

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

December 22, 2016
The Southwest Virginia Health Authority

Preface

The health care policy of the Commonwealth of Virginia related to Southwest Virginia dramatically changed during the 2015 session of the Virginia General Assembly with the adoption of a series of amendments to the authorizing legislation of the Southwest Virginia Health Authority. These legislative actions signed into law by the Governor of the Commonwealth of Virginia on April 15, 2015 created a process to enable the approval of a cooperative agreement to facilitate the provision of quality, cost-efficient medical care to rural patients even in other anticompetitive situations. The legislative policy applies solely to health care in the jurisdictions of the Southwest Virginia Health Authority.

On February 16, 2016, Mountain States Health Alliance and Wellmont Health System delivered an application for the approval of a cooperative agreement to the Authority for consideration. ***“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”*** presents both a brief overview of the material submitted by the Applicants for authorization to enter into a cooperative agreement in Southwest Virginia and highlights of the input provided by many stakeholders as well as a record of the process the Authority undertook to reach its decision.

Our report provides background on the Southwest Virginia Health Authority and a record of the actions we took on the application submitted by the Mountain States Health Alliance and Wellmont Health System.

This report is not intended to be a fully comprehensive representation of all of the information considered and reviewed by the Authority or a complete documentation of every issue researched, discussed or debated. The volume of the information prevents such a detailed report.

The Authority hopes this report informs the reader of the mission of our Authority, the unique challenges our region confronts, the actions undertaken by the Authority in review of the application for approval of a cooperative agreement in Southwest Virginia, and the decision we reached.

For more information, please visit the Authority’s website at www.swvahealthauthority.net.

Acknowledgements

The Southwest Virginia Health Authority wishes to acknowledge the contributions of Dennis Barry, Esq., and Richard Brownlee, Ph.D., and Tom Massaro, M.D. for their insight, guidance and assistance in the review of the Application, Ms. Delilah McFadden for her ongoing support of the Authority, and to Ashley Russell, for her assistance throughout our consideration of the Application.

We express our gratitude to the FTC staff for their engagement in our process. As noted several times, they are all bright, intelligent, engaging people.

We acknowledge the contributions of the insurance community and their associations, including the information made available to us, during our deliberations. We appreciate their participation in our review.

Finally, we offer our sincere appreciation to the people of Southwest Virginia and the health care providers who endeavor every day to provide their care. You inspire us.

Table of Contents

The Southwest Virginia Health Authority	1
Organization and Membership.....	2
The 2009 Report: A Regional Blueprint For Health Improvement and Health Prosperity.....	3
2011 Blueprint Progress Report	4
Southwest Virginia: A Unique Region and Challenge.....	9
Cooperative Agreements in Southwest Virginia	11
The Virginia Process for Cooperative Agreements	13
The Role of the Southwest Virginia Health Authority	13
The Role of the Virginia Commissioner of Health	15
The Federal Trade Commission	17
The Pre-Submission Report.....	18
The Application For A Cooperative Agreement	22
The Wellmont Health System Strategic Process	23
The Applicants Propose a Unique Solution For Southwest Virginia.	24
The Proposed Primary Service Area	25
The Applicant Assessment of Benefits and Advantages.	26
The Applicant Commitments	27
Potential Disadvantages of the Cooperative Agreement.....	27
Alternatives to the Cooperative Agreement.....	28
The Projected Effects of the Cooperative Agreement on Volume, Price and Revenue.....	28
Measuring Achievement of Commitments.	28
Governance of the New Health System.....	28
Separating the Parties.....	29
Our Review of the Application	30
Delivery of the Application	30
Board Member Conflicts.....	32
The Authority Working Groups.....	33
Health Care Quality Working Group.....	36

Population Health Working Group.....	38
Health Care Access Working Group.....	38
Health Care Cost Working Group	40
Competition Working Group	40
Working Group Questions	40
Engagement of Staff	43
Active Promotion of Authority Activity.....	44
America’s Health Insurance Plans	44
Lee County Hospital.	44
Virginia Association of Health Plans	45
Presentation by The Applicants	46
The Completeness Determination	46
Virginia Association of Health Plans Objections to Application Status	49
Staff Recommendation on Completeness.....	50
Public Comment	50
A Summary of Written Public Comment.....	50
Community Written Public Comment	50
Written Public Comment from the Federal Trade Commission	51
Response of the Applicants to the Staff Written Comments	55
Written Public Comment From the Payer Community.....	56
Anthem Health Plans of Virginia, Inc.	56
Virginia Association of Health Plans	57
America’s Health Insurance Plans	57
Applicant Response to Written Public Comment.....	58
The Public Hearing.....	59
Final Review of the Application	67
The Federal Trade Commission Meeting	67
Preliminary Comments of the Staff of the FTC	67
A Review of Competition by the FTC Staff	69

A Review of the Economic Analysis and Alternative Arrangements	70
A Review of the Commitments by the Staff of the FTC.....	72
Comments on The Plan of Separation and the Commitment Enforcement Mechanism	74
A General Discussion of the Application with the Board of Directors.....	74
Investigation Overview.....	74
Role of FTC Staff	74
Comparison of Virginia Statute and FTC Merger Guidelines.....	75
Other Cooperative Agreements.....	75
Impact of Public Support for Cooperative Agreement.....	75
Information Considered by the FTC Staff	75
Impact of Anthem Market Size	75
Size of Merger.....	76
Examples of Commitments.....	76
The Effect of Competition on the Rural Hospitals.....	76
Virginia Legislative Process.....	76
Affordable Care Act	77
Self-Insurers.....	77
Impact of Competition on Health Outcomes.....	77
Out-Of-Market Acquisition of Both Applicants.....	94
City of Norton and Wise County	94
Merger-Specific Savings	94
Substance Abuse Services.....	95
Examples of Other Commitments.....	95
Authority Staff Questions.....	95
Savings.....	95
Contentious Provider-Payer Negotiations.....	95
Challenges to Applicant Responses	96
Challenges to the Applicant Response to FTC Comments	96
Uniqueness of Southwest Virginia.....	96

Samples of Other Commitments.....	96
Board Discussion with FTC Staff	97
Final Public Comment.....	98
Public Comment – VAHP Response to Federal Trade Commission Staff.....	98
Final Presentation of the Applicants to the Authority	99
Alternative Options.....	99
FTC Staff Position: Merger is Anti-Competitive	100
A Call To Rely Upon Evidence.....	100
Enforcement	100
Other Cooperative Agreements.....	101
Investment	101
Alternative Approaches	101
Governance of the New Health System.....	102
Pricing Cap Concerns.....	102
Out-of-Market Job Impact	102
Rural Feeder Hospitals	103
Options and the Region	103
Question: 2% Payer Issue.....	103
Value-Based Reimbursements	104
Barriers For Entry	104
Substance Abuse Commitment.....	104
New Entrants In the Market	104
Price Cap Versus Price Floor	104
Lee County	105
Negotiating Strength and Price Caps	105
Essential Services	106
Strategic Behavioral Health.....	106
Repurposing Faculties	106
Hospital Emergencies.....	106
Health Information Systems	106
Local Hospital Boards.....	107
Requiring Stronger Commitments	107

Staff Presentation on Commitments.....	107
Staff Presentation to the Board	107
Staff of the Southwest Virginia Health Authority	107
Staff Reaction to the FTC.....	108
A Different Approach.....	108
Competition in Wise County.....	109
A Review of Whether Competition Works in Southwest Virginia	109
A Review of the Commitments	109
A Change of Circumstances	110
The Applicants' Financial Strength	110
Commitment Enforceability.....	110
Competition.....	111
The Authority's Role Going Forward.....	111
The Staff Opinion.....	111
The Opinion of Professor Brownlee	112
Brownlee: A Unique Solution for Southwest Virginia.....	112
The Comments of Dr. Tom Massaro	113
A Review of the Benefits and Disadvantages	114
The Revised Commitments.....	117
Accountability Scoring Revisions.....	151
Additional Information About the Wellmont Process	154
RECOMMENDATION.....	156
Culmination of the Review	156
Parameters of Consideration.....	156
A Review of the Benefits.....	159
Benefit: Quality of Care	159
Benefit: Population Health Improvement	160
Benefit: Facilities.....	161
Benefit: Cost-Efficiency Improvements.....	161
Benefit: Improvement in Utilization of Resources.....	161

Benefit: Avoidance of Duplication of Resources	162
Benefit: Participation in Medicaid	162
Benefit: Total Cost of Care	162
Other Benefits	163
Board Consideration of the Disadvantages	163
Disadvantage: Payer Ability to Negotiate	164
Disadvantage: Reduction in Competition Among Providers	165
Disadvantage: Quality, Availability, and Price	165
Disadvantage: Availability of Less Restrictive Alternatives	165
Other Disadvantages	166
A Weighing of Benefits and Disadvantages	166
Recommendation of the Authority	167
A Weighing of Likely Benefits and Likely Disadvantages?	167
Recommendation For Approval	167
Conclusion	168

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Members of the Southwest Virginia Health Authority

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* Denotes a member who has declared a conflict of interest pursuant to Section 2.2-3100, et seq. of the Code of Virginia or is prohibited from participating in the Authority's deliberation of the Application as set forth in Section 15.1-5384.1(D) of the Code of Virginia with respect to consideration of the Commonwealth of Virginia Application for a Letter Authorizing Cooperative Agreement Pursuant to Virginia Code §15.2-5384.1 and the regulations promulgated thereunder at 12 VACS-221-10 et seq. submitted by Mountain States Health Alliance and Wellmont Health System on February 16, 2016.

The Southwest Virginia Health Authority

The health of the economy and the health of the region remain closely connected in Southwest Virginia. The Virginia General Assembly created the Southwest Virginia Health Authority (the “Authority”)¹ to “confront unique challenges in the effort to improve health care outcomes and access to quality health care,”² further noting the importance of coordinating “quality, cost efficient medical care to rural patients.”³

Significant geographic challenges complicate the delivery of health care in Southwest Virginia. Many demographic factors make health care availability critical and

The Authority initially encompassed the counties served by the LENOWISCO Planning District Commission (County of Lee, County of Wise, County of Scott, and City of Norton) and the Cumberland Plateau Planning District Commissions (County of Buchanan, County of Dickenson, County of Russell, and County of Tazewell). Later, the General Assembly added the County of Smyth, the County of Washington and the City of Bristol to membership in the Authority.⁴

The General Assembly directed the Authority to 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.⁵ The Authority launched its work on this mission in 2007.

Southwest Virginia Health Authority

VISION

TO ACHIEVE CONTINUOUS IMPROVEMENT IN THE HEALTH AND PROSPERITY OF THE REGION.

MISSION

TO IMPROVE QUALITY OF LIFE IN THE REGION BY ENHANCING, FOSTERING, AND CREATING OPPORTUNITIES THAT ADVANCE HEALTH STATUS AND PROVIDE HEALTH RELATED ECONOMIC BENEFITS FOR PEOPLE OF ALL AGES.

VALUES

COLLABORATIVE.
FLEXIBLE AND ADAPTABLE.
INNOVATIVE.
DATA-DRIVEN AND EVIDENCE BASED.
INCLUSIVE.
HOMEGROWN.
INTEGRATIVE.
ACCOUNTABLE TO COMMUNITY.
HAVING INTEGRITY.

¹ The Virginia General Assembly enacted Chapter 53.1 under Title 15.2 of the Code of Virginia. Originally formed as the Southwest Virginia Health Facilities Authority, the word “Facilities” was eventually dropped from the name by the legislature.

² VA CODE ANN. §15.2-5368(B).

³ VA CODE ANN. §15.2-5368(B).

⁴ VA CODE ANN. §15.2-5370.

⁵ VA CODE ANN. §15.2-5368(B).

Organization and Membership

The membership of the Board of Directors of the Authority includes a wide range of regional health leaders, health care providers, local representatives and members of the Virginia General Assembly. By statutory requirement, the following organizations and individuals serve on the Board of Directors of the Authority:⁶

- The Executive Director for the Coalfield Economic Development Authority, or his designee;
- The Chief Executive Officer of the Norton Community Hospital located in the City of Norton, Virginia, or his designee;
- One representative from the Lonesome Pine Hospital;
- The Chief Executive Officer of the Virginia Community Healthcare Association, or his designee;
- The Chief Executive Officer of the Russell County Medical Center, or his designee;
- The Chief Executive Officer of the Clinch Valley Medical Center, or his designee;
- The District Health Director for the Cumberland Health District, or his designee;
- The District Health Director for the LENOWISCO Health District, or his designee;
- The Dean of the University of Virginia School Of Medicine, or his designee;
- The Dean of the School of Dentistry at the Medical College of Virginia of Virginia Commonwealth University, or his designee;
- The Dean of the Lincoln Memorial University-DeBusk College of Osteopathic Medicine, or his designee;
- The Chancellor of the University of Virginia's College at Wise, or his designee;
- The President of the East Tennessee State University Quillen College of Medicine, or his designee;
- The President of Frontier Health, or his designee;
- The President of the University of Appalachia College of Pharmacy, or his designee;
- The President of the Edward Via Virginia College of Osteopathic Medicine, or his designee;
- The Chairman of the Board of the Southwest Virginia Graduate Medical Education Consortium, or his designee;
- Two members of the Senate to be appointed by the Senate Committee on Rules;

⁶ VA CODE ANN § 15.2-5370.

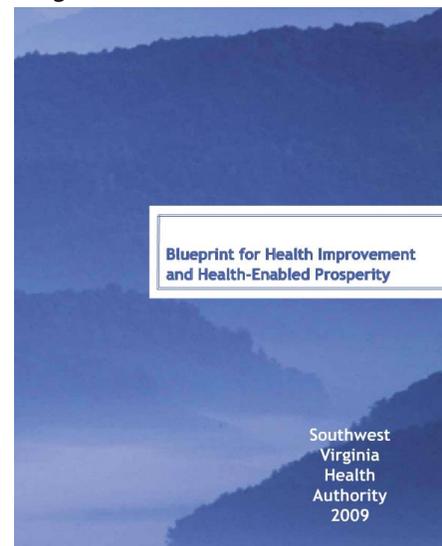
- Two members of the House of Delegates to be appointed by the Speaker of the House of Delegates in accordance with the principles of proportional representation contained in the Rules of the House of Delegates;
- One member appointed by the County of Buchanan, the County of Dickenson, the County of Lee, the County of Russell, the County of Scott, the County of Tazewell, the County of Wise, and the City of Norton, and,
- One member may be appointed from the County of Smyth, the County of Washington, and the City of Bristol.⁷

For over a decade, the Authority and the regional health care leaders serving on the Board of Directors have invested significant time developing strategies, monitoring the progress of the region's health, and promoting the connection between a healthy workforce and prospering families. In late 2007, shortly after the Authority's creation, the Board of Directors of the Authority concluded that a formal strategic blueprint was needed to help direct operations and future projects. The Authority met, in conjunction with the Healthy Appalachia Institute at the University of Virginia College at Wise, a regional collaboration among critical thinkers, scholars, system planners and leaders in government, education, business and health care who promote resources, ideas and strategies to foster a healthier citizenry in Central Appalachia. The Authority reviewed health care data and held a planning retreat in May 2008. Several months later, the Authority released its first comprehensive report.

The 2009 Report: A Regional Blueprint For Health Improvement and Health Prosperity

On June 10, 2009, the Authority released the first definitive regional health assessment and strategic plan for improving quality of life in the Southwest Virginia by addressing health related issues entitled: *"Blueprint for Health Improvement and Health Enabled Prosperity."*

This document summarized the region's health challenges and provided information on the circumstances confronting in Southwest Virginia's coalfields as well as a comprehensive plan for improving the health and quality of life of the region. This Blueprint sought to concentrate the activities of the Authority for the foreseeable future toward a specific set of goals, which would be updated from time-to-time. The Blueprint set forth twenty goals for addressing the health of region covering a range of subjects including improving the health status of the region, advocating for effective care payment systems in the region and payment parities, improving access to health care providers, improving health entity collaboration and integration where appropriate, seeking partnership and collaboration with hospitals to enhance services, improving health career workforce development,



⁷ The term of the local representatives is staggered, as set forth in VA CODE ANN § 15.2-5370.

enhancing academic engagement in regional health, improving the quality of life for at-risk children and families in the region, increasing resources for mental health and substance abuse, advocating for job creating economic incentives, supporting regional education and economic development efforts, and empowering individuals and communities to better maintain their own health. The Authority divided the goals in the Blueprint into three categories: Near (0-2 years); Intermediate (3-9 years); and Long-Term (10+ years). In 2011, the Authority released a progress report on the Blueprint.

2011 Blueprint Progress Report

“Our vision is to achieve continuous improvement in the health and prosperity of the region.”⁸ The 2011 Progress Report noted that many stakeholders in the region believed that the biggest success of the original report was that the strategic blueprint existed. The Authority had brought together “competitors and disparate organizations from across multiple sectors and geographic boundaries to create solutions for the health disparities of the region” to create a regional plan.⁹ The 2011 report described the following success stories since the launch of the Authority’s efforts:

BLUEPRINT FOR HEALTH IMPROVEMENT AND HEALTH-ENABLED PROSPERITY

PROGRESS REPORT 2011

- Telemedicine became a covered benefit in 2010
- The Virginia Department of Health launched a pilot program for expanded dental hygienists
- The region conducted a dental workforce study
- The region published the *Blueprint for Substance Abuse and Misuse in Southwest Virginia*
- The region launched a “grow our own” health care workforce development effort
- The region launched Healthy Eating, Active Living (HEAL) Appalachia to fight childhood obesity
- The region expanded activities related to women’s cancer
- The Health Wagon, together with regional stakeholders, expanded nurse practitioner capacity to increase patient access
- The Commonwealth launched a significant regional outdoor recreational plan
- Regional stakeholders expanded access to clean, safe water and wastewater treatment

“Substantial improvement, however, will require an effort across a generation, and the goals and objectives of this strategic plan serve as a roadmap for this change.”
Progress Report 2011

⁸ Progress Report 2011, Blueprint for Health Improvement and Health-Enabled Prosperity, Southwest Virginia Health Authority (2011) 2 (“Progress Report”).
⁹⁹ *Id.* at 3.

- The Authority expanded its membership to include a recognition of the other regional health care efforts underway
- The Authority and other stakeholders hosted several roundtable discussions to continue to highlight regional health care issues

Each of these milestones confirmed the Authority's belief that addressing the health care concerns of Southwest Virginia required a multi-faceted long-term approach with stakeholders invested in the success of the families of Southwest Virginia. The Authority's work continued and five years following the issuance of this report, the Authority amended and updated the goals.

Blueprint for Health Improvement and Health-Enabled Prosperity Approved January 7, 2016

During their January 7, 2016 meeting the Authority adopted revised goals for the region following several weeks of research and stakeholder meetings across the region. The Authority's goals represented an ambitious, achievable, measurable plan intended to be attained by 2020 incorporating the entire geographic footprint of the Authority's participating jurisdictions. The goals present specific targeted aims of achievement and preliminary strategies in the areas of healthy starts for children, healthy minds, healthy behaviors, healthy communities, and effective system of health care as follows:

2016 Goals

The Blueprint for Health Improvement & Health – Enabled Prosperity reflects the collaborative work of community members and organizations in identifying priority goals and strategies for population health improvement in Southwest Virginia. The aims, goals and preliminary strategies (“PS”) in this document are ambitious, achievable, measurable, and intended to be attained by 2020. They apply to a geographic “region” that includes the counties of Lee, Scott, Wise, Dickenson, Buchanan, Tazewell, Russell, Washington, Smyth, and cities of Norton and Bristol.

Aim 1.0: Healthy Starts for Children

Goal 1.1: Decrease by .5% across the region, the percent of children who do not meet the PALS K benchmarks in the fall of kindergarten and require literacy interventions, with no jurisdiction exceeding 20% failure to meet the benchmark

PS: Increase Pre-K and Head Start enrollment; Increase day cares with Star Quality Program Certification

Goal 1.2: Increase percent of third graders who pass the Standards of Learning third grade reading assessment to 80% or better, with no sustained decline in any jurisdiction

Goal 1.3: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) to 80%

PS: Increase reporting to VIIS; Increase EMRs (to feed into) that automatically populate immunizations into VIIS; increase access to immunizations at primary care provider offices; share TN and VA immunization registry data

Goal 1.4: Increase percent of boys and girls, age 13-17, who receive three doses of HPV vaccine, to 80%

PS: Increase access to vaccine in primary care clinics, and school based clinics

Goal 1.5: Increase number of children, ages 1-18, who receive preventive oral health services

PS: Increase medical providers who are trained, and provide fluoride varnish; increase the number of dentists who will see children as young as age 1; increase visits to dentist for children ages 1-4; increase number of FQHC locations who provide oral health services integrated with primary care; increase number of dental hygienists working under remote supervision working in VDH, FQHC, School Based Clinics, Head Start; increase number of school based oral health services to include dental sealants

Goal 1.6: Decrease rate of child abuse and neglect across the region

Goal 1.7: Decrease infant mortality rate across the region

Goal 1.8: Decrease total preterm births across the region

Goal 1.9: Increase percent of women who receive early (first trimester) and adequate prenatal care to 80%

PS: Increase percent of pregnant women enrolled seeing OB provider in the first trimester; increase percent of women who have 10 or more prenatal visit

Goal 1.10: Decrease percent of women who use alcohol and/or tobacco use during pregnancy

PS: Increase screening of pregnant women using evidence based tools eg. AUDIT, CAGE, etc; increase referrals and treatment options

Goal 1.11: Decrease number of children born with Neonatal Abstinence Syndrome

PS: Increase screening of pregnant women for drug use using evidence based tools; increase referrals and treatment options

Goal 1.12: Decrease teen pregnancy rate by 25% in all jurisdictions, with no jurisdiction trending upward

Goal 1.13: Increase percent of women who initiate breastfeeding

Aim 2.0: Healthy Minds

Goal 2.1: Increase the number of certified or licensed professionals treating mental health and substance use disorders (SUD), including core mental health professionals, as defined by HRSA, sufficient to eliminate the Mental Health Professions Shortage Area Designation in the region. Core mental health professionals as defined by HRSA include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

PS: Increase number of Licensed Substance Abuse Treatment Professionals; increase locations with integrated primary care and behavioral health services

Goal 2.2: Increase access to diverse services for SUD treatment, including intensive outpatient, inpatient and residential

PS: Increase SUD treatment services integrated with primary care

Goal 2.3: Increase the number of people who receive specialty treatment for SUD in the region

PS: Increase screening and referral to treatment using evidence based screening tools for alcohol and SUD in settings including urgent care,

emergency dept, primary care; decrease hospitalizations related to mental health and SUD

Goal 2.4: Decrease number of drug/poison deaths in the region

PS: Expand access to naloxone for lay rescuers and first responders; increase provider training on appropriate use of opiates in chronic pain management; decrease number of Fentanyl, Hydrocodone, Methadone, Oxycodone (FHMO) deaths

Goal 2.5: Decrease suicide rate to equal or below state rate of 12.9 per 100,000

PS: Increase depression screening and referral in care settings including emergency dept and primary care; increase community education and resources to identify persons at risk of suicide

Aim 3.0: Healthy Behaviors

Goal 3.1: Increase the percent of adults who receive an annual influenza vaccine to 70%

Goal 3.2: Decrease percent of adults in the region who are overweight or obese to equal or below the state goal of 63%.

PS: Decrease sugar sweetened beverage intake; Increase percent of adults who report consumption of five or more servings of fruits and vegetables per day

Goal 3.3: Decrease percent of children in the region who are overweight, or obese (BMI > 85% for age and gender)

PS: Improve access to data on children who are overweight or obese; increase consumption of five servings of fruit and vegetables per day; decrease sugar sweetened beverage intake.

Goal 3.4: Decrease percent of adults who did not participate in any physical activity during the last 30 days to no more than 20% across the region

PS: Increase access to outdoor recreation; increase access to free/affordable organized community activity programs; increase walking/biking/hiking venues

Goal 3.5: Increase percent of high school graduates who are enrolled in an institute of higher education within 16 months after graduation to equal the state goal of 75%. Institutes of higher education can include, but are not limited to, universities, colleges, institutes of technology, vocational schools and trade schools.

Goal 3.6: Decrease the percent of adults who report using tobacco to no more than 12% across the region

PS: Set intermediate goal to reduce tobacco use to 20% by 2018; increase number of tobacco free environments by policy and legislation (public housing, public and private organizations, automobiles with children, etc.); increase cost of tobacco; repeal restrictive state laws that prohibit localities from addressing tobacco use.

Goal 3.7: Decrease initiation of alcohol, tobacco, and other drugs (ATOD), including e-cigs in adolescents

PS: Increase evidence based prevention education in school, community, and faith based settings; increase schools that administer and report data from YRBS; Monitor data on reported use of electronic cigarettes (e-cigs); increase cost of tobacco; enforce restriction of sales of tobacco to people under age 18; increase number of environments that are tobacco free

Goal 3.8: Increase access to oral health care services using traditional and innovative models of oral health care delivery, to include a sufficient number of dentists to eliminate the Dental Health Professions Shortage Area Designation.

PS: Increase number of dental providers at fixed locations within the region; increase number of dental hygienists working under remote supervision, working in FQHCs and rural health clinics; pilot dental therapy practitioner model; expand Medicaid to include coverage for oral health care for adults

Goal 3.9: Decrease rate of avoidable deaths from heart disease, stroke, or hypertensive disease in the region equal to or below the state goal of 40 per 100,000

Goal 3.10: Decrease morbidity and mortality (age-adjusted) related to diabetes

PS: Increase percent of people with diabetes who receive annual A1C testing; increase number of people with diabetes who participate in a diabetes education program; decrease hospitalizations related to uncontrolled diabetes

Aim 4.0: Healthy Communities

Goal 4.1: Decrease rate of unemployment across the region

Goal 4.2: Increase households with access to high speed internet to equal or above the state goal of 72%

Goal 4.3: Decrease percent of households that are food insecure for some part of the year to no greater than 10%

Goal 4.4: Create a model for collaboration across agencies and organizations to share data and resources for the purpose of population health improvement

Goal 4.5: Increase number of communities that adopt policies, environmental and systems changes (PES) to support healthy living

PS: Educate state and local government and private leaders on how the work done in their respective communities contributes to the health and well-being of all regional residents, and how policies have intended and unintended impacts on health. Consider policies related to built environment, complete streets, walking trails, bike lanes, restaurants, farmers markets, and tobacco use, etc.; Create a model for communities to evaluate, monitor, and track sustainable PES change

Aim 5.0: Effective System of Health Care

Goal 5.1: Increase access to certified specialty care providers, with a focus on endocrinology, cardiology, pulmonary, and oncology

Goal 5.2: Increase percent of adults appropriately screened for colon, cervical, and breast cancer based on standards of care

Goal 5.3: Increase the number of hospitals in the region meeting the state goal for prevention of hospital-onset C.difficile infections to 100%

PS: Obtain data on hospital onset C.Difficile from hospitals utilized by Virginia residents located in Tennessee and Kentucky

Goal 5.4: Decrease hospitalizations for ambulatory care sensitive conditions to no greater than 1100 per 100,000

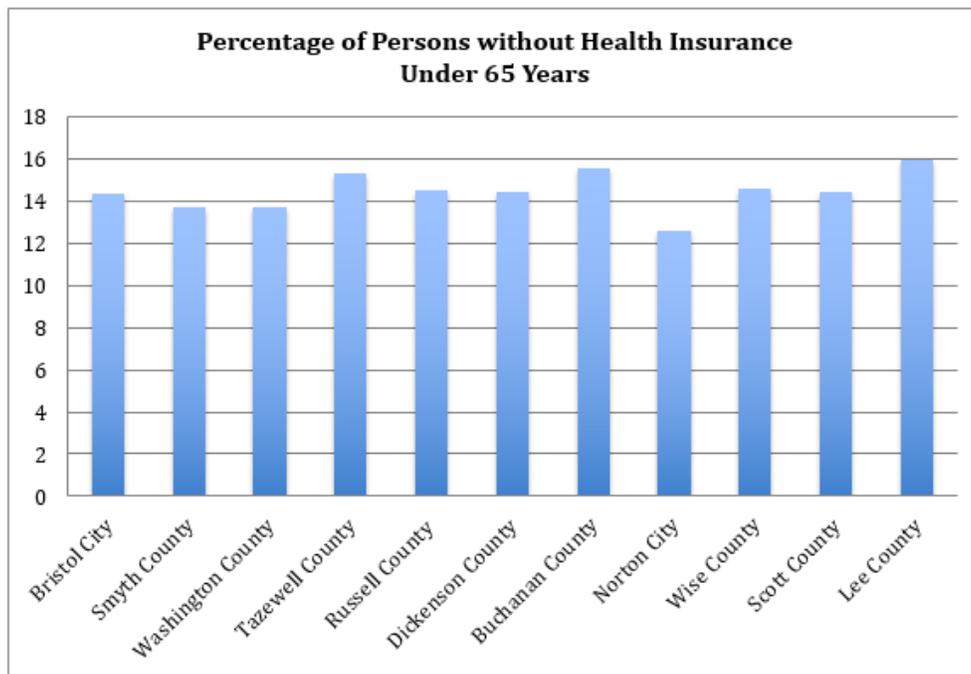
PS: Obtain data from VHI and all payers claim databases for Virginia residents admitted to hospitals in Virginia, Tennessee, and Kentucky

Goal 5.5: Increase Health Information Exchange (HIE) in regional health systems serving upper east Tennessee and Southwest Virginia

PS: Implement data sharing between regional health systems, including but not limited to, Wellmont Health System, Mountain States Health Alliance, Veterans Administration System, Holston Medical Group, and Tennessee and Virginia Departments of Health.

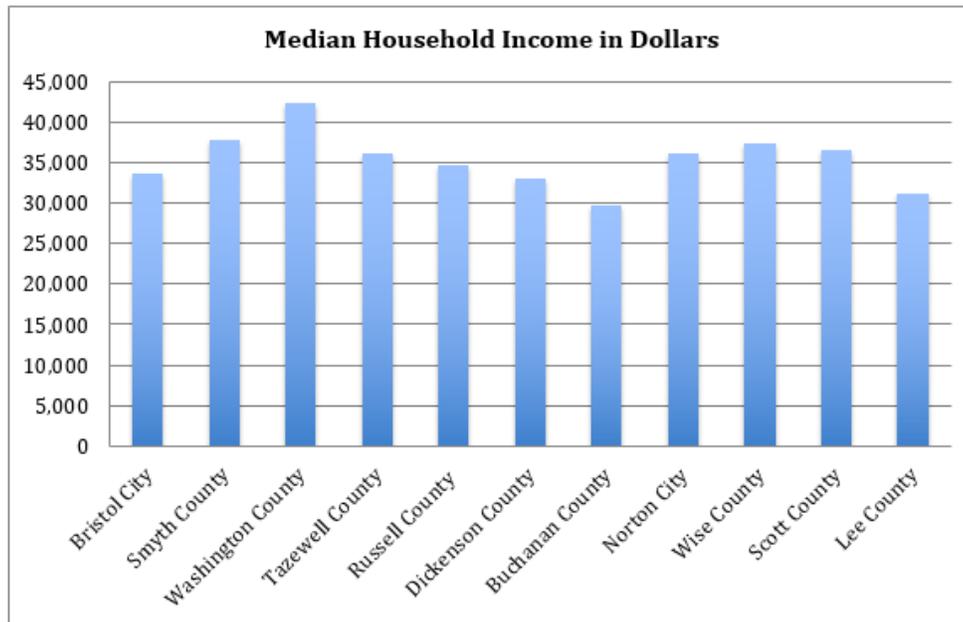
Southwest Virginia: A Unique Region and Challenge

From the Cumberland Gap throughout Virginia’s coal fields to the Blue Ridge Mountain range, Southwest Virginia remains a beautiful, economically challenged, struggling region of the Commonwealth. The nine counties and two independent cities of this region contain sweeping vistas of indescribable beauty and stunning realities of everyday poverty. The mountains and roadways of the region have always served to insulate and at times isolate the region. Individual communities – once the home of thriving economies – now struggle to absorb thousands of job losses from declining coal industries and a declining population exacerbated by an aging population and the exodus of young families. The health of the region and the health of the people are directly linked in a troubling spiral downward.¹⁰ The data available from the United States Census Bureau presents the following picture of the region:

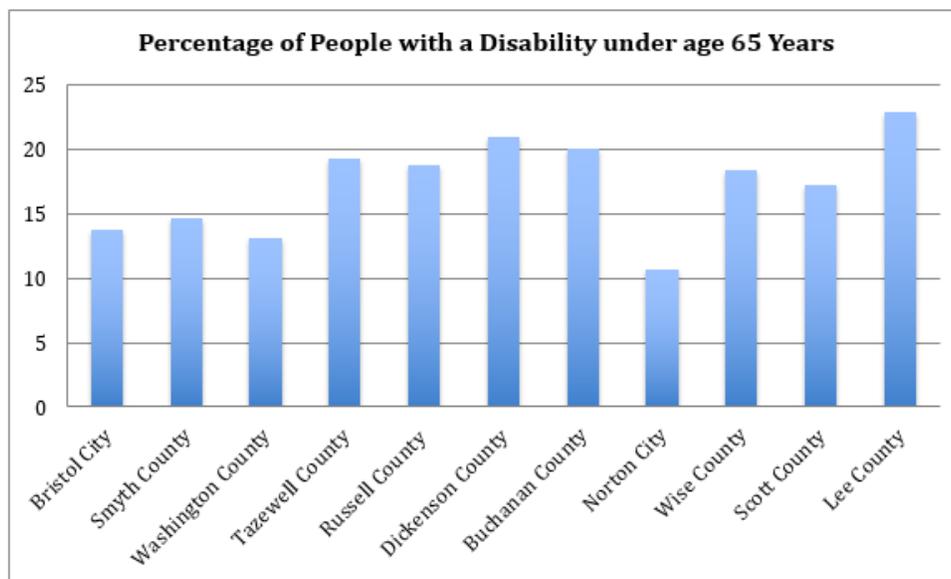


Percentage of persons without health insurance, under age 65 years in select counties (noted above) in Virginia, 2011-2015. Statistics from U.S. Census Bureau, <http://www.census.gov/quickfacts/table/PST045215/51>.

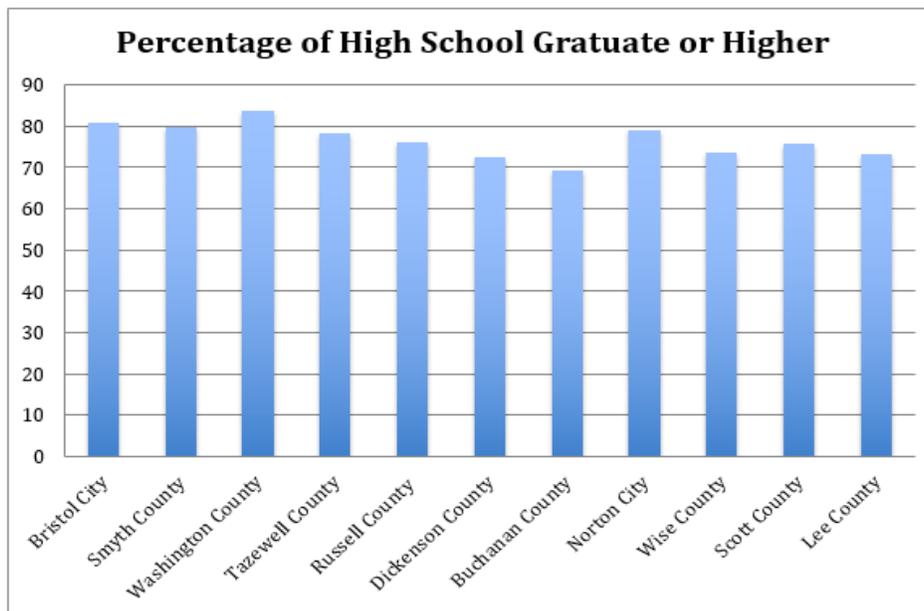
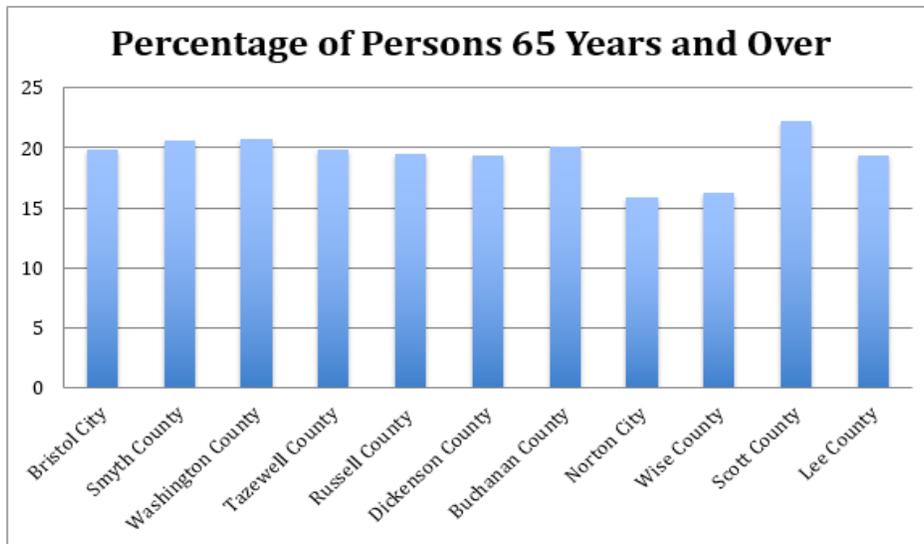
¹⁰ During the October 26, 2016 meeting of the Authority, Dr. Sue Cantrell shared with her fellow board members several graphic representations of the status of several health care issues in the region.



Median household income (in 2015 dollars) in select counties (noted above) in Virginia, 2011-2015. Statistics from U.S. Census Bureau, <http://www.census.gov/quickfacts/table/PST045215/51>.



The percentage of people with a disability under the age of 65 in select counties (noted above) in Virginia, 2011-2015. Statistics from U.S. Census Bureau, <http://www.census.gov/quickfacts/table/PST045215/51>.



The percentage of people that are a high school graduate or higher, based on persons age 25+ in select counties (noted above) in Virginia, 2011-2015. Statistics from U.S. Census Bureau, <http://www.census.gov/quickfacts/table/PST045215/51>.

Cooperative Agreements in Southwest Virginia

During the 2015 legislative session, the Virginia General Assembly expanded the ability of the Authority to participate in the achievement of its goals by creating a new mechanism to confront the significant health care challenges in Southwest Virginia. With adoption of Section 15.2-5384.1 of the Code of Virginia and execution of the legislation by Governor Terry McAuliffe on April 15, 2015, the Commonwealth of Virginia adopted a policy to encourage “cooperative, collaborative, and integrative arrangements, including mergers and acquisitions, among hospitals, health centers, or health providers who might otherwise be

competitors.”¹¹ While recognizing the unique challenges of health care in rural communities, the General Assembly placed the focus of this new policy solely on Southwest 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.**¹²

Only parties located within any locality participating in the Authority may submit an application for approval of a proposed cooperative agreement to the Authority.¹³ This unique solution now exists to confront our unique challenge. A cooperative agreement documents the relationship and expectations among the Commonwealth, the Authority, and two or more hospitals for the sharing, allocation, consolidation by a merger or other combination of assets, 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.¹⁴ Any health care providers submitting an application for approval of a cooperative agreement must state in detail the nature of the proposed arrangement between them, including without limitation the parties' goals for, and methods for achieving, population health improvement, improved access to health care services, improved quality, cost efficiencies, ensuring affordability of care, and, as applicable, supporting the Authority's goals and strategic mission.¹⁵ In creating a process for the submission and approval of cooperative agreement the General Assembly vested in the Authority the responsibility to review cooperative agreements between hospitals, health

¹¹ VA CODE ANN § 15.2-5384.1(A).

¹² VA CODE ANN § 15.2-5368(B) and (C).

¹³ VA CODE ANN § 15.2-5384.1(C)(1).

¹⁴ VA CODE ANN § 15.2-5369.

¹⁵ VA CODE ANN § 15.2-5384.1(C)(1).

centers, or health providers who might otherwise be competitors.¹⁶ The General Assembly recognized that these arrangements might create situations where competitive health care providers would explore and enter such agreements and they created a public policy regarding these arrangements:

“To the extent such cooperative agreements, or the planning and negotiations that precede such cooperative agreements, might be anticompetitive within the meaning an intent of state and federal antitrust laws, **the intent of the Commonwealth with respect to each participating locality is to supplement competition with a regulatory program** to permit cooperative agreements that are beneficial to citizens served by the Authority...”¹⁷

A hospital, for example, may negotiate and enter into proposed cooperative agreements with other hospitals in the Commonwealth if 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. Benefits to such a cooperative agreement may include, but are not limited to, 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.¹⁸

The Virginia Process for Cooperative Agreements

Virginia has a two-prong structure for the review and approval of cooperative agreements: a review of the application by the Authority and action on the application by the Virginia Commissioner of Health. Applicants located in the participating jurisdictions of the Authority file their request for approval of a cooperative or collaborative relationship that might otherwise be anticompetitive with the Authority; however, ultimate control over the relationship rests with the Virginia Commissioner of Health.

The Virginia General Assembly recognized that the Authority had been attempting to confront the factors impacting the health outcomes prevalent in Southwest Virginia. For over a decade the members of the Authority Board of Directors have been on the frontline of this issue and by placing the recommendation of the Authority as an initial step in the cooperative agreement approval process, the General Assembly required any applicants to first convince the Authority that the likely disadvantages resulting from a loss of competition by the granting of a cooperative agreement would be offset by greater benefits likely to result from the granting of a cooperative agreement.

The Role of the Southwest Virginia Health Authority

The General Assembly considered the Authority uniquely positioned to implement its policy as our members witness every day the consequences of health care policies in the communities throughout Southwest Virginia and how those policies impact the families all across the region. The General

¹⁶ VA CODE ANN § 15.2-5368 *et seq.*

¹⁷ VA. CODE ANN. 15.2-5384.1(A) (emphasis added).

¹⁸ VA. CODE ANN § 15.2-5384.1(B).

Assembly focused the responsibilities of the Authority on several main objectives: (1) receive applications for cooperative or collaborative agreements between otherwise competing health care providers, (2) review applications to determine completeness, (3) widely publicize the existence of an application throughout Southwest Virginia, (4) coordinate public comment on an application; and (5) review the Application to determine whether, under the given criteria, the application should be recommended to the Commissioner of Health for approval.

After applicants submit an application for a cooperative agreement, the Authority first must determine whether the application is complete within the meaning of the statute. The General Assembly did not provide direct and specific measurements to determine completeness and vested the Authority alone with making this determination. If the Authority determines that an application is not complete, the Authority may request additional information from the Applicants. The Applicants must deliver a copy of the complete application to both the Commissioner and the Office of the Attorney General at the same time that it is submitted to the Authority. Given that applicants will likely be competitors, the General Assembly enabled the parties to request confidential treatment of certain information.¹⁹

After the Authority determines that the application is complete, the Authority must initiate a period of public comment when both written public comment and oral public comment may be submitted to the Authority for consideration. The Authority must give wide notice of its actions throughout the region it serves.²⁰

Following the twenty-day written public comment period, the Authority and the Commissioner must schedule a public hearing for additional public comments. Applicants have the ability to respond to the written public comment received by the Authority.²¹ The hearing shall be held no later than forty-five days after receipt of the application (the date upon which an application is deemed complete) and notice of the public hearing must be widely distributed to both interested parties and the public.²² Virginia law requires the Authority to determine whether the proposed cooperative agreement should be recommended for approval by the Commissioner within 75 days of the date of receipt of the completed application, unless the Authority exercises its right to extend the review period.²³

In its review of a submitted application, the Authority may consider the proposed cooperative agreement and any supporting documents submitted by the Applicants, any written comments submitted by any person, any written response by the Applicants, and any written or oral comments submitted at the public

¹⁹ If applicants believe the materials submitted contain proprietary information that are required to remain confidential, such information must be clearly identified and the applicants shall submit duplicate applications, one with full information for the Authority's use and one redacted application available for release to the public. VA. CODE ANN. § 15.2-5384.1(C)(1).

²⁰ The Authority, promptly upon receipt of a complete application, shall publish notification of the application in a newspaper of general circulation in the LENOWISCO and Cumberland Plateau Planning Districts and on the Authority's website. See VA. CODE ANN. § 15.2-5384.1(C)(2).

²¹ Applicants may respond in writing to the comments within 10 days after the deadline for submitting comments.

²² Notice of the hearing shall be mailed to the applicants and to all persons who have submitted written comments on the proposed cooperative agreement. The Authority, no later than 15 days prior to the scheduled date of the hearing, also shall publish notice of the hearing in a newspaper of general circulation in the LENOWISCO and Cumberland Plateau Planning Districts and on the Authority's website. VA. CODE ANN. § 15.2-5384.1(C)(2).

²³ The Authority may extend the review period "for a specified period of time" upon fifteen days of notice to the applicants VA. CODE ANN. § 15.2-5384.1(D).

hearing.²⁴ The Authority must review a proposed cooperative agreement in consideration of the Commonwealth's policy to facilitate improvements in patient health care outcomes and access to quality health care, and population health improvement in rural communities.²⁵ If the Authority determines that the proposed cooperative agreement should be recommended for approval, it then provides such recommendation to the Commissioner of Health for the Commonwealth of Virginia.²⁶

The General Assembly provided both great flexibility and firm directives to the Authority to enable the members of the Board of Directors to complete their tasks. The determination of completeness was left to the Authority – allowing it great latitude to question applicants and determine whether the application truly provides enough information for a wide-based public review. Yet, the General Assembly provided a very specific standard for making a recommendation to the Commissioner about an application.

The Role of the Virginia Commissioner of Health

While the General Assembly recognized the local knowledge and responsibility of the Authority, the enacted legislation empowers the Commissioner of Health to undertake a final review of any application. After reviewing the application and asking any additional questions necessary to make a decision, the Commissioner may approve an application. If an application is approved, the Commissioner is charged with the enforcement and monitoring of the resulting cooperative agreement.

First, upon receipt of the Authority's recommendation, the Commissioner may request from the Applicants such supplemental information as the Commissioner deems necessary to the assessment of whether to approve the proposed cooperative agreement. The Commissioner shall consult with the Attorney General of Virginia regarding his assessment of whether to approve the proposed cooperative agreement.²⁷

Second, on the basis of his review of the record developed by the Authority, including the Authority's recommendation, as well as any additional information received from the Applicants or any other data, information, or advice available to the Commissioner, the 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.²⁸ The Commissioner may reasonably condition approval of the proposed cooperative agreement upon the parties' commitments to achieving the improvements in population health, access to health care services, quality, and cost efficiencies identified by the parties in

²⁴ VA. CODE ANN. § 15.2-5384.1(D).

²⁵ *Id.*

²⁶ VA. CODE ANN. § 15.2-5384.1(F)(1)

²⁷ VA. CODE ANN. § 15.2-5384.1(F)(2)

²⁸ *Id.* The Commissioner shall issue his decision in writing within 45 days of receipt of the Authority's recommendation. However, 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. The Commissioner's decision to approve or deny an application shall constitute a case decision pursuant to the Virginia Administrative Process Act. *Id.*

support of their application for approval of the proposed cooperative agreement. Such conditions are fully enforceable by the Commissioner of Health.²⁹

If approved, the cooperative agreement is entrusted to the Commissioner for active and continuing supervision to ensure compliance with the provisions of the cooperative agreement. The parties to an approved cooperative agreement must report annually to the Commissioner on the extent of the benefits realized and compliance with other terms and conditions of the approval. The report shall describe the activities conducted pursuant to the cooperative agreement, including any actions taken in furtherance of commitments made by the parties or terms imposed by the Commissioner as a condition for approval of the cooperative agreement, and shall include information relating to price, cost, quality, access to care, and population health improvement. The Commissioner may require the parties to a cooperative agreement to supplement such report with additional information to the extent necessary to the Commissioner's active and continuing supervision to ensure compliance with the cooperative agreement. The Commissioner shall have the authority to investigate as needed, including the authority to conduct onsite inspections, to ensure compliance with the cooperative agreement.³⁰

Finally, the Commissioner can enforce a cooperative agreement, or ³¹ revoke a cooperative agreement upon a finding that (i) the parties to the agreement are not complying with its terms or the conditions of approval; (ii) the agreement is not in substantial compliance with the terms of the application or the conditions of approval; (iii) the benefits resulting from the approved agreement no longer outweigh the disadvantages attributable to the reduction in competition resulting from the agreement; (iv) the Commissioner's approval was obtained as a result of intentional material misrepresentation to the Commissioner or as the result of coercion, threats, or intimidation toward any party to the cooperative agreement; or (v) the parties to the agreement have failed to pay any required fee. All proceedings initiated by the Commissioner under this chapter and any judicial review thereof shall be held in accordance with and governed by the Virginia Administrative Process Act.³²

Ultimately, the Commissioner is responsible for the agreement. ³³

²⁹ *Id.*

³⁰ VA. CODE ANN. § 15.2-5384.1(G)

³¹ If the Commissioner has reason to believe that compliance with a cooperative agreement no longer meets the requirements, the Commissioner shall initiate a proceeding to determine whether compliance with the cooperative agreement no longer meets the requirements. In the course of such proceeding, the Commissioner is authorized to seek reasonable modifications to a cooperative agreement, with the consent of the parties to the agreement, in order to ensure that it continues to meet the requirements of this chapter. VA. CODE ANN. § 15.2-5384.1(H)

³² *Id.*

³³ The Commissioner shall maintain on file all cooperative agreements that the Commissioner has approved, including any conditions imposed by the Commissioner. Any party to a cooperative agreement that terminates its participation in such cooperative agreement shall file a notice of termination with the Commissioner within 30 days after termination. VA. CODE ANN. § 15.2-5384.1(I). The Commissioner shall be entitled to reimbursement from the parties seeking approval of a cooperative agreement for all reasonable and actual costs, not to exceed \$75,000, incurred by the Commissioner in his review and approval of any cooperative agreement approved pursuant to this chapter. VA. CODE ANN. § 15.2-5384.1(J). In addition, the Commissioner may assess an annual fee, in an amount established by regulation promulgated by the State Board of Health that does not exceed \$75,000, for the supervision of any cooperative agreement approved pursuant to this chapter and to support the implementation and administration of the provisions of this chapter. *Id.*

The Federal Trade Commission

The FTC staff actively engaged in commenting upon the consideration of the Application throughout the process. While the various comments expressed by the various staff, including staff from the Commission's Bureau of Competition, Bureau of Economics, and Office of Policy Planning shared written and oral public statements, the comments on their face noted that they did not necessarily represent the official views of the Commission or any particular Commissioner of the Federal Trade Commission. The members of the Board of Directors actively considered their input and deliberated upon their assertions.

Beginning September 17, 2015 with a letter to the Virginia Department of Health,³⁴ the FTC staff³⁵ became active participants in the consideration of the Virginia policy for granting cooperative or collaborative agreements. The initial letter from the Federal Trade Commission staff transmitted public comment on the proposed regulations of the Virginia Department of Health contained an overview of the Federal Trade Commission staff's expertise and stated the interest of the staff in monitoring the proposed application. While reviewing the proposed regulations, the staff noted:



"Consideration of whether credible efficiencies can offset a merger's anticompetitive harm depends not only on the magnitude of those efficiencies, but also on the extent to which those efficiencies are likely to be passed through to consumers. Thus, the greater the likely anticompetitive harm from a merger – as with a merger to monopoly or near-monopoly – the greater and more likely to be passed through to consumers the efficiencies need to be to pass muster under antitrust laws."³⁶

Following this initial engagement, the FTC staff remained an active and contributing participant in the Authority's review and consideration of the Application. The Authority enjoyed direct access to the staff of several divisions of the Commission and the benefit of constant guidance.

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³⁴ Letter to Susan Puglisi, Esq., Sept. 17, 2015 ("Puglisi Letter").

³⁵ "These comments express the views of the FTC's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. These comments do not necessarily represent the views of the Commission or of any individual commissioner. The Commission has, however, voted to authorize staff to submit these comments. The Commission also authorized staff to provide oral comments at today's quarterly meeting of the Virginia Board of Health. See <http://www.vdh.state.va.us/administration/meetings/documents/pdf/Agenda%20September%202015.pdf>

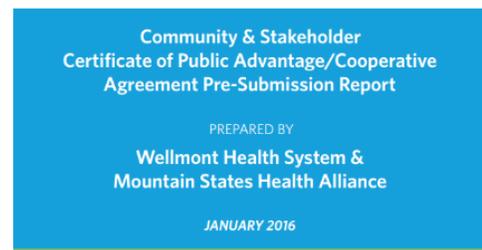
³⁶ See Puglisi Letter.

The Pre-Submission Report

On January 7, 2016, two not-for-profit health systems, Mountain States Health Alliance and Wellmont Health System, publicly released the *“Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report”* (the *“Pre-Submission Report”*) announcing their intention to move forward with their plan to combine the two organizations forging a new approach to health care in the region with a “vision apart from traditional mergers so common in the healthcare industry today,”³⁷ utilizing a “once in a lifetime opportunity to create a long-last legacy of improved health.”³⁸ The report noted that the two systems serve the residents of Southwest Virginia and Northeastern Tennessee, which according to data they provided is a region in Virginia that performs significantly below the state averages in several health care indicators, as well as national averages, making the region rank among the “unhealthiest counties in the United States.”³⁹

The two systems collectively operate seven hospitals in Virginia.

Mountain States Health Systems has five hospitals (Dickenson Community Hospital, Johnston Memorial Hospital (Washington County, Virginia), Norton Community Hospital, Russell County Medical Center, and Smyth County Community Hospital). Wellmont Health System has two hospitals in Virginia (Lonesome Pine Hospital (Big Stone Gap, Virginia) and Mountain View Regional Medical Center (City of Norton, Virginia), as described in Appendix II to the Pre-Submission Report:



About Our Systems



Wellmont Health System operates six hospitals and numerous outpatient care sites, serving communities in Northeast Tennessee and Southwest Virginia. Wellmont's mission is to deliver superior healthcare with compassion, and we consistently rank among the nation's best for high-quality outcomes and processes of care.



Mountain States Health Alliance operates 13 hospitals and numerous outpatient care sites across a 20-county, four-state region. Mountain States is committed to its mission of bringing loving care to healthcare – and we passionately pursue healing of the mind, body and spirit to meet the needs of the individuals and communities in our region.

³⁷ *Community & Stakeholder Certificate of Public Advantage/Cooperative Agreement Pre-Submission Report* (2016) (Pre-Submission Report”) 2.

³⁸ Pre-Submission Report 24.

³⁹ *Id.* at 10.

System	Facility	Applicant Description
Wellmont	Lonesome Pine Hospital (Big Stone Gap, Virginia)	A 60-licensed bed facility that has served the community since 1973. Lonesome Pine is a community hospital offering a full array of services, including emergency services and a variety of inpatient and outpatient services. The hospital serves as a teaching facility in partnership with schools such as Lincoln Memorial University. The Southwest Virginia Cancer Center, serving medical and radiation oncology patients, is part of Lonesome Pine Hospital operations. Lonesome Pine is staffed with 167 physicians, of whom 80% are board certified, and nearly 400 employees.
Wellmont	Mountain View Regional Medical Center (Norton, VA)	Mountain View is a 118-licensed bed full-service hospital and offers a full array of services, including emergency services and a variety of inpatient and outpatient services. Mountain View joined Wellmont in 2007 and it is operated as a facility of Lonesome Pine Hospital under one Medicare provider number. Mountain View Regional Medical Center houses the system's only hospital-based long-term care unit. For financial reporting purposes, Mountain View is consolidated with Lonesome Pine.
MHSA Joint Venture	Dickenson Community Hospital (Clintwood, VA)	Dickenson Community Hospital is one of two critical access hospitals operated by Mountain States Health Alliance. The hospital is licensed for 25 beds and provides emergency services and a variety of inpatient and outpatient services to the residents of Dickenson County.
MSHA Joint Venture	Johnston Memorial Hospital (Abingdon, VA)	Johnston Memorial Hospital (JM) is a 116-bed community hospital which was relocated to a new, state of the art facility in 2011. At that time, JM was recognized as the first Gold Leadership in Energy and Environmental Design (LEED)-certified hospital in Southwest Virginia providing a full array of services, including emergency services and a variety of inpatient and outpatient services
MHSA Joint Venture	Norton Community Hospital (Norton, VA)	Norton Community Hospital has served Southwest Virginia and Southeastern Kentucky since 1949. The 129-bed, acute care facility provides a full array of services, including emergency services and a variety of inpatient and outpatient services. Norton Community was the first American Osteopathic Association- accredited teaching facility in the commonwealth of Virginia and hosts residents in internal medicine.
MHSA	Russell County Medical Center (Lebanon, VA)	Russell County Medical Center is a 78-bed, acute care and behavioral health hospital. The hospital serves the residents of Russell County, Virginia, and provides behavioral health services, emergency services, and a variety of inpatient and outpatient services.
MHSA Joint Venture	Smyth County Community Hospital (Marion, VA)	Smyth County Community Hospital is a 44-bed, acute care facility located in Marion, Virginia. Smyth County's services also include a 109-bed skilled nursing care facility, branded as Francis Marion Manor Health & Rehabilitation. The hospital has served the residents of Smyth County, Virginia, for more than 45 years through a full array of services, including emergency services and a variety of inpatient and outpatient services. Smyth County Community Hospital also owns 100% of Southwest Community Health Services, Inc., described below.

The Pre-Submission Report contained several statements from the Applicants about the costs of operating these rural hospitals, and provided background on the process of combining the two health systems, reminded the reader of the launch of the informational website www.BecomingBetterTogether.org, and reported that since the initial public announcement regarding the proposed merger in April 2015, the Applicants had participated in 40 community and media events to publicly discuss the potential merger. The Pre-Submission Report reviewed the approval process, highlighting the two distinct and different process to be conducted by the Commonwealth of Virginia and the State of Tennessee, with each jurisdiction separately evaluating the benefits and disadvantages of the proposed combination of the health care systems.



Throughout the Pre-Submission Report the Applicants provided insight into their future plans, beginning with a comprehensive vision statement about the new health care system they proposed to form. In the Pre-Submission Report section entitled "Rationale for the Merger," the Applicants presented two alternatives for the two systems: (1) merge the two systems locally capturing unique opportunities with local leadership or (2) independently merge each of the two systems with separate large health systems outside the region. The Applicants set forth the following basis for the proposed combination of the health care systems:

- The closure of numerous rural hospitals since 2010 as well as the purchase of rural hospitals by large multistate health systems or for-profit entities "that lack deep-rooted understanding of local community health needs and have fiduciary obligations unaligned with the health of the local economy;"⁴⁰
- Significant economic factors for the two systems based, at least partially, on their unique location and health care population create long-term viability issues and challenge the continuance of locally governed health care systems;
- A commitment to maintaining regional assets;
- Existence of an enforcement mechanism;
- Redundant services have also created significant debt; and,
- A recognition that the benefits in Virginia obtained from the local merger – and the conditions placed upon the merger by the Cooperative Agreement – would not likely be available under an outside merger.

The Applicants reported their conclusion that the independent merger of each local system with a health care system located or controlled outside the region was not the best alternative for the region stating that:

The boards of Wellmont and Mountain States believe the purchase of our local health systems by larger systems from outside our region is more likely to increase costs, reduce access, and negatively impact jobs.

We believe our proposed alternative is better. It is the only model that maintains local governance, provides a unique opportunity to sustain and integrate health care delivery for our residents into a high-quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in our region, and invests those dollars in the improved health of our region while also preserving local jobs.⁴¹

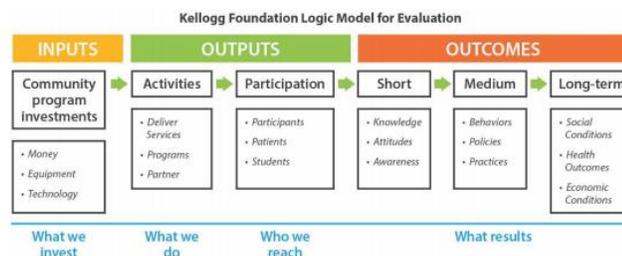
⁴⁰ *Id.* at 7.

⁴¹ *Id.* at 8.

The Applicants suggested that one of the main commitments of the new system will be a commitment to improving community health.⁴² The Applicants proposed the development of a comprehensive plan guiding much of the actions going forward and alluded to the specific contractual commitments the Applicants proposed to make as part of the combined system. The Applicants noted the presence of the supervision by the Commonwealth of Virginia and the State of Tennessee and informed the public of the steps the health systems intended to take to reduce costs to insurers and patients, including fixed-rate increases, a commitment to not increase hospital negotiated rates by stated values, the adoption of a common technology platform, and other similar actions aimed at controlling costs and more efficiently operating the combined system.⁴³ The Applicants also proposed that the savings resulting from the merger would be reinvested with the region.⁴⁴



Finally, the Applicants promoted a framework for accountability based upon active monitoring, evaluating and accountability. They stated that they proposed to use the Kellogg Foundation's Logic Model.⁴⁵ To establish a path forward, a vision statement adopted by the boards of directors of both health care systems contained thirteen shared goals to be undertaken in the creation of the new system.⁴⁶ These aspirations included becoming known for outstanding clinical outcomes and superior patient experiences, partnering with physicians to achieve better quality at lower cost for patients, businesses, and payers, working with academic partners, building new population health models leveraging electronic health records, and becoming a national model for rural health care delivery and rural access to care.



The Pre-Submission Report also presented

⁴² *Id.* at 11.
⁴³ *Id.* at 20.
⁴⁴ *Id.* at 9.
⁴⁵ *Id.* at 24.
⁴⁶ *Id.* at 5.

the proposed service area of the combined health system together with a facilities list (which included all inpatient, outpatient, clinic and support facilities of the two health care systems except those facilities in which the health care systems do not own a controlling interest).

The Application For A Cooperative Agreement

On February 16, 2016 Mountain States Health Alliance and Wellmont Health System submitted to the Authority the "*Commonwealth of Virginia Application for a Letter Authorizing Cooperative Agreement Pursuant to Virginia Code §15.2-5384.1 and the Regulations Promulgated Thereunder at 12 VCAS5-221-10 et seq.*" (the "Application") (Mountain States Health Alliance and Wellmont Health Systems, collectively, the "Applicants")⁴⁷ seeking to merge two health care systems serving Southwest Virginia. When combined with the exhibits submitted with the Application, the material comprised nearly four thousand pages of information.⁴⁸ The vast amount of material provided extended well beyond the 141-page application to over forty-five exhibits. Both



parties submitted information each deemed proprietary under Section 15.2-5384.1(C)(1) of the Code of Virginia. The two entities proposed the creation of a unified health system, which during the review process they announced would be named Ballad Health.⁴⁹ The Applicants also simultaneously filed an application under the State of Tennessee Certificate of Public Advantage process. While the Authority monitored the progress of the actions of the State of Tennessee, the Authority proceeded independent of the State of Tennessee, as the Authority's activities focused on the counties and cities participating in the Authority. Starting with notice that an application would be filed, the Applicants began the process of delivering, explaining, defending and discussing their application to the Authority's Board of Directors.

Mountain States Health Alliance, a not-for-profit health care organization, operates thirteen (13) hospitals.⁵⁰ With a history tracing over one hundred years of providing health care in the region, Mountain States Health Alliance emerged in 1998 when Johnson City Medical Center acquired six hospitals in Tennessee from the Columbia-HCA. The first Virginia hospital became part of the system in 2006 when Mountain States Health Alliance acquired part of Smyth County Community Hospital. Later, four other Southwest Virginia hospitals joined the system.⁵¹ During the 2013 fiscal year, Mountain States Health Alliance had an average daily census of 734 over 1,669 licensed beds.⁵²

⁴⁷ Barbara Allen, Chairman of the Board Mountain States Health Alliance, Alan Levine, President & Chief Executive Officer Mountain States Health Alliance, Roger Leonard, Chairman of the Board Wellmont Health System, Bart Hove, President and Chief Executive Officer, Commonwealth of Virginia Application For A Letter Authorizing Cooperative Agreement Pursuant to Virginia Code § 15.2-5284.1 and the regulations promulgated thereunder at 12VACS-221-10 et seq. February 16, 2016 (the "Application").

⁴⁸ The applicants requested confidential treatment of a portion of the information submitted. § 15.2-5384.1 (C)(1) of the Code enables applicants to designate information as confidential and proprietary.

⁴⁹ Following the submission of the application, the parties announced the new name for the combined health system. See <http://becomingbettertogether.org/>.

⁵⁰ <https://www.mountainstateshealth.com/about-us>

⁵¹ Application at 22.

⁵² See Application.

Wellmont Health System provides health care in Northeast Tennessee and Southwest Virginia. Formed as a not-for-profit in 1996,⁵³ Wellmont Health System resulted from a combination of Bristol Regional Medical Center and Holston Valley Medical Center located in Tennessee.⁵⁴ Wellmont Health System operates five acute care hospitals and one critical access hospital with 1,011 licensed beds and, during fiscal year 2013, a daily census of 430 patients.⁵⁵

Both Mountain States Health Alliance and Wellmont Health System are based in Tennessee with the headquarters of Mountain States Health Alliance located in Johnson City, Tennessee and the headquarters of Wellmont Health System located in Kingsport, Tennessee.

The Wellmont Health System Strategic Process

The Application began with a review of the recent Wellmont Health System effort to review its own “internal strategic and financial position, industry trends, and the organization’s goals for the future of health care with its service area.”⁵⁶ The Application summarized the Wellmont Health System process as evaluating “all reasonable options with the objective of sustaining community assets vital to the region while achieving high quality patient care at the lowest possible cost.”⁵⁷ By April 2014, the Board of Directors of Wellmont Health System launched a “strategic options process” to consider options.⁵⁸ Wellmont Health System emerged in 1996 with the merger of Bristol Regional Medical Center in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee and now includes, among other services, four rural hospitals, a physician network and several ambulatory sites.⁵⁹ Five Wellmont Health System hospitals are acute care hospitals and one hospital is a critical access hospital with a daily census during fiscal year 2013 of 430 for the 1,011 licensed beds.⁶⁰

In April 2015, the Board of Directors of Mountain States Health Alliance and Wellmont Health System unanimously voted to “explore the creation of a new, integrated and locally governed health system.”⁶¹ In the Application, the parties state their belief that the “merger is the only model that effectively maintains local governance, provides a unique opportunity to sustain and integrate health care delivery for residents into a high quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in the region, and invests those dollars in the improved health of this region while also preserving local jobs.”⁶² The merged system will include all assets, ownership interests, subsidiaries and controlled affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by the parties at the time the cooperative agreement is authorized.

⁵³ <http://www.wellmont.org/Our-Mission/About-Us/>.

⁵⁴ Application at 23.

⁵⁵ *Id.* at 23.

⁵⁶ *Id.* at 4.

⁵⁷ *Id.*

⁵⁸ *Id.* at 5.

⁵⁹ *Id.* at 23.

⁶⁰ *Id.*

⁶¹ *Id.*

⁶² *Id.* at 5.

The Applicants asserted that Southwest Virginia represents a unique competitive environment in health care. The Applicants have a history of competitive engagement. The two systems are the only hospital in several counties:

Jurisdiction	Hospital
County of Dickenson	Dickenson Community Hospital (Mountain States)
County of Russell	Russell County Medical Center (Mountain States)
County of Smyth	Smyth County Community Hospital (Mountain States)
County of Washington	Johnston Memorial Hospital (Mountain States)
County of Wise	Lonesome Pine Hospital (Wellmont)
City of Norton	Mountain View Regional Medical Center (Wellmont) Norton Community Hospital (Mountain States)

Residents frequently travel across state lines to receive health care. In Virginia, the main area of direct competition between the two Applicants is in the adjoining jurisdictions of Wise County and the City of Norton. Wellmont Health System owns two hospitals in Wise County and Mountain States Health Alliance owns one hospital in this area. The Applicants provided significant statistical data documenting their competitive environment for inpatient, outpatient, urgent care facilities, CT and MRI facilities, ambulatory surgical centers, and physicians.⁶³ The Applicants addressed the impact of the proposed cooperative agreement on physicians by stating: “[a] large number of independent physicians in the community will not be a party to the Cooperative Agreement.”⁶⁴

The Applicants Propose a Unique Solution For Southwest Virginia.

The Applicants stated that Southwest Virginia has unique health care challenges. “The cost of this poor health is not sustainable. This region is a unique geographic area that requires a unique solution.”⁶⁵ To address these challenges, the Applicants stated three goals to pursue under the proposed cooperative agreement: (1) reduce cost growth, (2) “improve the quality of health care services and access to care, including the patient experience of care,” and (3) “enhance overall community health in the region.”⁶⁶ The Applicants reported that “savings realized through the merger, by reducing duplication and improving coordination, will remain within the region and be reinvested in ways that significantly benefit the community through the addition of new services and capabilities, improved choice and access, effective management of costs and investment in improving the quality of health care and economic development in the region.”⁶⁷

⁶³ The Application contains additional information and exhibits providing significantly more detail about this information.

⁶⁴ *Id.* at 65.

⁶⁵ *Id.* at 10.

⁶⁶ *Id.*

⁶⁷ *Id.*

The Proposed Primary Service Area

The Applicants proposed a primary service area of twenty-one counties in Virginia and Tennessee that includes the following Virginia counties: Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe and the City of Bristol and the City of Norton. The Applicants reported that most of their hospitals are smaller rural hospitals with bed capacities that far exceed utilization.⁶⁸ The hospitals of the Applicants in this area include:⁶⁹

Health System	Hospital	Staffed Beds	Licensed Beds	Average Daily Census
Wellmont	Lonesome Pine	21	60	10
Wellmont	Mountain View Regional	18	74	13
MSHA	Norton Community	50	129	35
MSHA	Russell County	49	78	29
MSHA	Smyth County	44	44	21
MSHA	Dickenson County	2	25	<1
MSHA	Johnston Memorial Hospital	112	116	65

In their review of the service area the Applicants provided the following data compiled from various sources including the United States Census Bureau⁷⁰:

County	Total Population	% Rural	Total Rural
Buchanan County, Virginia	24,098	100%	24,098
Dickenson County, Virginia	15,903	100%	15,903
Grayson County, Virginia	15,533	99.9%	15,514
Lee County, Virginia	25,587	99.6%	25,475
Russell County, Virginia	28,897	88.2%	25,483
Scott County, Virginia	23,177	82.1%	19,034
Smyth County, Virginia	32,208	75.3%	24,248
Tazewell County, Virginia	45,078	51.9%	23,390
Wythe County, Virginia	29,235	75.3%	22,023
Washington County, Virginia	54,876	71.7%	39,333
Wise County, Virginia	41,452	56.7%	23,491
City of Norton, Virginia	3,958	2.6%	102
City of Bristol, Virginia	17,835	0.0%	7

⁶⁸ *Id.* at 17.

⁶⁹ *Id.* at 18 and 19.

⁷⁰ *Id.* at 16.

Total Virginia	357,837	37.2%	258,101
Total Tennessee	604,472	62.8%	242,169
Proposed Geographic Service Area	962,309	52.0%	500,270

This region represents the entire Southwest Virginia region covered by the participating localities in the Southwest Virginia Health Authority.

The Applicant Assessment of Benefits and Advantages.

The Applicants stated that “[c]ommunity health is affected by a complex variety of factors including genetic predisposition, behavioral patterns, social circumstances, environmental exposures, and access to quality health care.”⁷¹ The Applicants suggested that Southwest Virginia and Northeast Tennessee have a “distinct culture, capacity and resource base that results in a unique set of health issues.”⁷² The Applicants proposed a series of commitments in the Application based upon the assertion that the “Parties believe that this merger is the only model that effectively maintains local governance, provides a unique opportunity to sustain and integrate health care delivery for residents into a high quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in the region, and invests those dollars in improved health of this region while also preserving local jobs.”⁷³

The Applicants suggested that many efforts in the past directed at improving health care in the region had many attributes but lacked “sustainable funding.” The Applicants based their population health improvement proposal upon implementing a planned strategy developed consistent with the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships process, and the Applicants proposed the adoption of this process to develop an action plan with regional stakeholders⁷⁴ and implement that plan with a coordinated investment of resources made available by the merger. The Applicants identified the following benefits as resulting from the proposed cooperative agreement:

- (1) A commitment to a ten-year population health improvement process involving investment of at least \$75,000,000, relying upon public health resources available at East Tennessee State University focused on several initiatives including:
 - Ensuring a “strong start” for children
 - “Helping adults live well in their community”
 - Promoting a drug-free community
 - Decreasing avoidable hospital admission and emergency room use
 - Improving access to behavioral health services⁷⁵

⁷¹ *Id.* at 99

⁷² *Id.* at 99.

⁷³ *Id.* at 129.

⁷⁴ *Id.* at 100.

⁷⁵ *Id.* at 7.

- (2) A commitment to improved access to health care and an investment of \$140,000,000 over ten years in the development of specialty services and the sustainment of currently unprofitable services⁷⁶
- (3) Commitments to “pricing, consolidation of services, and standardization of practices”⁷⁷
- (4) A Commitment for at least \$85,000,000 in investments over ten years for research and education
- (5) Avoidance of the duplication of hospital resources⁷⁸
- (6) Improvements in Patient Outcomes⁷⁹
- (7) Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve⁸⁰
- (8) Enhanced Behavioral Health & Substance Abuse Services

The Applicants proposed other benefits, including major investments in the continuum of care related to behavioral health and substance abuse issues, the creation of integrated technology systems and improvement to the quality and availability of health care services in the region.⁸¹

The Applicant Commitments

The Applicants offered thirty commitments to address any potential adverse impacts resulting from the granting of a cooperative agreement.⁸² The Applicants divided the proposed benefits into five categories: improving community health, enhancing health care services, expanding access and choice, improving health care value: managing quality, cost and service, and investment in health education/research and commitment to workforce. The Applicants stated they would report on their activities in a Community Health Annual Report documenting the success of the Applicants at achieving the targeted health improvement areas adopted by the Applicants with the Commissioner of Health and community stakeholders.⁸³

Potential Disadvantages of the Cooperative Agreement

The Applicant’s asserted that the Cooperative Agreement did not create disadvantages. “The parties do not foresee any adverse impact on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement.”⁸⁴ Later in the Application the Applicants again stated:

“The parties do not foresee any adverse impact on population health, or quality, access, availability cost or price of health care services to patients or payers as a result of the Cooperative Agreement. The projects and commitments identified in this

⁷⁶ *Id.*

⁷⁷ *Id.* at 7.

⁷⁸ *Id.* at 8.

⁷⁹ *Id.* at 8.

⁸⁰ *Id.* at 9.

⁸¹ *Id.* at 91-93

⁸² *Id.* at 129-134.

⁸³ *Id.* at 103-105.

⁸⁴ *Id.* at 10.

Application will result in significant benefits and clearly improve health care in the region.”⁸⁵

Rather, the parties foresee the Cooperative Agreement resulting in significant benefits as detailed in this Application.”⁸⁶

Alternatives to the Cooperative Agreement

The Applicants provided a description of a limited number of collaborative activities, such as blood bank services, joint responses to Ebola awareness and preparedness, and the Susan G. Komen effort.⁸⁷ They stated that they have “attempted to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.”⁸⁸

The Projected Effects of the Cooperative Agreement on Volume, Price and Revenue

The parties provided significant information on the insurance contracts and payer agreements utilized by both systems including information deemed proprietary and confidential. The Applicants stated that “[l]ike other health systems across Virginia and the nation, the Parties negotiate with commercial health insurance providers for inclusion in the health insurance plans they offer to employers and individuals.”⁸⁹

Measuring Achievement of Commitments.

The Applicants proposed an ongoing evaluation of the public advantages resulting from the merger based upon the Institute of Health Improvements’ Triple Aim goals based upon quantitative measures.⁹⁰ The parties proposed a scoring system where successful achievement of the various commitments is weighted to assess whether the Applicants are fulfilling their obligations. For example, if the “Overall Achievement Score” calculated by the Applicant’s proposal is equal to or greater than seventy percent (70%), the evidence presented would be deemed definitive evidence of the continuing benefit of the cooperative agreement, a score of fifty percent (50%) to seventy percent (70%), depending upon the circumstances, may entitle the Commonwealth to seek a modification of the cooperative agreement.

Governance of the New Health System.

The merged health system will be governed by a board of directors of seventeen (17) members with fourteen (14) voting members and three (3) non-voting members: the Executive Chairman, the Chief Executive Officer, and the President of East Tennessee State University (an *ex officio* member).⁹¹ The proposed structure includes sixteen residents of the State of Tennessee and one resident of the Commonwealth of Virginia.

⁸⁵ *Id.* at 128.

⁸⁶ *Id.* at 10.

⁸⁷ *Id.* at 24.

⁸⁸ *Id.* at p. 95.

⁸⁹ *Id.* at 29.

⁹⁰ *Id.* at p. 98.

⁹¹ *See* Application, Exhibit 431, Article 2, Master of Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance Dated as of February 15, 2016.

Separating the Parties.

The parties proposed a plan of separation reviewed by FTI Consulting, Inc., an independent health care consulting firm.⁹² The Applicants included a copy of the initial plan of separation as an exhibit to the Application; however, during the review process the Applicants provided a copy of the more detailed plan of separation provided to the State of Tennessee.

[The remainder of this page intentionally left blank.]

⁹² *Id.* at 135.

Our Review of the Application

Delivery of the Application

On February 16, 2016 the Authority received an application for approval of the cooperative agreement on behalf of the Applicants. Following delivery of the Application, the Board of Directors began its work in earnest undertaking a series of events adhering to both of the directives of the enabling statute and the Chairman’s goal of a public, open process through both the statutorily defined process and the regular and special meetings of the Authority’s Board of Directors.

The process of receiving and then reviewing the Application became a long, deliberate process. As reported by [The Bristol Herald Courier](#) on May 26, 2016:

“We have a long way to go,” board Chairman Terry Kilgore said after the hour-long meeting at the Southwest Virginia Higher Education Center.

The ten months the Authority devoted to the Application included the following events (with statutory events noted red print):

February 16, 2016	Applicants submitted Application for a cooperative agreement
March 3, 2016	Authority working groups formed
March 15, 2016	Meeting of the Board of Directors of the Authority
March 28, 2016	Health Care Cost Working Group Meeting
March 30, 2016	Initial determination of conflicts of interest status
April 7, 2016	Health Care Cost Working Group Meeting
April 11, 2016	Employees hired
April 12, 2016	Population Health Working Group Meeting Health Care Quality Working Group Meeting
April 13, 2016	Competition Working Group Meeting
April 13, 2016	Meeting of the Board of Directors
May 9, 2016	Health Care Cost Working Group Meeting
May 10, 2016	Meeting of the Executive Board of the Authority
May 13, 2016	Population Health Working Group
May 19, 2016	Competition Working Group Meeting
May 23, 2016	Health Care Quality Working Group Meeting
May 25, 2016	Meeting of the Board of Directors
May 27, 2016	Authority submitted questions to the Applicants
June 8, 2016	Applicants requested clarification on Authority questions

June 24, 2016	Authority responded to Applicant questions
July 5, 2016	Authority representatives met with Applicants
July 13, 2016	Applicants submitted responses to Authority questions
July 25, 2016	Applicants submitted supplement responses to Authority's questions
August 1, 2016	Competition Working Group
August 22, 2016	Meeting with Applicants
August 26, 2016	Meeting of the Board of Directors
August 26, 2016	Board of Directors Deems Application "Complete"
September 1, 2016	Publication of Notice of Receipt of Complete Application
September 1, 2016	Beginning of Public Comment Period
	Health Care Quality Working Group Meeting
September 8, 2016	Population Health Working Group
September 9, 2016	Clarification of Public Comment Period
September 15, 2016	Publication of Notice of Public Hearing
September 19, 2016	Meeting with Applicants (re: Commitments)
September 26, 2016	Listening Session: University of Virginia Wise (Wise County)
September 27, 2016	Listening Session: Lebanon High School (Russell County)
September 30, 2016	Conclusion of Public Comment Period
October 3, 2016	Meeting with Applicants to Discuss commitments (two or fewer directors present)
October 3, 2016	Public Hearing: Southwest Virginia Higher Education Center
October 10, 2016	Meeting with Applicants to discuss commitments (two or fewer directors present)
October 14, 2016	Applicant response: FTC Staff Written Public Comment
October 21, 2016	Applicant's response: Anthem, VAHP and AHIP Written Public Comment
October 25, 2016	Health Care Access Working Group Meeting
October 26, 2016	Authority Board of Directors Meeting to Hear Presentation by FTC Staff
October 27, 2016	Authority Board of Directors Meeting
November 7, 2016	Authority Board of Directors Meeting
November 7, 2016	Application recommended to Commissioner of Health for Approval
November 22, 2016	Delivery of recommendation to Commissioner of Health
December 22, 2016	Delivery of report regarding recommendation

Board Member Conflicts

Ms. Rebekah Stefanski, who is legal counsel to the Virginia Conflict of Interest and Ethics Advisory Council, made a presentation to the Board of Directors on March 15, 2016 to review the Virginia State and Local Government Conflicts of Interest Act. Ms. Stefanski and the Board engaged in a long discussion about the Conflicts of Interest Act and its implications on the decision before the Board of Directors.

Upon delivery of the Application, the first order of business for the Authority involved determining which members of the Board of Directors were statutorily unable to participate in the review of the Application.

One of the great strengths of the Authority comes from the diverse backgrounds of the individuals on the Board of Directors and the wide range of professional and personal experiences each brings to the deliberations. Many members of the Board of Directors work in the health care industry and several are employees of the Applicants. Two different criteria exist preventing certain members of the Board of Directors from participating in the review and deliberation of the Application: The Virginia State and Local Government Conflict of Interest Act and Section 15.2-5384.1(D) of the Code, which prevents certain members from participating.

Any applicants to the proposed cooperative agreement under review, and their affiliates or employees, who are members of the Authority, as well as any members of the Authority that are competitors, or affiliates or employees of competitors, of the Applicants proposing such cooperative agreement, are ineligible to participate as a member of the Authority in the Authority's review of, or decision relating to, the proposed cooperative agreement; however, this prohibition on such person's participation does not prohibit the person from providing comment on a proposed cooperative agreement to the Authority or the Commissioner.⁹³

First, the Authority worked with the Virginia Conflict of Interest Advisory Council to review which members of the Board of Directors had a conflict of interests under the Virginia State and Local Government Conflict of Interest Act.⁹⁴ The Virginia Conflicts Act provides a single body of law applicable to all state and local government officers and employees related to conflicts of interest, to develop a uniform standard of conduct for officers and employees throughout the Commonwealth.⁹⁵ Virginia law provides a two-step process for determining whether an official may participate in a decision in which the official may have a personal interest. First, the individual must determine whether a personal interest exists and second, whether the personal interest is of a nature that it prohibits the individual's participation in the process of reviewing the Application.

Section 2.2-3101 of the Code defines a "personal interest" as "a financial benefit or liability accruing to an officer or employee or to a member of his immediate family" and further states that such an interest shall exist as a result of the following:

⁹³ *Id.*

⁹⁴ Pursuant to Section 2.2-3115 of the Code, a member of the Board is considered an official subject to the Virginia Conflict of Interests Act.

⁹⁵ VA CODE ANN §2.2-3100 *et seq.*

- (i) ownership in a business if the ownership interest exceeds three percent of the total equity of the business;
- (ii) annual income that exceeds, or may reasonably be anticipated to exceed, \$5,000 from ownership in real or personal property or a business;
- (iii) salary, other compensation, fringe benefits, or benefits from the use of property, or any combination thereof, paid or provided by a business or governmental agency that exceeds, or may reasonably be anticipated to exceed, \$5,000 annually;
- (iv) ownership of real or personal property if the interest exceeds \$5,000 in value and excluding ownership in a business, income, or salary, other compensation, fringe benefits or benefits from the use of property;
- (v) personal liability incurred or assumed on behalf of a business if the liability exceeds three percent of the asset value of the business; or
- (vi) an option for ownership of a business or real or personal property if the ownership interest will consist of clause (i) or (iv) above.⁹⁶

The Authority determined that anyone with a conflict based on definition of a “personal interest in a contract” or a “personal interest in a transaction” would be excluded from the process of review of the Application. The Authority reviewed conflicts related to employees of the Applicants, related to a board volunteer on the finance committee of one of the Applicants, related to academic partners of the Applicants, related to Board members that are part of organizations that have strategic relationships with the Applicants, and related to regional health care organizations that have affiliations with the Applicants.

Second, Section 15.2-5384.1(D) of the Code of Virginia states that any applicants to the proposed cooperative agreement under review, and their affiliates or employees, who are members of the Authority, as well as any members of the Authority that are competitors, or affiliates or employees of competitors, of the Applicants proposing such agreement, shall not participate as a member of the Authority in the Authority’s review of, or decision relating to, the proposed cooperative agreement.

Following the review of the Virginia Conflicts Act and the specific provision of the Authority’s enabling legislation regarding employees of the Applicants, the Authority determined that 8 members of the Board of Directors could not participate in the review of the Application, as listed on Schedule 1, and 2 members of the Board of Directors also declared a conflict of interest for a total of 10 non-participating members of the Board of Directors.

The Authority Working Groups

In recognition of the significant amount of information that had been delivered to the Authority and needed to be reviewed to determine whether the application was complete, as contemplated by the statute, on March 15, 2016 the Authority adopted the following resolution establishing working groups to help assess the information within the Application focused on the following five key areas: competition, health care access, health care cost, health care quality, and population health, aligning the working groups with the statutory guidance for reviewing cooperative agreement applications.

⁹⁶ VA CODE ANN §2.2-3101.

Resolution for Working Groups

WHEREAS, the Southwest Virginia Health Authority recognizes that during the August 2015 meeting a policy was adopted to allow for formation of working groups for the review of cooperative agreement applications; and,

WHEREAS, the Southwest Virginia Health Authority has received such cooperative agreement application and wishes to create working groups; and

WHEREAS, the Southwest Virginia Health Authority desires to have each director serve and identify volunteers as well who might desire to serve on such working groups and upon the recommendation of the chair of a committee appoint such persons to serve on the proposed working groups;

NOW THEREFORE BE IT RESOLVED, the following working groups are created:

The Population Health Working Group. This working group will focus its review of the Application on the population health issues, such as the Authority's goals, regional health issues, academic engagement, and health related workforce issues.

The Health Care Cost Working Group. This working group will focus its review of the Application on the issues directly related to health care cost, such as ensuring accountability of the cost of care, improving regional collaboration and integration, and reviewing cost efficiencies discussed in the Application.

The Health Care Access Working Group. This working group will focus its review of the Application on the issues related to access to health care, including, improves access to health care, enhancement of care, preservation of hospital facilities, improvement of utilization, avoidance of duplication of hospital resources, and participation in the Commonwealth of Virginia Medicaid program.

The Health Care Quality Working Group. This working group will focus its review of the Application on the issues related to quality of health care issues set forth in the Application, including promoting collaboration and the utilization of technology, enhancement care, and improvement of utilization of resources.

The Competition Working Group. This working group will focus its review of the Application on 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" and will consider issues related to ensuring accountability of the cost of care, improving health entity collaboration and regional integration, gains in the cost efficiencies on services provided by the Application, and improvements in the utilization of resources and avoidance of the duplication of resources.

RESOLVED, that the Authority hereby creates the Population Health Working Group of the Southwest Virginia Health Authority; and be it further,

RESOLVED, that the Authority hereby appoints Dr. David Sarrett, Dr. Karen Rheuban, Ms. Susan Mayhew, the honorable Charles Carrico and Ms. Susan

Copeland as members of the Population Health Working Group with the honorable Charles Carrico designated as the Chair of such working group; and be it further,

RESOLVED, that the Authority hereby creates the Health Care Cost Working Group of the Southwest Virginia Health Authority; and be it further,

RESOLVED, that the Authority hereby appoints Ms. Donna Henry, Mr. Sam Neese, Mr. Larry Mosley, Ms. Tabitha Crowder, the honorable Will Morefield and Dr. Michael Weiting as members of the Health Care Cost Working Group with Ms. Donna Henry designated as the Chair of such working group; and be it further,

RESOLVED, that the Authority hereby creates the Health Care Access Working Group of the Southwest Virginia Health Authority; and be it further,

RESOLVED, that the Authority hereby appoints, Ms. Susan Mayhew, Ms. Sandy O'Dell, Mr. Ron Prewitt, Mr. Craig Horn, the honorable Terry Kilgore and Dr. Wendy Welch as members of the Health Care Access Working Group with Ms. Sandy O'Dell designated as the Chair of such working group; and be it further,

RESOLVED, that the Authority hereby creates the Health Care Quality Working Group of the Southwest Virginia Health Authority; and be it further,

RESOLVED, that the Authority hereby appoints Dr. Donna Henry, Dr. Sue Cantrell, Ms. Donna Murray, the honorable Ben Chaffin, and Dr. Tooke-Rawlins as members of the Health Care Quality Working Group with Dr. Tooke-Rawlins designated as the Chair of such working group; and be it further,

RESOLVED, that the Authority hereby creates the Competition Working Group of the Southwest Virginia Health Authority; and be it further,

RESOLVED, that the Authority hereby appoints all members of the Board of Directors as members of the Competition Working Group with Mr. Sam Neese designated as the Chair of such committee.

The five working groups reviewed, assessed and discussed the Application in public meetings to determine if the benefits of the proposed Application outweigh the disadvantages pertaining the focus area of the working group. No one other than Authority Board of Directors members served on the working groups. The groups were asked to review the Application and determine if more information was necessary to determine whether the application could be deemed complete, as set forth in the statute. Each working group held meetings and reviewed both the Application and supporting information, especially during the final phase of review to determine whether the Application was complete. The Chairs of the working groups engaged with representatives of the Applicants to better understand the information and review it, and the working groups also confirmed that the Applicants had considered the Authority's regional goals. The following information provides an overview of their activities.

Health Care Quality Working Group

The **Health Care Quality Working Group** focused on the enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction.

The Quality Working Group met and produced a significant set of questions:

QUALITY

The Quality Task Force finds the following questions to be unanswered.

1. The Application stresses the importance of an independent medical practice community to the competitive environment in the region. The trend nationally is for increased employment of physicians by hospitals. The value-based payment world of bundled payments, ACOs etc., integrated systems are focused and require full cooperation to be efficient. The task force has the following questions:
 - a. How will the new system operate as an integrated system utilizing non-employed physicians for their ACO and do other models exist that have shown this model succeeds?
 - b. What percent of the independent practice physicians work in out-patient only practice settings (physicians do not serve in attending roles for patients who are admitted to acute care facilities)?
 - c. How are these physicians integrated into the decision making process regarding quality of care?
2. In the most recent (Spring 16) version of the Leapfrog safety scorecard, no hospitals in either applicant system scored "A" in patient safety metrics and several received "C" grades. Please provide specific details of how the new system will improve and assure the quality and safety performance in each hospital and facility.
 - a. Please include how "A" level patient safety criteria can be addressed in the separation criteria that will eventually be in place.
 - b. Please include what additional quality measures are followed by the new system outside those currently required by the Medicaid and Medicare payors.
 - c. How will the clinical protocols be developed and how do they differ than those used by the two systems without the merger?
3. The Parties propose common credentialing standards at all hospitals (p. 38 of the Application). Please discuss the role of the medical staff of each facility in establishing credentialing standards, and how credentialing and privileges differ between small community based hospitals and the larger, tertiary hospitals. Please include:
 - a. How are physicians currently on staff of both types of facilities (tertiary care, rural, and the new repurposed facilities) represented in determining standards?

- b. How are the independent physicians involved in determining standards?
 - c. How does this differ from current practice?
4. How will the system address the maintenance of separate and independent medical staff functions at each hospital and any barriers to the introduction of new initiatives to improve population health metrics and to introduce best practice guidelines? Include comments on how you anticipate integrating these functions across the new system?
5. Improved clinical information services are a key to higher quality and lower cost delivery of care. The Parties have committed to a uniform technology platform across the new system. The following questions remain:
 - a. What is the projected (reasonable) timetable for implementation of the new system.
 - b. How will the new system be accessible to the independent physician groups the hospital plans to maintain?
 - c. Consistent within Stark Law limitations, to what extent is the new health system able to assist independent physician groups in gaining access to the common platform?
 - d. How will ambulatory practice platforms within the system and independent practices be included in tracking quality outcomes?
6. The Application focuses on mostly hospital quality measures all hospitals are required to track. What quality measures are used for the nursing facilities, home health, and physician practices owned and operated by the New Health System?
7. Quality and Access cannot be separated when in the rural setting. The current application provides assurance for maintaining as acute care facilities only hospitals in Tennessee. The remaining facilities (all Virginia hospitals) are open within the next 5 years for "re-purposing" according to this document. The task force for quality believes the following questions must be answered prior to consideration.
 - a. Which facilities in Virginia will function as acute care hospitals for their community?
 - b. Which facilities in Southwest Virginia will offer access to quality obstetrical and gynecologic care?
 - c. Recognizing the current Virginia hospitals offer emergent care to a large region, if repurposing several of these facilities for rural areas, which will offer an emergency room for stabilization of acutely ill patients prior to transport?
8. Virginia graduates more physicians than there are residency positions. Most recently the legislature has agreed to fund additional residency positions located in areas of need, such as Southwest Virginia. In addition, the recently developed residency programs have an impact on bringing up to date quality health care to the Southwest Virginia region. Considering the impact to assuring a physician workforce for Southwest Virginia supporting both access and quality will the residency programs in Abingdon, Norton, and Lonesome Pine be maintained?

The Quality Working Group's effort became an integral part of the revisions to the commitments.

Population Health Working Group

The **Population Health Working Group** focused on the enhancement of population health status consistent with the regional health goals established by the Authority.

The Population Health Working Group met on April 12, 2016, to begin to review the documents associated with the Application. After reviewing the working group charter, they discussed health rankings for Virginia counties and cities and the adverse health status indicators of the region. They reviewed the aspirational goals of the Applicants as set forth on page five of the Application and began active review of the Application. Dr. David Sarrett noted that while the Application contained several references to academic and research and development, he presented several questions related to the academic training effort and the research and development effort. He stated that oral health outcomes should be included.

Health Care Access Working Group

The **Health Care Access Working Group** focused on preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care and participation in the state Medicaid program.

The Health Care Access Working Group met on April 4, 2016. The Working Group discussed the need to determine whether the Application was complete. They discussed areas of access to be considered by the committee such as the geographic location of the existing hospitals, the distances patients travel for inpatient services, specialists and where they are located, whether independent providers will be forced out in favor of practices associated with the new system, and a review of several specialty care practices (OBGYN, Surgery, Gastroenterology, Pediatrics, Geriatrics, Psychiatric, Endocrinology, Outpatient Rehab, Physical Therapy, Occupational Therapy, and Speech Therapy). The Health care Access Working Group also discussed the following additional areas to be reviewed by the group: the work force, payor contracts, and proposed services to meet any gaps in services available. The Health Care Access Working Group also discussed the lack of services available in Lee County. The members of the group expressed concerns regarding the location of the Level I and Level II facilities. The group also expressed the need to better understand the timeframe set forth in the facilities plans and to understand the number of representatives from Southwest Virginia on the board of directors of the new health system. The group expressed concerns about the status of the Dickenson County facility and the potential loss of services. The Health Care Access Working Group also sought information concerning whether independent practices and providers would be forced out of competition. Finally, the group discussed the substance abuse treatment services proposed in the Application.

The Health Care Access Working Group had another meeting on April 13, 2016, where it reviewed the information gathered since the first meeting as well as the following information still being sought:

- There is a void in Lee County with no inpatient health care and a population of 25,000. One of the Applicants, Wellmont Health System, closed their hospital, and the other applicant, Mountain States Health Alliance has recently been assisting the county. The group noted that there was no discussion of the plans related to Lee County in the Application and wanted to explore why.

- The Dickenson County hospital is a small hospital and the group discussed the need to explore what was going to happen to that facility.

- The group wanted more information about the Level 1 Trauma Center and where it would be located.

- The group identified the need to learn more about how the Applicants will work with charity clinics in the region.

- The group wanted to learn how the new health system would interface with private behavioral health services.

- Dr. Cantrell reported that with respect to OB/GYN's, there were practices in the Wise County/ City of Norton area, Bristol, Abingdon and Marion, with labor and delivery services also available at Johnston Memorial.

- Ms. Welch reported that most complex surgery is occurring in Kingsport, Bristol and Johnson City. She said more information is needed about the helicopter services and other transport services.

- Dr. Cantrell reported that there is one Gastroenterology service provider in the LENOWISCO planning district area who perform procedures, but no consultations. She stated there are providers in Washington County and Smyth County, but she believed the Cumberland Plateau planning district needs this service.

- Dr. Cantrell reviewed the pediatricians available in the region, including in Washington County, Bristol, and Smyth County as well as Wise County. She noted that there were also nurse practitioners seeing children.

- Ms. Welch stated that there was not information about geriatrics in the Application.

- Ms. O'Dell reported that there are four credentialed psychiatrists in the Wise County area. She discussed a plan for a psychiatric residency program in the region.

- Dr. Cantrell reported that there was an endocrinologist in Cumberland Plateau region two to three days a week and no providers in the LENOWISCO planning district.

- The information provided in the Application regarding outpatient rehabilitation physical therapy, occupational therapy and speech services.

The Working Group reviewed several workforce issues, including salary issues, the commitment to electronic health records, and the belief that no hospital in Virginia is guaranteed for continuation to remain open. Ms. O'Dell led a discussion about the payer contracts and the impact of the Application on

competition. The Working Group developed questions related to charity care and the need to identify ways to meet gaps in services available in the region.

Health Care Cost Working Group

The **Health Care Cost Working Group** focused on gains in the cost-efficiency of services provided by the hospitals involved, improvements in the utilization of hospital resources and equipment, avoidance of duplication of hospital resources, and total cost of care.

The Health Care Cost Working Group met on March 28th to begin its review of the material and analysis of the Application. They reviewed their mission and initially focused on three sections of the Application that dealt with budget and finance issues. There was a discussion about who would oversee the proposed new health system. Delegate Morefield discussed contacting Secretary of Health and Human Services, Bill Hazel, for input on their questions. The Health Care Cost Working Group met again on April 7, 2016.

Competition Working Group

The **Competition Working Group** focused on the extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers; the extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement; the extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and the availability of arrangements that are less restrictive to competition and 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.

Working Group Questions

Throughout the Working Group meetings, the members and the Chairs of the Working Groups extensively reviewed the Application and examined the material provided. The Working Groups identified issues where they needed additional information and collectively produced sixty-eight questions that the Authority submitted to the Applicants. The Applicants delivered their initial response on July 13, 2016; and, after requesting clarification of certain questions, the Applicants provided additional responses on July 25, 2016.⁹⁷

In their response to the Authority's questions, the Applicants included a cover letter setting forth additional information, noting that "[w]e believe the benefits of the proposed cooperative agreement are substantial, and given the increasingly difficult environment rural hospitals are operating in, we believe

⁹⁷ The questions and the responses are available on the Authority's website, available at www.swvahealthauthority.net.

there is an urgency to completing this process.”⁹⁸ In addition to delivering a seventy-one page response (plus exhibits) to the Authority’s questions, in their cover letter, the Applicants made the following arguments in support of the cooperative agreement:

- *The only plan which guarantees continued access is the proposed cooperative agreement.* The Applicants reported that even after capital investment of several hundred million dollars, more than 1/3 of the rural hospitals operated by the Applicants in Southwest Virginia have operating losses, which means the hospitals are supported by other hospitals in the Applicant systems.⁹⁹
- *Southwest Virginia is at a crossroads.* The Applicants stated that they shared the Authority’s vision “to achieve continuous improvement in the health and prosperity of the region” of Southwest Virginia, a region with a rich cultural heritage that continues to confront significant economic problems. The Applicants noted that portions of Southwest Virginia had experienced population decline of 9% in the past five years.
- *Competition has failed Southwest Virginia.* The Applicants made the following statement in their cover letter:

“The reality is simple. Robust competition has led to overcapacity, higher debt, and as you evidence in your letter, several indicators that the competition and cost resulting from it did not result in better quality.”¹⁰⁰

The Applicants stated that the “competition for bricks and mortar and the human resources associated with them” created a heavily-bedded infrastructure.

- *Changes in cost reimbursements and business insurance practices reversed historic payment models.* The Applicants reported that the changing nature of reimbursements have caused a decrease in hospital admissions, physicians utilizing observations instead of admissions, and physicians trying to keep patients from being admitted.¹⁰¹
- *The Applicants have made significant commitments to population health.* The Applicants reviewed the needs of the pediatric population and the challenges this population confront, and the Applicants asserted that no system undergoing a merger is making the commitments the Applicants have proposed.
- *Southwest Virginia’s hospitals have been struggling for several years.* According to the Applicants, the rural hospitals operated by the Applicants have annual operating loss of at least \$19,500,000. This annual loss figure does not include capital investment, but does include an annual loss of \$11,000,00 related to the Southwest Virginia facilities.¹⁰² The Applicants reported that the “[t]he competitive model existing to date in the region has

⁹⁸ Alan Levine and Bart Hove, Letter to the Southwest Virginia Health Authority, July 13, 2016 (“Responses”).

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 2.

¹⁰¹ *Id.* at 3

¹⁰² *Id.* at 4.

resulted in seven hospitals operated by Mountain States and Wellmont operating over eleven Southwest Virginia counties with an average daily census of only 173 – an average occupancy of 33% percent [sic] and about the census of a single hospital.”¹⁰³

- *The Applicants cannot remain independent and an out-of-market merger is not the best solution.* The Applicants asserted that any out-of-market acquirer would likely do the following three things: leverage their size to seek higher pricing from payers, eliminate local corporate jobs, and close unprofitable services and facilities.¹⁰⁴
- *The cooperative agreement legislation is an opportunity.* The Applicants stated that the Virginia General Assembly provided an opportunity for “an innovative model of regional health community health improvement with any potential negative consequences of reduced competition under active supervision from the Commonwealth.”¹⁰⁵

The Applicants responses restated and supplemented much of the information provided in the original application. In the supplemental response of July 13, 2016, the Applicants provided a report that the merged health system will employ approximately 3,800 Virginia residents and nearly forty percent of these people will work in Tennessee.¹⁰⁶ The following physicians are employed in Virginia:¹⁰⁷

County	WHS Employed	MSHA Employed	MSHA Affiliated	Independent
VIRGINIA TOTAL	100	104	54	539
BRISTOL CITY	15	0	0	0
BUCHANAN	0	0	0	24
DICKENSON	0	0	4	17
GRAYSON	0	0	0	4
LEE	2	0	0	16
NORTON CITY	37	0	0	0
RUSSELL	8	8	0	33
SCOTT	0	0	0	19
SMYTH	0	3	0	39
TAZEWELL	0	0	0	96
WASHINGTON, VA	23	67	28	130
WISE	12	7	17	86
WYTHE	3	19	5	75
ALL OTHER COUNTIES	240	195	44	1,637
TOTAL	340	299	98	2,176

¹⁰³ *Id.*

¹⁰⁴ *Id.* at 5.

¹⁰⁵ *Id.* at 6.

¹⁰⁶ Supplement to Responses to Questions Submitted May 26, 2016 By Southwest Virginia Health Authority in Connection with the Application For Letter Authorizing Cooperative Agreement, July 25, 2016, 1.

¹⁰⁷ *Id.* at Exhibit 14.

Finally, the Applicants provided additional information regarding primary service areas based upon information available to them within their systems as follows:

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliated
Grand Total (Overlap/Non-Overlap)		2,913	74.7%	11.7%	10.3%	3.4%
ORTHOPEDICS	X	135	85.9%	1.5%	11.1%	1.5%
OTHER SPECIALTIES	X	269	85.1%	6.7%	6.7%	1.5%
PEDIATRICS & NEONATOLOGY	X	177	84.7%	3.4%	4.0%	7.9%
OBSTETRICS & GYNECOLOGY	X	116	80.2%	5.2%	11.2%	3.4%
PRIMARY CARE	X	794	77.3%	15.9%	4.4%	2.4%
NEUROSCIENCES	X	73	76.7%	6.8%	12.3%	4.1%
GENERAL SURGERY	X	115	70.4%	3.5%	12.2%	13.9%
ENDOCRINOLOGY, DIABETES & METABOLISM	X	13	69.2%	23.1%	7.7%	0.0%
PSYCHIATRY, PSYCHOLOGY & SOCIAL SERVICES	X	80	66.3%	8.7%	22.5%	2.5%
HOSPITALIST	X	275	53.1%	17.1%	25.5%	4.4%
ONCOLOGY & HEMATOLOGY	X	76	51.3%	27.6%	10.5%	10.5%
PULMONOLOGY	X	44	43.2%	38.6%	11.4%	6.8%
URGENT CARE	X	104	36.5%	6.7%	49.0%	7.7%
CARDIOVASCULAR	X	146	34.2%	47.3%	17.8%	0.7%
RADIOLOGY		74	100.0%	0.0%	0.0%	0.0%
RHEUMATOLOGY		16	100.0%	0.0%	0.0%	0.0%
PATHOLOGY & LABORATORY MEDICINE		31	100.0%	0.0%	0.0%	0.0%
EMERGENCY MEDICINE		236	98.3%	0.0%	0.8%	0.8%
ENT		25	96.0%	4.0%	0.0%	0.0%
GASTROENTEROLOGY		55	94.5%	0.0%	5.5%	0.0%
NEPHROLOGY		16	93.8%	0.0%	6.3%	0.0%
PHYSICAL MEDICINE & REHABILITATION		14	92.9%	7.1%	0.0%	0.0%
UROLOGY		29	89.7%	0.0%	10.3%	0.0%

Engagement of Staff

On April 11, 2016, the Authority hired three part-time employees to assist the Board of Directors in the review of the Application and related material. These staff members worked as a team, effectively combining their different perspectives and backgrounds to guide the Board of Directors through this review. These gentlemen brought a deep knowledge of health care, including the clinical, business and legal aspects of health care, to this process. They each have financial acumen and experience with health care mergers. The staff have no special knowledge of Southwest Virginia and did not conduct an audit or similar review of the accounting records of business policies of the Applicants. The three part-time staff members engaged by the Authority are:

Tom Massaro, M.D. Over his career Dr. Massaro, who trained as a pediatrician, served as the medical director of a pediatric intensive care unit, director of the helicopter service at the University of Virginia, and chief medical officer at the University of Virginia Medical Center before resigning to develop and be the dean of the first medical school in Botswana. Dr. Massaro now serves on the faculty of the Darden School of Business at the University of Virginia as well as on the faculty of the School of Law at the University of Virginia.

Richard Brownlee, Ph.D. Dr. Brownlee taught for almost forty years at the at the Darden Graduate School of Business at the University of Virginia, where he now serves as Professor Emeritus. He was Chair of the Accounting Area, and he taught courses in managerial and financial

accounting, including mergers and acquisitions. Dr. Brownlee is a CPA and served as a consultant to the CFA Institute. He has also worked with national and global corporations and with governmental organizations and has experience in the establishment of successful and sustainable public-private partnerships.

Dennis Barry, Esq. Mr. Barry, who is a retired lawyer, graduated from the University of Virginia School of Law in 1975. A partner in three law firms over his career, he ended his career at King & Spalding. Since 1983, Mr. Barry practiced in Washington, DC. Mr. Barry focused his practice exclusively with health care clients, principally hospitals from all regions of the country. His particular area of focus was Medicare coverage, payment and compliance. He will teach a course on Medicare at the University of Virginia School of Law in the Spring Semester of 2017.

Active Promotion of Authority Activity

At the outset, the Chairman of the Authority stated a desire to have wide public distribution of information about the Application. The Authority created and expanded an email distribution list of reporters, writers, stakeholders and interested parties that reach more than 50 names. The Authority created additional links on its website, developed a nearly weekly email update that eventually grew to a distribution list of almost 90 names of interested parties (including members of the Board of Directors), and held public information sessions on September 26th and 27th at Lebanon High School and University of Virginia Wise to allow the Applicants and the Authority to reach citizens that would be effected by the merger to hear and comment on the process.

Throughout the process several stakeholders provided the Authority written input or public testimony during the many Authority meetings.

America's Health Insurance Plans

On May 25, 2016, America's Health Insurance Plans ("AHIP") delivered written comments to the Authority, requesting that it "take all actions necessary to protect consumers from anticompetitive hospital consolidation in the Commonwealth of Virginia."¹⁰⁸ AHIP provided a detailed economic analysis conducted by two economists and stated "the merger is likely to significantly reduce competition and raise prices for consumers."¹⁰⁹ Finally, AHIP encouraged the Authority not to approve the merger and "let the transaction be analyzed by the federal antitrust agencies under the standard antitrust review process."

Lee County Hospital.

At the May 25th meeting of the Board of Directors, representatives attended from the Lee County Hospital Authority and the Lee County community. Mr. Ronnie Montgomery, the Vice Chairman of the Lee County Hospital Authority, started by reminding the members of the Board of Directors that the Lee County Regional Medical Center closed on October 1, 2013, with only days' notice of the impending closure. He

¹⁰⁸ *Written Comments of America's Health Plans Submitted to The Southwest Virginia Health Authority, May 25, 2016* ("AHIP Comments").

¹⁰⁹ *Id.* at 2.

noted that depending upon your location in Lee County, the hospital in Big Stone Gap is twenty-one miles, but from the Rose Hill community in Lee County, the trip is nearly forty-five miles. He noted that with the closure of the hospital, residents had to find other places for medical care. Mr. Montgomery said there is a patient out-migration for pulmonary, general medicine, cardiology, orthopedics and gastroenterology services. He said that his main message was that Lee County did not want to get lost in the merger process.

Ms. Melanie Jorgerson, a resident of Lee County, spoke to the Board about requiring the re-opening of the Lee County hospital as a condition to the approval of the cooperative agreement.

Ms. Jill Carson, a member of the Town Council of Pennington Gap and a member of Virginia Organizing asked the members of the Board of Directors to imagine several everyday scenarios resulting from the closure of the Lee Regional Medical Center, such as this:

"I just want you to imagine for a moment receiving a call from one of your children crying out in excruciating pain for help and then having to travel twenty-one miles to get to your nearest hospital just to find out what is going on with your child. For a parent like myself I would suspect a lot of you sitting here, those twenty-one miles expended to an eternity travelling those twenty-one miles."

Mr. Howard Elliott, a Commissioner of the Lee County Hospital Authority, discussed the residual effect of losing the hospital in the community. He explained that Lee County immediately lost 150 jobs when the hospital closed. "I personally feel like we can never attract any commercial or economic businesses in our county without a hospital," he said. Mr. Elliott also discussed the impact of the existence of the United States Penitentiary in Lee County and the impact of transporting the prisoners the additional distance to the closest hospital.

Finally, Sheriff Gary Parsons addressed the Authority. He spoke about the strain on the rescue squad organizations in Lee County, noting that there can be a significant wait time to get rescue squad services. He said this strain included fuel costs and other budget impacts. He also talked about the great distances in Lee County:

[T]he fact of the matter is that the "golden hour" is lost. I can't tell you, only doctors can give you an opinion that if someone had gotten there quicker they may have lived or they may not have lived, but we have people begging for help. I feel sorry for my 911 dispatchers trying to get help to them. People are on the phone crying for help and we are doing all we can do to help them. It is an incredible liability, but we have actually loaded people in a cruiser to meet the rescue squad because you can't just sit there waiting.

Sherriff Parsons appealed for help for the people of Lee County.

[Virginia Association of Health Plans](#)

Mr. Doug Gray, Executive Director of the Virginia Association of Health Plans addressed the Authority at the May 25th meeting of the Board of Directors, informing the Board that his association represented the payers who people rely upon for services. He said that in the region 70.3% of the discharges are from

Medicaid and Medicare, so that a large amount of the business comes solely from the government and that commercial plans pay for about 17.5% of the discharges. There are six health plans that contract with the two hospital systems in the region and all six are members of his association.

Mr. Gray asked the members of the Board of Directors to consider several themes while they reviewed the Application:

- The government has been expanding access to care (more than just "ObamaCare"). Payment for these services costs significant money. In the commitments there is no guarantee to include the health plans he represents as customers.
- Care is moving from in-patient to out-patient care.
- More providers are needed, more locations are needed, and different types of providers are needed, which means the area needs more than one entity "running the show."

Mr. Gray stated that he is an advocate for his members. He said eight of his association's members are affected by the merger. Five of the members are in the top ten payers list for Wellmont Health System and Mountain States Health Alliance. Three of his members are Medicaid health plans that are more Virginia oriented. He noted that the application for the cooperative agreement does not deem Medicaid as a principal payer – only commercial payers that pay more than two percent.

Mr. Gray stated that he did not believe the Authority would "pass a review" of the FTC if there was one. "If you don't have a real plan for supervision and that supervision is not going to be inexpensive and it has to be paid for, and that supervision has to say, you said you would do X; and you are doing Y. There's only one entity to talk to at this point, so that is a big challenge," he said.

Finally, Mr. Gray stated "big ifs" currently occurring in Richmond: Medicaid expansion and Certificate of Need reform. He reviewed these issues with the Board and his written statement was included in the minutes of the May 25th meeting.

Presentation by The Applicants

The Applicants appeared before the Board of Directors several times during 2016 addressing questions from the Authority Board members and providing additional information for the Board's consideration.¹¹⁰

The Completeness Determination

The process for consideration of the Application distinguished between the delivery of an application for a cooperative or collaborative agreement and the actual receipt of an application upon which the Authority must act. Section 15.2-5384.1(C)(1) of the Code indicates that "parties located within any participating locality may **submit** an application for approval of a proposed cooperative agreement to the

¹¹⁰ See generally, Minutes of the Southwest Virginia Health Authority, 2016.

Authority.”¹¹¹ Applicants are required to “state in detail the nature of the proposed arrangement between them, including without limitation the parties' goals for, and methods for achieving, population health improvement, and improved access to health care services, improved quality, cost efficiencies, ensuring affordability of care, and, as applicable, supporting the Authority's goals and strategic mission.”¹¹²

Section 15.2-5384 of the Code provides that, “[t]he Authority shall determine whether the application is complete.” No specific guidance is given to the Authority regarding this responsibility. Merriam-Webster defines “complete” as “having all necessary parts, elements, or steps.”¹¹³ Once the Board of Directors of the Authority deemed the Application complete, there is no statutory guidance for the Authority to request more information; however, the public, the Applicants, and other stakeholders had the opportunity to provide additional information to the Board of Directors. The statute also grants the Commissioner of Health the opportunity to request additional information from the Applicants.

Upon submission of the Application, which included nearly 4,000 pages of documentation, the Authority immediately realized that it was dealing with a considerable amount of information to process and review. The Authority established a working group structure, employed staff to assist in the review of the Application, received input from the public during its regular meetings, and sought additional information from the Applicants. Paramount to the Authority's determination of completeness was whether the Board of Directors believed it had sufficient information to fulfill its responsibilities under the statute. The Board of Directors understood the distinction between making a determination that the Application was complete and making a recommendation upon the Application itself. The Authority reviewed the criteria upon which it would be required to act to determine the benefits and disadvantages of the proposed cooperative agreement.

On March 15, 2015, the Authority established a working group structure to review the material provided in the Application. The various working groups held a total of sixteen meetings to consider the material provided with the Application. Considerable debate and discussion occurred. The Authority searched for additional resources to assist with the review and employed as staff three well-credentialed individuals with relevant experiences in the health care industry and related professions. These individuals actively advised the Authority and its leadership. They provided expertise and insight to augment the professional knowledge, experiences and community insight of members of the Board of Directors. The Authority encouraged input from stakeholders. Public comment from citizens of the region, representatives of the Applicants, and representatives of stakeholders provided additional knowledge to the Board of Directors as it considered the Application's status. Finally, the Authority requested additional information from the Applicants. Sixty-eight questions were submitted to the Applicants, who provided additional information supplementing their initial application.

¹¹¹ VA. CODE ANN. § 15.2-5384.1(C)(1) (emphasis added).

¹¹² *Id.*

¹¹³ Merriam-Webster Dictionary.

Counsel reviewed the process undertaken by the Board of Directors¹¹⁴ and noted that it had been “deliberate, diligent and inquisitive” and noted that the determination of completeness is analogous to an administrative action and will likely be assessed on whether the determination was “arbitrary and capricious”.¹¹⁵ Counsel instructed the members of the Board of Directors to consider the following questions gleaned from the statutory language as they determined completeness:

1. Do you believe the Applicants have stated in sufficient detail the nature of the proposed arrangement?
2. Do you believe the Applicants have set forth their goals for each of the following:
 - a. Population health improvement;
 - b. Improved access to health care services;
 - c. Improved quality;
 - d. Cost efficiencies; and
 - e. Ensuring affordability of care.
3. Do you believe the Applicants have set forth their goals for supporting the Authority’s goals and strategic mission?
4. Do you believe you have enough information to weigh the benefits of the following:
 - a. Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction;
 - b. Enhancement of population health status consistent with the regional health goals established by the Authority;
 - c. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
 - d. Gains in the cost-efficiency of services provided by the hospitals involved;
 - e. Improvements in the utilization of hospital resources and equipment;
 - f. Avoidance of duplication of hospital resources;
 - g. Participation in the state Medicaid program; and

¹¹⁴ Jeffery K. Mitchell, Completeness, Memorandum to the Board of Directors, August 25, 2016.

¹¹⁵ To avoid a determination that the Authority’s decision was “arbitrary and capricious”, the Authority must base its decision on a consideration of the relevant factors. During the inquiry there must be relevant correlation between facts and judgment that articulate a satisfactory judgment or explanation that is not arbitrary, capricious or unreasonable. *Turner v. Board of Supervisors*, 263 Va. 283, 288, 559 S.E.2d 683, 686 (2002).

- h. Total cost of care.
5. Do you believe you have enough information to weigh the disadvantages “attributable to any reduction in competition” from the following:
- a. The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;
 - b. The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;
 - c. The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and
 - d. The availability of arrangements that are less restrictive to competition and 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

As the Authority began to consider whether the Application was complete, Mr. Erik Bodin, Director of the Office of Licensure and Certification of the Virginia Department of Health, wrote to the Applicants on August 9, 2016 requesting additional information on behalf of the Virginia Department of Health pursuant to Section 15.2-5384.1(F)(2) of the Code. Counsel instructed the members of the Authority’s Board of Directors that the request from the Virginia Department of Health was not relevant to their determination of completeness, as the statute provided the Commissioner with the authority to ask for information outside the Authority’s process. Counsel stated that Mr. Bodkin’s questions did not pre-suppose that the Board of Directors would determine the Application complete. The Authority needed only assess whether it had sufficient information upon which to act, as the Commissioner’s responsibility under the statute is far more expansive than the Authority’s and therefore may require additional information beyond what is necessary for the Authority to make its determination. In short, counsel informed the Board that the existence of these open questions from the Virginia Department of Health was not relevant to the Authority’s determination of completeness.

Virginia Association of Health Plans Objections to Application Status

On August 25, 2106 the Virginia Association of Health Plans submitted extensive comments to the Authority requesting that the Authority not deem the Application complete.¹¹⁶

¹¹⁶ See Letter to The Southwest Virginia Health Authority August 25, 2016

The Association stated that the Application lacked specificity in a number of areas and that, if the Authority deemed the Application complete, the review process and related time periods would become activated. "The Commonwealth should not be handicapped in its review process due to lack of specific information and commitments."¹¹⁷ The Association stated that the potential harm to competition had not been properly addressed, the benefits were vague and illusory, the Applicants had made a commitment to produce a report, not outcomes, the proposed scoring system was inadequate, and specific efficiencies had not been identified.

Staff Recommendation on Completeness

Each of the three staff members recommended that they determine that the Application was complete. On August 25, 2016, the Board of Directors convened in executive session to review the proprietary information delivered with the Application. Later that afternoon, on a motion by Delegate Morefield, the Board of Directors deemed the Application complete.

Public Comment

A Summary of Written Public Comment

On September 1, 2016, the Authority published public notice of the Applicant's complete Application and notification of the public comment period in the *Kingsport Times-News*, *Bluefield Daily Telegraph*, *The Virginia Mountaineer*, *The Bristol Herald Courier*, and on the Authority's website. This announcement launched the written public comment period.

By the conclusion of written public comment period on September 30, 2016, the Authority received comments from the FTC staff, Anthem Blue Cross and Blue Shield, AHIP, Virginia Association of Health Plans, thirteen individuals, eleven businesses, five educational entities, two towns, two chamber of commerce, and one Industrial Development Authority. In total the Authority received forty written public comment submissions, five of which opposed the merger.

Two distinct sets of comment become notable among the written public comment: (1) community leaders and community representatives overwhelmingly speaking in favor of the cooperative agreement and (2) the FTC staff and representatives of the payer community urging caution or speaking against the cooperative agreement.

Community Written Public Comment

Overwhelming local and regional support exists for recommending approval of the Application. The following comments are representative of the vast majority of the written public comments received:

- "As one of the largest employers in the region...I've concluded that I should submit a Statement of Support regarding the merger of our two regional health systems..."

Rick Nunley

¹¹⁷ *Id.* at 2.

Bristol Compressors

- "I'm writing to you as Owner and President [of] Wolf Hills Fabricators in reference to the merger of Wellmont and Mountain States Health Systems. I am a private citizen who lives in Southwest, VA and purchases health coverage for 50 employees and their dependents. Like many people in the region my family and I have been served by both health systems over the past several years. From a personal and business standpoint I strongly support the merger of the two entities."

Eric Miller, President
Wolf Hills Fabricators

- "I believe our region faces many of the same issues as other parts of the world but also that we have a unique set of needs. Many of those unique needs stem from our work or way of life and heritage. Other [sic] needs stem from our geography or other factors. I believe by merging or integrating Wellmont Health System and Mountain States Health Alliance many of our needs can be met."

Larry D. Yates, Mayor
Town of Haysi, Virginia

- "I am a concerned citizen who is against the merger of Mt. States and Wellmont Hospitals. The merger would take away the patients' choices and the employers' choices. It would also take away competition which is important in any community."

George H. Moore
(Together with a petition containing 21 signatures)

- "I am thrilled at the prospect of Wellmont and Mountain States coming together to further grow our osteopathic residency programs by combining our resources to advance the quality of care in our region.

Maurice Nida, D.O., FACOI, DME
Primary Care Physician, Wellmont Medical Associates
Director Of Osteopathic Graduate Medical Education

- "It is extremely important to us that decisions about health care of our area be made by local people who care about our region. We don't want to lose control of our hospitals."

Allen J. and Alison E. Abel
Smyth County

Second, the FTC staff has serious concerns about the impact of granting the cooperative agreement, and state and national representatives of the health insurance community strongly supported not recommending the Application to the Commissioner of Health for approval.

Written Public Comment from the Federal Trade Commission

On September 30, 2016, the staffs of the Federal Trade Commission Bureau of Competition, Bureau of Economics, and Office of Policy Planning provided written public comment to the Application.¹¹⁸ The

¹¹⁸ Letter to Southwest Virginia Health Authority and Marissa J. Levin, M.D., MPH regarding Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health System, September 30, 2016 ("FTC Written Comment"). The staff noted in footnote number one to the letter that "[t]hese comments express the views of the FTC's Bureau of Competition, Bureau of

extensive documentation provided by the FTC staff based upon their year-long review of the proposed merger provided the Authority an overview of the reasons the Federal Trade Commission was interested in the merger and the experience the agency brings to its review of this situation. Acknowledging the mission of the Authority, the staff stated that the mission of the Federal Trade Commission “to preserve competition that will benefit consumers and enhance innovation in healthcare markets,” while enforcing antitrust laws “are consistent with the ‘triple aim’ of health care reform to improve quality, enhance patient experience and access to care, and reduce costs.”¹¹⁹

The staff note acknowledged the unique challenges of Southwest Virginia, but stated “[c]ompetition is no less important in rural and economically-stressed communities than it is in urban and more prosperous ones.”¹²⁰ The FTC staff stated their “concern that the proposed merger of Mountain States and Wellmont would undermine, rather than advance, the Authority’s goals” and that “proposed merger presents substantial risk of serious competitive and consumer harm in the form of higher healthcare costs, lower quality, reduced innovation, and reduced access to care.”¹²¹ While stating that competition between the Applicants “greatly benefits area employers and residents,” the FTC staff set forth arguments that on the basis of quantitative economic analyses, including recognition that the market concentration resulting from the merger was higher than past hospital mergers that have been found anticompetitive.¹²² The FTC staff challenged the proposal’s benefits, many of which they believe could be provided independently or through other forms of collaboration, and stated that the merged hospitals “would have strong financial incentives to circumvent regulatory commitments...”¹²³ The FTC staff also stated:

*If the cooperative agreement is approved, the harm resulting from the reduction in competition is likely to far outweigh any potential benefits. Consequently, we urge the Authority and the Commissioner not approve the cooperative agreement.*¹²⁴

The FTC staff asserted that the Authority’s statutory review of cooperative agreements is similar to staff’s statutory guidance and then provided commentary for the Authority’s consideration on each statutory-stated benefit¹²⁵ and significant commentary on potential disadvantages of the proposed merger.¹²⁶ The staff stated that not all hospital mergers are challenged:

The FTC declines to challenge transactions that might raise competitive concerns when there is compelling evidence that the likely benefits of the

Economics, and Office of Policy Planning. These comments do not necessarily represent the views of the Commission or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit their comments.”

¹¹⁹ Bureau of Competition, Bureau of Economics, Office of Policy Planning, *Federal Trade Commission Staff Submission to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application of Mountain States Health Alliance and Wellmont Health Systems Pursuant to Virginia Code § 15.2-5384.1 and the regulations promulgated thereunder at 12VACS5-221*, September 30, 2016 (“FTC Written Comments”).

¹²⁰ *Id.*

¹²¹ *Id.* at 2.

¹²² *Id.* at 4.

¹²³ *Id.*

¹²⁴ *Id.* at 5.

¹²⁵ *See Id.* at 27-58.

¹²⁶ *See Id.* at 17-26.

transaction would be of sufficient magnitude to offset the potential harm from lost competition. It should be noted, however, that the greater the likelihood of harm from a proposed merger, the more substantial any claimed benefits must be to conclude that the benefits outweigh the harms. Indeed, [e]fficiencies almost never justify a merger to monopoly or near-monopoly.¹²⁷

The FTC staff then provided a significant amount of information about the assessment of the merger under the Commission's merger guidelines. The FTC staff stated that the two health systems "compete vigorously to be included in health plan networks and to attract patients."¹²⁸

The FTC staff provided extensive empirical data of their review of the proposed merger, and the FTC staff also provided several exhibits supporting their comments all of which are available on the Authority's website.

In their written comments, the staff also provided an assessment of each of the perceived disadvantages. They reviewed their concerns regarding the impact of the proposed merger on the ability of payers to negotiate with the merged health system, specifically in terms of relative bargaining leverage, stating "the proposed merger between Mountain States and Wellmont would greatly enhance the hospitals' bargaining power, which would lead to substantially higher prices for consumers."¹²⁹ Also of significant concern to the staff of the Federal Trade Commission is the impact of the merger on the ability of payers to negotiate with the merged system. "Because the FTC is concerned about the impact that healthcare mergers will have on consumers, we take serious the impact that a hospital merger will have on the ability of insurers to negotiate competitive process and other contractual terms on consumers' behalf."¹³⁰ The staff argued that the proposed merger would lead substantially higher price for consumers. The FTC staff also challenged the impact of the proposed merger on the competition for physician services and ancillary health care services, quality, availability and price of healthcare services for patients in Southwest Virginia, as well as suggesting that less restrictive arrangements exist for the Applicants to consider in pursuing their goals.¹³¹ The staff challenged the assertion of the parties that out-of-market health systems would have a negative impact on the region¹³² and stated that "the antitrust laws are not an impediment to legitimate, procompetitive collaboration that would benefit consumers."¹³³ Further, the FTC staff stated that "[t]he elimination of competition between Mountain States and Wellmont will significantly diminish the hospitals' incentives to maintain or improve current levels of quality, patient experience, and access to services and innovative technology, because the combined hospital system would no longer risk losing patients to its pre-merger rival."¹³⁴

¹²⁷ FTC Written Comment, p. 7 *quoting* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES (2010).

¹²⁸ FTC Written Comment, p. 8. The staff quoted a 2015 article in [The Bristol Herald Courier](#) in which the Chairwoman of Mountain States Health Alliance described the health systems as "fierce competitors." See David McGee, *Wellmont, Mountain States Health Alliance Officials Make Deal Public*, BRISTOL HEALTH COURIER (Apr. 2, 2015).

¹²⁹ *Id.* at 19.

¹³⁰ *Id.* at 18.

¹³¹ *Id.* at 21-16.

¹³² *Id.* at 25.

¹³³ *Id.* at 25.

¹³⁴ *Id.* at 23.

The FTC staff also extensively commented on the benefits claimed by the Applicants, including questioning the ability to verify the benefits, questioning whether the benefits are incremental to the benefits that would be achieved without the merger, and asserting that the efficiencies “appear to be modest in magnitude and unlikely to offset the significant disadvantages to the merger.”¹³⁵

The FTC staff noted that they sought assistance from experts on their evaluation of the Applicants’ quality of care and health improvement claims.¹³⁶ In their extensive comments on the benefits, the staff stated certain identified benefits could be achieved without the merger, certain benefits were vague or have limited information to support the claimed benefit. The words “unclear,” “limited information,” “no indication,” “speculative,” “unsubstantiated” and similar words questioning the benefits proposed by the Applicants occur numerous times throughout the FTC staff comments.

The FTC staff asserted that the proposed plan of separation is not an effective remedy to a failure of the parties to meet commitments in the cooperative agreement. The FTC staff cautioned that “[t]he Authority should carefully evaluate [the] claimed quality benefits and cost savings.”¹³⁷ Finally, in closing the staff encouraged the Authority to consider six questions:

- (1) Will the proposed merger substantially reduce competition, allowing the combined hospital system to negotiate higher prices for healthcare services, and reducing its incentives to maintain or improve quality of care?
- (2) Are the claimed benefits (a) credible and verifiable, (b) likely to be achieved and passed through to consumers, (c) achievable only through *this* merger, and (d) of sufficient magnitude to outweigh the proposed merger’s significant disadvantages?
- (3) Have Mountain States and Wellmont substantiated their plans sufficiently to ascertain the steps, timeframe, and costs necessary to (a) consolidate clinical services, (b) surpass volume thresholds that they are not already capable of achieving independently to improve patient health outcomes, and (c) achieve projected synergies and cost reductions?
- (4) Will the proposed regulatory commitments effectively mitigate the competitive harms of the merger, and are they capable of being successfully implemented and objectively monitored, to determine whether the cooperative agreement is meeting the stated public policy goals?
- (5) Does the cooperative agreement offer any meaningful mechanism to discipline the combined hospital system if it fails to meet its regulatory commitments, and can the Plan of Separation offered by Mountain States and Wellmont realistically be achieved?
- (6) How long do the Authority and Commissioner intend to provide regulatory oversight of the cooperative agreement, and what will happen in the event that the underlying legislation is repealed or revised to allow the cooperative agreement to expire?¹³⁸

¹³⁵ *Id.* at 28-29.

¹³⁶ *Id.* at 8.

¹³⁷ *Id.* at 4.

¹³⁸ *Id.* at 65-66.

The FTC staff concluded the written public comment with the following statement “[i]n our assessment, the likely benefits of the cooperative agreement do not outweigh the likely disadvantages of the elimination of competition between Mountain States and Wellmont, and the proposed commitments do not change this conclusion.”¹³⁹

Response of the Applicants to the Staff Written Comments

On October 14, 2016, the Applicants responded to the written comments submitted by the FTC staff¹⁴⁰ reminding the Board of Directors of the Authority that the comments did not represent the views of the Federal Trade Commission and lacked merit.¹⁴¹ The Applicants opened their response with a lengthy explanation of the new policy of the Commonwealth of Virginia to allow cooperative agreements and noted that the objections of the FTC staff to the policy of the Commonwealth of Virginia are not relevant, and closed with a review of the FTC staff comments on the cooperative agreement or COPA arrangements of other states.¹⁴²

The Applicants stated that the application of a traditional antitrust framework was not appropriate to review of cooperative agreements and was recently rejected in West Virginia.¹⁴³ The Applicants also refuted the arguments of the FTC staff related to the rate commitments, quality and access commitments, behavioral health services commitments, and other commitments by rejecting them as speculative or without merit.¹⁴⁴

The Applicants stated that Southwest Virginia is a “unique geographic region that requires a unique solution to its significant health care challenges” and that the staff of the FTC either ignore this situation or “only tangentially refers to the specific geography, population, and health issues facing Southwest Virginia and ignores the substantial health care challenges of the area.”¹⁴⁵ The Applicants again promoted the benefits of a common clinical information technology platform across the two health care systems, noting the difference a common platform and a health information exchange, which is a different type of system.¹⁴⁶ The Applicants recited a number of benefits to a common clinical information technology platform.¹⁴⁷

The Applicants referred to and provided additional statistical information supporting their responses, including [Exhibit 2](#) to their response which sets forth several health indicators for the counties in Southwest Virginia:

¹³⁹ *Id.* at 66.

¹⁴⁰ The Chairman granted the Applicants additional time to respond to the written public comments.

¹⁴¹ Mountain States Health Alliance and Wellmont Health System, Response to 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, October 14, 2016.

¹⁴² *Id.* at 1-7, 37-38.

¹⁴³ *Id.* at 7-12.

¹⁴⁴ *Id.* at 22-36.

¹⁴⁵ *See Id.* at 22-24

¹⁴⁶ *Id.* at 27-32

¹⁴⁷ *Id.* at 29

Virginia Geographic Service Area Health Rankings¹

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Virginia	21 st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

University of Wisconsin Population Health Institute. County Health Rankings 2015.
Accessible at www.countyhealthrankings.org

¹ The full listing of county health rankings for the Geographic Service Area may be found in Table 15.1 of the Application.

Written Public Comment From the Payer Community

Anthem Health Plans of Virginia, Inc.

On September 30, 2016, Anthem Health Plans of Virginia, Inc., which does business as Anthem Blue Cross and Blue Shield, submitted comments to the Authority during the written public comment period. In their comments, Anthem noted that the Chairwoman of the Federal Trade Commission identified five reasons why mergers like the one contemplated between the Applicants “run a high risk of ‘leading to increased healthcare costs and lower quality and decreased access to care.’”¹⁴⁸ Anthem summarized the Chairwoman’s concerns that these type of mergers (1) “[f]ail to replicate the benefits of competition,” (2)

¹⁴⁸ Submission of Anthem Health Plans of Virginia, Inc. (Trades as Anthem Blue Cross and Blue Shield in Virginia) To The Southwest Virginia Health Authority On The Review of the Commonwealth of Virginia Application for a Letter Authorizing Cooperative Agreement From Wellmont Health System and Mountain States Health Alliance, September 30, 2016.

require “constant and active oversight,” (3) “can be circumvented by the hospitals,” (4) “reduce incentives to lower costs or innovate,” and (5) “may not last, which can leave payors and ultimately consumers vulnerable when they expire.”¹⁴⁹ Anthem noted that “in twelve counties the Parties are the only providers of hospital inpatient services.”¹⁵⁰

Anthem’s thirty-page submission asserted that the Applicants significantly understated the competitive risks, offered illusory and substantiated benefits, provided only a commitment to report not achieve results, did not reflect significant investments beyond what the Applicants are currently doing, and does not contain a meaningful scoring system. Anthem further stated that the Applicants could achieve many of the alleged benefits without merging “with their closest competitor.”¹⁵¹

Virginia Association of Health Plans

On September 29, 2016, the Virginia Association of Health Plans submitted comments during the written public comment period.¹⁵² The Association, which represents 10 insurance carriers in the Commonwealth, stated that there are “3 health insurers offering individual products filed with the Virginia Federal Health Exchange totaling 28 commercial plans in the Southwest Region of Virginia, 6 insurers with over 300 plans both on and off the exchange in the small and large group markets and 3 plans offering Medicare Advantage Plans.”¹⁵³ Regarding the review of the Application, the Association stated the “purported benefits that the Parties claim are exceedingly vague and unsubstantiated.”¹⁵⁴ The Association challenged the process for evaluating the performance of the Applicants under the cooperative agreement and the existence of an active regulatory system to monitor their performance.

The Association expressed concern about the impact of a lack of competition on the Medicaid Managed Care Organizations, stating that currently five organizations participated in Southwest Virginia, but the Applicants did not deem these organizations “principal payers,” because they did not meet the two percent (2%) threshold set forth in the Application. The Association urged the Authority not to recommend the Application to the Commissioner of Health.

America’s Health Insurance Plans

The September 30th submission during the written public comment AHIP included “*An Economic Analysis of The Proposed Merger Between Wellmont Health System and Mountain States Health Alliance*,” written by Michael Doane and Luke Froeb of Competition Economics, LLC, which reached the following conclusions:

- The merged health systems would have a seventy-seven percent market share;
- Each Applicant is the other Applicant’s closest competition;

¹⁴⁹ *Id.* at 1-2.

¹⁵⁰ *Id.* at p 7.

¹⁵¹ *Id.* at 14-16.

¹⁵² See Letter to The Southwest Virginia Health Authority, September 29, 2016

¹⁵³ *Id.*

¹⁵⁴ *Id.* at 2.

- The “willingness to pay” modeling framework predicts significant price increases.¹⁵⁵

AHIP noted that although “COPAs may have the worthy goal of attempting to prevent, through regulation, harm to consumers from hospital mergers, COPA regulation cannot substitute fully for competition.”¹⁵⁶ They stated that “[t]he best approach is to prevent anticompetitive mergers and preserve competition in Virginia.”¹⁵⁷

Applicant Response to Written Public Comment

The Applicants were able to respond in writing to the comments made during the written public comment period within ten (10) days after the deadline for submitting comments expired.¹⁵⁸ Due to the issue concerning the counting of “days” among the Authority and Virginia Department of Health (“VDH”) Regulations, the period for which the Applicants could respond to written public comment was extended until October 14, 2016.

On October 14, 2016, the Applicants provided its written response to the FTC’s written public comments, making the following statements in response to the written comments delivered by the payer community and its associations:

- The argument raised by Anthem and the FTC ignore the reality that Virginia chose a different policy approach by enacting the statute authorizing cooperative agreements. “The Commonwealth’s sovereign policy is to encourage health care mergers – even mergers that may be anticompetitive within the meaning of federal and state antitrust laws – where the benefits outweigh the disadvantages resulting from the loss of competition between the merging parties.”¹⁵⁹
- The Applicants stated that the focus on the belief that the proposed merger is anticompetitive did not balance the factors stated in the Virginia cooperative agreement statute. Further, the legislation applies only to Southwest Virginia.
- The Applicants stated that the claim that the proposed benefits were “illusory and unsubstantiated” relied upon an assertion by Anthem that the proposed benefits should only “take into account those benefits that are merger-specific,” which is not in the Virginia statute. The Applicants further noted that the payer community was attempting to incorrectly argue that the antitrust law concepts apply to the cooperative agreement consideration.¹⁶⁰

¹⁵⁵ Mara Osman, Written Comments of America’s Health Insurance Plans Submitted to the Southwest Virginia Health Authority, September 30, 2016.

¹⁵⁶ *Id.*

¹⁵⁷ *Id.*

¹⁵⁸ VA CODE ANN §15.2-5384.1(C)(2).

¹⁵⁹ Mountain States Health Alliance and Wellmont Health System, *Response By Applicants To Submissions Of Anthem Health Plans of Virginia, Inc., Virginia Association Health Plans, and America’s Health Insurance Plans and Supporting Memorandum To The Southwest Virginia Health Authority Regarding Cooperative Agreement Application*, October 21, 2016, 1.

¹⁶⁰ *Id.* at 2-3, 15.

- The Applicants strongly refuted Anthem’s claims that the Applicants are already making investments which could equal the amount of the \$450,000,000 investment described in the proposed commitments. The Applicants had formed the commitments based upon the Southwest Virginia Health Authority’s *Blueprint for Health Improvement and Health Enabled Prosperity*.
- The Applicants’ response to the assertion about maintaining local control of the hospital systems stated that the payer assertion was “both dismissive of and disrespectful to the people of the region...”¹⁶¹
- Regarding the claim that the proposed benefits could be obtained without the merger, the Applicants stated that “Anthem provides no basis for this speculation other than to cite self-serving press releases posted by the out-of-market acquirers.”¹⁶² The Applicants specifically reviewed the results of the Novant acquisition of Prince William Health System.¹⁶³
- The Applicants stated that Anthem claim that the commitments of the Applicants needed to mirror the results of competition was legally inaccurate.¹⁶⁴
- The Applicants rejected Anthem’s complaints about the proposed rate commitments because the comments were not relevant given the policy decision of the Commonwealth to enable cooperative agreements and did not constitute a regulation as claimed.¹⁶⁵
- The claim that the proposed commitments were vague was unfounded. The Applicants’ response reviewed several specific commitments.¹⁶⁶
- The Applicants stated that Anthem’s claim that the separation agreement was not publicly available was factually incorrect.¹⁶⁷
- Regarding the report submitted by AHIP, the Applicants stated the report was drafted prior to the Application being submitted by the Applicants and the report ignored “the significant health care challenges in Southwest Virginia and the significant commitments of the Parties, including pricing commitments.”¹⁶⁸

The Public Hearing

The Code vests the Authority with the responsibility for scheduling a public hearing on the Application in conjunction with the Commissioner, following the written comment period.

On October 3, 2016, the Authority held a public hearing in conjunction with the Commissioner’s office pursuant to Section 15.2-5384.1(C)(2) of the Code on the proposed cooperative agreement. The public

¹⁶¹ Payer Comment Response, p.5.

¹⁶² *See Id.*

¹⁶³ *See Id.* at 6.

¹⁶⁴ *See Id.* at 7

¹⁶⁵ *See Id.* at 9-12.

¹⁶⁶ *See Id.* at 12-15.

¹⁶⁷ *See Id.* at 15

¹⁶⁸ *Id.* at 16

hearing, which started at 5:00 p.m. ended at 6:34 p.m., allowed members of the public to make comments on the proposed cooperative agreement.

Eric Bodine, Director of Office of Licensure and Certification with the Virginia Department of Health, led the public hearing noting that with the passage of House Bill 2316 during the 2015 General Assembly Session the statutory provisions enabling the creation of cooperative agreements. He stated that the public hearing was being held to take comments on the requested cooperative agreement. After a brief presentation by the Applicants, twenty-four members of the public provided comments:

Steve Smith, President and CEO, Food City

- "I believe that this merger proposed by Mountain States Health Alliance and Wellmont is one of the most effective ways for our region to address both the cost of health care and the population health challenges that our communities face."
- "The health systems have agreed to place limits on their negotiated rates with insurance which gives us a degree of certainty about health care costs that we've never had before. And this commitment, in my mind, is unprecedented and is an offer that we would probably not be able to get from anywhere else."
- "They've also committed to reinvesting the savings from this merger into initiatives that would improve community health and enhance service offerings within our area."

Martin Kent, President and Chief Operating Officer, The United Company¹⁶⁹

- "COPA is not right for everyone. In fact, I would propose that it only makes sense when circumstances dictate. What I would submit to you is those circumstances exist in our region."
- "A merger of these two health systems would one, not only allow the health systems to enjoy economies of scale, but, secondly, increase, not decrease, which I know is one of the concerns, but increase those services: pediatric services, mental health services, addictive services, just a few of the many services that could be increased and are desperately needed in our region."

Bill Hayter, President and Chief Executive Officer, First Bank and Trust Company

- "We have 330 employees, and believe me, I am very in tune to insurance costs as we pay out nearly \$22,000,000 a year in insurance premiums."
- "[Y]ou might ask why would I be interested two entities coming together and not creating competition to help hold down costs. And, it is just as they have pointed out before, I believe the duplication of services cannot only assist in providing efficiencies but the \$450,000,000 that would be invested back into the community...is very important our area."

Shannon Scott, County Administrator, County of Wise

- "I support this merger."

Rick Collie, Executive Vice President and CEO, Wise County Chamber of Commerce

- "A healthy business community goes hand-in-hand with a healthy population..."

¹⁶⁹ Mr. Kent noted he served on the Bristol Regional Hospital Board and had been engaged on the Steering Committee for the Population Health working group of the Applicants.

- “Most of our businesses are small family-owned businesses so the cost of health care is an increasing concern...”
- “[The Applicants] agreed to limit their negotiated rate with insurers which will help our insurers and our businesses pay premiums and are self-insured and second they have agreed to keep all of our hospitals operational as clinical and health care intuitions for at least five years. These assurances we probably would not get with another merger.”
- “[A]s the Wise County Chamber of Commerce, we do urge you all to take into consideration to approve the cooperative agreement for Wellmont and Mountain States. And again, like many of the other speakers, we believe this is a once in a lifetime opportunity for us to make a lasting impact on the health and economic stability of our region.”

Ed Roop, Vice President, Farmers and Miners Bank, County of Wise

- “I have been a banker in Wise County for over forty years and being that many years in banking I have been through a lot more mergers than I even want to think or talk about. And to be perfectly honest a lot of those mergers didn’t turn out too well for Southwest Virginia and the people of Southwest Virginia. But, those mergers were between banks and for-profit companies that had headquarters and offices that were hundreds of miles away and the first time that they needed to cut expenses they would look far away from the corporate headquarters to do those cuts and it landed right in our lap along with other expenses and fees and all that was passed on to the customers. But this merger I don’t see is anything close to what we’re talking about in those instances.”
- “But just think of what we could do under one merged health care system, where you could take those campuses that we have now, and take those good employees that we have now, and provide more services, get rid of the duplication of services, and how much better it would be for Wise County and all of Southwest Virginia.”

Beth Rhinehart, President and CEO, Bristol Chamber of Commerce¹⁷⁰

- “Our chamber Board of Directors passed a resolution in support of the merger almost a year ago and continue their support.”
- “I feel our region’s health care should be decided by the people who live, work, worship and raise their families here. This will be possible through the proposed merger which will create a locally governed health system. ”
- “Personally working in the health system, I saw how duplication of services had the potential to get in the way of true effectiveness and efficiencies of health care delivery, just by nature of the competition alone. The focus of one merged entity would eliminate duplication of services, and allow areas that need our greatest attention to be addressed, such as mental health and drug abuse. The cooperative agreement would change this from looking like a traditional merger; it would have diligent and active oversight and supervision by the Commonwealth of Virginia.”
- “The newly emerged entity will be one of the strongest health systems in our country. This means they will be known for the best clinical outcomes and patient experiences. This translates to better health outcomes for our families, and greater life expectancy in a region that currently experiences some of the worst outcomes. The best clinicians and employees will want to practice and live here and that, in turn, will be one of the greatest economic drivers our region could ever ask for.”

¹⁷⁰ Ms. Rhinehart noted that she is a former employee of Wellmont Health System.

Otey Dudley, Past President, E. Dillion & Company¹⁷¹

- "I go back a lit bit, a few years ago, at Johnston Memorial. We were faced with a lot of the challenges today...shrinking reimbursements, more regulations, infrastructure needs...and we begin to look around as trustees of the institution that had been in existence for 100 years and say: what's best for us in the future? What's best for the citizens of the area? Not just the Town of the Abingdon but the region. I have always thought of us as a regional health care facility. Since I have business in Russell County that's very important too. We wanted to keep . . . we wanted a partner would could trust. We wanted to partner local. We want to have people we knew instead of being a part of the system somewhere in Richmond or New York or wherever it might be. And we make a decision to affiliate with Mountain States and looking back today I think it was a very positive move for us and the community when I see what we have been able to add to the services with the support of Mountain States."
- "Mental health care is a huge issue. Substance abuse is a huge issue in this part of the state."
- Working together I think we will certainly enhance and improve Southwest Virginia."

Mark Seidman, Deputy Assistant Director, Mergers IV Division, Federal Trade Commission¹⁷²

- Mr. Seidman noted that the FTC staff had submitted extensive written public comment.
- "As part of its mission to preserve competition and protect consumers the FTC regularly evaluates hospital mergers assessing the likely impact on competition and whether any benefits from a merger would outweigh the harm to consumers. The FTC only challenges mergers when a thorough economic and legal analysis along with real world evidence demonstrate that the merger would substantially lessen competition. The FTC staff has spent more than a year analyzing the proposed merger between Mountain States and Wellmont. Thus far our investigation has led us to have significant concerns about the negative effects this merger of vigorous competitors is likely to have on hospital pricing and quality of care for residents of Southwest Virginia."
- "We recommend that the Authority and Virginia Department of Health deny the hospitals' cooperative agreement application."

Charles Ward, President, Miner's Exchange Bank¹⁷³

- "I think it makes good sense to allow two primary care providers in our area to continue providing the valuable services through an alliance that will be beneficial to everyone."
- "We have known for some time that Wellmont and Mountain States are going to merge with somebody, but the question is should they be allowed to merge with each other or should they be forced to merge with another health care provider outside our area who has little knowledge about the unique health care issues that we face in our region. I think it makes good sense to allow two primary care providers in our area to continue providing their valuable services through an alliance that would be beneficial to everyone."
- "First of all, there is a promise and a commitment that all existing facilities will remain operational as clinical and health care facilities for at least five years. Five years. That's a long time. And, it is a commitment that an outside partner would probably be unwilling to make."

¹⁷¹ Mr. Dudley noted that he is a past Trustee of Johnston Memorial Hospital.

¹⁷² Mr. Seidman noted that the views were the views of the staff.

¹⁷³ Mr. Ward stated he is also the Chairman of the Board, Norton Community Hospital.

- “Secondly, there is a commitment to make millions of dollars in investments in health care in our region, including \$75 million to address critical health issues including addiction treatment services and substance abuse prevention programs, \$140 million to enhance existing health care services that are provided such as community-based mental health services, telemedicine services which bring a high level of expertise into our rural communities, and the recruitment of pediatrics sub-specialists to help our children. \$85 million to support the training and the continuing of education of the health care professionals in our area. No health care system from outside our area would be willing to make these types of commitments.”

Michael Robinson, Director, A Linwood Holton Governor’s School

- “In my humble opinion, this merger will not only improve health care in our region, but improve pediatric opportunities for health care in our region as well.”
- “I am also impressed with the significant focus on children in the commitment list. For example, they’ve promised to invest \$140 million over 10 years in enhanced health care services including pediatric subspecialists in areas that, right now, are very underserved in our area. They’ve also promised to help develop and dedicate pediatric emergency facilities throughout the region, in conjunction with Niswonger Children’s Hospital and set up pediatric telemedicine for kids in rural areas to help them stay close to home for their care.”
- “The investments will address common health issues such as diabetes, type 1 and type 2, childhood obesity, and improving birth outcomes, all of which improve the education of our children.”
- “I’m also thrilled to see their commitment to education, they’ve talked and been a part of meetings where we have talked about making sure that kids read by third grade.”

Scarlet Hall, Oncology Community Navigator, Triumph Cancer Navigators

- “With this merger, it will allow us to have less duplication between the two systems so we can focus on improving or enhancing support in [mental health], and I see it making a great impact in the lives of people in our community.”

David Ring, Manager of Governmental Affairs and Strategic Projects, Strongwell

- “Without reservation, Strongwell supports the merger.”
- “First, between 2015 and 2016, our health care costs increased 23 percent.”
- “A healthier employer is going to translate into lower health care costs.”
- “Competition in the health care sector works differently than that in other industries. There are significant cost redundancies that relate to the duplication of not only services but equipment and buildings as well. Inefficiencies will be reduced from integrated resources. A consolidated board resulting from the proposed merger will be in a better position to offer transparency to reduce these redundancies.”

Dave Nutter, Virginia Hospital and Health Care Association

- “We strongly support this proposed merger.”
- “This merger will have the immediate benefit of providing economies of scale in sharing resources and expertise needed to ensure access to care to thousands of Virginians in Southwest Virginia.”

- “The merger of Wellmont and MSHA presents a unique opportunity for these two systems to make an even greater investment in Southwest Virginia through initiatives that are designed to increase value in the health care services, focusing on improving the health and wellbeing of the region as a whole, and not simply being a provider in inpatient and outpatient hospital services.”
- “Both organizations have a legacy of caring for the people in the communities they serve, which will only become stronger as a result of this combination.”
- “Regarding costs, the larger national trend of combinations and integration of providers has coincided with historic lows in overall health care spending.”

Jeffrey Hundman, Chief Executive Officer, Clifton Companies¹⁷⁴

- “We have met with legislators and we have met with Mountain States and we are fully supportive of the merger of the hospitals and the physician practices. Where we have posed a recommendation to the health Authority and we’ve talked to Mountain States about it is that we do have concerns with the ancillary services. We do want to make sure that this robust market that currently exist in Southwest Virginia remains a competitive environment, remains open to those companies that have invested many, many years, over 35 years of their blood sweat and tears, in providing those services to their neighbors. It truly is an environment of neighbors serving neighbors just like Mountain States and just like Wellmont and we want to continue making those services.”
- “So we asked the authority to consider the recommendations of making sure that there is open choice for all patients that are visiting the Mountain States and Wellmont facilities, the new Ballad health care, and saying that yes you can pick the for your services that you want, the companies you want and still continue to help support over 300 families within Southwest Virginia throughout all of Southwest Virginia that are providing those services to services today and are positioned to provide those services in the future.”

Chuck Slemp, Commonwealth Attorney, City of Norton and County of Wise

- “I see health care having a direct correlation on the criminal justice system.”
- “...almost 90% of [of our cases] are touched by drugs or substance abuse...”
- “I believe that the merger between Wellmont and Mountain States presents a once in a lifetime opportunity for our community leaders to have a positive impact on both these critical issues: law enforcement and also medical treatment.”
- “The merger proposal presents \$75 million over 10 years for improvements to community health. Now, I am thrilled when I read the list of things that this \$75 million is going to go to: preventing substance abuse among children, and looking to reduce prescription drug painkillers, combatting drug addiction through crisis management, residential treatment, which is essential, and community based support, providing residential addiction treatment services, offering behavioral health crisis management and establishing outpatient treatment services.”

Ken Heath, Town of Marion

- “Our hope is that this merger is approved and it brings the best opportunities to providing health to the region.”
- “We hope the merger provides the best outcome while retaining the personnel, and keeping our people working, and retaining the facilities that we so need throughout the region.”

¹⁷⁴ Mr. Hundman stated that he is a former CFO of Mountain States Health Alliance.

Jake Schrum, President of Emory & Henry College¹⁷⁵

- “[S]ince we have a new school of Health Sciences in Marion Virginia and we are also very interested in the health authority’s commitment to provide research dollars for the kind of research work that we will be doing at our school of health sciences especially as it relates to falls and obesity. Those are very, very important to all of us in this part of the central Appalachia and so we are very thankful to the health authority for considering that.”

Gene Couch, President of Virginia Highlands Community College

- The health care industry has faced unprecedented challenges over the past from years and we recognize that. As part of that we have the opportunity to – as a part of this merger -- provide high quality training opportunities going forward for the future. As a result of that, Virginia Highlands and I am in support of this application for a merger, and I have confidence in the systems and the leadership that they will make it a positive outcome for our region.

Robert Baratta, America’s Health Insurance Plans

- “[O]ur request that the Authority take all actions necessary to protect consumers for anti-competitive hospital consolidation in this part of Virginia.”
- “AHIP advocates across the country for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality and innovation.”
- “We have previously raised concerns to the Authority about the merger.”
- “COPA regulation cannot substitute fully for competition.”

Skip Skinner, Retired Executive Director of the LENOWISCO Planning District Commission¹⁷⁶

- “This is a once in a lifetime opportunity.”
- “[S]everal private employers here that pay the bottom health care costs that have indicated their support for this program and this process and they are welcoming the opportunity. We are kind of unique in this area. Everybody recognizes that, but this is an opportunity to get things right. And I would urge to Authority to continue forward with the approval of this application.”

Kyle Shreve, Director of Policy, Virginia Association of Health Plans

- “We represent ten insurance carriers that operate in the Commonwealth including three that operate in this region in the fully-insured affordable care market, as well as five Medicaid Managed Care health plans that manage the Commonwealth’s Medicaid dollars.”
- “We have serious concerns with this merger. We have expressed several times to the Authority.”
- “There is still on plan for active supervision by the Commonwealth.”
- “[E]ven outpatient services would be impacted by this [merger]”

¹⁷⁵ Dr. Schrum served as Co-Chair of one of the working groups.

¹⁷⁶ Mr. Skinner noted he is a member of the Wellmont Lonesome Pine Board of Directors and the Wellmont Health System Board of Directors.

- "As it currently stands, we urge you to oppose the merger"

William L. Moore, Richmond, Virginia

- "I am here to deliver a petition against the merger."
- "It's about choice. Here in Washington County it's a little different situation than in the coalfield counties."
- "If we have the merger, probably not going to be a choice in over an hour in any direction, . . . and that includes employment, not just for patient care, but employment ..."

Brian Dawson, Regional Director For Emergency Services, Johnston Memorial Hospital¹⁷⁷

- "Even though we want to go backwards we can't. Health care is not what it was five years ago. I have watched that change."
- "So we have a path before us we get to make a choice. We can merge. We cannot merge depending on what these regulatory agencies say. We don't merge and I think that our organizations will be forced to merge with other outside organizations and then the people who make decisions about our health care, about my job and about what I can do with my patients or offer my patients, are people that I don't know who don't live here."
- "The FTC and the insurance agencies would like you to think we can go backwards in time. I don't think we can. So I think we're faced with some difficult decisions. But I think we've got to get one before us and I fully support the merger."

The public hearing ended at 6:34 p.m. The recording of the public hearing is available on the Authority's website.¹⁷⁸

¹⁷⁷ Dr. Dawson noted he served on the Johnston Memorial Hospital Board.

¹⁷⁸ See <https://swvahealthauthority.net/minutes>.

Final Review of the Application

The Authority began final phase of the review of the Application on October 27, 2016 with a presentation by its staff. The day before the meeting, the Authority held a special meeting with the FTC staff to discuss the Application and the comments provided by the FTC staff.

The Federal Trade Commission Meeting

The staff of a number of bureaus and departments of the FTC have been heavily engaged in the consideration by the Authority of the application submitted by Wellmont Health System and Mountain States Health Alliance. The Chairman visited with the staff of the FTC in Washington, D.C. on August 24, 2106. On October 26, 2016, the following FTC staff met with the members of the Board of Directors of the Authority in a special meeting of the Board of Directors:

Mark Seidman Deputy Assistant Director
Mergers IV Division, Bureau of Competition,

Aileen Thompson, Ph.D., Assistant Director,
Antitrust II Division, Bureau of Economics,

Goldie Walker, Attorney
Mergers IV Division, Bureau of Competition

Stephanie Wilkinson, Attorney Advisor
Office of Policy Planning

Guia Dixon, Attorney
Mergers IV Division, Bureau of Competition.

Three additional staff members participated by telephone: **Alexis Gilman**, Assistant Director, Mergers IV Division, Bureau of Competition, **Lien Tran, Ph.D.**, Antitrust II Division, Bureau of Economics, and **Rena Rosenzweig**, Research Analyst, Antitrust II Division, Bureau of Economics.

Preliminary Comments of the Staff of the FTC

Prior to initiating the prepared comments of the staff, Mr. Seidman noted several conditions to their presentation. The staff presentation might be constrained by confidentiality issues or regarding legal issues upon which the Commission had not yet opined; however, he noted that he hoped to answer any questions or follow-up after the meeting. He also reminded the members of the Board of Directors of the "standard caveat" that the FTC has authorized the staff to participate in this meeting; however, the remarks are the comments of the staff and not the views of the Commission or any individual commissioner. Finally, he noted that in a situation such as this cooperative agreement, multiple

"WE TAKE SERIOUSLY OUR ROLE IN PROTECTING CONSUMERS IN THIS REGION, WHICH IS WHY WE HAVE SUBMITTED A LENGTHY PUBLIC COMMENT AND SOUGHT TO PARTICIPATE IN THIS STATE REVIEW PROCESS AS MUCH AS POSSIBLE." – MARK SEIDMAN

remedies and potential adverse effects exist and he did not want any of the comments to be viewed as a particular endorsement of any particular plan.

Finally, Mr. Seidman noted that the staff had reviewed the written response provided by the Applicants to the written public comments submitted by the FTC staff. He reiterated that the FTC staff made clear during their presentation that they were not at the meeting to criticize the public policy decisions that Virginia had made. Mr. Seidman said that they have attempted to review the Application "through the lens laid out in the [Virginia] legislation." He reminded the Board that the FTC's mission is to maintain competition by protecting consumers. He said the staff is not questioning the policy choice made by the Virginia legislature. He said they structured their public comment and their analysis following the legislative framework.

Next, Mr. Seidman reported that the staff was not prosecuting an antitrust case against the merger through the public comment or the comments at the October 26, 2016 meeting. Their role was to provide their extensive experience in reviewing hospital and other health care related mergers to help the Authority understand the nature of the risks presented by the Application and to identify the challenges or shortcomings of the Application. He noted that the two health systems were making an extraordinary request when they sought approval for a merger that will create a virtual hospital monopoly in Southwest Virginia.

Mr. Seidman reminded the Authority that the Applicants had the burden to fully describe the benefits of the merger and how the commitments will mitigate any harm presented. They needed to demonstrate that the benefits likely to result from the proposed outweigh the disadvantages likely to result from the reduction of competition. Mr. Seidman stated that the factors the Authority was considering in reviewing the Application were very similar to the factors in the standard merger guidelines analysis published by the FTC, including considering factors such as the impact on quality of care and the potential for cost savings.

Mr. Seidman also noted that the FTC staff was "well aware of the economic and health care challenges facing Southwest Virginia." He stated that contrary to the statements of the Applicants, "we are not blind to these realities."

Finally, Mr. Seidman said that the question for the FTC staff, and more importantly the question for the Authority, was "whether this merger is the only way to address the issues at the cost of replacing virtually all hospital competition in the area." Mr. Seidman stated that the Applicants had not provided any "concrete information about alternative arrangements available." Instead, he said, the Applicants were requesting Southwest Virginia to take on a tremendous risk that the post-merger monopoly power could be effectively "constrained by government regulation and counterbalanced by promises that may be difficult to enforce, will take years to materialize and to which the Authority and the Department of Health may have limited ability to remedy if the parties fail to fulfill their promises."

A Review of Competition by the FTC Staff

Ms. Goldie Walker next discussed the dynamics of hospital competition. Ms. Walker focused her comments on three specific areas: (1) the relevance of hospital competition in the review of the cooperative agreement, hospital competition in general and how it affects patients and employers in Southwest Virginia, (2) the loss of competition resulting from the cooperative agreement, and (3) a review of the cooperative agreement and the benefits and disadvantages of the proposed cooperative agreement.

Ms. Walker stated that a review of competition is a relevant factor for the Authority to consider because the Virginia statute expressly states that the Authority must consider the harm resulting from the loss of competition. She noted that all four disadvantages listed in the statutory guidance provided to the Authority relate to competition: negotiation with health insurers, competition among health care providers, impact on price and quality of health care, and the availability of less restrictive alternatives. Ms. Walker stated that while the Applicants have questioned the value of competition and its relevance to competition in this market, she noted that it is inaccurate to say it is not relevant, based upon the requirements of the statute for the review of the cooperative agreement.

Next Ms. Walker informed the Authority that two stages of hospital competition exist: (1) hospitals compete for inclusion in health insurers' networks and (2) hospitals compete for patients. First, she noted that to be included in a network, hospitals negotiate prices, which largely depend upon the bargaining position of the parties. She reviewed examples of negotiating leverage and stated that pre-merger the bargaining position of each of the Applicants is limited by the existence of the other system. She stated that the parties are close competitors which impacts their negotiating posture with insurers. Ms. Walker noted that insurers are often a proxy for patients so if prices go up for insurers, then insurers will pass on those higher prices to their employers. Then employers pass along the increase to employees in the form of higher deductibles, co-payments and other out-of-pocket expenses. She noted that self-insuring employers feel the real cost of price increases. Second, Ms. Walker noted that in the second stage of competition, hospitals compete to attract patients and patient referrals, where competition is based upon quality, innovation, access and availability of a hospital service. She warned the members of the Board of Directors that a merger could negatively impact these factors and that such impact not only affects insured patients, but uninsured patients as well.

Ms. Walker further noted that there is overwhelming evidence that each Applicant is the other's closest competition. She noted the existence of economic studies, litigated cases, and the experience of the FTC staff that stated that the merger is highly likely to lead to higher prices and lower quality. Ms. Walker said that the parties do not meaningfully dispute these claims. She stated that although the Applicants argue that the Virginia legislature's goal was to displace competition, and therefore consideration of competition is irrelevant, the loss of competition must be considered. She noted that the Virginia Department of Health regulations allowed for consultations with the FTC staff during the review of the cooperative agreement.

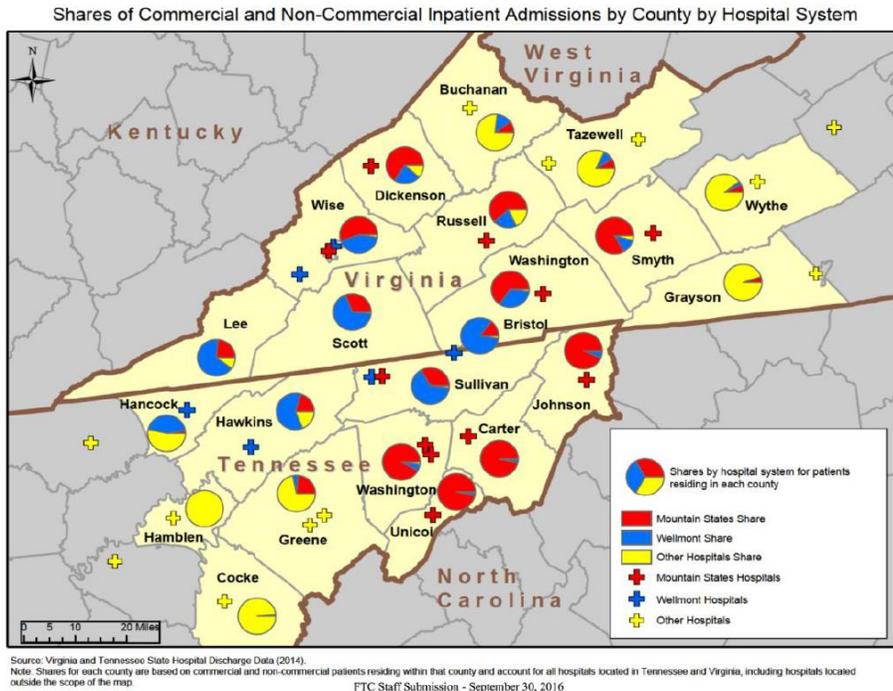
Next, Ms. Walker provided a review of the proposed benefits of the cooperative agreement, noting that the staff had reviewed numerous hospital mergers and the proposed benefits and potential harms on competition of such mergers. She reviewed the statutorily identified benefits, which she noted the staff had extensively reviewed in the written public comments they submitted. She stated that it was their opinion that the Applicants had not shown that “meaningful benefits outweigh the harm. Ms. Walker focused on whether the parties sufficiently demonstrated that their claimed benefits were substantiated and could only be achieved through this merger. She noted that the statute required consideration of less restrictive alternatives to achieve any claimed benefits or a better balance of benefits over disadvantages. She stated the question was whether the proposed merger was the only way to achieve the given benefits.

Ms. Walker, like Mr. Seidman, noted that for the Authority to grant this extraordinary request for a near monopoly near the region, the Applicants should be very clear about the proposed benefits they claim. “The Applicants have not shown that most of their claimed benefits can only be achieved through this merger and not through other means having the same or lessor anticompetitive effects,” she stated. She reminded the Authority that the staff identified several claimed benefits that she felt lacked the specificity necessary, as well as sufficient detail to verify the benefits. She encouraged the Authority to hold the Applicants to a high standard of specificity concerning the claimed benefits providing several examples of staff concerns, including noting the existence of a health information exchange already in operation in the region.

Finally, Ms. Walker concluded by stating that the FTC staff did not believe that the Applicants had shown that the benefits of the cooperative agreement outweigh the harm or that the Authority should take the significant risk that these benefits will actually be achieved.

[A Review of the Economic Analysis and Alternative Arrangements](#)

Dr. Eileen Thompson, an economist, discussed the economic analysis conducted by the FTC staff and the potential for less restrictive alternatives. Dr. Thompson informed the Authority that the Bureau of Economic Analysis of the FTC had utilized inpatient discharge data for the region to study the impact of the merger. She reviewed the following “pac man map” with the Authority:



She stated that each circle represents the shares by hospital systems for the patients living in a particular county. She stated that the diagram mainly shows the role of the two hospitals in the region, noting that some patients do seek out other hospitals than the Applicants', but the number of people seeking those other hospitals is small. She noted that the staff utilized a patient choice model to predict where patients would have gone if their first choice hospital was not available. She explained the process of predicting patient choices, based upon distance of travel, diagnosis and other factors. Her Bureau's analysis revealed that the Applicants are extremely close competitors. She reported that about eighty-five percent (85%) of Wellmont Health System patients have Mountain States Health Alliance hospitals as their second choice if Wellmont Health System is unavailable to them as an option. A similar number of Mountain States Health Alliance hospital patients would choose a Wellmont Health System hospital as their second choice if a Mountain States Health Alliance hospital was not available to them. She stated that this percentage represented a high level of competition between the two systems. She said that the internal staff analysis noted the potential for price increases of up to 100%, which is broadly consistent with economic studies of past mergers. Dr. Thompson reported that economic studies of mergers of competing hospitals in concentrated markets often lead to price increases of more than 20% and gave examples for the Board to consider. Dr. Thompson noted that the Applicants have agreed to limit price increases, but she stated that the staff's analysis is very informative because it provides a measure of the additional market power that could arise as a result of the merger. Even if the price caps are effective, she said, the market power may manifest itself in other ways. As an example, she noted that with the increased market power there may be decreased incentive to invest in quality care initiatives with the absence of competition.

Next, Dr. Thompson stated that given the significant market power of the proposed merger, the Authority needed to consider whether less restrictive alternatives existed for competition that could achieve the same benefits. She noted one of the statutory factors requires the Authority to consider whether these options exist. She noted that as the FTC staff stated in their written public comment, they believe that many of the benefits the Applicants hope to achieve could be accomplished through other alternative arrangements, such as independently by an Applicant acting on its own or through a collaboration that would not involve a full merger (such as joint ventures or contractual arrangements). She said that although extensive guidance regarding these arrangements is available on the FTC website, the staff is not aware of efforts of the Applicants to investigate these types of collaborative arrangements.

Dr. Thompson noted that the Applicants could achieve similar through an alternative merger arrangement that did not involve a merger between two very close competitors (*i.e.*, “out of market mergers”). She said the Applicants have expressed concerns that such an out of market merger may lead to substantial price increases; however, she challenged this assertion, noting that the two systems are not “small, independent, stand-alone hospitals.”¹⁷⁹ She noted the challenges in relying on economic studies like the one cited by the Applicants and stated that some studies suggest that when a hospital becomes part of a larger system it gains the additional bargaining power of the system.

She noted that the Applicants also raised concerns that an out-of-market-merger would lead to more job losses and facility closures than the cooperative agreement, but she called such concerns speculative. Dr. Thompson noted that Wellmont Health System had received offers but the alternatives were not public. She encouraged the Authority get additional information.

[A Review of the Commitments by the Staff of the FTC](#)

Ms. Stephanie Wilkinson, from the Office of Policy Planning, provided comments on the commitments of the Applicants, especially the price commitments. She stated that the Applicants recognize that the merger is likely to raise significant anti-trust concerns, so they have attempted to mitigate the anti-trust concerns on pricing and quality by proposing several commitments that they claim would restrict their post-merger pricing and contracting behavior and lead to quality improvements. Ms. Wilkinson first noted that that the Applicants stated that their monetary commitments are possible *solely* because of the savings to be realized from merger efficiencies. She noted that experience had demonstrated many mergers do not achieve their planned efficiencies; which means that if they do not achieve the savings there are serious doubts they could invest the funds. Even though some of the commitments have been revised, she stated that the commitments would still prove difficult to implement, monitor and enforce – and would not replicate the benefits of competition. She stated that generally such commitments are inadequate to prevent consumer harm.

¹⁷⁹ Dr. Thompson noted that the parameters of the study cited by the Applicants was not applicable because of the size of the hospitals in the study.

Ms. Wilkinson stated that the FTC staff attempted to share their concerns about the commitments in the written public comment, but that the comments should not be considered to be an exhaustive list of the concerns. She noted that the Applicants stated that a change in circumstances could change the feasibility or meaningfulness of the commitments which are not possible to see today. She informed the Board that the FTC is not in a position to determine what commitments will be necessary for the benefits of the cooperative agreement to outweigh the disadvantages. Their goal, she said, is to raise the issues, questions and concerns that the Authority may wish to consider as they review the application. She stated that:

"Ultimately the burden is on the Applicants to demonstrate that their proposed commitments will work and that the benefits will outweigh the disadvantages. The Authority and the Commissioner will have to decide if they are comfortable with the commitments and that the commitments are sufficient and whether they will have the ability and resources to monitor and enforce the commitments in perpetuity."

Next, prior to focusing on the price commitments proposed by the Applicants, Ms. Wilkinson stated that the FTC staff continued to have concerns about whether the quality commitments could be achieved. She noted that economic studies demonstrated that a reduction in competition is likely to cause a reduction in quality. She stated that adverse effects are particularly likely in markets with pricing restrictions because pricing restrictions can reduce incentives to improve or maintain quality. Ms. Wilkinson stated that the FTC staff continued to believe that the price commitments are unlikely to protect consumers from price increases likely to result from the loss of competition. She noted remaining ambiguity and suggested it was not possible to foresee all of the possible ways the price commitments could fall short. Further, she noted that the changing health care models make judging the commitments difficult. Finally, Ms. Wilkinson posed several issues that the Authority may wish to consider:

- The Applicants stated that prices will increase less with the merger; however, it is possible in a competitive market that payers could negotiate price reduction which would be better for consumers. She encouraged the Authority to question whether such price reductions had been achieved in prior years. Without the merger, payers might be able to mitigate or resist price increases.
- The price cap is likely to be a floor, despite Applicant plans to the contrary, because the commitment seems to guarantee no rate lower than the cap.
- Ms. Wilkinson said it is unclear how the price cap would apply to services that do not have fixed rates.
- Ms. Wilkinson said it is unclear how the Applicants determined the \$10,000,000 in estimated cost savings and noted that the estimate is non-binding.
- There does not appear to be any way for the Commissioner to oppose price increases, if the mediation is unsuccessful.
- While the Applicants revised the definition of principal payers, it is still limited to those payers who provide more than two percent (2%) of the new health system's total revenue.

After noting the existence of concerns raised by Amerigroup, Virginia Association of Health Plans raised additional points about the price plans that the Authority may wish to consider.

Ms. Wilkinson noted that after the merger there would be “no meaningful competition and only limited competition” for certain services. She warned that there would be nothing to prevent the new health system from exercising its market power for maximum negotiation leverage.

Finally, Ms. Wilkinson said that effective enforcement mechanisms for the commitments still seemed to be lacking.

[Comments on The Plan of Separation and the Commitment Enforcement Mechanism](#)

Mr. Seidman noted that the only apparent enforcement mechanism is the plan of separation, which was discussed in detail in the FTC staff’s written public comments. He noted that the Tennessee submission by the Applicants of a plan of separation still raised concerns. He reviewed the plan, stating that it is unlikely that the Virginia and Tennessee Departments of Health would conclude in the first eighteen months that the merger had failed, because this is not enough time to make such a determination – absent some obvious failure by the Applicants. Several of the commitments, he noted, will not be completed in the first eighteen months. He noted that the separation of the assets of a merged system is extremely difficult, based upon the FTC’s experience. He raised several additional concerns about the practical application of a separation strategy. He expressed concern with this “nuclear option,” which he said would have to be utilized in conjunction with the State of Tennessee. Mr. Seidman added that he continued to see no consequences if a commitment is not met.

[A General Discussion of the Application with the Board of Directors](#)

The FTC staff made themselves available for questions following their presentation and an extension conversation occurred.

[Investigation Overview](#)

During the question and answer session, Mr. Barry asked the FTC staff if they could share some indication of the investigation they had done during the past year. Mr. Seidman stated that while the information was confidential, the staff generally tried to talk to as many market participants as possible. He said their analysis is not to see who is supporting a merger, but instead on what competition looks like in the market and what impact the merger might have.

[Role of FTC Staff](#)

Mr. Barry asked Mr. Seidman to review the role of the staff and the Commission, noting that again the FTC staff had provided caveats to its participation, as it did in the written public comment. He asked why the Commission had not acted and how common it was for the staff to be so engaged without Commission action. Mr. Seidman noted that the investigation was ongoing and the Commission would be asking very specific questions. Ms. Wilkinson noted it is very common for staff to submit comments as they did in this case.

Comparison of Virginia Statute and FTC Merger Guidelines

Mr. Barry questioned the comparison of the Virginia statute and the FTC merger guidelines and whether the weighting of the advantages and the disadvantages is the same as the FTC staff has given it and asked whether there were any circumstances where the FTC would not oppose a merger. Mr. Seidman stated that the FTC has not taken a position on the merger as an anti-trust issue; however, the staff has stated their opposition to the cooperative agreement – as it stands now. He was not certain whether there were scenarios they could recommend because of the hypothetical nature of such a deliberation. He reminded the Authority that the mission of the Federal Trade Commission is to promote competition and to place a premium on competition. Ms. Wilkinson added that the staff was not aware of any evidence that the proposed regulatory scheme would yield a better outcome than continued competition and that is why the staff favored continued competition. She further stated that the staff was aware of economic studies that show the benefits of competition.

Other Cooperative Agreements

Mr. Barry and the FTC staff engaged in a discussion regarding the potential for other cooperative agreements to provide evidence that benefits had been achieved in the same way as market studies of mergers showed the impact of the mergers. They discussed the few cooperative agreement arrangement or COPA situations – such as Montana and North Carolina – whether the arrangement had existed a long time. The staff commented that they were not aware of any studies on price and quality under these arrangements, but that publicly available information, which raised concerns, had been shared by the FTC staff with the Authority.

Impact of Public Support for Cooperative Agreement

Mr. Barry asked whether the substantial public support of employers and the business community figured into the analysis of the staff. The FTC staff commented that such support is a secondary factor to their primary goal of understanding the competitive dynamics of the situation before and after the merger. Mr. Barry inquired whether the FTC staff believed the self-insured employers were acting against their own self-interest in supporting the merger. Mr. Seidman noted that while the staff could not speculate about individual motivations, there were often various reasons people spoke up on mergers, including business reasons that might not always be economic.

Information Considered by the FTC Staff

Mr. Barry inquired about the documentation the staff had received from third parties; however, the staff noted that all such information was confidential.

Impact of Anthem Market Size

Mr. Barry asked the FTC staff about the impact of the fact that Anthem has a nearly 80% market share of the insurance non-governmental market and is on record in Virginia opposing the merger. The FTC staff

noted that the market share of a party before the deal does not change after the deal. The staff investigation focuses on what changes following the merger, especially when such changes have a significant impact.

Size of Merger

In a response to a question from Chairman Kilgore, the FTC staff noted that the proposed merger under discussion was on the larger end, in terms of merger size. The FTC staff noted that they focus as much on the degree of competition, which in the pending case was very large, more than the number of hospitals.

Examples of Commitments

Dr. Rawlins followed with a question about the impact of this market share, asking the FTC staff how to make the commitments more effective. Mr. Seidman noted that the commitments could be more clear, especially with the respect to the 2% payer parameter. Further, he asked what power the Commissioner of Health had to enforce the commitments.

The Effect of Competition on the Rural Hospitals

Dr. Rawlins noted that competition has not helped the rural hospitals. She noted that during the discussions with the Applicants, the working group leaders asked very tough questions and received, in her opinion, a lot of guarantees about what the Applicants would do.

“We asked a lot of tough questions as an Authority.” Dr. Rawlins

She noted that under the current situation there were no guarantees about what might happen with the rural hospitals and that the Applicants had provided a commitment to keep them open for at least five years and further to provide certain services in the localities. She noted that was a “big commitment” to the Authority. She asked whether the FTC thought about the fact that the region had so many rural hospitals. The FTC staff confirmed their consideration of the rural hospitals and reminded the Authority that it should not consider the rural hospitals in isolation, as often such rural hospitals fed patients to tertiary hospitals. The FTC staff reiterated its concern that the commitment regarding rural hospitals was vague and that it was for only five years, which could be a relatively short period in the life of the proposed merger, and that “health care institutions” are not necessarily hospitals. Dr. Rawlins stated that the Applicants had proposed very specific services that would be offered; however, the staff commented that such services could potentially (because of the vague wording) be offered to residents of a locality by a facility outside the locality.

Virginia Legislative Process

The FTC staff noted that it was not involved in the legislative process related to the creation of the cooperative agreement legislation in Virginia.

Affordable Care Act

Senator Carrico asked the FTC staff to explain why, given the Commission's concerns about near monopolies, their impact on competition, the nature of limited price increases and how that it is geared to the offer of caps in the prices increases, the federal government appeared not to be controlling the impact of the Affordable Care Act ("ACA") on the insurance providers, thereby creating, in some markets, a near monopoly as insurers are "bailing out" the markets. He asked how such a situation did not raise antitrust concerns. The FTC staff stated that the Commission's position was that the goals of the ACA to reduce prices, improve quality, and increase access, are consistent with the goals of the anti-trust laws. Senator Carrico asked whether insurance companies leaving the market is a concern to the FTC. Ms. Wilkinson noted that the FTC has the authority to investigate insurance markets and health care provider markets, but that the United States Department of Justice focuses on the challenging issues raised by Senator Carrico. She noted that there is no anti-trust exception to the ACA.

Self-Insurers

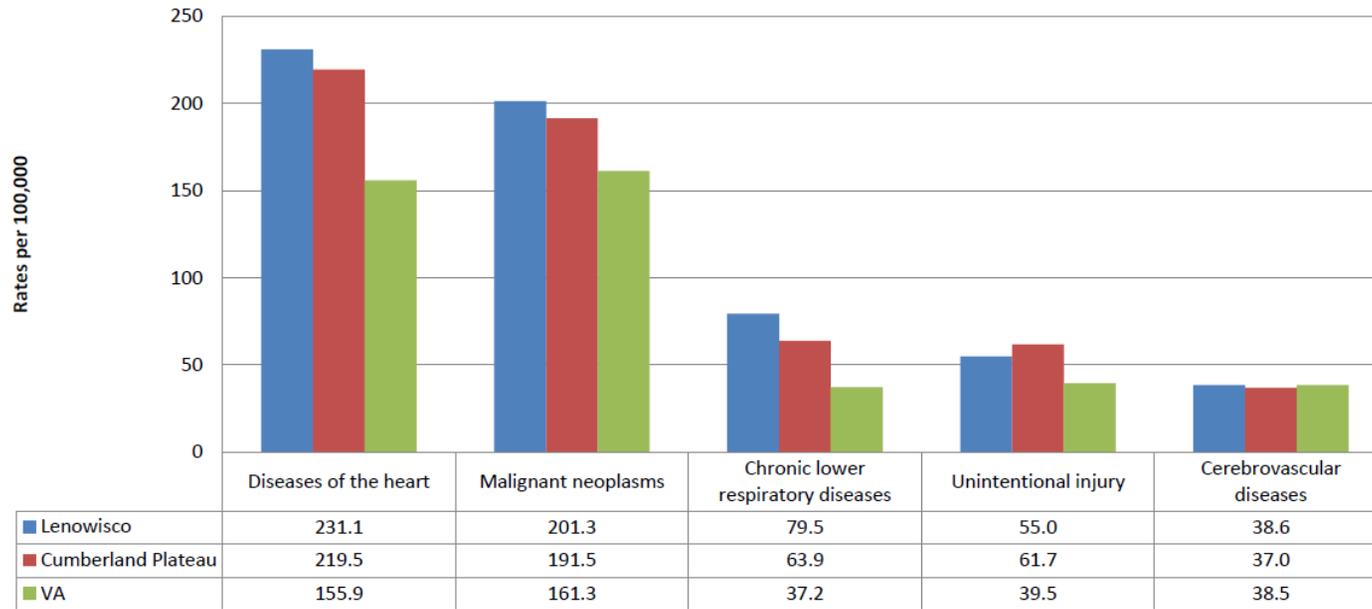
The FTC staff and the Authority engaged in a discussion regarding the self-insurance community and their support of the merger. The FTC staff noted that the price increases were likely passed on to consumers and it was likely that price savings could be as well. They stated that insurance companies compete against each other so they would have an incentive to pass along. Mr. Mitchell noted that it is possible that the insurers would not pass the savings along to consumers, especially when one has significant market leverage.

Impact of Competition on Health Outcomes

Dr. Cantrell next provided several charts showing poor health outcomes which have occurred in the current market with competition. She questioned just how well competition had served Southwest Virginia. She reviewed the top five causes of death, the cancer incidence rate, mortality rate and other information and provided the following graphs for consideration:

Top 5 Causes of Death

Top 5 Causes of Death
Age-adjusted rates per 100,000



Top 5 Causes of Death

Rank	Virginia
1	Malignant neoplasms: 161.3
2	Diseases of the heart: 155.9
3	Cerebrovascular diseases: 38.5
4	Chronic lower respiratory diseases: 37.2
5	Unintentional injury: 39.5

Rank	LENOWISCO
1	Diseases of the heart: 231.1
2	Malignant neoplasms: 201.3
3	Chronic lower respiratory diseases: 79.5
4	Unintentional injury: 55.0
5	Cerebrovascular diseases: 38.6

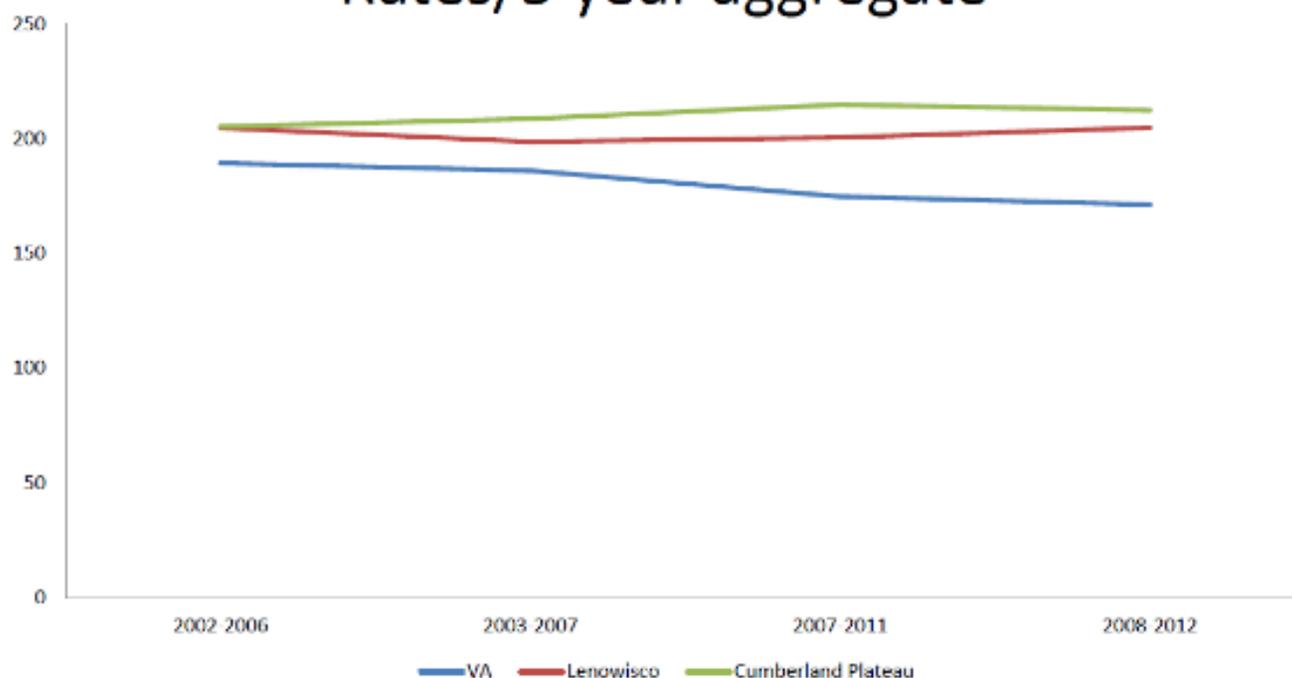
Rank	Cumberland Plateau
1	Diseases of the heart: 219.5
2	Malignant neoplasms: 191.5
3	Chronic lower respiratory diseases: 63.9
4	Unintentional injury: 61.7
5	Influenza & Pneumonia: 37.7

Cancer Incidence/Mortality

	LENOWISCO	Cumberland Plateau	VA	
All Sites				
Incidence	387.6	387.5	443.9	Incidence: new cases detected per year
Staging - % localized	38.40%	42.00%	46.00%	
Mortality	212.4	204.8	171.2	
Breast (Female)				Staging-% localized : percent of cancers detected when "localized" which generally improves prognosis, assuming adequate access to care and quality of care
Incidence	103.7	76.4	125	
Staging - % localized	62.90%	57.70%	62.30%	
Mortality	25.9	26.4	22.7	Mortality: cancer as a primary or contributing cause of death
Colorectal				
Incidence	38.2	39.7	39.5	
Staging - % localized	39.20%	35.30%	39.70%	
Mortality	17.9	18.5	14.9	
Lung				
Incidence	83.4	75.1	64.5	
Staging - % localized	17.80%	17.90%	19.10%	
Mortality	73.1	67.9	48.2	

Source: Cancer in Virginia: Overview and Selected Statistics, August 2014

Cancer Mortality Rates/5 year aggregate



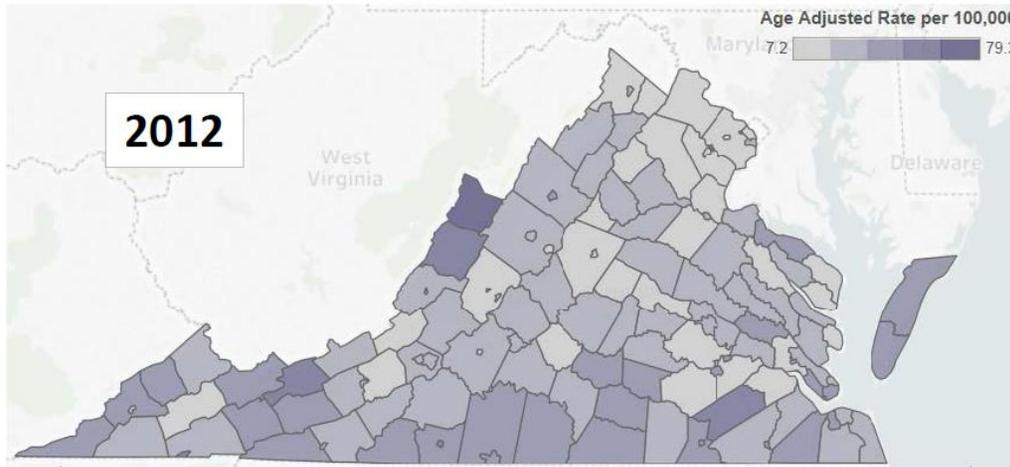
Note: Data exclude basal and squamous cell skin and in situ cancers except urinary bladder. Rates are per 100,000 persons and are age-adjusted to the 2000 U.S. standard population.

Note: There was one cancer death with unknown location, therefore the state total is one greater than the sum of the health districts.

* Includes White, African American and other races

Diabetes Mortality

70
60
50
40
30
20
10
0

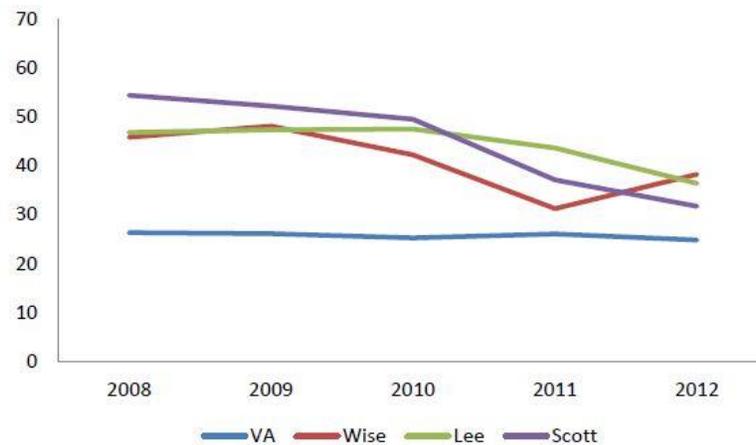
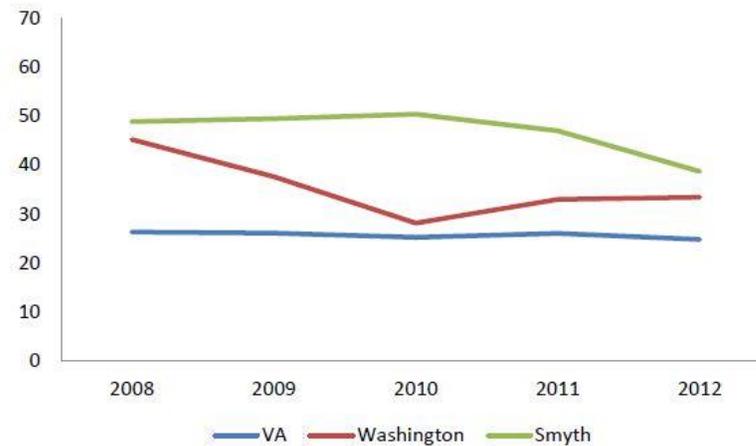
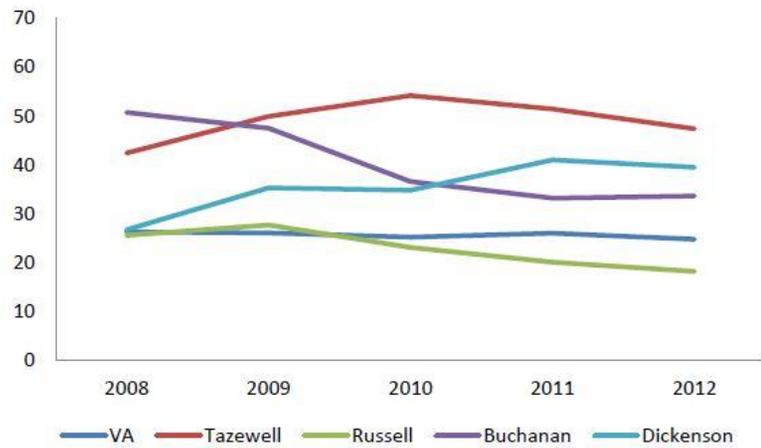


	2008	2009	2010	2011	2012
VA	26.3	26.1	25.2	26.0	24.8
Wise	45.8	48.1	42.2	31.2	38.2
Lee	46.8	47.3	47.5	43.6	36.4
Scott	54.4	52.2	49.5	37.1	31.7
Tazewell	42.4	49.9	54.2	51.4	47.4
Russell	25.6	27.7	23.1	20.1	18.2
Buchanan	50.7	47.5	36.6	33.2	33.6
Dickenson	26.7	35.3	34.8	41.0	39.5
Washington	45.2	37.6	28.1	33.0	33.4
Smyth	48.9	49.5	50.4	47.0	38.7

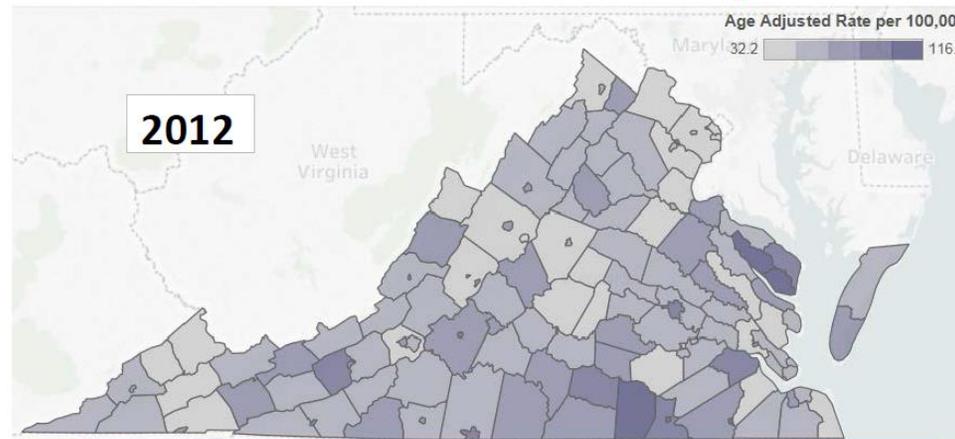
2008 2009 2010 2011 2012

— VA — Wise — Lee — Scott

Diabetes Mortality Rates per 100,000

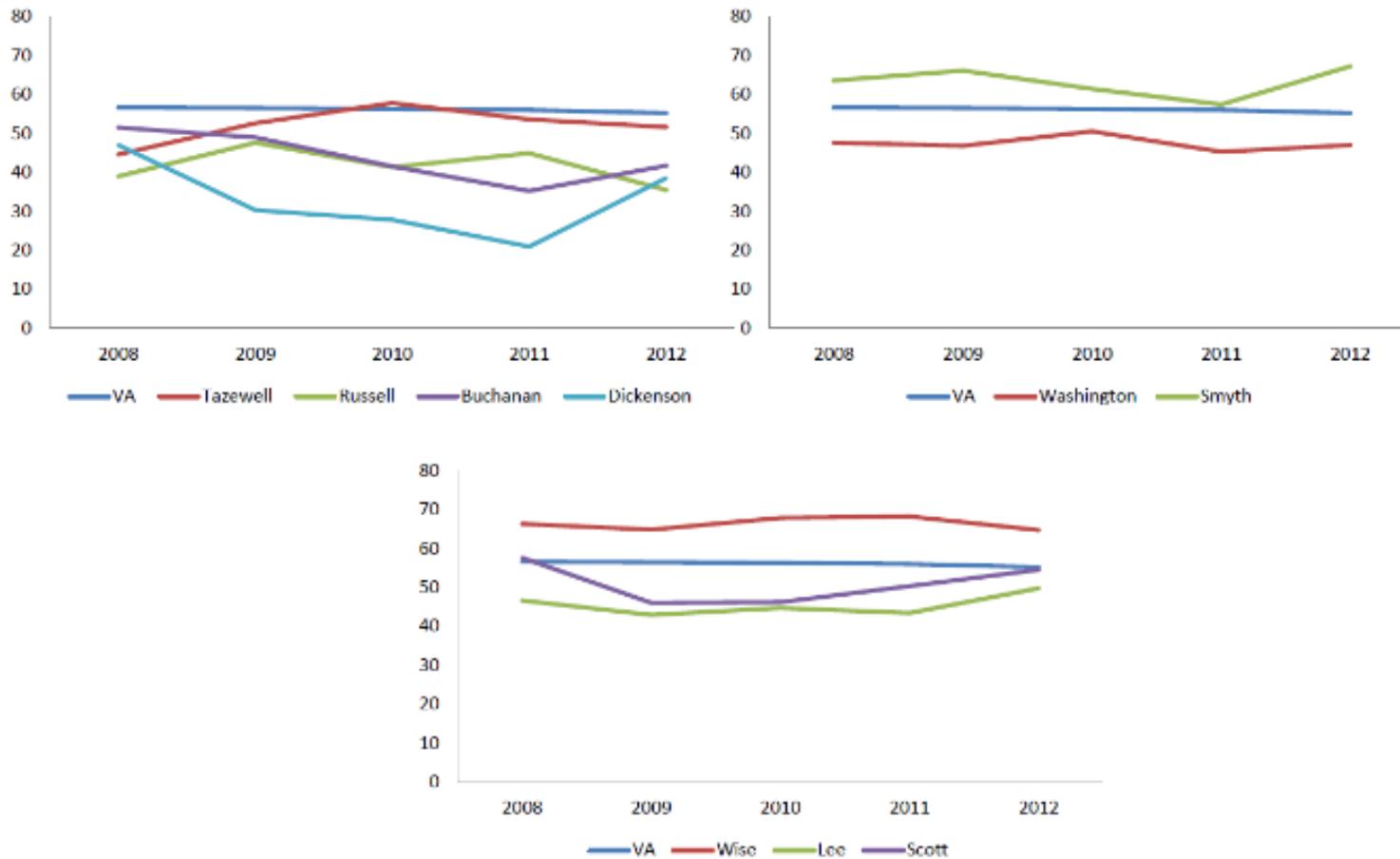


Stroke Mortality

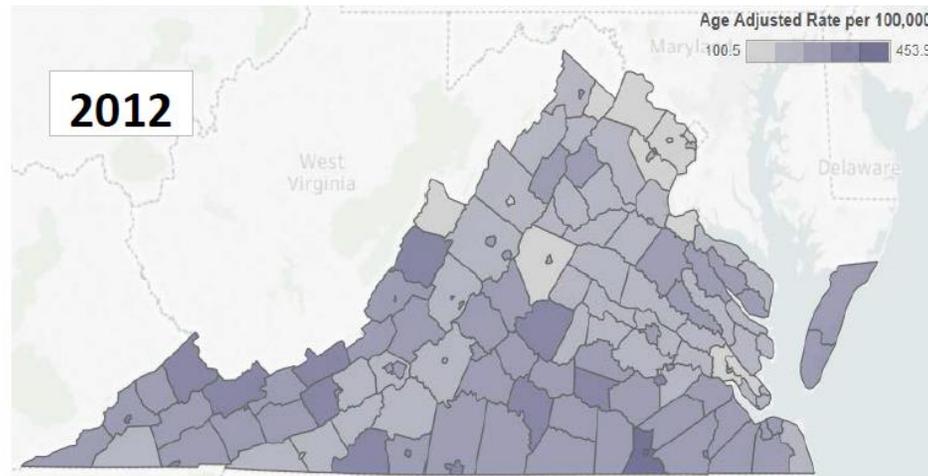


	2008	2009	2010	2011	2012
VA	56.6	56.5	56.3	56.0	55.2
Wise	66.3	64.8	67.8	68.2	64.7
Lee	46.6	42.9	44.7	43.4	49.8
Scott	57.6	46.0	46.2	50.3	54.5
Tazewell	44.6	52.6	57.8	53.6	51.6
Russell	39.0	47.6	41.3	44.9	35.5
Buchanan	51.5	49.0	41.5	35.2	41.7
Dickenson	47.0	30.3	27.8	20.9	38.5
Washington	47.6	46.8	50.5	45.3	47.0
Smyth	63.6	66.1	61.4	57.4	67.2

Stroke Mortality Rates per 100,000

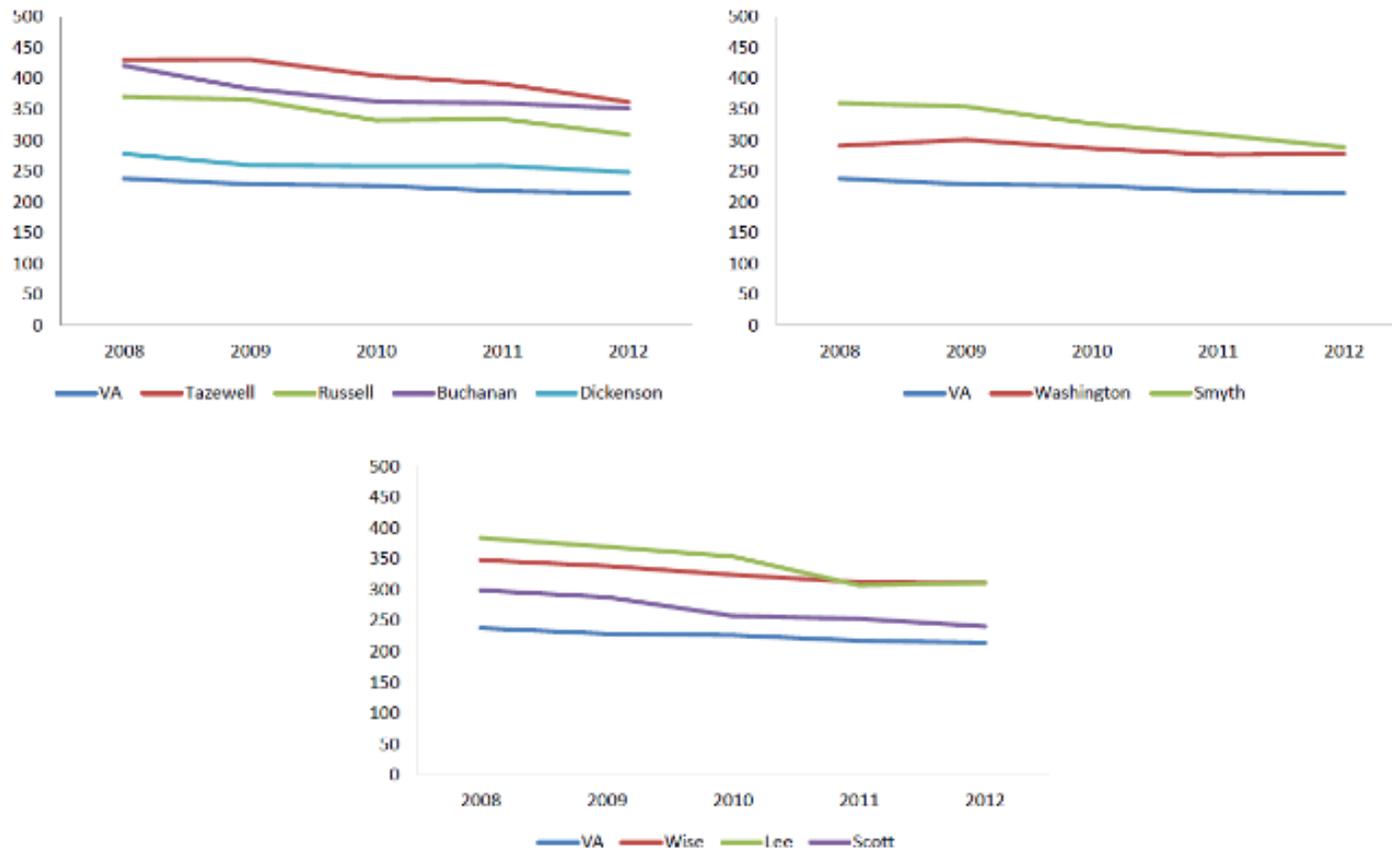


Heart Disease Mortality

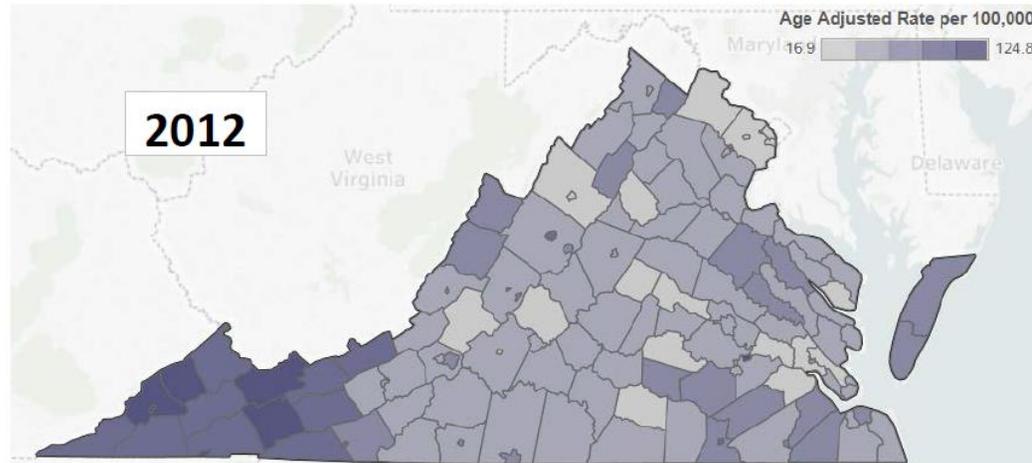


	2008	2009	2010	2011	2012
VA	238.2	229.1	226.7	218.0	214.2
Wise	348.5	338.9	324.4	312.6	311.7
Lee	384.4	370.1	354.4	307.6	311.3
Scott	299.6	288.4	258.0	253.2	241.0
Tazewell	430.5	430.8	405.1	391.6	362.4
Russell	370.9	366.2	332.7	334.4	309.5
Buchanan	421.4	383.6	363.0	360.2	352.0
Dickenson	278.3	259.9	258.2	258.7	248.8
Washington	291.4	301.0	287.3	276.6	278.4
Smyth	360.2	355.0	327.2	309.3	289.2

Heart Disease Mortality Rates per 100,000

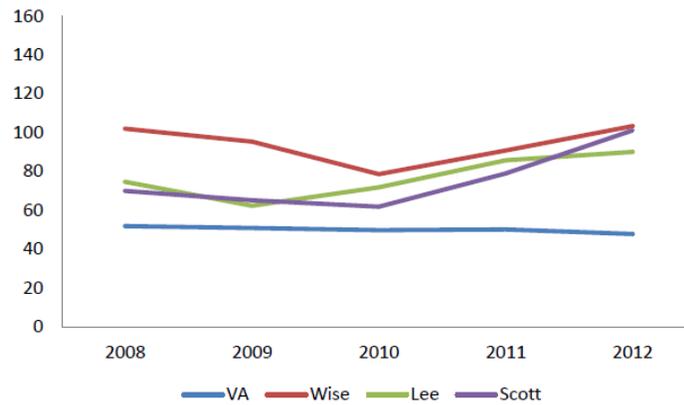
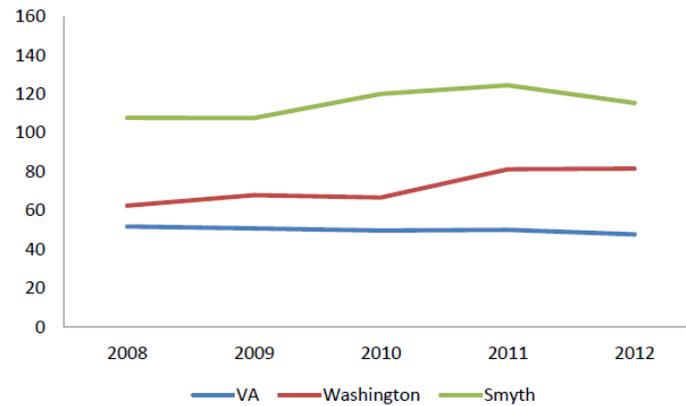
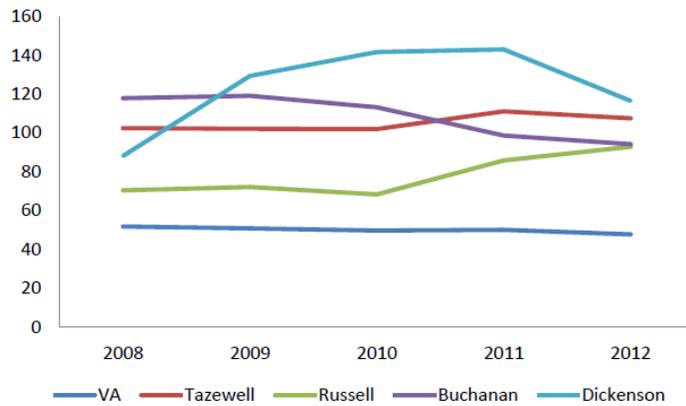


COPD Mortality

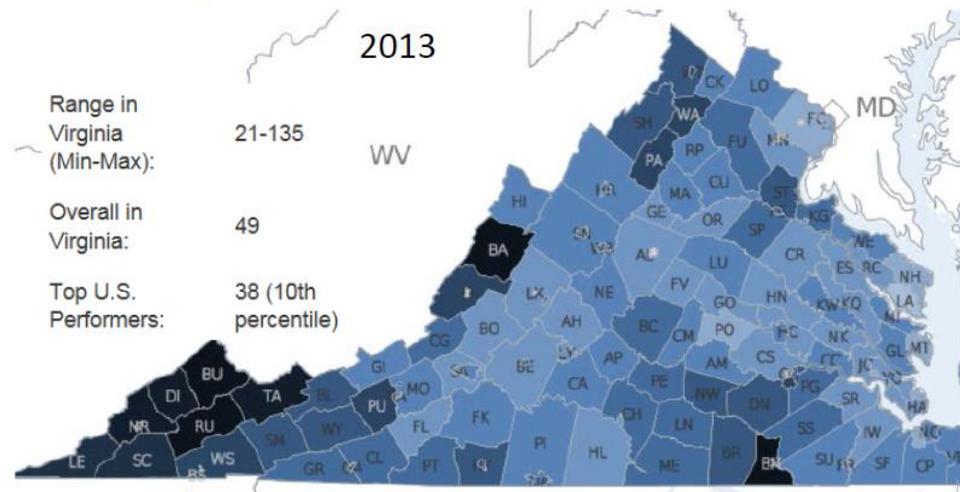


	2008	2009	2010	2011	2012
VA	51.8	50.9	49.7	50.1	47.8
Wise	102.0	95.3	78.6	90.8	103.4
Lee	74.7	62.3	71.8	85.7	90.1
Scott	69.9	65.1	61.8	78.9	101.1
Tazewell	102.5	102.1	102.0	111.1	107.6
Russell	70.5	72.2	68.3	85.8	92.9
Buchanan	117.9	119.1	113.2	98.7	94.2
Dickenson	88.2	129.4	141.7	143.1	116.6
Washington	62.6	68.0	66.7	81.3	81.7
Smyth	107.8	107.7	120.1	124.6	115.4

COPD Mortality Rates per 100,000



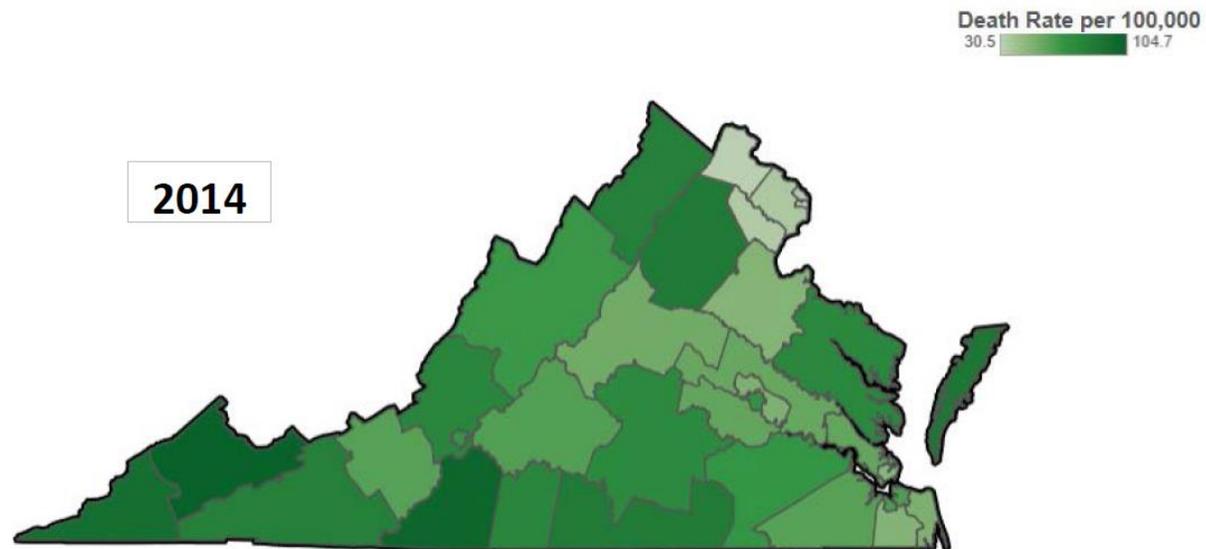
Preventable Hospital Stays per 1,000 Medicare Enrollees



	2010	2011	2012	2013
VA	58.0	59.0	55.0	49.0
Wise	145.0	160.0	126.0	105.0
Lee	160.0	158.0	135.0	95.0
Scott	98.0	123.0	106.0	94.0
Norton	152.0	150.0	126.0	99.0
Tazewell	125.0	150.0	130.0	101.0
Russell	182.0	184.0	160.0	130.0
Buchanan	136.0	175.0	182.0	135.0
Dickenson	114.0	131.0	130.0	111.0
Washington	86.0	96.0	90.0	84.0
Smyth	94.0	99.0	77.0	70.0
Bristol	118.0	126.0	110.0	94.0

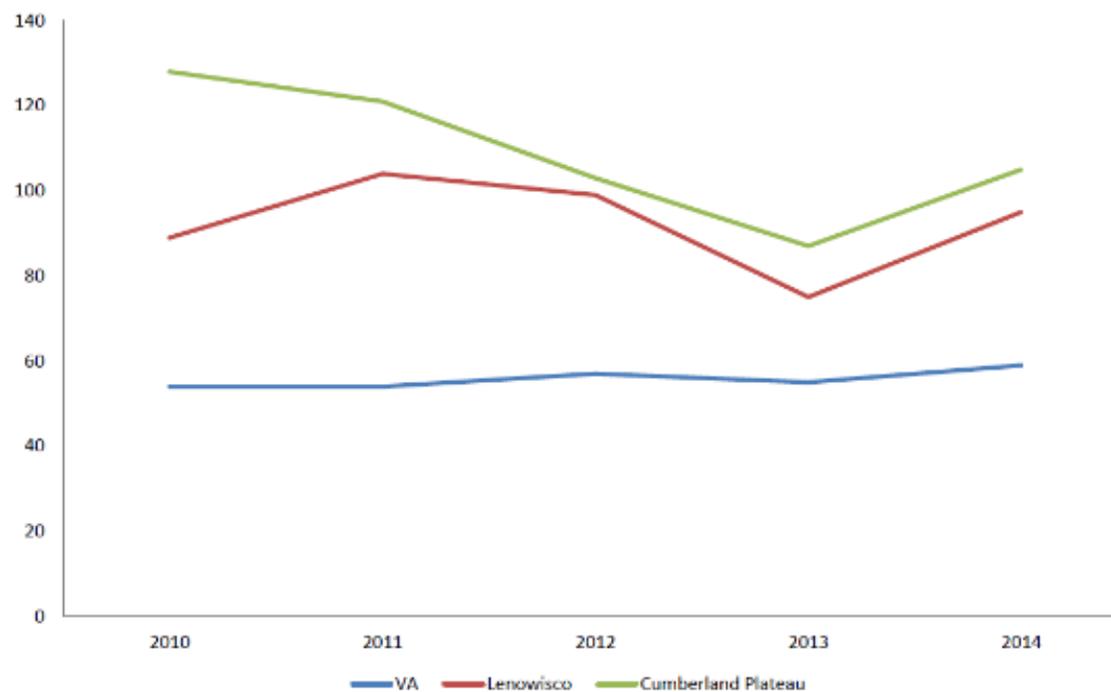
Source: County Health Rankings

Unintentional Injury Mortality

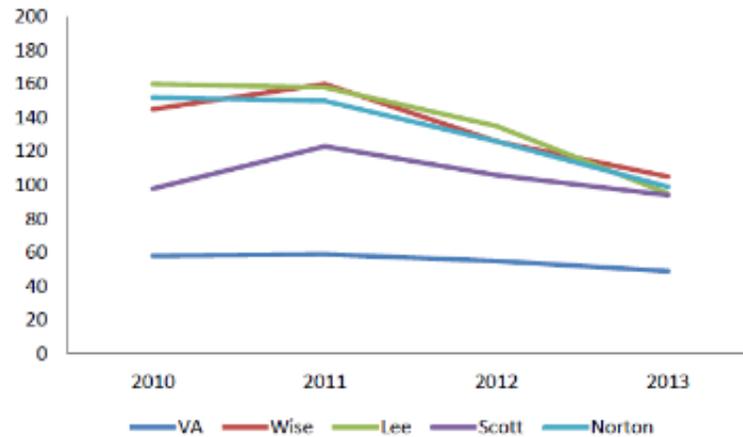
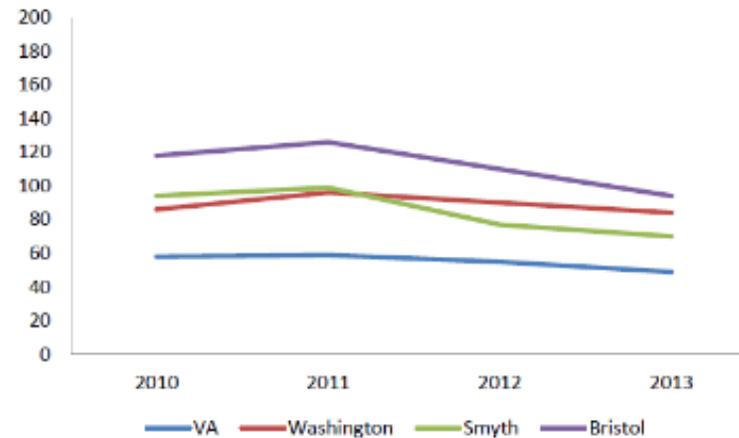
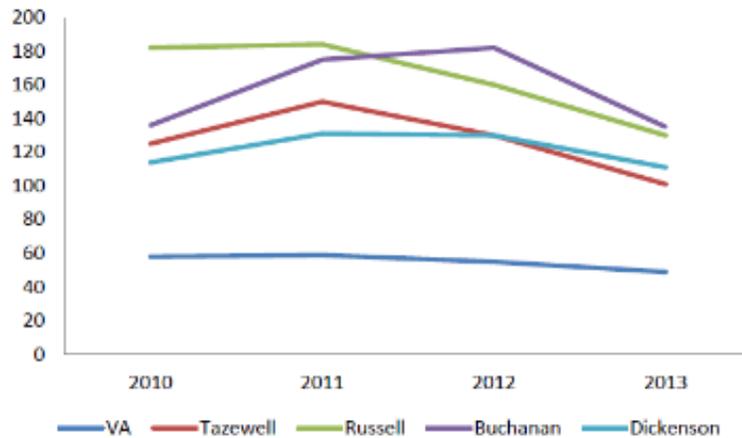


	2010	2011	2012	2013	2014
VA	54.0	54.0	57.0	55.0	59.0
Lenowisco	89.0	104.0	99.0	75.0	95.0
Cumberland Plateau	128.0	121.0	103.0	87.0	105.0

Unintentional Injury Mortality Rates per 100,000



Preventable Hospital Stays



Source: County Health Rankings

After reviewing this information, Dr. Cantrell asked how competition contributed to these outcomes and how a change in competition could improve those outcomes. "These are outcomes from a time when we had fairly robust competition... and they are not good," she said. Dr. Cantrell noted that this information is generally an indicator of quality of care and access and that these realities have been the subject of a lot of discussion. She stated that additional resources were needed to address significant challenges. "How will continuing competition change this picture?" she asked.

Dr. Thompson stated that the FTC staff reviewed the information of the Applicants compared to national data, but not specifically to Virginia data. The FTC staff generally felt positive about the Applicant data in comparison to national data. Dr. Thompson noted that economic studies show that generally competition is more likely to lead to higher quality of care. She referenced the two studies earlier cited that referred to the experience in the United Kingdom which showed better quality existed where there was competition.

Ms. Wilkinson stated when considering the question: "How is this merger likely to improve any of these outcomes?", that the Authority should consider whether there are other options beyond the merger, such as alternative collaboration to achieve the benefits, independent actions the parties could take, or alternative mergers that the parties could undertake and achieve the benefits without incurring the risks associated with a monopoly. Mr. Barry asked whether payment in the United Kingdom hospitals studied was tied to quality. The FTC staff stated it was not certain and was researching.

Out-Of-Market Acquisition of Both Applicants

Regarding an out of market merger, Mr. Barry asked the parties to confirm that the out-of-market merger of both systems with a single out-of-market system would generate the same concerns, and the FTC staff said yes.

City of Norton and Wise County

Mr. Barry asked whether the two applicants could take their combined facilities in the City of Norton/Wise County market and combine them in a joint venture. The staff was unable to respond to such a specific question noting the existing of the advisory opinion process.

Merger-Specific Savings

Mr. Barry again noted that several members of the Authority did not think competition had worked well. The FTC staff noted that there is nothing stopping the Applicants from putting money into the initiatives; however, the Applicants have noted the existence of finite resources. Mr. Barry stated that the elimination of duplicative services is a merger specific savings in this instance and asked whether the FTC staff would agree that such savings were, in this situation, a "merger-specific savings." The FTC responded that it was hard to determine without something concrete in terms of the alternative merger options. The FTC staff and the Authority discussed the Certificate of Public Need implications

on the market and competition and whether the Certificate of Public Need structure was relevant. The staff noted that its reference to market entry – given such a significant combined health system – is impactful because it could be expensive and difficult to enter the market once the Applicants are combined. The FTC staff noted that Mountain States Health Alliance had objected to a recently filed Certificate of Public Need for a behavioral clinic.

Substance Abuse Services

Dr. Rawlins noted that no significant inpatient substance abuse services exist in the region and that the region suffers from a drug epidemic; therefore, the Authority members took very seriously the commitments regarding substance abuse, plus the commitment to undertake research and improve public health.

Examples of Other Commitments

Dr. Rawlins asked whether the FTC staff had examined situations where the language for commitments was better written, especially for controlling costs. Mr. Seidman noted that the Commission's policy focuses on competition and the benefits of competition and that competition typically yields better results. Although he said it was not an endorsement of the structure, he noted that the West Virginia legislation provided for significant oversight by the Attorney General of West Virginia.

Authority Staff Questions

Chairman Kilgore asked the FTC staff whether there were any questions supplied by the staff of the Authority that had not been asked that the FTC staff believed it should address. The FTC staff responded probably.

Savings

Ms. Wilkinson noted that with respect to the projected benefits of the merger, experience and evidence demonstrated that savings from mergers are not often realized. She added that since the commitments are subject to cost savings, the staff has a serious concern about whether the savings will be achieved allowing the benefits to be funded.

Contentious Provider-Payer Negotiations

Mr. Barry and the FTC staff reviewed the dynamics of a contentious provider-payer negotiation when providers and insurers are unable to come to an agreement and an insurer is unable to provide coverage for a hospital. The FTC staff noted that such tough negotiations are simply competition playing out and that the key focus is on the bargaining leverage of the parties. Mr. Barry asked whether the staff had seen the contracts of the relationships between Applicants and the payers, and Mr. Seidman noted such information would be confidential. Mr. Barry noted that the information was provided on a confidential basis to the Authority.

Challenges to Applicant Responses

Mr. Barry then asked why, when hospitals routinely spin-off or divest single hospitals, the situation created by the Commissioner of Health withdrawing approval for the cooperative agreement in the future would present such a difficult situation. He questioned whether at that point the FTC could step in and challenge the merger. Mr. Seidman responded that while technically it might be possible to step in and challenge a merger at that point, the practical issues to be considered at that moment in time would be significant. He reviewed some examples and suggested that the Authority not approve the cooperative agreement application assuming that the FTC could step in later if such a situation arose. Mr. Barry inquired why the FTC staff considered it so hard to unwind a merged system in the future and the staff responded by noting the difficulty in separating combined services, which might have been moved to another facility, as well as other such challenges.

Challenges to the Applicant Response to FTC Comments

Mr. Barry asked the FTC staff whether the Applicants in their written response to the FTC's public written comment, had stated any facts, assumptions or citations that the FTC staff believed were misleading. Mr. Seidman noted there were several areas on which he might respond; however, he focused his response on two footnotes (footnote 11 and footnote 19) in which he believed that the quotes of a Commissioner had been taken out of context.

Uniqueness of Southwest Virginia

Chairman Kilgore asked the staff how much they looked at the uniqueness of Southwest Virginia when considering their comments, especially the very rural nature of the hospital locations in Southwest Virginia. Mr. Seidman stated that the staff was very aware of the challenges facing the region, but the challenges do not make competition any less important. Dr. Thompson stated that the staff believed there were better ways to achieve the goals, short of a merger that would be longstanding and hard to unwind.

Samples of Other Commitments

Ms. Wilkinson noted that some Authority members had inquired as to how common it for systems to offer commitments like the ones the Applicants proposed. She stated it is not uncommon.

The Chairman thanked the FTC staff for travelling to "far Southwest Virginia." Mr. Mitchell closed the session by noting for the Authority the incredible level of access that the Authority had been given to the FTC staff, and the Chairman stated his gratitude.

Board Discussion with FTC Staff

Finally, following the presentation, the FTC staff delivered several additional information items.¹⁸⁰

In Virginia, the overall percentage of self-insured plan enrollees is 58%.¹⁸¹

Ms. Wilkinson provided a review of the FTC advisory opinion process.

Ms. Wilkinson noted that the Authority requested a review of the following six points regarding the proposed price commitments:

- (1) Have regional payers been able to negotiate price reductions in prior years? This may help the Authority determine whether price reductions are possible in a competitive market.
- (2) Have regional payers been able to resist or mitigate price increases in prior years? This may help the Authority determine whether payers would be able to negotiate lower price increases in a competitive market than would be guaranteed using the proposed price growth cap.
- (3) How would the price growth cap apply to services that do not have fixed rates? For example, under contracts that include percentage discounts off the hospital's charge master, would it be possible for the New Health System to inflate its charge master rates if it no longer faces any significant competition, so that it could capture higher prices and revenues for services without running afoul of the price growth cap?
- (4) How did the Applicants calculate the estimated \$10 million in annual savings to consumers as a result of the price commitments, particularly if they are relying on payers to pass along any savings to consumers? Explain why this estimate is nonbinding.
- (5) Is there any mechanism for the Commissioner to oppose rate increases that exceed the price growth cap? Although the cooperative agreement calls for mediation between the New Health System and Principal Payers if they are unable to reach agreement on a negotiated rate, it is unclear what happens if the mediation is unsuccessful in resolving the dispute.
- (6) Which payers would fall below 2% of the New Health System's total net revenue, such that they would be excluded from the price commitments? Why is it necessary to exclude any payers that negotiate rates from the price commitments?

Ms. Wilkinson noted that the list was not intended to be exhaustive of the potential concerns of the FTC.

Ms. Wilkinson noted, in response to a question from the Authority, that "it is not uncommon for acquirers of hospitals to make promises to keep the acquired hospitals open for a minimum period of

¹⁸⁰ Stephanie Wilkinson, FTC Response to Authority Questions, Electronic Mail October 27, 2016 *citing* P Fronstin, *Self-Insured Health Plans: State Variation and Recent Trends by Firm Size*, 33 Employee Benefit Research Institute Notes 11 (Nov. 2012)

¹⁸¹ *Id.*

time and to commit to making financial investments in the acquired hospital.”¹⁸² Ms. Wilkinson provided several examples of such commitments.

Final Public Comment.

On October 27th, 2016, the Board of Directors of the Authority began formal consideration of the Application. The meeting began with an opportunity for public comment.

Public Comment – VAHP Response to Federal Trade Commission Staff

At the beginning of the October 27th meeting, Kyle Shreve, who was representing the Virginia Association of Health Plans (“VAHP”), appeared again before the Authority. He reminded the Authority that VAHP represented ten plans in Virginia across the entire spectrum of health insurance. He said that VAHP continued to have serious concerns about the rate commitments and that the merger would put his members at a tremendous disadvantage. He reported that the insurers have significant network adequacy requirements and the inability to reach an agreement with the new health system would be significant and that disruptions could occur. He said the providers could choose not to contract with an insurer and customers would be at a severe disadvantage.

Next he stated that VAHP still had serious reservations concerning the commitments of the Applicants. He recognized Medicaid Managed Care Organizations were included in the revised 2% threshold but ambiguity remained about which principal payers would be covered. Mr. Shreve stated that no commitment was made to enter into an agreement with every payer. There was only a commitment to talk to each payer in good faith, not to enter into a contract. He also commented that great concern remained regarding the enforceability of the commitments, noting that the mechanism for active supervision was still not established and he questioned whether there were adequate resources for the Department of Health to regulate the commitments.

With respect to substance abuse, Mr. Shreve commented that progress was made during the General Assembly session but insurers continued to face significant challenges finding qualified providers in some regions. Medicaid data revealed that 50% of substance abuse diagnoses come from the southwest region of Virginia but only 16% of the population lives in the region. Mr. Shreve said there are an incredible number of people in the region with substance abuse issues. He said more providers are needed and that a commitment from one provider will not get the job done. More providers are needed and competing with one entity will be difficult.

He also stated that his organization wanted to formally associate itself with the comments made by the FTC staff on October 26th. He suggested that a number of economic studies have been done that need to be examined by the Authority. “It is a part of the statute that the Authority take a look at the competitive benefits and if they prove the benefits versus loss of competition does it change in the way you do that is in included studies,” he said.

¹⁸² *Id.* at 2.

Mr. Shreve further discussed the challenges of one provider addressing all of the issues of Southwest Virginia. He stated that the Applicants said 70% of the discharges would be government payers. He noted that the government is turning more and more to managed care organizations to get the best deal possible. He said the negotiating posture of the parties is critical. He noted the rigorous review process for the merger of the insurance companies and that the Department of Justice had sued. He asked that the same process – including FTC review – play out in the Southwest Virginia review process.

Final Presentation of the Applicants to the Authority

Mr. Bart Hove, President and CEO of Wellmont Health System, started his presentation by thanking the members of the Authority Board of Directors:

“The devotion of your time, the emphasis and effort that you have put into not only the analysis of our application but also the numerous meetings, committee work, discussions that we have had with the Authority in trying to attain common ground in meeting and addressing many of the health care needs on the horizon in Southwest Virginia has been phenomenally impressive to me as an individual in health care for many, many years to see that kind of dedication and work and I just have to applaud the Authority and all of your members.”

Mr. Hove stated that he had been in the management of health care since 1975 and over that forty-one years he had seen numerous changes. He said that the Authority was considering a transformational approach to health care in Southwest Virginia. He noted that Southwest Virginia’s challenges of declining population, poor health, and a weak economy, combined with the second lowest reimbursement rate in the United States, posed real challenges for the region and the Applicants.

Alternative Options

He reported to the Board that Wellmont Health System did look outside the region for a merger partner; however, those potential partners were not talking about reinvesting in the community. He said the potential partners intended to leverage the organization and send the revenues to locations outside the region. Further, there were no commitments to the region like the financial commitments of the Applicants, including the commitment to build the psychiatric and behavioral health facilities proposed. Mr. Hove noted that the Authority’s Blueprint had aided them in their planning for the region and that the proposed cooperative agreement for Southwest Virginia was in direct response to the unique set of challenges confronted in Southwest Virginia.

Mr. Hove then discussed the state law enabling the consideration of the cooperative agreement. He said the new state law recognizes and even encourages mergers that are anti-competitive:

“The Commonwealth’s sovereign policy is to encourage health care mergers where the benefits outweigh the disadvantages resulting from the loss of competition between the merging parties. This policy is so important to the legislature that the law even encourages mergers that are anti-competitive within the meaning and intent of

state and federal antitrust laws. In those instances, the Commonwealth's intent is to supplant competition with a regulatory program for cooperative agreements that are beneficial to Southwest Virginia."

He noted that many organizations have raised concerns, but have failed to offer any solutions or an acknowledgement that the *status quo* is unacceptable. Finally, Mr. Hove briefly described the Supreme Court's action exempting state action from federal antitrust laws.

Mr. Alan Levine, President and CEO of Mountain States Health Alliance, started his comments by thanking the Board of the Authority and noting that the process of consideration of the Application had made the Application better.

FTC Staff Position: Merger is Anti-Competitive

Mr. Levine said that the staff of the FTC stated that the Application for the cooperative agreement potentially created an anti-competitive environment and should be evaluated according to the traditional antitrust analysis framework of the FTC. Mr. Levine stated that the merger under consideration is a merger under Virginia's cooperative law, not federal law. The Virginia law uses a state supervised regulatory program to replace any lost market-based competition to assure pro-consumer benefits in other ways. He stated that there are benefits other than competition – like the commitments.

A Call To Rely Upon Evidence

Mr. Levine then challenged several of the assertions of the staff of the FTC. Mr. Levine said that the complaint that the cap on rate increases will cause higher prices is not credible unless someone has evidence to support the asserted statements of price increases. He said the Applicant's payer contracts had been confidentially provided and they did not support the FTC staff concerns. Mr. Levine stated that currently the Applicants had committed to price reductions to payers if the merger happens; and there is no such commitment, nor reason to believe prices to payers would drop if the merger does not happen. Mr. Levine asked the Authority to base its decision on evidence, not speculation or studies of mergers where there were no commitments regarding rates and no monitoring or supervision by a state. Mr. Levine also addressed Mr. Shreve's concern that the commitments were not sufficient regarding the need to contract with all payers who may be active in the region. Mr. Levine expressed dissatisfaction with the current state of the insurance market in the region where Anthem is by far the dominant health insurer in the nongovernmental market, and said that the new health system would welcome the opportunity to deal with new entrants into the health plan market, assuming that they had a reputation for ethical dealing and timely payment.

Enforcement

Regarding enforcement, Mr. Levine stated that the Applicants would face very serious consequences if they violated or did not perform the commitments to which they had agreed. If the Commissioner of

Health withdrew approval for the transaction, the new health system would be subject to antitrust enforcement which could force breaking up the system. As an example, Mr. Levine noted the Department of Justice is currently suing Carolinas Healthcare System in North Carolina, which formed through out-of-market acquisitions. He stated that there are tools available to the federal government and Attorney General to utilize if the cooperative agreement is violated.

Other Cooperative Agreements

Mr. Levine stated that the Mission system in North Carolina, which operated for over twenty years under a COPA, never had an allegation of improper activity.

Investment

Mr. Levine noted that the proposed investment could only happen with a merger of the Applicants. He stated that the Applicants hired consultants to validate the projected synergies. The systems projected saving \$120,000,000 a year by year 5 which is 6% of the combined operating expenses. They believe this level of savings is very “doable” and conservative. Further, he stated that the Applicants’ plan recognized that if they do all of the things planned, revenue would decline. The Applicants’ challenge was to reduce unnecessary utilization, invest dollars, and sustain margins. He reminded the Board of the challenges rural hospitals faced, stating that 70 rural hospitals have closed in recent years and that *Governing Magazine* projected 30% of America’s rural hospital will be closed in two to three years.¹⁸³

Alternative Approaches

Mr. Levine reviewed the potential for options other than the proposed merger. He stated that with an out-of-market merger, the two systems would still be competing. He again noted that the challenge of the Southwest Virginia market is to sustain margins with a declining population, declining use rates and other issues. He said one option for each Applicant was to find a system to join that could help it obtain an increase in reimbursements. He reported that this is the choice – between the challenges of the marketplace and the need to increase reimbursements – that Wellmont Health System and Mountain States Health Alliance confront.

Mr. Levine noted that Anthem raised the example of Prince William Health System’s out-of-market acquisition that the Applicants should consider. Mr. Levine said they reviewed the merger and concluded, based upon publicly available data, that the out-of-market acquisition of Prince William Health System, produced negative results: a few years after the acquisition the data suggested higher prices, poor results in value-based purchasing and less patient satisfaction. He addressed the challenges raised by the FTC staff about the studies the Applicants had used to support their

¹⁸³ In their response to the questions presented by the Authority, the Applicants quoted Mattie Quinn, *Governing States and Localities*, July 2016. See Alan Levine and Bart Hove, Letter to Southwest Virginia Health Authority, July 13, 2016.

arguments by citing other sources. He noted that studies suggested that the acquisition of one of the Applicants by an out-of-market system could result in price increases about both systems.

As examples of systems to consider, Mr. Levine suggested that the Authority considered other states where cooperative agreements existed, especially West Virginia. He stated that none of the cooperative agreement relationships that the Applicants had examined (e.g. North Carolina, Montana, South Carolina or West Virginia) went as far in commitments as those offered by Wellmont Health System and Mountain States Health Alliance. He focused on the example of Mission, which is in North Carolina, noting that according to State of North Carolina data, gross revenue per adjusted admission was lower than peer hospitals and that Mission's expenses for adjusted admissions were lower than peer hospitals as well. He said that payers saw no difference in negotiating with Mission than other providers in North Carolina and he cited an Urban Institute study noting that Mission's hospital care in Asheville, North Carolina, was among the highest value in the United States. He said he could not say that these results happened because of the COPA, but it did not hurt. Mr. Levine asked how FTC staff would challenge the cooperative agreement without analyzing the data, and he encouraged the authority to rely on data not speculation.

Governance of the New Health System

Mr. Levine noted that he recognized that governance of the merged system remains a significant issue to the Authority. He said the Applicants have boards of directors that understand rural health care. He noted that eight of the thirteen Mountain States Health Alliance hospitals and four of the six Wellmont Health System hospitals are rural. He stated that the Applicants have competency based boards with broad rural hospital experience. He said the boards of the health systems consider the needs of hospitals when board members are selected. He added that 75% of board members serve on the local boards of the rural hospitals and have an active understanding of what is going on at the hospitals.

Pricing Cap Concerns

Mr. Levine stated that the staff of the FTC said pricing could increase by 100% under the cooperative agreement. He reminded the Board that the FTC staff provided no evidence of this assertion, and did not take into account the pricing commitments made by the Applicants. He said the only evidence available is the existence of the pricing caps and the contractual arrangements that had been submitted in confidence to the FTC, although the FTC's conclusions were not consistent with those contracts. The Applicants also furnished information regarding some payer contracts to the Authority.

Out-of-Market Job Impact

Mr. Levine noted that the staff of the FTC stated that an out-of-market merger for one applicant with continued competition in the market by the other Applicant might not result in job losses. Mr. Levine rejected this assertion however, arguing that the FTC staff did not provide any evidence to support their statement. Mr. Levine cited a health system merger in Florida (the acquisition of HMA by

Community) where, following the merger, the entire corporate offices were eliminated and the building sold. Further, Mr. Levine said the synergies of an out-of-market merger would inure to the benefit to the acquirer's balance sheet. He said the synergies under the cooperative agreement would stay in the region. He concluded that the position of the staff of the FTC was not correct.

Rural Feeder Hospitals

Mr. Levine reviewed the FTC staff's assertion that the economic success of the local, rural hospitals could not be reviewed in isolation, because the local hospitals were feeder hospitals to the tertiary regional hospitals. He said the statements by the staff of the FTC were "simply not true." As an example, even though Mountain States Health Alliance has a hospital in Russell County, Wellmont Health System has doctors in Russell County and they refer patients to Wellmont Health System facilities. He said the Lee County Regional Medical Center closed, but referrals are still going to Wellmont Health System. He said it is inaccurate to say that to obtain the referrals one of the Applicants has to have a hospital in the county.

Options and the Region

Mr. Levine stated that "if anybody believes there is a better way for us to shore up the health care resources for Southwest Virginia, they have had two years to provide that guidance; and, the only proposals we have received that achieve the goals of your blueprint is what we proposed." Mr. Levine stated that the Anthem example of the hospital in Prince William County is not working. He said an out-of-market merger will not work because of the results for the region. Mr. Levine noted the economic challenges of the region and called to the attention of the Authority the recent Eastman reduction in workforce of hundreds of jobs. "People need to understand what is happening in this region," he said. He said the expertise of the staff of the FTC is competition, not understanding the economic considerations of this region.

Question: 2% Payer Issue

Dr. Cantrell asked for an explanation of why the commitments to negotiate and contract with payers with prices below the rate of cost increases for inputs to the new health system applied only to "principal payers," defined as those with 2% market share. Mr. Levine responded that the Applicants would prefer more insurers in the market, but he noted that one insurance provider currently in the market today has a larger market share of the insurance market than the merged health system will have in the health care market following the merger. He said 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. He said those payers above the 2% threshold account for 97% of the commercial business.

Dr. Rawlins asked Mr. Levine to address why the separation agreement has only an eighteen-month time period. Mr. Levine said that looking past eighteen months is difficult to know what the market is going to look like over time.

Dr. Rawlins asked if the Commissioner of Health and the Attorney General had the type of oversight required and whether the Attorney General would be amenable to engagement. The Chairman of the Authority noted that the Attorney General represents the Virginia Department of Health. Mr. Levine stated that nothing in the statute precludes the Attorney General to use his or her powers at any time. "If we're doing behavior that is anti-consumer or harmful to consumers I would expect the Attorney General to use whatever power they have," he said.

Value-Based Reimbursements

Dr. Cantrell asked Mr. Levine whether value-based reimbursement would become a factor. Mr. Levine acknowledged that competition is important, but stated the Applicants would still face competition from providers outside of the immediate area and gave the examples of hospitals in Nashville, Tennessee, or Mission Health in North Carolina and other places people travel. He stated that Pikeville, Kentucky receives \$18,000,000 from the Commonwealth of Kentucky and actively competes with the three hospitals in the Wise County/City of Norton area. He said the Applicants are already competing with this system and LifePoint in Smyth County and Russell County. Mr. Levine said that the comment that competition drives quality more than reimbursements is wrong. Today, Federal government incentives for reduced readmissions and penalties for more readmissions together with the fact that some payers would pay for readmissions is what is changing the market. There are incentives to control readmissions.

Barriers For Entry

Mr. Levine said there are no barriers to entry for physicians. He said the Applicants support independent physicians.

Substance Abuse Commitment

Mr. Levine stated that no payers were currently paying substance abuse care, which explained why no one was providing such services in the region.

New Entrants In the Market

Considering why there have been few entrants into the market, Mr. Levine stated that factors like the existence of a declining population market, a declining use rate, an unfavorable payer mix, and one dominant payer show that competition is not working in Southwest Virginia.

Price Cap Versus Price Floor

The Chairman asked Mr. Levine whether the commitments with respect to pricing set a cap or a floor on the pricing structure (because prices will go up that much each year). Mr. Levine responded that the pricing commitment set a cap based upon indexes referenced.

Lee County

Mr. Mosley noted that three years ago Wellmont Health System met with the leadership of Lee County and informed the County that Wellmont Health System might reduce services at the Lee County Regional Medical Center, but that it was not going to close the hospital. In a few weeks the hospital had closed. Lee County was forced to negotiate with Wellmont Health System for the purchase of the building and attracting partners was extremely difficult because of the conditions Wellmont Health System put on the purchase agreement. He said Wellmont Health System did everything it could to block competition from utilizing the building. He asked how Wellmont Health System could do that and asked why the Authority should trust them now.

First, Mr. Levine stated that rural hospitals are facing closure and there will likely be additional losses in rural hospitals. He noted he would defer to Mr. Hove on the specifics of the Lee County situation, but that the cooperative agreement provides a commitment not to close the facilities for five years.

Mr. Hove noted that he was not with Wellmont Health System when the Lee County situation occurred and that he had worked with Lee County to transition the facility and help the County, specifically including a waiver of limitations on competitors coming in and using the facility.

Mr. Levine concluded by stating that the restrictions that Wellmont Health System put in the transaction were likely there because of the competitive environment of the two systems. "Wellmont was trying to keep Mountain out," he said.

Negotiating Strength and Price Caps

Mr. Levine addressed whether the merger put the Applicants in a better position with large payers. Mr. Levine stated it did not, because of the pricing cap commitment. He said that the Applicants have imposed limits on their ability to negotiate and the Applicants would be in a better position to merge with a larger out-of-market system. Mr. Levine reviewed the negotiating dynamic with essential hospitals that payers had to have in their network. He said an out-of-market system would likely have the leverage to drive reimbursement rates up to match the out-of-market rates. The local lower wage index causes lower reimbursement rates. Leverage comes when the larger system has a number of "must have" hospitals for the insurance company payer. Mr. Levine stated that the Applicants are giving up that potential out-of-market leverage in exchange for inpatient competition. Mr. Levine also stated that, if an out-of-market merger occurred for one of the Applicants, when one system achieved pricing increases, the other system in a market usually follows with matching price increases.

Dr. Cantrell asked Mr. Levine to explain the question from the FTC staff regarding how price caps would apply to non-fixed rate prices and whether it would be possible to inflate charge master rates so as to negate the effect of the price caps commitments. Mr. Levine first explained the existence of the charge master – which is a list of all charges for patient interactions. He said insurance payers disregard the charge master. He said the charge master may be relevant for setting costs for the uninsured, but then the Applicants discount or write-off the charges based upon ability to pay.

Essential Services

Senator Chaffin asked Mr. Levine to explain the concept of the essential services. Mr. Levine stated that no decisions have been made to close a hospital but the Authority members wanted to know what would happen if a hospital did close, so together a list of essential services that would be maintained had been developed and provided to the Authority in the revised commitments.

Strategic Behavioral Health

Mr. Levine addressed the comments by the FTC staff that Mountain States Health Alliance had challenged the Certificate of Public Need application of Strategic Behavioral Health. Mr. Levine said that in the application, the potential provider said they would only provide Medicaid or charity coverage to 5% of their patients. In other words, Mr. Levine said, the group intended to cherry pick the commercial payers, leaving the charity cases to the existing providers. He said the Applicants did not object to the creation by Holston Medical Group of a diagnostic service even though it was direct competition.

Mr. Levine said that the Applicants wanted to build a residential addiction treatment facility, which he said was desperately needed. He also stressed the need to examine community care for addiction. He said that the goal of the Applicants was to meet with the Authority, agree on the priorities, and go fund them. If problems develop, the Authority would proceed to develop a corrective action plan.

Repurposing Facilities

Senator Chafin asked Mr. Levine to explain the Applicants' plans for the growth of behavioral health services in Russell County, like the growth that had occurred in Dickenson County. Mr. Levine replied that re-purposing beds to alternative uses, like in Dickenson County, was exactly what the Applicants hoped to do.

Hospital Emergencies

Ms. Welch asked about a situation where there was no hospital and someone had a heart attack. Mr. Levine noted that an emergency department would still be there. If someone cannot afford to pay, the Applicants typically discount it or write it off.

Health Information Systems

Dr. Cantrell stated that according to the FTC, one Applicant already partners with One Partner for health information exchange and in thinking about the common IT platform, that was a long process. The region enjoyed the health information exchange until 2011. She asked whether there was a shortcut from the long implementation process. Mr. Levine stated that both of the Applicants had been submitting data to the health information exchange. Mr. Levine noted that the health information exchange is not an interactive system and a physician can only access limited data. He said the concept of an electronic health record system is much different, a very expensive project, but

would allow doctors to work together across the system and throughout the community. He said this is much different than a health information exchange.

Local Hospital Boards

Mr. Neese asked Mr. Levine to discuss the local ownership of some of the hospitals. Mr. Levine stated that Johnston Memorial, Smyth County, Dickenson County, and the City of Norton are Virginia corporations that are joint ventures with the local people. Changes in services require a supermajority of local hospital governing bodies to vote.

Requiring Stronger Commitments

The Applicants provided the Authority with an initial list of commitments, which the Authority rejected. Authority members gave extensive consideration to both the substance of the commitments, many of which were deemed insufficiently specific and immeasurable, and the mechanism for enforcement of the commitments, which the Authority determined was not clear from the Application. Several Authority Board members openly objected to the initially proposed scoring system. As a result, several members of the Authority, led by the chairs of the Working Groups, engaged in active consideration of the commitments to make them measurable and meaningful.

Staff Presentation on Commitments

Staff Presentation to the Board

As the Board of Directors began active consideration of the application, Mr. Barry led a presentation on behalf of the Authority's staff of Professor Brownlee, Dr. Massaro, and himself. Mr. Barry noted at the outset during their work on this project, the staff had "had the privilege of meeting a lot of smart, committed people who are passionate about what they're doing in the region here."

Staff of the Southwest Virginia Health Authority

Mr. Barry re-introduced the staff team to the Board and audience and noted that this multi-disciplinary team took a collaborative approach to reviewing the application. He stated that Dr. Massaro, who is a pediatrician, has a clinical background, served in the administration of University of Virginia Medical Center and started a medical school in Botswana. He noted that Dr. Massaro has a dual appointment with Darden School of Business of the University of Virginia and the University of Virginia School of Law. Mr. Barry stated that Professor Brownlee is an *emeritus* professor and former chair of the accounting area at the Darden School of Business of the University of Virginia who has worked on several mergers and acquisitions and has experience with public-private partnerships. Mr. Barry noted he is a "recovering lawyer," having retired two years ago. A graduate of the University of Virginia School of Law, Mr. Barry said his practice of over forty years focused on a broad representation of health care clients who were almost entirely hospitals and health systems, including not-for-profit and investor owned, ranging from 15 bed hospitals to 1,500 bed institutions. Mr. Barry

noted that the team has a deep knowledge of health care – both clinical and legal – and experience with health care mergers.

Mr. Barry then informed the Board that there were certain actions that the Authority staff did not undertake. He said they did not do an audit of the financial information presented by the Applicants and they did not do an independent investigation of the Applicants, except for perhaps some basic research on the Internet. He said they did not review the business policies to any significant extent. Finally, he noted that, with exception of Dr. Massaro, the team had limited knowledge of Southwest Virginia.

Mr. Barry reminded the Board of Directors that it was presumed that the members of the Board of Directors had a special familiarity with the region and he encouraged them to exercise their independent judgement, taking into account what they know about the area, what they know about the Applicants, and what they know about health care. Mr. Barry said the Board was uniquely well-suited to know about the area.

Staff Reaction to the FTC

Mr. Barry reminded the Authority that they had received a sixty-seven-page letter, plus exhibits, from the FTC staff stating that the proposed merger was a “really, really bad idea.” He noted that the FTC was charged with preserving competition and that the individuals interacting with the Authority are dedicated, smart people who are acting in goodwill with no personal gain for the position they took on this merger. He encouraged the Board not to disregard the positions of the FTC staff out of hand and, instead, to look at them carefully.

A Different Approach

Mr. Barry stated that, in his opinion, doctrinal difference existed between the position of the FTC staff and the Virginia General Assembly. He reminded the Authority that the Virginia legislature enacted a statute that established the position of the Commonwealth of Virginia on this matter. If, he said, the Application was approved, then it is the policy of Virginia that these hospitals are exempt from federal and state antitrust issues. He said this was called the “state action” doctrine, but reminded the Board that he was not an antitrust attorney. He stated that the very premise of the General Assembly’s actions is that but for this new law enabling the existence of cooperative agreements, a merger approved under this law could not go forward because it would violate the antitrust laws.

Finally, Mr. Barry noted that while the FTC staff suggested that elements of the Virginia statute resemble the merger guidelines issued by the FTC, the standard of review under the Virginia statute was different, or the Virginia statute would not be necessary. He told the Authority that the whole point of the Virginia statute was to permit actions that would not be permitted under the federal antitrust laws, noting that the factors do not have to be weighed the same as under federal law, because the presumption under the Virginia law was that there are different standards.

Competition in Wise County

Mr. Barry noted that both the Applicants and FTC staff agreed that among the Applicants there was not much direct competition except in the Wise County – City of Norton area. Mr. Barry noted, however, that the market is not just Virginia and not just Wise County. He stated that while there is no agreement among the Applicants and the FTC staff as to exactly the geographic boundaries of the market, such an agreement was not necessary for the Authority to act. He reminded the Authority there was a free exchange of patients, physicians, vendors, contractors across the state borders, which was partially the reason both states were reviewing the merger. Mr. Barry told the Authority members it would be a mistake to just consider Virginia facilities and that the members should focus on what was happening to Virginia patients.

A Review of Whether Competition Works in Southwest Virginia

Mr. Barry stated that the FTC staff had asserted the position that competition has served the Southwest Virginia market well to date; however, he argued that the Authority members needed to make their own judgements on whether competition had positive outcomes for the region. He reminded the Board of Directors that Dr. Cantrell had distributed charts showing health outcomes in the region that were well below the Virginia averages for such indicators.

Mr. Barry reminded the Authority that their staff had asked the FTC staff whether such factors in Southwest Virginia as the rural nature of the area, the high unemployment, the high numbers of uninsured patients, transportation obstacles, the low educational attainment, the level of poverty, and the lack of insurance or underinsurance effected how well the competitive market works in Southwest Virginia. In response, he said that the FTC staff gave the general policy response that the FTC believes competition works well in all markets. He stated that whether competition works in markets like Southwest Virginia was unclear and that he believed these demographic factors impact how well competition worked in the market.

A Review of the Commitments

Mr. Barry started his review of the revised commitments by reminding the Board members that the effort to review and revise the commitments started shortly after the Authority deemed the Application complete. He said the process included an active review of the commitments, the sharing of ideas among the working groups, the staff, and the Applicants, and three nearly all day meetings with the staff and the Applicants and one or two Board members of the Authority present either in person or by telephone. He said the meetings were well attended by the representatives of the Applicants and that the process involved significant discussions with a number of redlined drafts circulating back and forth between the staff and the Applicants, which he said was indicative of negotiating an important contract.

He stated that the staff hoped that the Commissioner of Health recognized the effort put forward, but the Authority needed to realize it was quite possible that the Commissioner will tweak the commitments. He said that everyone involved sought specificity in the commitments, but reminded the Authority that the commitments would be incorporated into a more formal agreement, the cooperative agreement, and they can be tightened up by the Commissioner's staff. He reminded the Authority that the commitments did not address every conceivable (or inconceivable) contingency. Finally, he noted that the staff made clear to the Applicants that while everyone trusted the representatives of the Applicants, the individuals in the room might not always be the representatives of the Applicants, so the drafting needed to assume they were not going to be involved.

He said the commitments cover the waterfront and attempt to avoid ambiguity, and he encouraged the Authority members to read them and understand them.

A Change of Circumstances

Mr. Barry reviewed the recognition in the commitments that something could go wrong and a change of circumstances could occur. He stated that the Commissioner of Health could require the Applicants to have a management consultant investigate the situation and offer an opinion on whether the change of circumstances was truly externally caused or was management's fault. Mr. Barry then addressed the concern raised by the FTC staff that the commitments go on "in perpetuity." He said this concern was unsettling to the himself and the other staff members as well. In the end, the revised commitments contained a provision that in ten years the parties and the Commissioner will meet and decide whether to renew the cooperative agreement and, if so, under what terms - taking into account changes in market, how well the parties have done, the Applicants' profitability and other factors.

The Applicants' Financial Strength

Mr. Barry then spoke to the Authority about the profitability of the Applicants. He told the story of a health care consultant who would travel to not-for-profit hospitals and remind them of the following lesson: "No margin. No mission." Mr. Barry said the Applicants need profitability to invest in the commitments. Mr. Barry informed the Authority that the bond debt of the Applicants is one level above junk status. He argued that such financial realities are not sustainable and limit the ability of the Applicants to serve the marketplace.

Commitment Enforceability

Mr. Barry then addressed the concerns raised by the FTC staff and others that the commitments were not enforceable. The Chairman of the Authority noted that the Commissioner of Health does have the authority to enforce the commitments and access to the Attorney General's office to assist in that effort. Mr. Barry said the suggestion by some that the Commissioner of Health would not do his or her job was troubling. Further, Mr. Barry noted that some people had stated that the only sanction

available for the Commissioner of Health is the so-called “nuclear bomb” of invoking the separation plan if parties do not meet the terms of the cooperative agreement. He said these stakeholders believed such an enforcement device is worthless because, if the parties do not meet their commitments, the Commissioner will not do anything about such failures to avoid disassembling the whole health care system in Southwest Virginia.

Mr. Barry reported that the response of the staff, with the agreement of the Applicants, was to score and weigh the commitments in categories to create a system of tracking the Applicants’ response to the commitments. He stated that some commitments are “do or die,” meaning that if the commitments in this category are not met, then the Commission of Health may notify the Applicants demand compliance within a short time period or termination of the cooperative agreement. Mr. Barry noted that with respect to other commitments factors and portion of completion will be considered. For example, the medical record project is scheduled to be done in 48 months, but if the implementation is close, it is unlikely the Commissioner of Health will terminate the agreement based upon near, but not full, completion. The more likely result is that the Commissioner of Health will require an update from the Applicants with a corrective action plan. He stated that such an accountability system is utilized everyday with governmental conditions required to participate in Medicare and Medicaid. Some of these standards are so critical that a violation causes a letter with a short term response or the provider is removed from the program. Mr. Barry noted that the majority of these issues had been successfully resolved. Other violations of the governmental conditions violated by a Medicare or Medicaid provider would receive a letter demanding a corrective action plan be delivered within sixty days. Either way, Mr. Barry stated the system of accountability works and would work in Virginia.

Competition

Mr. Barry stated that there would definitely be a loss of competition.

The Authority’s Role Going Forward

On a question from an Authority member, Mr. Barry informed the Board of Directors that there was a conduit between the Authority and the Commissioner of Health in the form of a joint group formed by two members from Authority and two from new Health system and that no members of the Authority with a conflict of interest could serve on this committee. The group would meet quarterly to assess progress under the commitments and compliance with the agreement. A member of the Authority would chair the group.

The Staff Opinion

Prior to reviewing each individual commitment and responding to questions from the members of the Authority Board of Directors, Mr. Barry noted that each member of the staff – a business school professor – a physician – and a recovering lawyer - would each share his thoughts on the

commitments. Although each of the employees of the Authority are in some way affiliated with the University of Virginia, the Authority understands and acknowledges that the opinions stated by Mr. Barry, Professor Brownlee and Dr. Massaro are their individual opinions and **not the opinions of the University of Virginia.**

The Opinion of Professor Brownlee

Professor Brownlee started his comments by stating that during his academic and consulting career around the world he had the privilege and the pleasure to be involved in a number of worthwhile and interesting projects, but had never been involved in project quite like the one under consideration by the Authority. Professor Brownlee said that when asked to participate, he first wanted to know more about the project and to understand the team. He thought that a doctor, an attorney who dealt in health care, and a business professor made a good team for this project. "In my opinion we have . . . brought most of the relevant expertise together. We've worked very, very well together and it is a team effort."

Brownlee: A Unique Solution for Southwest Virginia

Professor Brownlee began by saying that the FTC staff presented themselves as "intelligent, well-educated, well-meaning and for some very good reasons, sincere in their belief that market competition should be preserved and fostered regardless of the characteristics of any particular market." He stated that the FTC staff said they were aware of the challenges of the people of Southwest Virginia, yet still believed preserving competition in the region was the best strategy. In reply, Professor Brownlee stated:

"[W]hen you live in an environment that only drinks Kool-Aid, it is easy to be accustomed to always ordering Kool-Aid no matter where you are. The core issue facing you as board members of the Authority, is whether you believe, after reviewing the extensive oral and written information presented to you over many months, that the market for health care in Southwest Virginia presents some significant and uncommon characteristics as to deem it unique enough to necessitate a solution other than pure competition. In other words, should Kool Aid give way to something else?"

Professor Brownlee stated he believed that the legislature thought that the region posed such a unique challenge that it first created the Southwest Virginia Health Authority and then realized that, despite all of its virtues, perhaps relying on competition was not effectively addressing the serious health needs of the region.

Finally, Professor Brownlee stated that a significant effort had been devoted to revising the commitments noting that, "[s]ince deeming the parties' Application complete, the Authority has spent months in negotiations with the parties in an attempt to arrive at a thorough, comprehensive, substantive, relevant, and yet reasonable, set of commitments to which the new health system will be accountable if the Application is approved. These revised commitments are, in my opinion, substantially improved compared to the parties' original commitments." He claimed that, he too,

believed that additional commitments may be added by the Commissioner. He stated that it was clear that, with respect to the FTC staff, they believed that regulation with enforceable commitments was less preferable than competition. He then stated:

As a business school professor for well over 40 years, I understood and advocated for the virtues of competition in the market; however, I also came to understand that there were not many pure markets where competition could occur as described in the textbooks. In reality, most markets were imperfect in a variety of dimensions. That, in fact, is the issue in the case of Southwest Virginia. Is the market for health care there so filled with imperfections that the traditional market solutions simply can't be expected to function properly and meet the serious needs of the people of the region? This is not an easy question to answer and, in my opinion, thoughtful well-intentioned people could review all of the relevant information and come to different conclusions. The Authority is in uncharted waters here, and no one has a crystal ball that can help make this difficult decision.

Professor Brownlee closed his presentation with a specific charge to the members of the Board of Directors of the Authority:

I believe all that each of you can do is to carefully review all of the relevant information that's been provided to you and to reach your own conclusion in a holistic manner by bringing together your mind, your heart, and your soul. For the decision that is made by the Authority's board will affect the lives of real people, with real families, who live in real communities here in Southwest Virginia.

The Comments of Dr. Tom Massaro

Dr. Massaro stated that thirty-five years ago when the University of Virginia opened the PICU unit in Southwest Virginia, many patients came from the region; however, as the local health systems have matured, the University hospitals did not get quite as many patients as they used to get from the region. He said that when the University of Virginia health system started the helicopter service, which was the first such service west of Interstate 95, Abingdon was one of the stops on the announcement tour. Dr. Massaro said that he had spent his academic life evaluating international health care systems and teaching health care policy and health reform around the world. He noted that health systems differ all over the world, but one issue he has confronted across all of them is the belief that competition is a good and important factor in the delivery of health care. Yet, he noted that every system he had encountered also believed it was important to manage and regulate competition when strategic issues of a nation or a region were in the balance. He told the Board that this balance of competition and strategic issues was the decision before them for consideration.

Dr. Massaro spoke at length regarding the possibilities created by the merger that would not otherwise be available to the region or its patients. He stressed the potential for innovation and creativity made is possible out of this merger stating that he believed these possibilities made it worth the effort of managing and restricting competition in this agreement.

"I have seen balances of competition worldwide, and, in general, when they are managed well, they can be extremely beneficial to the populations they serve," he said.

Dr. Massaro said that he believed that the merger had the potential to deliver public health benefits to the population of Southwest Virginia that would not be available any other way. He noted that as a pediatrician, the goal of a robust pediatric subspecialty care network in the merged system sharing the approach toward the care of children would be better, more efficient and more effective to those children here than if they stay apart or if they are acquired, merged or some other way deal differently with the region. Dr. Massaro noted that every day the American system compromised competition for what it believed to be the strategic better interest of the country, state or region. He gave several state and federal examples. "We regulate competition all of the time," he said, adding that "the region's needs...all of those justify the regulation and the management of competition." Dr. Massaro stated that he believed the pending merger in Southwest Virginia provided an innovation in public policy that would shed light on other regions of the country. "If I lived in this region, I would enthusiastically support this merger and do everything I could to bring about the best parts of the intent and goals of this program," he said.

A Review of the Benefits and Disadvantages

Mr. Barry next reviewed each of the statutorily identified benefits and disadvantages. He noted that the word "*likely*" preceded each list and by its very nature, the Authority was being asked to consider something inherently speculative. "We don't know the future," Mr. Barry said. He stated that the Board members needed to make a reasonable judgement that the benefits are likely to exceed the disadvantages, and Mr. Barry argued it would be reasonable for a Board member to conclude that the situation creates a monopoly and therefore the member does not want to support it.

He noted there were very few COPAs or cooperative agreements in effect so the only real evidence is anecdotal with little or no peer reviewed analysis and acknowledged that to some extent the process inherently involved guess work.

Mr. Barry then reviewed each of the elements of the statutory criteria in detail, a few notable comments include:

- A number of sources of quality metrics already exist; however, the Authority and the Applicants would meet and potentially establish new ones.
- Mental health services are not offered because they lose money and through their commitments the Applicants are committing themselves to furnish money to a money losing health care service. He stated the same dynamic applied to substance abuse.
- Mr. Barry requested Dr. Massaro address population health and Dr. Massaro noted that the area of population health is one of the real new ways to think about delivering care is the application of public health principles to patient groups. He said that until very recently doctors focused on one patient - the one in front of the doctor. While that benefitted the patient in front of the doctor, the approach did little

for the next patient with the exact same conditions. This created a situation where different doctors treat differently. Today, medical schools are educating physicians to think not only about individual patients but populations from which they are derived. "55 year-old males with type 2 diabetes are more alike than they are different," he said. And if we can figure out how to develop best practice, that is less expensive, more efficient and effective to bring people to a higher health status by looking at groups – which is why information is so important – that's population health in the twenty-first century. These commitments really do recognize that this strategy is a new commitment applying resources more efficiently for the patient better for the society as a whole. "The Applicants have a real understanding of population health and opportunities are great to serve the patients in the region," he said.

- Regarding access, Mr. Barry noted that the Applicants had made a commitment to maintain facilities for five years as health care facilities (not hospitals) coupled with a commitment to provide identified essential services should the hospital close. He stated that this is a stronger position than currently exists. 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. Mr. Barry stated that services may close, but the trade-off may be a more profitable system funding the commitments. He told the Board that the question of what happens in five years is speculation and encouraged the directors to make their decision.
- Mr. Barry stated that whether or not the savings are achieved is still unknown. The parties have been able to plan in great deal because of the nature of the discussions that would need to occur are barred under the antitrust laws. Mr. Barry stated that during his legal career he had worked with the consultant that the Applicants hired and found the consultant competent, FTI, which was smart and knowledgeable of health care. FTI took the proprietary information supplied by both organizations and calculated a savings of \$120,000,000 a year 10, which provides an estimate of \$1,200,000,000 in savings. The parties have made commitments of only \$450,000,000 so there is room for shortfalls. The parties have stated they took a conservative approach. The question is, Mr. Barry stated, "What is likely?" He noted that these savings are only achieved with the proposed merger, not an out of market merger.
- Mr. Barry noted that there would be some pain on the employment side, but the Applicants believed that the historic rate of attrition would lower the employee account. The Applicants had made commitments for protection of employees who lose their job as a direct result of the merger.
- Higher volume at the remaining sites, should result in greater efficiency enhancing quality. FTC questioned.
- Mr. Barry discussed the COPN implications and not that all of these facilities went through COPN process but a lot of what was necessary at inpatient facilities is no longer necessary.
- Mr. Barry reviewed the effect of proposed merger on Medicaid program noting that the hospitals will want to participate and had included a commitment to negotiate with Medicaid managed care programs. Mr. Barry also noted that the Applicants had stated that the 2% threshold in the commitment covers 97% of the commercial payers, which is 30% of the total population. He felt this was sufficient, especially because the 2% threshold was defined by payer not by product line.
- Mr. Barry reviewed the rate commitment in detail and noted that percentage of charge master rates contracts are "fading away." Mr. Barry reviewed the current payment system and value-based payment. Mr. Barry noted that new hospitals are

going where the money is – which is not Appalachia. He reviewed the mediation process set forth in the commitment. He reminded the Authority that the Commissioner has a lot of authority and will be grading the applicant's results. He noted that, as the FTC staff stated, disputes get resolved as part of the negotiation process.

- Mr. Barry said the granting of the Application would result in a marked reduction in competition; and that, but for the commitments and the monitoring and supervising by Commonwealth of Virginia, granting this cooperative agreement would be a bad idea. That's where this comes down. He encouraged the Board to consider whether by statute the benefits the region gets by the commitments outweigh the disadvantages of a loss of competition. He said some sites will close, some services will terminate, but the commitments provide some protections.
- Regarding the availability of less restrictive options, he said it was the judgement of the staff that "what we have not now is not sustainable. One level of junk status and hanging on is not sustainable. Not good for system or community. Something is going to change. He said there might be benefits from a sale to an outside party, but the leadership of the buyer and seller, not the leadership of the two systems or the Authority would have that conversation. There would be no input on those commitments. He also said that piecemeal approach across the system makes no sense because having asked the FTC staff for an example of a workable solution, the staff simply referred to the approval process set forth in the Federal Trade Commission regulations.
- Mr. Barry stated that in the response to the question, "What can go wrong?" He reminded the Board that if it did not recommend approval of the agreement, the process stopped at the Authority review level. He said there were concerns if the merger is not approved: facilities could close, services levels could be reduced at a level worse than in the cooperative agreement, quality could suffer. If the application is approved, the cost efficiencies might not work, but with such a significant difference between the projected savings and the commitments, room exists to miss some of the savings targets. He said the Applicants may default on the commitments and the Commissioner of Health would have to address the failures. He noted the systems could also become incredibly profitable and such profitability would provide more opportunity for community investment. He reminded the Board of Directors that the cooperative agreement would be reviewed in ten years.
- Mr. Barry reminded the Board that the FTC staff had stated that it would be impossible to go backwards and "unscramble the egg." He reminded the Board that the FTC staff had given examples. He stated that he believed the concern was overstated. Mr. Barry said that from his experience systems buy and sell hospitals all of the time that have been previously completely integrated into one system. He said hospitals can be divested, but of course a closed hospital has less value.

Following Mr. Barry's comments and the Chairman's call for questions from the Authority members, Mr. Mitchell stated that during the previous twenty-four hours (October 26th and October 27th), the Board of Directors had had devoted around seven hours to dealing with the cooperative agreement. He stated that in addition to the more than 4,500 pages of information, the hours of meetings, and the additional information from the FTC staff the Board members had a significant level of information to review. He recommended that the Board recess to reconvene eleven days later to complete their consideration. He believed the time would enable the Board time to absorb the

information that they had received. The Board agreed and recessed the meeting until November 7, 2016.

The Revised Commitments

A comparison of the proposed commitments and the revised commitments follows:

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COMMITMENTS CHART

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
1.	For all Principal Payers,* the New Health System will reduce existing commercial contracting to fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	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 ¹⁸⁴ , 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. ¹⁸⁵ Timing: First full fiscal year following the first contract year after the formation of the New Health System.	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,* the New Health System will reduce existing commercial contracting to for fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation % 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. Timing: First full fiscal year following the first contract year after the formation of the New Health System.

¹⁸⁴ *Note From The Commitments:* 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 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.

¹⁸⁵ *Note From The Commitments:* 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.

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>Amount: The estimated annual savings to consumers for the combination of Commitments 1 and 2 are \$10 million in lower health care costs annually.¹⁸⁶</p>	<p>Amount: The estimated annual savings to consumers for the combination of Commitments 1 and 2 are \$10 million in lower health costs annually.</p> <p>[new footnotes included (listed below)]</p>
2.	<p>For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per</p>	<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>For subsequent contract years, 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 increase 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,</p>

¹⁸⁶ 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.

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
	<p>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 as a process to resolve any disputes.</p>	<p>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 mediation¹⁸⁷ 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.</p>	<p>2018.</p> <p>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 mediation⁴ 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.</p>

¹⁸⁷ Note From The Commitments: 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.

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>Timing: Subsequent contract years.</p> <p>Amount: The estimated annual savings to consumers for the combination of Commitments 1 and 2 are \$10 million in lower health care costs annually.</p> <p>Metric: Easily verifiable.</p>	<p>Timing: Subsequent contract years.</p> <p>Amount: The estimated annual savings to consumers for the combination of Commitments 1 and 2 are \$10 million in lower health care costs annually.</p> <p>Metric: Easily verifiable.</p>
3.	<p>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). New Health System would agree to resolve through mediation any disputes in health plan contracting.</p>	<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>Timing: Immediately upon closing of the merger and then upon expiration of existing contracts or with</p>	<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). New Health System would agree to 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 quality and negotiates in good faith. New Health System will resolve through mediation any disputes in as to whether this commitment applies to the proposed terms of a health plan contracting 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>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>contracts with any new payers coming into area, and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Complaints from payers and credible report by the New Health System.</p>	<p>Timing: Immediately upon closing of the merger and then upon expiration of existing contracts</p> <p>or with contracts with any new payers coming into area, and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Complaints from payers and credible report by the New Health System.</p>
4.	<p>The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.</p>	<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>Timing: Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new payers coming into area, and</p>	<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 agree to 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>Timing: Immediately upon closing of the merger and</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>	<p>then upon expiration of existing contracts</p> <p>or with contracts with any new payers coming into area, and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>
5.	The New Health System will participate meaningfully in a health information exchange open to community providers.	<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>Timing: No later than 36 months after closing.</p> <p>Amount: Up to \$6 million over 10 years.</p> <p>Metric: The New Health System shall report annually to the Commissioner on mileposts toward meeting this commitment.</p>	<p>The 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 open to community providers 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>Timing: No later than 36 months after closing.</p> <p>Amount: Up to \$6 million over 10 years.</p> <p>Metric: The New Health System shall report annually to the Commissioner on mileposts toward meeting this commitment.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
6.	The New Health System will collaborate with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	<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>Timing: No later than 36 months after closing.</p> <p>Metric: The New Health System shall report to the Commissioner on the mileposts toward meeting this commitment.</p>	<p>The Commitment: 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 the overall health of the region:to deliver such outcomes at the highest possible value.</p> <p>Timing: No later than 36 months after closing.</p> <p>Metric: The New Health System shall report to the Commissioner on the mileposts toward meeting this commitment.</p>
7.	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>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>Timing: Immediately upon closing of the merger and ongoing.</p> <p>Amount: No incremental cost.</p> <p>Metric: Annual report and complaints, if any, from payers.</p>	<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>Timing: Immediately upon closing of the merger and ongoing.</p> <p>Amount: No incremental cost.</p> <p>Metric: Annual report and complaints, if any, from</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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			payers.
8.	<p>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.</p>	<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. In addition, the New Health System will timely report and include on its web site its performance compared to the Medicare quality measures including readmission statistics. 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>Timing: Annually, based upon when the New Health System establishes its annual quality goals.</p> <p>Metric: Compliance with commitment as agreed upon and modified subsequently.</p>	<p>The: 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>Timing: Annually, based upon when the New Health System establishes its annual quality goals.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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			<p>Metric: Compliance with commitment as agreed upon and modified subsequently.</p>
9.		<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 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>Timing: Immediately upon closing of the merger and ongoing.</p> <p>Amount: Extent of additional cost is unknown but is not immaterial.</p> <p>Metric: 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</p>	<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 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>Timing: Immediately upon closing of the merger and ongoing.</p> <p>Amount: Extent of additional cost is unknown but is not</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>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> <p>additi</p>	<p>immaterial.</p> <p>Metric: 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>
10.		<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 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</p>	<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 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</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>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>Timing: Immediately upon closing and ongoing.</p> <p>Metric: Credible report.</p>	<p>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>Timing: Immediately upon closing and ongoing.</p> <p>Metric: Credible report.</p>
11.		<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 an affiliate, receives under bond or other debt documents, must be furnished to the Authority and the Commonwealth.</p>	<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 an affiliate, receives under bond or other debt documents, must be furnished to the Authority and the Commonwealth.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>Timing: Ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Credible report.</p>	<p>Timing: Ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Credible report.</p>
12.		<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>Timing: Ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Credible report and easy to determine.</p>	<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>Timing: Ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Credible report and easy to determine.</p>
13.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain	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 —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

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
	States, and will provide all employees credit for accrued vacation and sick leave.	the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave. Timing: First year. Metric: Easily verifiable.	vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave. Timing: First year. Metric: Easily verifiable.
14.	The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health Systems Board of Directors.		The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health Systems Board of Directors.
15.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. The New Health System will 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.	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. Timing: By the end of the first full fiscal year upon closing of the merger. Amount: The estimated incremental investment in addressing salary/pay rate differences is approximately \$70 million over 10 years. Metric: Credible report which shall be provided confidentially in order to preserve a competitive	The 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 address any 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. Timing: By the end of the first full fiscal year upon closing of the merger. Amount: The estimated incremental investment in

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>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>	<p>addressing salary/pay rate differences is approximately \$70 million over 10 years.</p> <p>Metric: 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>
16.		<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 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.</p> <p>Timing: 5 years.</p> <p>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,</p>	<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 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.</p> <p>Timing: 5 years.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>including ongoing attrition in the workforce as inpatient hospital use rates continue to decline.</p> <p>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.</p>	<p>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.</p> <p>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.</p>
17.	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.	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	The 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

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>and training.</p> <p>Timing: No later than 24 months after closing.</p> <p>Metric: Credible report.</p>	<p>enhancement and training.</p> <p>Timing: No later than 24 months after closing.</p> <p>Metric: Credible report.</p>
<p>18.</p>	<p>With academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.</p> <p>The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than \$85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.</p>	<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>Timing: 10 years.</p> <p>Amount: Combination of commitments 17 and 18 total \$85 million.</p>	<p>With academic partners in Virginia and Tennessee 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 and implement, 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 the region 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>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>Metric: 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>Timing: 10 years.</p> <p>Amount: Combination of commitments 17 and 18 total \$85 million.</p> <p>Metric: 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</p>
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	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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			and businesses.
19.	<p>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.</p>	<p>Commitment: 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 opportunities, capacity and competitiveness of the proposals.</p> <p>Timing: 10 years.</p> <p>Amount: Combination of commitments 17 and 18 total \$85 million.</p> <p>Metric: 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</p>	<p>The New Health System will work closely with ETSU and other 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 in Virginia and Tennessee 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 within the region 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 opportunities, capacity and competitiveness of the proposals.</p> <p>Timing: 10 years.</p> <p>Amount: Combination of commitments 17 and 18 total \$85 million.</p> <p>Metric: 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</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>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>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>
<p>20.</p>	<p>The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. 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.</p>	<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 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>Timing: Implementation No later than 48 months after closing.</p> <p>Amount: Up to \$150 million.</p> <p>Metric: Implementation of promised system with mileposts along the way. The mileposts shall be proposed by New Health System no later than three</p>	<p>The 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 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>Timing: Implementation No later than 48 months after</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>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>closing.</p> <p>Amount: Up to \$150 million.</p> <p>Metric: 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>21.</p>	<p>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 scoped of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.</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 will continue to provide essential services in the community. For purposes of this commitment, the following services are considered "essential services":</p> <ul style="list-style-type: none"> • Emergency room stabilization for patients; • Emergent obstetrical care; • Outpatient diagnostics needed to support emergency stabilization of patients; 	<p>All 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 scoped scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.In the event that the New Health System repurposes any hospital, it will continue to provide essential services in the community. For purposes of this commitment, the following services are considered "essential services":</p> <ul style="list-style-type: none"> • Emergency room stabilization for patients;

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<ul style="list-style-type: none"> • 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. <p>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.</p> <p>Timing: Ongoing.</p> <p>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.</p> <p>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.</p>	<ul style="list-style-type: none"> • 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.
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	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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			<p>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.</p> <p>Timing: Ongoing.</p> <p>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.</p> <p>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.</p>
22.	The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher-level services are available in close proximity to where the population lives	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	The New Health System will maintain 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

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>lives.</p> <p>Timing: Immediately upon closing of the merger and ongoing.</p> <p>Amount: Not applicable.</p> <p>Metric: 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>	<p>proximity to where the population lives.</p> <p>Timing: Immediately upon closing of the merger and ongoing.</p> <p>Amount: Not applicable.</p> <p>Metric: 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>
23.	<p>The New Health System will maintain open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospitals-based physicians, as determined by the New Health System's Board of Directors.</p>	<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>Timing: Immediate upon closing of the merger and ongoing, subject to current contractual obligations.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>	<p>The 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 hospitals-based physicians, 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>Timing: Immediate upon closing of the merger and ongoing, subject to current contractual obligations.</p> <p>Amount: No cost.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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			Metric: Easily verifiable.
24.	The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.	<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>Timing: Immediate upon closing of the merger and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>	<p>TheIn 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>Timing: Immediate upon closing of the merger and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>
25.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	<p>The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.</p> <p>Timing: Immediate upon closing of the merger and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>	<p>The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.</p> <p>Timing: Immediate upon closing of the merger and ongoing.</p> <p>Amount: No cost.</p> <p>Metric: Easily verifiable.</p>
26.	The New Health System will commit to the development of a comprehensive physician needs assessment and	<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</p>	<p>The In order to enhance access to services for patients, and to ensure robust choices remain in the market for</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
	<p>recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference. The Parties expect the combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.</p> <p>The New Health System will ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.</p>	<p>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>Timing: Every 3 years, starting within the first full fiscal year.</p> <p>Amount: 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>Metric: 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 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</p>	<p>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. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference. The Parties expect the combined system to facilitate this goal by employing physicians 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 ensure The New Health System will promote recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.</p> <p>Timing: Every 3 years, starting within the first full fiscal year.</p> <p>Amount: 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>Metric: 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 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</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>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>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>27.</p>	<p>The New Health System will create a new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.</p> <p>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.</p> <p>The New Health System will develop pediatric specialty centers and Emergency Rooms in Kingsport and Bristol with further deployment of 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>Enhancing health care services:</p> <ol style="list-style-type: none"> 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. 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. 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 pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick 	<p>Enhancing health care services:</p> <p>a. The a. In an effort to enhance treatment of substance abuse in the region, the New Health System will create a new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region. serving the people of Southwest Virginia and Tennessee.</p> <p>b. The 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.</p> <p>c. The As part of the priority of preserving hospital services in geographical proximity to the communities traditionally served by the</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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	<p>The New Health System commits to spending at least \$140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.</p>	<p>diagnosis and treatment in the right setting in close proximity to patients' homes.</p> <p>Timing: 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>Amount: \$140 million over 10 years including physician recruitment referenced in number 25 above.</p> <p>Metric: The New Health System will include in the annual report for the second full fiscal year the plan for enhancing health care services, and in that report and each following, shall include in the annual report progress in implementing the plan and expenditures made.</p>	<p>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 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>Timing: 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>Amount: \$140 million over 10 years including physician recruitment referenced in number 25 above.</p> <p>Metric: The New Health System will include in the annual report for the second full fiscal year the plan for enhancing health care services, and in that report and each following, shall include in the annual report progress in implementing the plan and expenditures made.</p>
<p>28.</p>	<p>The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than \$75 million over ten years in population health improvement.</p>	<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</p>	<p>The In an effort to enhance population health status consistent with the regional health goals established by the Authority, the New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of 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</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>Commonwealth and Tennessee to collaborate with the New Health System to establish a regional plan that disregards state boundaries.</p> <p>Timing: 10 years.</p> <p>Amount: \$75 million.</p> <p>Metric: 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>Discussion: 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>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>Timing: 10 years.</p> <p>Amount: \$75 million.</p> <p>Metric: 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>Discussion: 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>
29.	The New Health System will not engage in "most favored nation" pricing with any health plans.		The New Health System will not engage in "most favored nation" pricing with any health plans.
30.		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	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

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<p>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> <p>Timing: Annual.</p> <p>Amount: Up to \$75,000 annually as part of the \$75 million for population health improvement, with annual CPI increases.</p> <p>Metric: 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>	<p>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> <p>Timing: Annual.</p> <p>Amount: Up to \$75,000 annually as part of the \$75 million for population health improvement, with annual CPI increases.</p> <p>Metric: 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>
31.		<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"> • 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; 	<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"> • 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;

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
		<ul style="list-style-type: none"> 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; The New Health System will ensure that 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 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. <p>Timing: Ongoing.</p> <p>Amount: No dollar cost.</p> <p>Metric: Easily verifiable.</p>	<ul style="list-style-type: none"> 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; The New Health System will ensure that 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 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. <p>Timing: Ongoing.</p> <p>Amount: No dollar cost.</p> <p>Metric: Easily verifiable.</p>
32.		<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>Timing: Annual.</p>	<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>Timing: Annual.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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		<p>Amount: No material cost.</p> <p>Metric: Receipt of compliant report.</p>	<p>Amount: No material cost.</p> <p>Metric: Receipt of compliant report.</p>
33.		<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>Timing: Annual and quarterly.</p> <p>Amount: No material cost.</p> <p>Metric: Easily verified.</p>	<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>Timing: Annual and quarterly.</p> <p>Amount: No material cost.</p> <p>Metric: Easily verified.</p>
34.		<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 remain in effect unless the change is agreed to by the Commissioner.</p> <p>Timing: If closing a facility is considered.</p> <p>Amount:</p> <p>Metric: Annual report will provide evidence of compliance with policy.</p>	<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 remain in effect unless the change is agreed to by the Commissioner.</p> <p>Timing: If closing a facility is considered.</p> <p>Amount:</p> <p>Metric: Annual report will provide evidence of compliance with policy.</p>

	Proposed Commitment	Revised Commitment	Changes From Initial Proposal
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35.		<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>Timing: Immediate upon closing of the merger.</p> <p>Amount: No cost.</p> <p>Metric: Creation of a Joint Task Force.</p>	<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>Timing: Immediate upon closing of the merger.</p> <p>Amount: No cost.</p> <p>Metric: Creation of a Joint Task Force.</p>
36.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the Virginia State Agreement.		
37.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.		

The Authority also considered two additional recommendations to the Commissioner concerning revisions to the Commitments and a time period by which re-consideration of the cooperative agreement would be appropriate.

A. Revision of Commitments – Recommendations by the Authority to the Commissioner

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,¹⁸⁸ 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 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.

B. Ten-Year Review of Cooperative Agreement – Recommendations by the Authority to the Commissioner

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

¹⁸⁸ *Note From The Commitments:* 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.

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, 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.

These commitments are significantly different than the originally proposed commitments.

Accountability Scoring Revisions.

The Applicants proposed an initial method of measuring their progress toward fulfilling their commitments and the Authority rejected this process. The Authority developed another process:

New: The parties proposed a scoring system in the initial application designed to measure the continuing public advantage of the Cooperative Agreement, along with proposed accountability mechanisms.

We propose that each commitment can be categorized into one of three groups: Protection, Conduct, and Investment Commitments. The suggested categorization of each commitment is listed below:

Category	Commitments
Protection Commitments	1,2,3,4,5,6,7,8,9,10,20,21,22,23,24,29,32
Conduct Commitments	11,12,13,14,15,16,28,30,31,33
Investment Commitments	17,18,19,25,26,27

Protection Commitments

Protection Commitments are designed specifically to mitigate any negative effects of the reduction of competition and provide assurances of access to services. Because each Protection Commitment is of significant importance to the fundamental goal of protecting payers, providers, and consumers, each must be fully met and attested to in each Annual Report filed with the state.

During an annual review process by the Commissioner and conveyance of a credible report to the New Health System to be audited as required in the regulations, the Commissioner may determine that a Protection Commitment is not being fulfilled and require an immediate corrective action plan from the New Health System and set forth a period of time for correction of not less than 90 days. If an acceptable plan is not submitted or corrective action is unsuccessful, the Commissioner may, at the Commissioner's discretion, compel immediate resolution under the procedure defined in regulation or negotiate with the parties to determine effective remediation or additional corrective action steps.

Conduct and Investment Commitments

Conduct and Investment Commitments provide significant public advantage above and beyond the fundamental goal of protecting payers, providers, and consumers and will be evaluated collectively each year to ensure that commitments are being achieved as determined by an Overall Progress Score under the Cooperative Agreement.

Conduct Commitments are agreements made between the Authority and the Parties which govern the actions of the New Health System. These commitments will be evaluated on a "Satisfied" (Score 100) or "Not Satisfied" (Score 0) scale. Each Conduct Commitment will be assigned a weight of 2% of the overall Cooperative Agreement Score. For any Conduct Commitment not achieved, the Commissioner may require a corrective action plan to ensure compliance.

Investment Commitments require significant implementation resources, timelines for achievement or both. It is proposed that progress for Investment Commitments be measured by introducing a scoring methodology adopted from the Association of State and Territorial Health Officials *National Public Health Performance Standards (NPHPS)*. Concurrent with the development of each implementation plan outlined for the Investment Commitments a questionnaire would be developed as part of the annual reporting process. For each Investment Commitment, evaluation questions would be agreed upon by both the parties and the state. Each of these questions would have equal weight in scoring that commitment. Each question would then be graded according to the NPHPS categories:

No Performance: 0% or absolutely no activity. Score 0.

Minimal Performance: Greater than zero, but no more than the 25% of the activity described within the question is met. Score 25.

Moderate Performance: Greater than 25%, but no more than 50% of the activity described within the question is met. Score 50.

Significant Performance: Greater than 50%, but no more than 75% of the activity described within the question is met. Score 75.

Optimal Performance: Greater than 75% of the activity described within the question is met. Score 100.

Each individual Investment Commitment will receive a score between 0 and 100 based on the average of all questions scored within that commitment. The score will be multiplied against the suggested weight of each investment (derived relative to investment size) in the table below and the weighted scores will be totaled.

Investment Commitment	Commitment Weight
17. Expand GME and Training	10%
18. Grow Research	10%
19. Adopt a Common Clinical IT Platform	25%
26. Improve Community Health	10%
27. Enhance Health Care Services	25%

For Investment Commitments that achieve any score less than Moderate Activity, the Commissioner may require a corrective action plan to ensure compliance and also require that any investment less than that agreed to in the annual plan be fulfilled in the subsequent year or that the plan be adjusted in agreement with the state to ensure ongoing benefit.

Example Overall Progress Scoring:

Conduct Commitments (Maximum Score of 20)

9 Conduct Commitments are satisfied. $100 \times 9 \times 2\% = 18$
 1 Conduct Commitment is Not Satisfied. $0 \times 1 \times 2\% = 0$
 Subtotal: $18 + 0 =$ **18 Conduct Commitment Points**

Investment Commitments (Maximum Score of 80)

Eight of eight questions for Commitment #17 are Optimal.
 $(8 \times 100) / 8 = 100$ Unweighted Score

Unweighted Score multiplied by weight: $100 \times 10\% = 10$ Weighted Points

Six of six questions for Commitment #18 are Optimal. $(6 \times 100) / 6 = 100$
 Unweighted Score

Unweighted Score multiplied by weight: $100 \times 10\% = 10$ Weighted Points

Four of six questions within Commitment #19 are Optimal and two are Significant $(4 \times 100) / 6 + (2 \times 75) / 6 = 91.7$ Unweighted Score
 Unweighted Score multiplied by weight: $91.7 \times 25\% = 22.9$ Weighted Points

Six of six questions for Commitment #26 are Optimal. $(6 \times 100) / 6 = 100$ Unweighted Score

Unweighted Score multiplied by weight: $100 \times 10\% = 10$ Weighted Points

Four of six questions within Commitment #27 are Optimal and two are at No Activity $(4 \times 100) / 6 + (2 \times 0) / 6 = 66.7$ Unweighted Score
Unweighted Score multiplied by weight: $66.7 \times 25\% = 16.7$ Weighted Points

Subtotal: $10.0 + 10.0 + 22.9 + 10.0 + 16.7 = \mathbf{69.6}$ Investment

Commitment Points.

Overall Progress Score

Conduct Commitment + Investment Commitment Points = $18 + 69.6 = \mathbf{87.6}$

Overall Progress Score

Continuing Public Advantage Score

Continuing Public Advantage cannot be achieved in a given evaluation year without fulfillment of all Protection Commitments and an Overall Progress Score of at least 60.

Continuing Public Advantage can be achieved during a particular year if individual Conduct or Investment Commitments receive a corrective action plan. However, failure to achieve success with corrective action plans within twelve months of enactment may result in the state compelling immediate resolution under the procedure defined in regulation.

Additional Information About the Wellmont Process

The Application informed the Board of Directors that during the Wellmont Health System strategic decision process, Wellmont Health System had issued requests for proposals to twenty-two groups and received nine proposals.¹⁸⁹ Wellmont Health System provided the Board of Directors, through their legal counsel, with information regarding the Wellmont Health System strategic review process stating:

“Throughout the first two phases, updates were provided to the community as the board narrowed its lists of candidates from around 12 initial serious inquiries/responses to 3 finalists. During this process the board made a defining choice to pursue a partnership with another not-for-profit health system based on a desire to continue to be a mission based community health system. It is important to note that the responses from potential partners were not binding documents and none of them remain as active proposals for consideration today. Because of the confidentiality requested by those potential partners to protect their own strategic direction, we are not at liberty to provide them.”¹⁹⁰

¹⁸⁹ Application at 5.

¹⁹⁰ Letter Gary Miller, Executive Vice President/General Counsel to J. Mitchell November 4, 2016.

Wellmont Health Systems reported that it ultimately chose a path forward and the selection of a partner based upon public feedback and the deliberations of the Wellmont Health System Board of Directors, which included several parameters:

- Protecting high quality health care, close to home is essential.
- Maintaining local control and governance is very important.
- Also important are keeping health care costs under control and supporting local academic institutions, as well as supporting economic growth.
- The prospect of merger within the region was passionately supported by many regional leaders.
- We saw compelling potential benefits of a regional merger.¹⁹¹

Wellmont Health System reported to the Authority that it spent significant time in discussions with multiple potential partners. Wellmont Health System informed the Authority that “in early 2015 the board determined that the best option for Wellmont and our region was a merger with Mountain States – a local health system known to us and other regional leadership who shares our commitment and vision for the future.”¹⁹² Wellmont Health System further explained its decision by stating:

As a health system that cares about our employees and our region and has the community’s best interests at heart, we wanted to work with a partner to find ways to achieve efficiency while minimizing impact on jobs and the economy. The reinvention of health care requires tens of millions of dollars in investment along with intellectual capital and infrastructure that will only be available to the systems who are strong financially and can spread those costs over a large organization. Rather than shrinking services and access points, scale achieved through the right partnership could also give us more flexibility to invest in our staff, improve our facilities and equipment, implement cutting edge technology, and preserve more jobs and high-level services. The achievement of correct scale could result in immediate financing improvement through supply cost savings, back office savings, and cost of capital alone. These improvements should have a positive impact on the economic potential of our organization and the communities we serve.¹⁹³

According to the Applicants, this assessment by Wellmont Health System occurred in the midst of very challenging times for rural hospitals. The Applicants noted that that both systems have a number of rural hospitals and that both systems confront the challenges permeating the health care network in America, including “reduced payment for services, services moving from inpatient to the outpatient setting, higher patient out-of-pocket costs due to increased copayments and

¹⁹¹ *Id.* at 2.

¹⁹² *Id.*

¹⁹³ *Id.*

deductibles...¹⁹⁴ in a “rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.”¹⁹⁵

RECOMMENDATION

On November 7, 2016, the Southwest Virginia Health Authority Board of Directors re-convened to conclude their review of the Application submitted by Mountain States Health Alliance and Wellmont Health System. The Chairman started the final consideration of the Application by noting that the Authority’s review process had been a very open process with several presentations, the formation of the working groups, the effort of the working group chairs, and the preparation of the questions submitted to the Applicants. He thanked the Authority’s staff for their input and expertise. The Authority engaged in extended deliberations of material with the Applicants and the other material the Authority received about how this transaction would impact the region of Southwest Virginia. The Chairman stated that the Application had been made better with respect to the commitments, the scoring system, and the board representation.

The Chairman commended everyone who had participated in the process, from the Applicants and their staff to the insurance companies and their associations who urged the Authority to “take all necessary actions to protect consumers from anti-competitive hospital consolidation.” He thanked them for their insights. He also thanked the public for their contributions through the written public comments and the public testimony. Finally, he thanked the FTC staff, who he said repeatedly and readily made themselves available.

Culmination of the Review

The meeting to conclude the review of the Application and act upon the Application as directed by the Code of Virginia represented the culmination of months of review and consideration. The Authority Board of Directors members considered the Application, their interaction with the representatives of the Applicants, the many presentations by stakeholders in the review process, including the FTC staff, the insurance companies and their representatives, health care providers in the region, and the public.

Parameters of Consideration

The General Assembly created the Authority with a unique focus on the Southwest Virginia health care stating:

- 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.

¹⁹⁴ *Id.*

¹⁹⁵ *Id.* at 5.

- 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.¹⁹⁶

During the 2015 legislative session, the General Assembly enacted legislation creating the ability of hospitals and other health care entities in localities that participate in the Authority to submit applications for cooperative agreements:

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.**¹⁹⁷

The General Assembly only enabled health care entities in the localities within the Authority's geographic area to submit an application for a cooperative agreement that might enable otherwise anticompetitive behavior. During the 2015 legislative session, the General Assembly established the Commonwealth's position on cooperative agreements in Section 15.1-5384.1:

The policy of the Commonwealth **related to each participating locality** is to encourage cooperative, collaborative, and integrative arrangements, including mergers and acquisitions among hospitals, health centers, or health providers who might otherwise be competitors. Such intent is within the public policy of the Commonwealth to facilitate the provision of quality, cost-efficient medical care to **rural patients**.¹⁹⁸

Again, this unique policy position was taken solely with respect to rural patients within the geographic footprint of the Authority.

The General Assembly segregated the responsibility for the approval and supervision of a cooperative agreement between the Authority and the Commissioner of Health. The Authority has a specific set

¹⁹⁶ VA CODE ANN. § 15.2-5368 (emphasis added).

¹⁹⁷ VA CODE ANN. §15.2-5368(C) (emphasis added).

¹⁹⁸ VA CODE ANN. §15.2-5384.1(A).

of responsibilities for the application, while other responsibilities, such as enforcement of the agreement, rest with the Commissioner of Health. The statute vests the Commissioner with the authority to approve the application for a cooperative agreement and vests in the Commissioner the responsibility for active supervision of a cooperative agreement, all based upon the Authority's recommendation:

"To the extent such cooperative agreements, or the planning and negotiations that precede such cooperative agreements, might be anticompetitive within the meaning and intent of state and federal antitrust laws, the intent of the Commonwealth with respect to each participating locality is to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority, and **to invest in the Commissioner the authority to approve cooperative agreements recommended by the Authority and the duty of active supervision** to ensure compliance with the provisions of the cooperative agreements that have been approved."¹⁹⁹

Mr. Mitchell reminded the Board that the statute also provided the standard of review they were to utilize:

The Authority shall review a proposed cooperative agreement in consideration of the Commonwealth's policy to facilitate improvements in patient health care outcomes and access to quality health care, and population health improvement, in rural communities and in accordance with the standards set forth in subsection E.

The General Assembly specified the type of information that the Authority may consider to include the proposed cooperative agreement and any supporting documents submitted by the Applicants, any written comments submitted by any person, any written response by the Applicants, any written public comment and any comments at the public hearing.²⁰⁰ The standard by which the Board of Directors must make a recommendation is also set forth in the Code:

The Authority **shall recommend for approval** by the Commissioner a proposed cooperative agreement **if it determines that the benefits likely to result outweigh the disadvantages likely to result from a reduction in competition** from the proposed cooperative agreement.²⁰¹

Mr. Mitchell noted that the Authority had reviewed over 4,500 pages of information with most of the focus on the commitments. He reminded the Board members that the staff had recommended that the originally submitted commitments by the Applicants be rejected and replaced with a revised set of commitments that staff had presented and that had been widely distributed on the Authority's website and other places. He noted that a comparative version showed the significance of the changes and that the Authority staff was available for a final review if necessary. The Authority also rejected the scoring system originally proposed by the applicants and proposed a new scoring system

¹⁹⁹ VA CODE ANN. §15.2-5384.1(C) (emphasis added).

²⁰⁰ VA CODE ANN. §15.2-5384D (emphasis added).

²⁰¹ VA CODE ANN. §15.2-5384.1(E)(1) (emphasis added).

The staff have divided the commitments of the Applicants into three categories: protection commitments, conduct commitments, and investment commitments. The protection commitments are designed to mitigate the potential negative consequences from the reduction of competition. The conduct commitments are designed to acknowledge and record the significant public advantages that the Applicants are proposing. The investment commitments require a significant expenditure of resources achieved from the merger, if allowed. A more sophisticated scoring system was developed to track the progress of the Applicants with the protection commitments either being met or not met and the conduct and investment commitments evaluated on a relative scale that would contemplate partial competition.

A Review of the Benefits

To analyze the application for likely benefits to occur the Authority decided to review each benefit individually. The statute requires a review of the following benefits:

"In evaluating the potential benefits of a proposed cooperative agreement, the Authority shall consider whether one or more of the following benefits may result from the proposed cooperative agreement:

- a. Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction;
- b. Enhancement of population health status consistent with the regional health goals established by the Authority;
- c. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
- d. Gains in the cost-efficiency of services provided by the hospitals involved;
- e. Improvements in the utilization of hospital resources and equipment;
- f. Avoidance of duplication of hospital resources;
- g. Participation in the state Medicaid program; and
- h. Total cost of care.²⁰²

The Authority individually considered each benefit.

Benefit: Quality of Care

"Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction"²⁰³

Dr. Rawlins, who chaired the Quality Working Group, stated that at the conclusion of the working group meetings, the group stated that with the commitments that have been made they believe the quality would exist and outweigh the problems. The Chairman noted that the

²⁰² VA CODE ANN. §15.2-5384.1(E).

²⁰³ VA CODE ANN. §15.2-5384.1(E)(2).

enhancement of the substance abuse programs and enhancing mental health services would be a key factors to consider in reviewing this benefit.

Dr. Rawlins made a motion that the Authority believes the cooperative agreement will enhance the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction given all of the commitments are carried out.

The Chairman noted that a number of the other working groups may also have input on this benefit. The Board discussed the implication of the language "improved patient satisfaction." Mr. Mitchell noted that throughout the discussion considerable attention was paid to the metrics that the hospitals report, and Mr. Barry noted that the federal agency surveys also require patient satisfaction input.

The Board considered which other commitments applied to benefit number one, in addition to commitment number 20. The members discussed that several commitments apply to this benefit.

The Board of Directors approved the resolution finding that the likely benefit of enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse, provided to citizens served by the Authority, resulting in improved patient satisfaction would result from the granting of the application for the cooperative agreement.

Benefit: Population Health Improvement

"Enhancement of population health status consistent with the regional health goals established by the Authority;"²⁰⁴

Senator Carrico, who chaired the Population Health Working Group, reported that the Population Health Working Group saw an enhanced ability for specialty care in mental health, substance abuse, chronic diseases that are related to obesity and diabetes connections and tobacco use and how it relates to heart disease and a conscientious effort to specialize in that area through their agreements to target those areas for the region through more extensive screenings and by building the addiction abuse facility to target the substance abuse area.

The Chairman asked Senator Carrico if he thought those commitments were consistent with the regional health goals established by the Authority and Mr. Carrico stated the thought they were consistent.

Mr. Carrico said that they the working group gave the Applicants five top priorities and the Applicants adopted these priorities, including oral care. Dr. Cantrell noted prenatal care, child health indicators, infant mortality and other indicators had also been discussed with the Applicants. She noted that the

²⁰⁴ VA CODE ANN. §15.2-5384.1(E)(2)(b).

data that would be available from the integrated health records to know the status of the community and whether the strategies were working and how to meet the priority needs.

The Authority Board of Directors adopted Senator Carrico’s resolution that the Authority finding that the benefit of the enhancement of population health status consistent with the regional health goals established by the Authority likely will exist as a result of the cooperative agreement.

Benefit: Facilities.

“Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care”²⁰⁵

Ms. O’Dell said that the Access Working Group spent a significant amount of time investigating where the current facilities in the system were located. She said that the group agreed that looking much past five years was probably not appropriate and the group was comfortable with the five-year commitment. She said the Access Working Group required the Applicants to develop a certain level of services if a facility was repurposed. She called the attention of the Board to Commitment 20, where the Applicants made the commitment. She said the Access Working Group did believe applicants did make a commitment and there as a benefit of the preservation of the facilities. Ms. O’Dell made a motion to recognize the likely existence of the benefit from granting of the cooperative agreement. The motion passed.

Benefit: Cost-Efficiency Improvements

“Gains in the cost-efficiency of services provided by hospitals involved”²⁰⁶

Ms. Donna Henry, who chaired the Cost Working Group, referred the Board to Commitments 1 and 2, which she described as the main commitments where the Applicants discussed health system estimates savings and a limit on pricing growth. The only concern that came from the Cost Working Group was who would monitor the commitments. She stated that the Cost Working Group became comfortable that the Commissioner of Health would monitor the commitments and therefore the Working Group was comfortable that the benefit would be achieved from the commitments.

The Authority adopted a resolution that, as noted by the Cost Working Group, a likely benefit of gains in the cost-efficiency of services provided by hospitals involved may result from the cooperative agreement.

Benefit: Improvement in Utilization of Resources

“improvements in the utilization of hospital resources and equipment”²⁰⁷

The Chairman noted that a significant amount of discussion had occurred on this subject, especially related to the rural hospitals. Dr. Rawlins noted that the Access Working Group discussed this issue

²⁰⁵ VA CODE ANN. §15.2-5384.1(E)(2)(c).

²⁰⁶ VA CODE ANN. §15.2-5384.1(E)(2)(d).

²⁰⁷ VA CODE ANN. §15.2-5384.1(E)(2)(e).

are well. Dr. Cantrell noted that over time local people had noticed that resources were utilized for one system to obtain equipment simply because the other system had the equipment, not necessarily to expand services in the community. The Board of Authority passed a resolution finding that the benefit of improvements in the utilization of the hospital resources and equipment likely exists as a result of the cooperative agreement.

Benefit: Avoidance of Duplication of Resources

“Avoidance of duplication of Hospital Resources”²⁰⁸

The Chairman noted that this issue had been discussed at length and the Board members discussed the issue, including the impact on the small low census rural hospitals. Dr. Rawlins noted that the benefit of the avoidance of the duplication of hospital resources would exist. The Board of Directors passed the resolution finding the likely benefit of the avoidance of the duplication of hospital resources existed.

Benefit: Participation in Medicaid

“Participation in the state Medicaid Program”²⁰⁹

Several working groups examined this benefit. The Access Working Group noted the relevant commitment to participate in the program and the Cost Working Group examined the insurance issues, the Medicaid participation, and the charity care policy. The Cost Working Group believed the poor citizens in Southwest Virginia would have better access to charity care under the proposed cooperative agreement. Dr. Cantrell noted that the government payers were 70% of the payers and it would be hard to contemplate the combined system not participating in the Medicaid program.

The Board passed a resolution finding that the benefit of the participation in the state Medicaid Program would likely exist under the cooperative agreement.

Benefit: Total Cost of Care

“Total Cost of Care”²¹⁰

The Authority engaged in a number of discussions on the total cost of care and the implications of the proposed merger while the Application was under consideration. The Chairman noted that Commitment 1 and Commitment 2 addressed this benefit and also noted the additional language that the Authority staff negotiated. The Chairman stated that while health care costs may rise in other parts of the nation, the costs will not rise as fast in Southwest Virginia under the cooperative agreement. Dr. Cantrell noted that as technology in health care continues to change, it is pure speculation as to what the cost of health care will be. She gave an example of HepC and the impact of the standards of care and the changes in technology on the cost of patient treatment.

²⁰⁸ VA CODE ANN. §15.2-5384.1(E)(2)(f).

²⁰⁹ VA CODE ANN. §15.2-5384.1(E)(2)(g).

²¹⁰ VA CODE ANN. §15.2-5384.1(E)(2)(h).

The Chairman stated that the benefit of the total cost of care in Southwest Virginia appears to be in proportion to growth with similar institutions and will be capped as noted in the commitments chart, primarily commitment number two and commitment number three.

The Board unanimously adopted the resolution finding that the benefit of controlling the total cost of care may exist under the cooperative agreement.

Other Benefits

The Board discussed other potential benefits likely to result from the cooperative agreement that are not listed in the statute. The Chairman noted that the merger would maintain the corporate offices in the region without having to rely on an outside partner agreeing to keep all of the jobs in the region. Mr. Neese noted that the commitments give support to hospitals that could otherwise be at risk. The Chairman noted that the research and development opportunities were significant.

Mr. Neese moved that the Board find that additional potential benefits were likely to result from the cooperative agreement, including the research and development, maintenance of at-risk hospitals in the area, and the maintenance of the jobs in the region. The board adopted the motion.

Board Consideration of the Disadvantages

Throughout the review of the cooperative agreement application the Board of Directors of the Authority discussed the impact of the cooperative agreement on competition. Many conversations were held with the FTC staff, representatives of insurers and regional stakeholders.

The Code of Virginia directs the Board of the Authority to consider the following disadvantages because of a reduction in competition likely to result from the proposed cooperative agreement including but not limited to the following factors:

- a. The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers;
- b. The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;
- c. The extent of any likely adverse impact on patients in the quality, availability, and price of health care services; and
- d. The availability of arrangements that are less restrictive to competition and 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.²¹¹

Mr. Mitchell noted that the consideration should not necessarily be limited to these factors. He also informed the Board that their ultimate determination was whether the benefits outweighed the disadvantages. The standard does not require the Board to determine that the disadvantages do not exist. The disadvantage might exist, but be mitigated by the commitments.

The Board considered each statutorily defined disadvantage and found that only disadvantage that was likely to exist was an adverse impact on the ability of payers to negotiate with the system

Disadvantage: Payer Ability to Negotiate

“The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations, or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers”

The Chairman noted that a significant amount of discussion occurred on this matter. He thanked AHIP and the Virginia Association of Health Plans for their insight and comment on this factor. He noted that the revised commitments attempted to address these concerns, especially commitment 3, and the commitment to a competitive market for insurance. He reminded the Board that there was a lot of discussion of principal payer and the definition of principle payer. There was much discussion on the smaller entrants in the market and that the Applicants should not act unreasonably with respect to them. Mr. Barry noted that Dr. Cantrell had referred to 70% of the market being governmental payer or Medicaid or Medicare related. The 30% - the vast majority of this is Anthem. Mr. Barry noted that “bad payers” exist in the marketplace and the Applicants wanted the ability not to deal with some payers, but that the Applicants had stated that they would prefer more payers, especially given Anthem’s dominance in the market.

Mr. Horn moved the that the Board of Directors finds that the disadvantage may exist. The motion passed.

Later in the meeting, the Board revisited this finding to determine whether they had determined that the disadvantage was mitigated. Mr. Mitchell noted that this mitigation concept was not part of the original resolution. Mr. Horne noted that he had purposefully left the language out. Mr. Horne stated he had concerns about self-insured groups and may disadvantage them, especially physicians. The Chairman noted that many members felt that the commitments would mitigate the concern and that several people who spoke at the public hearing were self-insurers who spoke in favor of the

²¹¹ VA CODE ANN. §15.2-5384.1(E)(3).

cooperative agreement. He noted at the end of the day the main decision was the weighing of the benefits and the disadvantages.

Disadvantage: Reduction in Competition Among Providers

“The extent of any reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement.”²¹²

The Board was provided a significant amount information about this matter, including the Applicant’s assertion that their commitment to an open system would mitigate this disadvantage. The Chairman reviewed a number of the commitments related to the mitigation of this disadvantage stating that it appeared that the Authority might find that the disadvantage was not likely to exist.

The Board unanimously passed Dr. Rawling’s a resolution that while the potential existed for a reduction in competition among physicians, allied health professionals, other health care providers, or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement, it had been mitigated by the commitment to maintain an open system and other commitments.

Disadvantage: Quality, Availability, and Price

“The extent of any likely adverse impact on patients in the quality, availability, and price of health care services;”²¹³

The Chairman noted that this topic had been discussed a great deal, including during consideration of the advantages of the cooperative agreement. He noted Senator Carrico’s comments about improved services. Dr. Cantrell stated that given the considerable discussion already about quality, availability and cost, and the benefits derived in those areas, that this disadvantage is “almost moot.” Mr. Mitchell reminded the Board of the graphs that Dr. Cantrell had previously distributed. Ms. Welch noted her concerns that availability will not increase and prices may increase, which is not a disadvantage but it may be there. Ms. O’Dell noted the ultimate weighing of the disadvantages and benefits.

Dr. Cantrell moved that the Board find that the likely adverse impact of quality, availability/access and price have been determined already likely to be more beneficial than disadvantage, and the Board adopted the resolution.

Disadvantage: Availability of Less Restrictive Alternatives

“The availability of arrangements that are less restrictive to competition and 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.”²¹⁴

²¹² VA CODE ANN. §15.2-5384.1(E)(3)(b).

²¹³ VA CODE ANN. §15.2-5384.1(E)(3)(c).

²¹⁴ VA CODE ANN. §15.2-5384.1(E)(3)(d).

Mr. Mitchell reminded the Board that it had received considerable comment, including from the FTC staff, that perhaps it was possible to accomplish the goals of the Applicants through means other than the cooperative agreement. He reminded the Board that the Applicants strongly disagreed; however, the Applicants did provide information on some limited projects on which they currently coordinate.

Dr. Rawlins stated that the risk is much greater that the small local hospitals could be closed if one of the systems was purchased by an outside buyer.

The Chairman noted that Wellmont Health System had provided a letter on their process. Mr. Mitchell stated that he had spoken to the attorney for Wellmont Health System regarding their process in attempt to determine whether he would learn anything that might require the Board to go into executive session and discuss the Wellmont Health System process with representatives of the system. He provided the letter from Mr. Miller.²¹⁵ Mr. Mitchell stated that nothing he learned during that discussion would, he believed, impact their deliberations.

Dr. Rawlins made a motion that the Board find that while the availability of other arrangements may appear less restrictive to competition they do not achieve the same benefit of guaranteeing rural hospital services and population health improvement that the current proposal does. The Board unanimously adopted this motion.

Other Disadvantages.

The Chairman asked whether there were any other disadvantages to consider.

The staff noted that while working on the commitments the staff tried to address any identified disadvantages during the revisions to the commitments. Dr. Rawlins noted that she and Mr. Neese believed that their concerns and the concerns of their working groups were addressed. Mr. Neese noted that the Competition Working Group had significant participation in the commitments revisions and that the final commitments reflected that participation. The Chairman noted that the staff considered the results of the Working Groups when negotiating the revised commitments with the Applicants. Several Board members also attended those meetings.

A Weighing of Benefits and Disadvantages

The Authority shall recommend for approval by the Commissioner a proposed cooperative agreement if it determines 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.²¹⁶

The Board of Directors considered its final recommendation in two stages. First, the Board determined whether the likely benefits outweighed the likely disadvantages. Next, the Board considered a motion to recommend approval of the proposed cooperative agreement.

²¹⁵ For more information about Mr. Miller's letter, see page 155 of this report.

²¹⁶ VA CODE ANN. §15.2-5384.1(E)(1).

Recommendation of the Authority

A Weighing of Likely Benefits and Likely Disadvantages?

The Board of Directors considered a motion to determine 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 taking into reconsideration the revised commitments and the revised scoring system. The Board members understood that the members with a conflict of interest could not participate in the vote and the record would indicate they did not participate.

Senator Chaffin moved that the Board of Directors of the Authority find 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 with the addition of the revised commitments and the revised scoring system.

The Board discussed at length whether the commitments were clear enough and were enforceable. Staff reviewed the commitments and expressed the opinion that the commitments were enforceable; and, in the event the cooperative agreement was terminated, then the antitrust officials at the state and Federal level can attack the organizations.

Mr. Barry noted that the Authority members had significant experience with the Applicants. The Authority aggressively negotiated the commitments and the Applicants understand what their commitment are. Part of the negotiated commitments is a new requirement to re-examine the agreement in ten years. Staff reminded the Board that the new scoring process recognized the different levels of the commitments, with the most significant commitments, competition, being either met or not, while the other commitments could recognize partial success.

Recommendation For Approval

Having found that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in a competition from the proposed cooperative agreement, the Board of Directors of the Authority voted to recommend that the application for a cooperative agreement be approved by the Commissioner with the revised commitments and revised scoring system. The Board of Directors noted noting the conflicts of interest of certain members of the Board of Directors and that these conflicted members of the Board of Directors did not participate in the Board's actions.

Conclusion

For over ten months, the members of the Board of Directors of the Authority devoted many hours to reviewing the material submitted by the Applicants, considering the information submitted by the stakeholders, such as the insurance community, and discussing the potential impact of the approval of the cooperative agreement. This report summarizes the highlights of that deliberation, capturing key issues and recording the efforts of the Authority; however, this report is only an overview of the Authority's activities.

The Authority recognizes that the General Assembly granted specific responsibility for the Application to the Authority – including receiving the Application, determining the completeness of the Application and weighing the likely benefits against the likely disadvantages resulting from a loss of competition. The Authority heard many arguments against recommending approval of the Application and carefully considered each one.

Southwest Virginia is a very unique region with specific challenges. Many of the revised commitments confront those challenges. The Authority rejected both the commitments originally proposed by the Applicants and the scoring system suggested to track the progress toward the commitments. The revised commitments and scoring system present a measurable and specific system of tracking the success of the Applicants toward achieving the goals of the Authority and the promises of the cooperative agreement.

In the end, the Authority's Board of Directors determined that the benefits likely to result from the proposed cooperative agreement outweighed the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement.

As Dr. Brownlee stated "the decision that is made by the Authority's board will affect the lives of real people, with real families, who live in real communities here in Southwest Virginia."

We carefully considered the issues. In the end, we voted to recommend the Commissioner of the Virginia Department of Health approve the request for a cooperative agreement filed by Mountain States Health Alliance and Wellmont Health System.