before the effectuation of separation, NHS would have unfettered ability to exercise its market power.</li></ol>
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