COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Office of Licensure and Certification

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December 22, 2016

Alan Levine
President and CEO, Mountain States Health Alliance
303 Med Tech Parkway, Suite 30
Johnson City, Tennessee 37604

Bart Hove
President and CEO, Wellmont Health System
1905 American Way
Kingsport, Tennessee 37660

Dear Mr. Levine and Mr. Hove:

Having received the Southwest Virginia Health Authority's recommendation that the State Health Commissioner issue a letter authorizing a cooperative agreement between the two health systems and, pursuant to the Code of Virginia, at §15.2-5384.1.F(2), I have attached a set of updated questions that, in consultation with the Office of the Attorney General, Dr. Levine would like responses to in order to begin the formal review process of the request for the letter authorizing a cooperative agreement. The earlier submission of questions sent on August 9, 2016 was intended to provide you with ample time to begin the provision of complete responses. Although many of these questions are the same or similar to the questions that were previously sent to you, I am requesting complete responses to this set of questions and, as you will see, additional information is required.

Please also submit the application fee of $50,000 with your responses.

Should you have questions please contact feel free to contact me at (804) 367-2102 or at Erik.Bodin@VDH.Virginia.Gov.

Sincerely,

Erik O. Bodin, Director
Office of Licensure and Certification

Cc James M. Daniel, Jr.
Hancock, Daniel, Johnson & Nagle, PC

Richard G. Cowart
Baker, Donelson, Bearman Caldwell & Berkowitz, PC

Request for Additional Information
Request for a Cooperative Agreement
Wellmont Health System and Mountain States Health Alliance

Virginia Department of Health

I. Preamble

Please note the following from *Virginia's Rules and Regulations Governing Cooperative Agreements*, 12 VAC 5-221.

"To address the unique healthcare challenges that exist in the Southwest Virginia community, the General Assembly authorized the Commissioner to approve or deny an application for a cooperative agreement following receipt of a recommendation for approval by the authority. To the extent an approved cooperative agreement might be anticompetitive within the meaning and intent of state and federal antitrust laws; it is the intent of the Commonwealth with respect to each participating locality to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the authority. 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. The commissioner is responsible for actively supervising the parties that receive the letter authorizing cooperative agreement to ensure compliance with the provisions that have been approved. Such intent is within the public policy of the Commonwealth to facilitate the provision of quality, cost-efficient medical care to residents of a participating locality." (12VAC5-221-10. Purpose)

Please note the following provisions of §15.2-5384.1. of the Code of Virginia "... if the Commissioner has requested additional information from the applicants, the Commissioner shall have an additional 15 days, *following receipt of the supplemental information*, to approve or deny the proposed cooperative agreement." In addition, 12VAC5-221-80(F) states "The commissioner shall not render a decision on the application until all supplemental information requested has been received."

Please note the following from § 15.2-5368 of the Code of Virginia:

"B. The General Assembly recognizes that rural communities such as those served by the Authority confront unique challenges in the effort to improve health care outcomes and access to quality health care. It is important to facilitate the provision of quality, cost-efficient medical care to rural patients. The provision of care by local providers is important to enhancing, fostering, and creating opportunities that advance health status and provide health-related economic benefits. The Authority shall establish regional health goals directed at improving access to care, advancing health status, targeting regional health issues, promoting technological advancement, ensuring accountability of the cost of care, enhancing academic engagement in regional health, strengthening the workforce for health-related careers, and improving health entity collaboration and regional integration where appropriate.

C. Technological and improved scientific methods have contributed to the improvement of health care in the Commonwealth. The cost of improved technology and improved scientific methods for the provision of hospital care, particularly in rural communities, contributes substantially to the increasing cost of hospital care. Cost increases make it increasingly difficult for hospitals in rural areas of the Commonwealth, including those areas served by the Authority, to offer care. Cooperative agreements among hospitals and between hospitals and others for the provision of health care services may foster improvements in the quality of health care, moderate increases in cost, improve access to needed services in rural areas of the Commonwealth, and enhance the likelihood that smaller hospitals in the Commonwealth will remain open in beneficial service to their communities.

The Commissioner believes that the information requested in this Request for Supplemental Information is necessary to her assessment of whether 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.

II. Instructions

Please provide all responses in PDF and Word formats. Where data or lists are requested please provide the information in PDF and Excel formats. Where necessary use Access format.

If the applicants believe the materials submitted contain proprietary information that is required to remain confidential, such information must be clearly identified and the applicants shall submit duplicate sets of supplemental information, one with full information for the Commissioner's use and one redacted set available for release to the public.

All supplemental information submitted to the Commissioner shall be accompanied by a verified statement signed by the Chairperson of the Board of Directors and Chief Executive Officer of each Party; or if one or more of the Parties is an individual, signed by the individual attesting to the accuracy and completeness of the enclosed information.

As has been done in prior submissions, the Applicants may use consultants to provide the requested detailed five (5) year forecasts.

Contact information shall include: name, title, address, email address and telephone number.

III. Definitions

All defined terms of *Virginia's Rules and Regulations Governing Cooperative Agreements*, 12 VAC 5-221, apply.

"Appendices" shall mean: the 3,791 page document labeled Application for a Letter Authorizing Cooperative Agreement – Exhibits.

"Facility" shall mean "Hospital" as defined in 12 VAC 5-221-20 of *Virginia's Rules and Regulations Governing Cooperative Agreements*.

"Five (5) year forecast period" shall mean FY 2016-2017, FY 2017-2018, FY 2018-2019, FY 2019-2020, FY 2020-2021.[1]

"Five (5) year historical baseline period" shall mean FY 2010-2011, FY 2011-2012, FY 2012-2013, FY 2013-2014, FY 2014-2015.[2]

"FY" shall mean the parties' fiscal year.

"MSHA" shall mean Mountain States Health Alliance.

"NHS" shall mean the proposed New Health System.

"Quantitative measures" means a set of measures used to objectively track the progress of a Cooperative Agreement over time to assess whether its benefits outweigh the disadvantages attributable to a reduction in competition resulting from the Cooperative Agreement.

"Two (2) year historical baseline period" shall mean FY 2013-2014 and FY 2014-2015.[3]
"Virginia facilities" shall mean any facility location in Virginia and operated by MSHA, WHS, or a corporation related to MSHA or WHS.

"WHS" shall mean Wellmont Health System.

"YTD" shall mean year to date.

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[1] Standard exhibits for two (2) and five (5) year historical period, YTD, and five (5) year forecast should list: 1) Service definitions, 2) Utilization statistics, 3) FTE by job class, 4) Revenues and Expense classifications consistent with Medicare cost report department definitions.

[2] Standard exhibits for two (2) and five (5) year historical period, YTD, and five (5) year forecast should list: 1) Service definitions, 2) Utilization statistics, 3) FTE by job class, 4) Revenues and Expense classifications consistent with Medicare cost report department definitions.

[3] Standard exhibits for two (2) and five (5) year historical period, YTD, and five (5) year forecast should list: 1) Service definitions, 2) Utilization statistics, 3) FTE by job class, and 4) Revenues and Expense classifications consistent with Medicare cost report department definitions.

IV. Questions Directly Provided in the Regulations

Provide full and substantive responses for each of the requests for information required by 12 VAC 5-221-70, as listed below with further detail provided regarding the specific information the Commissioner is requesting. If the applicants believe that a full and substantive response has already been provided to the requests contained in 12 VAC 5-221-70, as further detailed below, provide the specific location within the application or attachments where it can be found.

1. A report(s) used for public information and education about the proposed Cooperative Agreement prior to the Parties' submission of the Application. The Applicants shall document the efforts used to disseminate the report(s). The report(s) shall include, but are not limited to:

   a. A description of the proposed Primary Service Area (PSA) and Secondary Service Areas (SSA) and the services and facilities to be included in the Cooperative Agreement. Please provide zip code data and maps for each service hospital and facility. The data and maps should clearly display the primary and secondary service areas for each facility, hospital or service.

   b. A description of how health services will change if the Letter Authorizing Cooperative Agreement is issued. Please provide a description and the date implemented (expected) for each service, hospital and facility for the five (5) year historical baseline, YTD and the five (5) year forecast period.

   c. A description of improvements in patient access to health care including prevention services for all categories of payers and advantages patients will experience across the entire service area regarding costs, availability, and accessibility upon implementation of the Cooperative Agreement and/or findings from studies conducted by hospitals and other external entities, including health economists, and clinical services and population health experts, that describe how implementation of the proposed Cooperative Agreement will be effective with respect to resource allocation implications; efficient with respect to fostering cost containment, including, but not limited to, eliminating duplicative services; and equitable with respect to maintaining quality and competition in health services within the service area and assuring patient access to and choice of insurers and providers within the health care system. Please provide description and data for each service, hospital and facility for the five (5) year historical baseline, YTD and the five (5) year forecast period.

   d. A description of any plans by the Parties regarding existing or planned facilities that will impact access for patients to the services currently offered by the Parties at their respective facilities, including expansions, closures, reductions in capacity, consolidation, and reduction or elimination of any services. Please provide a description and the date implemented (expected) for each service, hospital and facility for the five (5) year historical baseline, YTD and the five (5) year forecast period.

e. A description of the findings from community or population health assessments for the service areas regarding major health issues, trends, and health disparities, including comparisons to measures for the state and similar regional areas, and a description of how the health of the population will change if the Letter Authorizing Cooperative Agreement is issued. Please provide a description and the date implemented (expected) for each service, hospital and facility for the five (5) year historical baseline, YTD and the five (5) year forecast period.

f. A description of the impact on the health professions workforce including long-term employment, wage levels, recruitment, and retention of health professionals. Please provide a description and the date implemented (expected) for each service, hospital and facility for the five (5) year historical baseline, YTD and the five (5) year forecast period.

2. A record of community stakeholder and consumer views of the proposed Cooperative Agreement collected through a public participatory process including meetings and correspondence. Transcripts or minutes of any meetings held during the public participatory process shall be included in the report. Please provide all information received from health insurers in a separate section of this response.

3. A summary of the nature of the proposed Cooperative Agreement between the parties.;

4. A signed copy of the Cooperative Agreement and a copy of the following.

   a. A description of any consideration passing to any Party, individual or entity under the Cooperative Agreement including the amount, nature, source, and recipient;

   b. A detailed description of any merger, lease, operating or management contract, change of control or other acquisition or change, direct or indirect, in ownership of any Party or of the assets of any Party to the Cooperative Agreement;

   c. A list of all services and products and of all hospitals and other service locations that are a subject of the Cooperative Agreement including those not located or provided within the boundaries of the Commonwealth of Virginia, and including, but not limited to, hospitals or other inpatient facilities, insurance products, physician practices, pharmacies, accountable care organizations, psychiatric facilities, nursing homes, physical therapy and rehabilitation units, home care agencies, wellness centers or services, surgical centers or services, dialysis centers or services, cancer centers or services, imaging centers or services, support services, and any other product, facility, or service; and

   d. A description of each Party's contribution of capital, equipment, labor, services, or other contribution of value to the transaction.

5. A detailed description of the current and proposed PSA and SSA for the Parties, including the PSA and SSA of each of the Parties' hospitals, not limited to the boundaries of the Commonwealth of Virginia. If the proposed PSA and SSA differ from the service areas

where the Parties have conducted business over the five (5) years preceding the Application, a description of how and why the proposed PSA or SSA differs and why changes are proposed; These shall include the five (5) year historical baseline period, YTD and the five (5) year forecast period.

6. A description of the prior history of dealings between the Parties for the last five years, including but not limited to, their relationship as competitors and any prior joint ventures, affiliations or other collaborative agreements between the Parties.

7. Documents sufficient to show the financial performance of each Party to the transaction for each of the preceding five (5) fiscal years including tax returns, debt, bond rating, and debt service, and copies of offering materials, subsequent filings such as continuing disclosure agreements and material event disclosures, and financial statements prepared by external certified public accountants, including management reports. This should include a description and summary of all aspects of the financial performance of each party for each of the preceding five fiscal years. Provide supporting documents or reference supporting documents previously provided.

8. A copy of the current annual budget and budgets for the last five years for each Party to the Cooperative Agreement. The budgets shall be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each Party. The budgets shall be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used shall be documented.

9. Projected budgets, including projects costs, revenues, profit margins, and operating ratios, of each Party for each year for a period of five years after a Letter Authorizing Cooperative Agreement is issued. The budgets shall be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used shall be documented.

10. A detailed explanation of the projected effects including expected change in volume, price, and revenue as a result of the Cooperative Agreement including:

    a. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

    b. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties to the Cooperative Agreement, if the Letter Authorizing Cooperative Agreement is issued including changes in percentage of risk-bearing contracts; and

    c. Identification of existing and future business plans, reports, studies or other documents of each party that:

(1) Discuss each Party's projected performance in the market, business strategies, capital investment plans, competitive analyses, and financial projections, including any documents prepared in anticipation of the Cooperative Agreement; and

(2) Identify plans that will be altered, eliminated, or combined under the Cooperative Agreement.

11. A copy of the following policies under the proposed Cooperative Agreement:

    a. A policy that assures no restrictions to Medicare and/or Medicaid patients, including Virginia Medicaid patients receiving services in Tennessee;

    b. Policies for free or reduced fee care for the uninsured and indigent;

    c. Policies for bad debt write-off; and

    d. Policies that require the Parties to the Cooperative Agreement to maintain or exceed the existing level of charitable programs and services.

12. A description of the plan to systematically integrate health care and preventive health services among the Parties to the Cooperative Agreement in the proposed geographic service area that addresses the following:

    a. A streamlined management structure, including a description of a single board of directors, centralized leadership, and operating structure;

    b. Alignment of the care delivery decisions of the system with the interests of the community;

    c. Clinical standardization;

    d. Alignment of the cultural identities of the Parties to the Cooperative Agreement;

    e. Any planned expansions, closures, reductions in capacity, consolidation, and reduction or elimination of any services;

    f. Any plan for integration regarding health professions workforce development and the recruitment and retention of health professionals; and

    g. Any plan for implementation of innovative or value-based payment models.

13. A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services that can be gained only through the Cooperative Agreement including:

    a. Proposed use of any cost saving to reduce prices borne by insurers and consumers;

b. Proposed use of cost savings to fund low or no-cost services designed to achieve long-term population health improvements. Please provide a five (5) year forecast of all "indices" or "measures" which quantify the benefits; and

c. Other proposed uses of savings to benefit advancement of health and quality of care and outcomes. Please provide a five (5) year forecast of all "indices" or "measures" which quantify the benefits.

14. A description of the market and the competitive dynamics for health care services in the Parties' respective service areas, including at a minimum:

a. The identity of any non-Party hospital located in the PSA and SSA and any non-Party hospital outside of the PSA and SSA that also serves patients in the Parties' PSA and SSA;

b. Estimates of the share of "hospital" services furnished by each of the Parties and any non-Party "hospitals";

c. Identification of whether any services or products of the proposed Cooperative Agreement are currently being offered or capable of being offered by any non-Party hospitals in the PSA and SSA and a description of how the proposed Cooperative Agreement will not exclude such non-Party hospitals from continued competitive and independent operation in the PSA and SSA;

d. A listing of the physicians employed by or under contract with each of the Parties' "hospitals" in the PSA and SSA of each Virginia facility, including their specialty and office location(s);

e. The identity of any potential entrants in the Parties' PSA and SSA and the basis for any belief that such entry is likely within the two calendar years immediately following the date the Letter Authorizing Cooperative Agreement is issued by the Department; and

f. A list of each Party's top 10 commercial insurance payers by revenue within the PSA and SSA of each Virginia facility.

15. A detailed description of each of the benefits that the Parties propose will be achieved through the Cooperative Agreement, including at each hospital. For purposes of this paragraph each benefit shall be described by an "index" or "measure". Two (2) year historical baseline period data, YTD and five (5) year forecast period data shall be provided for each "index" or "measure". Please provide the detailed description for each and every "index" or "measure" that has been calculated by the Applicants in the five (5) year historical period. For each benefit include:

a. A description specifically describing how the Parties intend to achieve the benefit defined by each and every "index or measure" utilized by the Applicants in the five (5) year historical baseline period;

b. A description of what the Parties have done in the past with respect to achieving or attempting to achieve the benefits independently or through collaboration and how this may change if the Cooperative Agreement is granted;

c. An explanation of why the benefit can only be achieved through a Cooperative Agreement and not through other less restrictive arrangements (address each "index" or "measure"); and

d. A description of how the Parties propose that the Commissioner measure and monitor achievement of the proposed benefit including the following (address each "index" or "measure"). Please provide a five (5) year forecast by facility for each "index" or "measure".

(1) Proposed measures and suggested baseline values with rationale for each measure to be considered by the Commissioner in developing a plan to monitor achievement of the benefit;

(2) The current and projected levels, and the trajectory, for each measure that would be achieved over the next five years under the Cooperative Agreement. For purposes of Section 15 each benefit shall be described by a "index" or "measure". Two (2) year historical data, YTD and five (5) year forecast data shall be provided for each "index" or "measure";

(3) The projected levels for each measure in five years in the absence of the Cooperative Agreement; and

(4) A plan for how the requisite data for assessing the benefit will be obtained. Describe all information systems presently in use by either Applicant to monitor each "index" or "measure".

16. A description of any potential adverse impact of the proposed Cooperative Agreement on population health, quality, availability, cost, and price of health care services to patients

17. A description of any commitments the Parties are willing to make to address any potential adverse impacts resulting from the Cooperative Agreement. Each such commitment shall at a minimum include:

a. The Parties' proposed benchmarks and metrics to measure achievement of the proposed commitments;

b. The Parties' proposed plan to obtain and analyze data to evaluate the extent to which the commitments have been met, including how data shall be obtained from entities other than the Parties; and

c. The Parties' proposed consequences if they do not meet a commitment.

18. A Plan of Separation. The parties shall provide an independent opinion from a qualified organization verifying the Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the Parties.

    The Plan of Separation shall include but not be limited to the following: "a written proposal submitted with an Application to return the parties to a pre-consolidation state, which includes a plan for separation of any combined assets, offering, provision, operation, planning, funding, pricing, contracting, utilization review or management of health services or any combined sharing, allocation, or referral of patients, personnel, instructional programs, support services and facilities or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by hospitals, including any parent or subsidiary at the time the consolidation occurs or thereafter". (See 12 VAC 5-221-20, definition of "plan of separation")

    The qualified organization shall also specify a detailed task plan and time table to achieve all goals of the Plan of Separation.

    The independent opinion from the qualified organization shall detail a complete three (3) year expense forecast to achieve the goals of the Plan of Separation in an effective and efficient manner. The Applicants shall detail which reserve funds presently under their control shall be used to fully finance the cost of the Plan of Separation.

19. A statement regarding the requirements for any Certificate(s) of Public Need resulting from the Cooperative Agreement.

20. A detailed description of the total cost to the Parties resulting from the Application for the Cooperative Agreement. Cost estimates should include costs for consultant, legal and professional services, capital costs, financing costs, and management costs. The description should identify costs associated with the implementation of the Cooperative Agreement, including documentation of the availability of necessary funds. The description should identify which costs will be borne by each Party. Costs already incurred should be detailed by year, individual, and vendor payment amounts.

21. An explanation of the reasons for the exclusion of any information requested in this section. If the Parties exclude an item because it is not applicable to the proposed Cooperative Agreement, an explanation of why the item is not applicable shall be provided.

22. A timetable for implementing all components of the proposed Cooperative Agreement and contact information for the person(s) authorized to receive notices, reports, and communications with respect to the Letter Authorizing Cooperative Agreement.

23. Records, reports, and documentation to support the information submitted pursuant to this section, including any additional supplemental information requested by the Commissioner.

V. Additional Information

In addition to the information requested above in accordance with Virginia's Rules and Regulations Governing Cooperative Agreements, the Commissioner requests the information as set forth below and deems such information necessary to her assessment of whether to approve the proposed cooperative agreement.

A. Financial (in detail for each facility)

1. Please describe how any bond covenants presently encumber any Virginia facility.

2. Please describe discussions (e.g., meetings, conversations) the applicants have had with any and each bond rating agency or rating official concerning this merger or Application.

3. Please provide the names, positions and contact information of any bond rating agency or rating official that has been communicated with concerning this merger or Application.

4. Provide audited versions of all schedules presented in the audited financial statements at MSHA and WHS for the year end June 30, 2016.

B. Graduate Medical Education

1. Please provide all reports issued by the Accreditation Council for Graduate Medical Education (ACGME) or individual residency review committees for each residency and fellowship program at any NHS facility in the past seven (7) years.

2. Please provide all schedules from the Medicare Cost Reports for the two (2) year historical baseline period detailing graduate medical education activity at any facility that will be part of the NHS. Transcribe these schedules into an Excel file.

3. Please list all residency and fellowship programs, identifying the sponsoring institutions and individuals responsible for each residency and fellowship program. Provide contact information for all responsible individuals.

4. Please provide an organization chart for the graduate medical education (GME) programs currently in place. List the individuals, with their titles responsible for each residency and fellowship program displayed on the organization chart. Provide the contact information for these individuals.

5. Please provide copies of affiliation agreements that exist related to the graduate medical education programs (residency and fellowship).

6. Provide a chart for all facilities showing the resident and fellow FTE positions by program and by location for the two (2) year historical baseline period and the YTD. Provide a five (5) year forecast of FTEs by program and by location. The historical numbers should tie to the Medicare Cost Report data requested above.

7. Please provide two (2) year historical baseline period, YTD and a five (5) year financial forecast period investments by any facility that will be part of the NHS in graduate medical education programs by program and facility. Clearly demonstrate whether the investments proposed are incremental.

8. Please provide detail of all present and planned relationships and affiliations of the NHS GME programs with Virginia institutions of higher education. Please provide the names, positions and contact information for the Virginia institutions concerning NHS GME programs.

9. Edward Via College of Osteopathic Medicine is located at Virginia Tech. Although this college is located outside the intended service area, are there any plans to develop academic or research programs at this or any Virginia institution of higher learning?

C. Research

1. Provide the resumes of the individuals responsible for research at MSHA and WHS. Provide the organizational charts of each existing research program. Indicate in detail how the research programs will be consolidated without having harmful effects on their stated purposes.

2. Provide the revenues and expenses for the two (2) year historical baseline period, YTD, and the five (5) year forecast period for the core research budget. Detail how the core research budget will be financed. Clearly demonstrate whether the investments proposed are incremental or lump sum.

3. Describe by facility any charitable endowment available for medical research. List the amount of the endowment, the type of medical research supported, the year the endowment was received, its duration and when it is expected to culminate in findings.

4. Please provide a listing by facility of any research protocol presently in force at any NHS facility. List the principal investigator of the protocol (and provide contact information). List the NHS investigator (and provide contact information). List the research sponsor (and provide contact information). List the amount of financing from the sponsor and the duration of the research.

5. Please provide all minutes of all committees which have evaluated informed consent and patient participation and protection for the two (2) year historical baseline period and YTD. Please describe in detail all collaborative effort in research with institutions located in Virginia.

6. Please describe the future of the research program at each Virginia facility in the NHS.

7. Describe the strategy by which the NHS will offer research benefits to Virginia residents greater than already offered at other Virginia academic medical centers?

8. For each research protocol list the number of patients and number of Virginia patients for the two (2) year historical baseline period.

9. Provide specific dollar amounts expected to be provided to research programs. Specify dollar amount, research program, issues studied and the expected outcome measures?

D. Tertiary Programs

1. Please detail the utilization by DRG (using VHI and an equivalent Tennessee patient level data base) of Virginia patients from the Virginia geographic service area at each of the three (3) NHS tertiary hospitals in Tennessee and at other Virginia tertiary competitors including Carilion Clinic, Inova, UVA Health System, VCU Medical Center and Sentara Healthcare over the two (2) year historical baseline period.

2. Please provide a DRG based definition of the tertiary services that each Applicant facility provides. This definition should be based on an assessment of DRGs that are uniquely or predominantly provided at an applicant's academic medical center and other Virginia academic medical centers.

3. Please calculate the market share of tertiary service in the Virginia geographic market defined in the Application that is held by each NHS tertiary provider and each Virginia competitor.

4. Assess the strengths and weaknesses in the NHS tertiary program compared to Carilion Clinic, Inova, UVA Health System, VCU Health, and Sentara Healthcare. Be specific for each specialty and sub-specialty program. Describe the strategy by which the NHS will offer benefits to Virginia residents greater than already offered at other Virginia academic medical centers. Justify that investment in the Applicants' academic medical centers is more effective than investment in Virginia competitors.

5. Provide a detailed description of how NHS tertiary programs will be consolidated and improved. Provide a two (2) year historical baseline information for current state, YTD changes and the expected condition for the end of the five (5) year forecast period. Be specific.

6. Why are there no plans for locating tertiary care services in a Virginia hospital or other facility within the merged system?

7. Please provide a listing by diagnostic related grouping (DRG) of the number of Virginia Medicaid patients admitted to each of the three tertiary hospitals for the two (2) year historical baseline period and YTD.

8. Please provide a listing of all physicians and physician groups that provide tertiary specialty services at the three tertiary hospitals. Please provide contact information for each practice. For each practice, list all physicians by specialty and sub-specialty, practice and indicate which have accepted Virginia Medicaid patients during the two (2) year historical baseline period and for YTD, and provide patient volumes by physician.

E. Medical Staff

1. Please provide copies of the existing medical staff by-laws for each Virginia facility of the NHS.

2. For the Virginia facilities, please provide a listing of medical staff members (name, credentials, age, unique physician identification number (UPIN), date of first appointment and specialty or board certifications held).

3. Please provide any report, memorandum or analysis of medical staff shortages developed in the five (5) year historical baseline period by WHS and by MSHA.

4. Please provide a listing of employed medical staff full time equivalents (FTE's) for each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period.

5. Provide documents relating to how past physician acquisitions and physician contractual agreements or affiliations have contributed to the NHS's ability to enter into risk based and/or value based contracts.

6. Consulting firms can typically conduct a physician needs assessment in 90 days. Please explain why this cannot be completed for Virginia facilities within 180 days post-merger?

F. Exclusive Contracts and Other Contracts

1. Please provide a listing of any officer, board member, advisory board member, employee, and their immediate family members that are a party directly or through stock ownership to a contract with either Applicant or their subsidiaries. Please provide financial disclosure statements of these individuals filed during the five (5) year historical baseline period.
2. Please provide a list of any exclusive contracts, by facility, for the provision of medical or healthcare services at each Virginia facility.

3. Please provide a copy of all such exclusive contracts.

4. Provide a list of all Virginia physicians with UPIN and contact information who operate under each exclusive contract. List the Virginia facilities where the physicians practice.

5. What existing groups, organizations, or associations will NHS work with or finance toward achieving the stated goals and commitments?

G. Governance

1. The applicants state that the proposed system will be "locally governed." What is meant by "local"? How will it be ensured that the health concerns of local communities expressed demographically or by the communication of local leaders continue to be addressed after the merger and that local governance is maintained?

2. Please list all current board members of MSHA, WHS and NHS and board or advisory board members for each individual facility in Virginia. For each member listed provide the address of residence, phone number, email address, business position and address and business phone number. Provide their date of actual appointment to the board. Show committee service with date of committee service.

3. What is the total number of MSHA board members? How many reside in Tennessee, in Virginia, or elsewhere?

4. What is the total number of WHS board members? How many reside in Tennessee, in Virginia, or elsewhere?

5. Please provide all disclosure of conflict of interest statements that have been filed in the three (3) most recent years by any board member, executive officer or physician that operates under an exclusive contract with any health care facility.

6. Please provide detail and documents on the current and proposed legal corporate organizational structure of each Virginia facility.

7. The mix of the board of directors and of senior management for the new system appears to parcel out duties equally between Mountain States Health Alliance and Wellmont Health System. How will the mix of the board of directors and senior management at NHS provide for a greater representation of Virginia facilities? Provide specific details.

8. Will NHS Executive compensation be linked to performance metrics designed to ensure that the NHS addresses the unique healthcare challenges that exist in the Southwest Virginia community? If so, please describe the components of the executive compensation system that will be utilized. If not, please explain why.

9. Provide a detailed plan, including an organization chart, for the streamlined management structure at the parent corporation and individual facility level.

H. Banking Relationships

1. Please describe all existing banking relationships by bank and by Virginia facility.

2. Please provide a copy of all banking service agreements in force during the five (5) year historical baseline period.

3. Please provide a listing of all directors, board members, employees, physicians, and their immediate family members that have a fiduciary responsibility in any bank that provides services to the Applicants.

I. Insurance Relationships

1. Please describe all existing insurance relationships by insurance company or carrier and by Virginia facility.

2. Please provide a copy of all insurance policies in force during the five (5) year historical baseline period.

3. Please provide a listing of all directors, board members, employees, physicians, and their immediate family members that have a fiduciary responsibility in any insurance carrier that provides services to the Applicants.

J. Health Insurance Relationships

1. Please describe all existing health insurance relationships by company and by Virginia facility.

   a. This should include plans offered to employees and plans entered into by each health care facility, hospital or service to provide care.

   b. Please provide copies of all such contracts currently in force.

2. Detail any plan, if one exists, for vertical integration or for providing a health insurance product unique to covering services offered by the NHS.

K. Questions Specific to Virginia Medicaid

1. The Application for a Cooperative Agreement excludes Medicaid fee-for-service and Medicaid managed care from the definition of "Principal Payers." *See e.g.* Application, page 10 (n.3). However, the revised Commitments Chart includes "Medicaid plans" as a primary payer.
   a. Describe the New Health System's current status, future plans, and commitments for contracts with Virginia Medicaid, Virginia Medicaid (Medallion) managed care plans, and managed long-term services and supports ("MLTSS" or "CCC Plus") plans. For each, describe the existing contractual agreements for fee increases and explain how they

will be changed under the commitments in the Cooperative Agreement. Also include whether the New Health System will commit to contracts with all of these plans for a specific period of time (include the specific health plan and the commitment for each). Will the New Health System commit to have concurrent contracts with a bare minimum number of Medicaid managed care plans, such as three, for both Medallion and MLTSS/CCC Plus?

b. Will the New Health System commit to include Medicaid fee-for-service and Medicaid managed care plans (Medallion and CCC Plus) for the value-based models and other innovations?

2. The Application commits to three tertiary hospitals (Bristol Regional, Johnson City Memorial, and Holston Valley Medical Center) – all located in the state of Tennessee. Mountain States Health Alliance opened Johnston Memorial Hospital in Abingdon, Virginia. Johnston Memorial provides significant obstetrics and acute care services to Medicaid members in the region. Describe the current and planned array of secondary, as well as tertiary services, offered at Johnston Memorial to meet the needs of Southwest Virginia Medicaid members who, in many cases, are required to travel significant distances over difficult roads and terrain, frequently in inclement weather, to access services at Johnston Memorial. In your description, please highlight services which are not available.

3. The Application, page 35, states that "for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community." Describe how the New Health System will evaluate whether services (including specialty services) are adequate to serve the geographic area. How will the New Health System ensure that services are not discontinued in a way such that it would adversely affect Virginia Medicaid members? Will the New Health System seek input from the Department of Medical Assistance Services or Southwest Virginia Health Authority before discontinuing *any* services?

4. The Application, page 42, states that "The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region." Please provide more information as to what academic institutions will be included. Does this include academic medical centers in Virginia that have established referral patterns in Southwest Virginia, such as the Virginia Tech Carillion School of Medicine and Research Institute in Roanoke and the University of Virginia in Charlottesville?
5. The Application, page 86, states "In the event of repeal or material modification of the Virginia Certificate of Public Need law and/or the Tennessee Certificate of Need law, the Parties solely with respect to outpatient, physician, and additional non-hospital health care services (collectively, the 'non-inpatient services'), reserve the right for the New Health System to enter into exclusive network and 'most-favored nation' agreements with insurers, and to engage in any other competitive practices that comply with antitrust laws regarding the non-inpatient services, notwithstanding the commitments stated in this Application." What written assurances/commitments can be made to avoid the risk of the Medicaid

population being potentially subject to disruption of care and the risks associated with extended travel to New Health System hospitals or medical centers resulting from an "exclusive network"?

6. Mental health, behavioral health, addiction, and substance abuse services are an important component of Medicaid, especially in the region the New Health System will serve. Please describe in greater detail the commitments the New Health System will make to address these needs. Include type of service, location of the treatment providers and facilities, number of beds available, and how decisions will be made as to whether to increase/reduce beds or treatment at a facility or in the community.

7. Please describe in detail the parties' current status, plans, and proposed commitments for the following:
   a. Providing community health support services, such as federally qualified health centers and mobile health/free care clinics, as well as any other means of treatment in rural areas.
   b. Engaging in care management services for Medicaid patients and their families.
   c. Having Medicaid eligibility workers in facilities.
   d. Access to primary care services.
   e. Contracting with the health insurers participating in the healthcare exchange.
   f. Selecting/accepting interns and residents (including, if applicable, any restriction placed on where interns and residents will be accepted from).
   g. Admission privileges for physicians/healthcare providers who are not employed/associated with the New Health Plan.
   h. Any limits placed on specialty/subspecialty treatment for Virginia Medicaid enrollees.

L. Mental Health, Addiction Recovery And Substance Abuse

1. Please describe the mental health, addiction recovery and substance abuse models of care and programs that will be available at each Virginia facility under the NHS.

2. Please describe the merged leadership structure for these programs and its location.

3. Please provide the number of FTE's by position for these programs at each Virginia facility for the two (2) year historical baseline period, YTD and for the five (5) year forecast period.

4. Please provide the utilization statistics for these programs by service type and by patient age at each Virginia facility for the two (2) year historical baseline period, YTD and for the five (5) year forecast period.

5. Please provide a revenue and expense forecast for each of these programs at each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period.

6. Please provide the names and contact information for the individuals presently responsible for mental health, addiction recovery and substance abuse programs at MSHA and WHS and each of their Virginia facilities.

7. Please provide the number of FTEs in these programs by position for the aggregate of all Virginia facilities, for the aggregate of all Tennessee facilities, and for the aggregate of all NHS activity for the two (2) year historical baseline period, YTD, and the five (5) year forecast period. Describe key assumptions of the forecast period.

8. Please provide the utilization statistics by detailed service type for all Virginia facilities, for all Tennessee facilities, and for all NHS activity for the two (2) year historical baseline period, YTD, and the five (5) year forecast period. Describe key assumptions of the forecast period.

9. For each of these programs please provide the revenue and expense detail for all Virginia facilities, for all Tennessee facilities, and for all NHS activity for the two (2) year historical baseline period, YTD, and the five (5) year forecast period. Describe key assumptions of the forecast period.

10. Please quantify the unmet need for each of these services in the Virginia geographic service area.

11. Describe the strategy by which NHS plans to facilitate and coordinate the care of persons in crisis, especially children and adolescents, with the activities and operations of Virginia's community services boards (CSBs).

M. Pricing

1. For each WHS and MSHA Virginia facility provide a listing of each and every third party payer, total revenues and total net revenue from each for the two (2) year historical baseline period, YTD, and the five (5) year forecast period. If the forecast is not retained at the Plan level have the model updated.

2. For the aggregate of MSHA facilities, the aggregate of WHS facilities, NHS facilities in Virginia, NHS facilities in Tennessee and all NHS facilities provide a listing of total revenue and net revenue for each and every third party payer, for the two (2) year historical baseline period, YTD and the five (5) year forecast period. If the forecast is not retained at the Plan level have the model updated. Reconcile this detailed data to the NHS Baseline Financial Model (p. 3639-3651) presented in the Appendices previously submitted.

3. Provide an electronic copy (with documentation) of the NHS Baseline Financial Model. List the contact information of all individuals who developed this model.

4. Provide an electronic copy (with documentation) of the NHS Baseline Financial Model showing each schedule previously presented for the aggregate of the Virginia facilities. Provide PDF and Excel versions of the schedules.

5. Provide a copy of any third party payer contracts governing payments for services to any Virginia facility presently in force (or in force during the two (2) year historical baseline period). Provide the contact information for the individual responsible for these contracts at the third party payer.

6. Please provide the contact information for the individuals responsible for the third party payer negotiations at MSHA and WHS.

7. Please provide a copy of the charge master utilized by MSHA and WHS in the two (2) year historical baseline period (Excel or Access formats only). Show item charges, item total revenue, and item total net revenue for MSHA and WHS facilities for each year.

8. Please provide the charge master currently in force for MSHA and WHS (in Excel or Access).

9. From the charge master for all hospitals, facilities and services (including outpatient and physician services) currently in force at MSHA and WHS create a new unified "baseline least price" charge master. This analysis should compare individual item charges at each system, and show the percent difference between systems(Excel or Access format only).

10. For any charge master item that is a purchased drug, supply or service, list the percent markup in each of the two (2) historical baseline period. Analyze and justify the approach to markups.

11. Please have the CFO at MSHA and the CFO at WHS certify by affidavit that all charge master items are fair and reasonable and were not designed to discriminate between patients and payers with different utilization characteristics. Please have your antitrust consultant(s) provide a similar affidavit.

12. Please provide a copy of any consultant report, internal report or memo, or finance committee or board minutes related to changes in the charge master, pricing strategy or policy, revenue maximization, or similar topics from 2009 to present.

13. Please describe the strategy by which NHS will implement a charge master policy.

    a. Will there be a unified charge master?

    b. How will Virginia facilities be treated?

    c. How will the charge master be different for tertiary teaching facilities and rural facilities?

    d. Will charge master prices be different for the same items in hospitals, outpatient facilities, physician services, or other settings?

    e. In the budgeting process, during which month are charge master prices typically updated?

14. Please provide detailed utilization and revenue statistics for hospital, outpatient and physician services for each Virginia facility for Medicaid Managed Care, Tricare, Medicare Advantage and any other governmental plans for the two (2) year historical baseline period, YTD and the five (5) year forecast period.

15. Please provide detailed utilization and revenue statistics for hospital, outpatient, and physician services for each tertiary hospital for Virginia Medicaid programs, Tennessee Medicaid programs, Tricare, Medicare Advantage, and any other government plans for the two (2) year historical baseline period, YTD, and the five (5) year forecast period.

16. Please provide detailed utilization and revenue statistics for hospital, outpatient and physician services for uninsured patients at each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period. Provide similar aggregate statistics for the Virginia facilities.

17. Please provide detailed utilization and revenue statistics for hospital, outpatient and physician services for charity care patients at each Virginia facility for the two (2) year historical baseline period, YTD and the five (5) year forecast period. Provide similar aggregate statistics for the Virginia facilities.

18. Please describe all changes in pricing implemented by MSHA and WHS since 2009.

19. Describe the applicants' strategy to reduce or restrain pricing for uninsured patients.

20. What are the proposed policies to reduce or restrain pricing for all third party payers including those that have less than 2% of volume?

21. For each Virginia hospital or service use the two (2) year historical basaeline period data to demonstrate quantifiably the impact of applying the proposed pricing mechanisms. Specifically, use the two (2) years of data to model which payors and patients would benefit and which would not. Provide a quantitative analysis of the benefits. Show that the proposed approach is equitable to all Virginia patients.

N. Market Analysis

1. The identity of any Party hospital located in the PSA and SSA and any Party hospital outside of the PSA and SSA that also serves patients in the Parties' PSA and SSA, regardless of state.

2. For each Virginia facility provide a listing of inpatient discharges and inpatient patient days (and a calculation of percentage of each total) by zip code.

a. Map the 75% and 90% service areas of each facility.

3. For each Virginia facility provide total charges (inpatient, outpatient and combined) by zip code.

a. Map the 75% and 90% service area for each statistic.

4. Please provide a supplement to Section 14 of the Application. In this supplement, consider only the Virginia geographic market area that has been defined in the Application. Revise all text and tables to summarize only the Virginia geographic market area that has been defined. For each table column provide absolute numbers and percentages in the columns.

5. Provide appendices which list all competitors that are counted in the supplement tables. Provide the contact information for each listed competitor. Calculate pre and post-merger HHI's[4] for all products, services and facilities. Provide the applicants' assessment of the strengths and weaknesses for each competitor listed.

6. Employ standard analysis to document any unmet and under-met need for product, services and facilities in the Virginia geographic service area. Describe in detail how the applicants' will fill that unmet or under-met need.

7. Please provide any competitor analysis or SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis that MSHA or WHS (or their consultants) have conducted since 2009.

8. Please provide a copy of all requests or orders from the FTC, any other federal agencies and from Tennessee antitrust agencies.

9. Please provide complete copies of all submissions to the FTC or any other federal agency or to any Tennessee agency.

10. Please provide copies of all strategic plans, management plans or operational plans developed for MSHA and WHS since 2009.

11. Specifically, how will the merged system provide information to governmental oversight officials and programs in both states so that the model of merger allows a complete portrayal of operations for sufficient oversight to be maintained and for federal antitrust laws not to be the basis of a legal challenge?

12. What percent of the population of the PSA and SSA will be served by the merged entity? What is the basis for all assumptions made?

13. An assurance that the Parties shall not leverage the market power gained as a result of the Cooperative Agreement to attempt to exclude, harm, or prevent the competitive operation of any actual or potential competing hospitals, services, physician practices, third party payer or facilities within the Parties' geographic service area.

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[4] The Herfindahl-Hirschman index (HHI) is a commonly accepted measure of market concentration.

O. The Virginia Facilities

1. Provide a list of services for each Virginia facility. Indicate which of the services currently offered is a "necessary or needed service", i.e. services that cannot be eliminated without undue disadvantages to Virginia patients. Provide a five (5) year forecast of additional services for each facility indicating necessary services.

2. If there is any intention to remove or consolidate any services over the five (5) year forecast period at any Virginia facility, please detail and justify these intentions.

3. If certain facilities are eliminated or their services are somehow truncated after five years, would the merged system be willing to consider, at that time, making a commitment that the remaining hospitals and services be maintained for a period of years?

   a. If so, please provide a detailed description of a commitment proposed by the NHS.

4. Detail appropriate quality and accessibility standards for each service offered or planned for the NHS. Provide data on these indicators for the five (5) year historical baseline period and YTD period. Provide a five (5) year and ten (10) year specific forecast for improvements based on current physical plant depreciation and useful life schedules.

5. Please explain the implementation milestones and dates over the five (5) year forecast period at each Virginia facility for the following programs:

   a. The Population Health Improvement Program

   b. Expanded Mental Health, Addiction Recovery, and Substance Abuse Prevention Program

   c. Academic and Research Opportunities

   d. Health Information System Improvements

   Be specific in detailing dates and milestones.

6. Provide any Joint Commission report issued for each WHS and MSHA Virginia facility since 2009.

7. Provide a listing by vendor (of services, products, or both) of the thirty (30) highest annual payments by each WHS and MSHA Virginia facility for the two (2) year historical baseline period.

8. Provide any report, analysis, memo, or committee minutes detailing the state of the physical plant condition at each Virginia WHS and MSHA facility, written during the last five (5) years.

a. If renovation or other corrective action was taken to address physical plant issues identified in the provided report, analysis, memo or committee minutes please provide the contract, work order, or other documentation detailing the work done.

9. Is there a model of services or operations (e.g., fee for service, enrolled population, capitation, etc.), that will be offered at the different NHS Virginia facilities? Describe for each Virginia facility.

10. Please provide revenue and expense statistics for each NHS Virginia facility for the five (5) year historical baseline period, YTD and the five (5) year forecast period.

11. Please provide detailed capital expense statistics for each NHS Virginia facility for the five (5) year historical baseline period, YTD and the five (5) year forecast period.

12. Please provide detailed break-down of FTE statistics by position for each NHS Virginia facility.

13. Please describe all clinical efficiencies at each Virginia facility expected to result from the merger. Detail when each will be implemented.

14. The applicants state that the merger will result in savings equal to the level of spending of a new $750,000 foundation. How was this calculated?

15. In the event that the merger is unwound due to unanticipated negative effects, and the plan of separation needs to be implemented, how do the applicants plan to maintain the smooth operation of the affected hospitals and facilities within the merged system, and prevent undue disruption so that existing access to health care services continues to be maintained? Will such a plan have a Virginia-specific component?

16. How will the applicants respond if only one of the states, either Tennessee or Virginia, decides to approve the cooperative agreement? Will the response be different if Tennessee approves and Virginia declines, or vice versa?

17. If the merger is approved by both states, how do the applicants plan to satisfy the need for health care if one state decides, or both states decide, later, that the benefits of the merger no longer outweigh the disadvantages attributable to the reduction in competition resulting from the merger?

18. To provide and promote access to health care, are there any plans for introducing mobile services and clinics to compensate for the lack of public transportation in the rural parts of the service area, especially those in Virginia?

19. Legal documents contained in the exhibits to the application indicate that Tennessee law was chosen to govern and interpret the merger agreement. How does this decision not place the merged system's Virginia hospitals and services at a disadvantage?

20. Are there any plans for directly providing access to needed health care services for residents of Lee County in the wake of the closure of Lee Regional Medical Center on October 1, 2013?

21. What is the specific strategy for NHS to align itself, as its application states it will, with the Virginia Plan for Well-Being developed in 2016? The Virginia Plan for Well-Being can be viewed at http://www.vdh.virginia.gov/Administration/VPfWB/.

22. While the NHS will develop pediatric specialty centers in Kingsport and Bristol, Tennessee, and deploy pediatric telemedicine and rotating specialty clinics to serve rural hospitals, is there a specific behavioral health component to this program? Will Virginia's needs be disproportionately met through the use of telemedicine?

23. In the application, it is stated that "labor efficiencies" will accrue from the merger. At many of public fora, such as town halls, held by MSHA and WHS in the service area, substantial concerns were voiced by members of the independent systems' workforce regarding employment post-merger. How do the applicants plan to ameliorate such concerns so that the NHS has a vibrant, well-trained and committed workforce that is satisfied with compensation, pay rates and benefits? Will efficiencies in the workforce accrue only from attrition or will there be steps taken that would tend to disrupt employees' satisfaction?

P. Population Health

1. Please describe the specific strategy to develop an integrated health system that will impact the agreed upon population health issues in the Virginia PSA and SSA.

2. Please list each Virginia facility that will adopt the concept of a "medical home".

   a. Detail the medical staff model at each Virginia facility to support this concept, or any other concept that emphasizes primary care and continuity of care.

   b. Detail the quantitative benefits of the number of patients in "medical home arrangements" for the two (2) year historical baseline period, YTD and the five (5) year forecast period.

3. Please detail the number of patients by county that either MSHA or WHS have by managed care fee for service and other arrangements in conjunction with their employed physicians in the two (2) year historical baseline period and YTD for each Virginia facility. Provide a five (5) year forecast for each Virginia facility. List the number of physicians by specialty that will be recruited by the NHS to enhance the percent of population under care.

4. Please describe the NHS program for women's services. For each NHS facility list the specific services for women. List any women's service that will not be provided at any Virginia or tertiary facility. Provide a two (2) year historical baseline period analysis of each

service, YTD and a five (5) year forecast of the women's services for each Virginia hospital or facility. Describe how the program will enhance benefits for women.

5. The applicants state that, over ten years, $75 million will be invested in population improvements, $140 million will be invested to expand mental health, addiction recovery, and substance abuse prevention programs, $85 million will be invested in developing research opportunities, and $150 million will be invested in developing health information systems. Describe the strategy for making these investments. With whom will these investments be made? Are these amounts net increases? Provide a two (2) year historical baseline period analysis, YTD and a five (5) year forecast which clearly demonstrates the net amounts. Show amounts in Virginia and Tennessee. How much of these totals are allocated and expended by Virginia facilities to improve health care in Virginia alone? Provide a two (2) year baseline for each Virginia facility and a ten (10) year forecast. How does the merged system plan to periodically demonstrate its progress in these areas and show its accountability?

6. How do the applicants plan to ensure that the resulting merged system will use savings that accrue from the merger to develop, as an exhibit to the application states, "best practice interventions aimed at the underlying causes of poor health in vulnerable populations"?

7. How will the presumed improvements in the various aspects of community health be evaluated and demonstrated? Be specific.

8. What are the unprofitable programs and services that the merger would allow the system's constituent hospitals to maintain? Be specific. Demonstrate the profit level of these programs with two (2) year historical baseline period, YTD and five (5) year forecast.

Q. Regional Exchange Of Health Information and Information Systems

1. Please provide any hospital long term information plans (including any consultants' reports) that have been developed at MSHA and WHS since 2009.

2. Provide documents relating to both merging parties' plans for electronic health records systems, including documents showing the current systems each is using now, plans to convert to a single records system, including its identity (including a timeline), expected benefits of the system versus using the health information exchange (HIE), and any consultant reports.

3. Provide documents relating to HIEs used by each merging party, including current usage, how information is shared, fees/costs/dues paid to use the system, how many other providers (physicians, outpatient facilities, or hospitals) currently use the system, how records are shared, the extent of patient records included in the exchange, and any consultant reports.

4. Provide documents relating to any plans to create the Common Clinical information technology (IT) platform, including any internal analyses and consultant reports.

5. Provide documents relating to any culture audits and any governance studies or audits conducted internally or externally, including the ultimate findings and any consultant reports.

6. Provide documents relating to MSHA's and WHS' use of tele-medicine in the area, including grant money obtained to develop and deploy such systems.

7. For MSHA and WHS list the existing hardware (major components) and existing software licenses by IT Vendor for hospital, outpatient, and physician information systems. Detail which hardware and software capabilities of the system are available in each Virginia facility. Provide copies of major systems software license agreements.

8. By position list the five (5) year historical period, YTD and five (5) year projected information system FTEs for the NHS, MSHA, WHS, the Virginia facilities, the MSHA facilities in Virginia and the WHS Virginia facilities.

9. By operating budget, list the five (5) year historical period, YTD and five (5) year projected information systems for the NHS, MSHA, WHS, the Virginia facilities, the MSHA facilities in Virginia and the WHS Virginia facilities.

10. By capital budget list the historical, YTD and five (5) year projected information systems for the NHS, MSHA, WHS, each of the Virginia facilities, the MSHA facilities in Virginia and the WHS Virginia facilities.

11. Please detail the five (5) year consolidation plan for information systems transition to information systems in NHS from MSHA and WHS.

12. Please provide the FTE operating and capital statistics for any regional data center located in Virginia during the five (5) year historical period and YTD. Detail the benefits. Provide these data for the five (5) year forecast period. If no Virginia regional data center exists or is proposed please explain why.

13. Explain your approach to the investment in high tech information systems jobs in Southwest Virginia.

14. Provide the applicants' anticipated five (5) and ten (10) year timeline with milestones for development and implementation for the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. If none presently exist, will one be developed? At a minimum, the timeline should include targeted objectives for each year following the formation of the NHS, including target dates for the following activities:

    a. Behavioral health capability. If the chosen Clinical IT system does not currently include

a behavioral health module, detail the applicants' plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors and any opportunities for facilitating the NHS' collaboration with Virginia's CSBs.

b. Integration of systems and/or linkage of records (medical, lab, pharmacy, diagnostic, and referral/scheduling).

c. Migration and/or archiving of pre-existing records.

d. Training for new users (System and non-System providers).

e. Patient access to information and protection of such information.

f. Capabilities for collecting, analyzing, and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers(System and non-System).

15. Provide estimates for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, and population health management and quality reporting capabilities. If relevant, provide estimated costs to offer EHR solutions for non-System providers, and estimated expenses to support connectivity for non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.

16. Please indicate what cost accounting and decision support information systems are utilized by each Applicant.

a. Provide copies of all standard annual and monthly reports produced during the two (2) year historical baseline period for each Virginia facility, hospital and service. Provide examples of all special user generated reports from these that are routinely used by the Applicant in the normal course of business.

b. Provide a copy of the standard cost accounting, decision support, budgeting and accounting system reports that were periodically provided to the Board of Trustees of each Applicant's during the two (2) year historical baseline period.

17. Please indicate what quality reporting systems are utilized by each Applicant.

a. Provide copies of all standard annual and monthly quality reports produced during the two (2) year historical baseline period for each Virginia facility, hospital and service. Provide examples of all special user generated reports from these that are routinely used by the Applicant in the normal course of business.

b. Provide a copy of the quality reports that were periodically provided to the Board of

Trustees of each Applicant's during the two (2) year hospital baseline period.

R. Charity Policies

1. Large multi-hospital systems in Virginia typically provide sliding scale reductions for individuals and formulize between 200% and 450% of the Federal poverty level. Please provide a detailed analysis of the cost of doing this for Virginia and Tennessee facilities in the NHS.

S. Salaries

1. Please provide a listing of the highest paid 100 employees in Virginia and in Tennessee for each Applicant showing name, gender, race, ethnic background, job title and annual salary, benefits and bonuses during the two (2) year historical baseline period.

2. Conduct a salary analysis by each job class in each system by race and gender. Analyze the data. If inequalities exist provide a five (5) year forecast to correct them.

3. Provide all minutes of the Compensation Committee of each WHS and MSHA facility's board over the five (5) year historical baseline period.

4. Provide copies of all studies of compensation conducted in the normal course of business over the last five (5) years.

T. Additional Questions

1. Provide information on the structure of Virginia physician practices to calculate the appropriate physicians' market share of the patient population. The bargaining power of a single physician is not equal to the bargaining power of a physician group. Therefore, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required. Please have the applicants' antitrust consultant certify these analyses.

2. Recalculate market shares using appropriate geographic market and output measures for the Virginia geographic market. Please have the applicants' antitrust consultant certify these analyses.

3. Provide a copy of the nonbinding April 2, 2015 Term Sheet referenced in the Master Affiliation Agreement and Plan of Integration, page 1 paragraph 6.

4. Provide the following exhibits referenced in the Master Affiliation Agreement, page 56:

   a. Exhibit C-1: Interim Parent Company Articles and Interim Parent Company Bylaws.

   b. Exhibit C-3: Amended Parent Company Articles.

   c. Exhibit C-4: Amended Parent Company Bylaws.

5. Identify any potential disadvantages that may result from the Cooperative Agreement in detail for each Virginia facility.

6. Detail whether the NHS intends to increase its market share in Virginia or West Virginia. If so, provide a forecast for the five (5) year forecast period.

7. Provide the number of current insurance contracts that represent less than 2% of patient services revenue. List the contracts. Provide a copy of the contracts.

8. Identify any potential insurers that would represent less than 2% of patient services revenue that do not currently contract with either system. Provide contract information.

9. Detail the percent of current insurance contracts that have fixed rate increases as written. Provide the amount and timing of these currentlyplanned fixed rate increases. These rates may be aggregated separately for MSHA and WHS if the mean and standard deviation of the planned fixed rates are included.

10. Provide the rate increases negotiated with third party payers for the past five years. These increases should be calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician, or non-hospital outpatient services.

11. Detail the proposed methodology to cap negotiated rates, including whether contractual out-of-pocket payments will be included.

12. Detail how the NHS will handle price setting for uninsured or private pay patients.

13. Provide the total amount detailed in the reports from MSHA and WHS, referenced in the Master Affiliation Agreement Section 10.04(d), setting forth all expenses incurred by the parties. Include justification for the above amount. Detail all additional merger-related expenses, including capital costs and management costs. Provide documentation of the availability of the necessary funds.

14. Provide additional detail on the activities to be funded by the following proposed community reinvestment: 1) the $75 million investment in population health improvements; 2) the $140 million to expand mental health, addiction recovery, and substance abuse prevention programs; and 3) the $85 million to develop and grow academic and research opportunities. How much of these totals are allocated to improve health care in Virginia alone? Provide two (2) year historical baseline period financial data, YTD and five (5) year forecast data for each program. Demonstrate that the investment net revenue is incremental revenue. How does the NHS plan to periodically demonstrate its progress in these areas and show its accountability?

15. Provide an updated amount of net expenditures on community health improvement, health professions education, and research as detailed on the applicants' most recent IRS Form 990 Schedule H.

16. Detail whether a $75 million investment in population health over ten years represents an increase in spending over that of past community health investment, and if so, provide an estimate of the aggregate planned population health investment.

17. Detail whether an $85 million investment in research and training over ten years represents an increase in spending over that of past research and training investment, and if so, provide an estimate of the aggregate planned research and teaching investment.

18. Compare and contrast the type of programs currently funded by Community Benefit spending, particularly in the categories above, with the planned investment over the next ten years.

19. Provide the audited financial statement for MSHA as of June 30, 2015. Provide the June 30, 2016 audited financial statements for MSHA and WHS. (See Exhibits 11.4-F)

20. Provide the current status regarding Fitch's Rating Watch for MSHA.

21. Provide the report prepared by FTI Consulting, Inc., i.e., the report that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger.

22. Detail how an additional layer of governance (i.e., the parent company) benefits the organization.

23. Provide an organizational chart for the resulting NHS.

24. Provide documents showing quality metrics for Unicoi Hospital before its acquisition by MSHA.

25. Provide documents from 2009 through 2012 relating to any plans, proposals, or bids to acquire Unicoi hospital.

26. Provide all documents relating to the opposition mounted by MSHA to prevent WHS from constructing a new hospital facility and emergency room in Washington County where MSHA operates its Johnson City hospital.

27. Provide documents, prepared in the ordinary course of business, relating to the merging parties' business plans, short term and long range strategies and objectives, and budget and financial projections covering the next five years as either a stand-alone or affiliated system.

28. Provide documents relating to each merging party's accountable care organization (ACO) and Shared Savings arrangements, and whether the ACO or Shared Savings arrangements are hospital-led or physician-led. Separately, for each physician, mid-level practitioner, or other health professional on whose behalf the merging party negotiates with health insurance plans or is reimbursed based on a health insurance plan's rate schedule with the party, or with whom a party has an affiliation or contractual arrangement, list:

a. Name;

b. Medical specialties;

c. Current office practice address or addresses;

d. Whether he or she has an affiliation agreement with the merging party (IPA, ACO or any other affiliation or contractual arrangements). Identify these arrangements.

e. Date on which he or she was acquired, employed by, and/or affiliated with the merging party; and

f. The number of patients he or she treated in each of the previous five years.

29. How do the applicants plan to ensure access within customary drive times to various health care services after five years if certain facilities are closed or services are eliminated? Are there plans, nascent or otherwise, to close any facility? Specifically, under the merger, there would be two hospitals located in Norton, Virginia. Are there any plans to cease operations of one of them?

30. Should the Lee County Hospital Authority fail to complete its project to reopen the former Lee Regional Medical Center as a critical access hospital, how do the applicants plan to meet the health care needs of the people in Pennington Gap and the surrounding area?

31. Do the price cap agreements apply to value-based or population-health contracts NHS signs with insurers?

32. Is there any other information known to or reasonably anticipated by the Applicants that would reveal anything important or helpful to the Commissioner in her statutory obligation to weigh the advantages and disadvantages of the proposed merger or to actively monitor the NHS?

33. Provide a copy of the full response MSHA sent to any request for proposals, or similar request, issued by WHS in or about 2014 related to their interest in engaging in a merger, acquisition, contract management or other such arrangement.

34. Has there been any discussion or have the Applicants been approached regarding the ultimate sale of the merged entity?

35. Provide a monetary value to the merger verses continued individual operation of the two systems.

36. Provide a complete copy of the "FTI" report.