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March 14, 2017

BY EMAIL (erik.bodin@vdh.virginia.gov) ONLY
Mr. Erik O. Bodin, Director
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1485

Re: Request for Additional Information – Response # 13

Dear Mr. Bodin,

Response # 13 to the questions received from your office on December 22, 2016, has been uploaded to the Citrix ShareFile platform.

Please contact me if you have any difficulty or questions in accessing the Citrix ShareFile platform. As permitted under Virginia Code § 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), the material that the parties believe to be proprietary is clearly marked and submitted in separate electronic files for confidential treatment.

Responses to the following questions are submitted as part of Response # 13:

Section V. Additional Information

N. Market Analysis
1 – Amended
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P. Population Health
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Additional responses will be provided as soon as possible. Please let me know if you or your staff has any questions related to the enclosed documents.

Sincerely,

Francis C. Oroszlan

cc: Peter Boswell
Allyson K. Tysinger

877783/1

RESPONSE #13

TO QUESTIONS

SUBMITTED DECEMBER 22, 2016

BY

VIRGINIA DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1

and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance

Wellmont Health System

Date: March 14, 2017

V.N.1. Amended

N. Market Analysis

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

AMENDED JOINT RESPONSE: WHS acquired Takoma Regional Hospital in Greene County, TN as of January 1, 2017 not as of December 31, 2016. We amend Response N-1, and accompanying **Exhibit N-1A**, which were submitted on January 31, 2017, to modify the following:

- The footnote in Response N-1 is modified to read as follows:

  [1] Takoma Regional Hospital was not considered one of the Parties' hospitals when determining the service areas, but note that it has since been acquired by Wellmont as of January 1, 2017.

- The footnote in **Exhibit N-1A** "Map of Hospitals In and Out of 75% and 90% Service Areas" is modified to read as follows, and **Amended Exhibit N-1A** is included:

  **The data provided include Takoma Regional Hospital as an independent hospital. Wellmont's acquisition of Takoma Regional Hospital, located in Greene County, Tennessee, was recently completed as of January 1, 2017.

INDEX OF DOCUMENTS:

- Exhibit N-1A Map of Hospitals In and Out of 75% and 90% Service Areas

V.N.4. Amended

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

JOINT AMENDED RESPONSE: We amend the original **Exhibit N-4** provided to the Commissioner on January 10, 2017. We have amended **Exhibit N-4** as indicated below to reflect that Takoma Regional Medical Center in Greene County, TN ("Takoma") was acquired by WHS as of January 1, 2017 and that MSHA has entered into an agreement to acquire Laughlin Memorial Hospital. In light of the acquisition by WHS of Takoma, if Tables 14.1 and 14.2 in the text of Application Section 14 were modified to reflect Takoma's current affiliation with WHS instead of its affiliation as of CY2014, the percentages reported would not change. This is due to the small number of discharges at Takoma coming from Virginia. We footnoted the Wellmont data in Table 14.1 in the text of updated Application Section 14 to note this. The revised **Exhibit N-4** is provided in its entirety, as amended.

The following paragraphs and tables included in **Exhibit N-4** were revised as indicated:

- **Application Section 14, page 54, from Exhibit N-4**

  There are eight general acute care hospitals in the Geographic Service Area that are not operated by WHS or MSHA: Clinch Valley Medical Center (Richlands, VA), Wythe County Community Hospital (Wytheville, VA), Carilion Tazewell Community Hospital (Tazewell, VA), Lakeway Regional Hospital, Buchanan General Hospital (Grundy, VA), Morristown-Hamblen Healthcare System, Newport Medical Center, and Laughlin Memorial Hospital, four of which are in Virginia as indicated.[80] Some residents of the Geographic Service Area leave the region to receive specialized care. The three service lines with the largest proportion of outmigration volume from the Virginia Geographic Service Area are Myeloproliferative Disorders, Mental Diseases and Disorders, and Multiple Significant Trauma. When patients leave the Geographic Service Area for medical care, they most frequently go to the Holston Valley Medical Center, Bristol Regional Medical Center, Johnson City Medical Center, Indian Path Medical Center, and Carilion Medical Center.

[80] Takoma Regional Medical Center in Greene County, TN was acquired by WHS as of January 1, 2017. MSHA has entered into an agreement to acquire Laughlin Memorial Hospital in Greene County, TN.

- **Application Section 14, page 55, from Exhibit N-4**

Table 14.1 – Share of Virginia GSA CY2014 Discharges, Current Systems[81]

System	Total	Share of Total Discharges
Mountain States	19,330	40.4%
Wellmont	16,191[82]	33.9%
Other	12,290	25.7%

Table 14.2 – Share of Virginia GSA CY 2014 Discharges, New Health System

System	Total	Share of Total Discharges
New Health System	35,521	74.3%
Independent Competitors	12,290	25.7%

- **Application Section 14, page 58, from Exhibit N-4**

Eight general acute care hospitals in the Geographic Service Area are not operated by WHS or MSHA: Clinch Valley Medical Center (Richlands, VA), Wythe County Community Hospital (Wytheville, VA), Carilion Tazewell Community Hospital (Tazewell, VA), Lakeway Regional Hospital, Buchanan General Hospital (Grundy, VA), Morristown-Hamblen Healthcare System, Newport Medical Center, and Laughlin Memorial Hospital, of which Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, and Buchanan General Hospital are in Virginia as indicated.[80]

- **Application Exhibit 5.2B "Inpatient" from Exhibit N-4**

Footnotes were added to Exhibit 5.2B included in **Exhibit N-4** to note that Takoma Regional Medical Center was acquired by WHS as of January 1, 2017 and that MSHA has entered into an agreement to acquire Laughlin Memorial Hospital.

[81] Shares for **Table 14.1** were calculated based on general acute care services excluding normal newborns (DRG 795).

[82] Because WHS acquired Takoma Regional Medical Center as of January 1, 2017, if Tables 14.1 and 14.2 were modified to reflect Takoma's current affiliation with WHS instead of its affiliation as of CY2014, the percentages reported in the Tables would not change. This is due to the small number of discharges at Takoma coming from patients in the Virginia service area.

INDEX OF DOCUMENTS:

- Exhibit N-4 AMENDED Updated Application Section 14 and Exhibits 14.1 and Exhibit 5.2

V.N.11.

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

JOINT RESPONSE: The Parties believe that they have developed, in consultation with the Authority, a system of governmental oversight that will allow a complete portrayal of the New Health System's operations and rigorous, long-term active supervision. 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 Commonwealth of Virginia. The oversight over the cooperative agreement to be provided by the Commissioner and the Authority will be thorough, rigorous and principled with a long-term focus.

In consultation with the Authority, the Parties have proposed revised metrics and commitments to those proposed in the Application in order to ensure that rigorous, meaningful oversight by the Commissioner and the Authority is established and maintained. Based on its extensive knowledge of the health care needs of the region, the Authority has provided valuable input on some specific areas of focus for a set of expanded commitments and details on ways in which achievement of these commitments can best be demonstrated and measured by the Authority and the Commissioner on an ongoing basis after the cooperative agreement is approved. **Exhibit G-1A** shows the New Health System's revised commitments. A number of the proposed revisions make the original commitments stronger or clearer, or make certain commitments Virginia-specific. The revised commitments also provide metrics (and accompanying timing) for each commitment to allow the Commissioner and the Authority to effectively measure compliance. Similarly, the Parties anticipate that the Commissioner, during her review of the Cooperative Agreement, may have additional input on specific focus of the Parties' commitments and how achievement of these commitments should be shown.

In the initial Application, the Parties proposed a scoring system designed to measure the continuing public advantage of the Cooperative Agreement, along with proposed accountability mechanisms. In consultation with the Authority, the Parties have proposed a modified scoring mechanism (attached as Exhibit P-7 and as new Application Exhibit 17.2). The document was provided to the Authority in October 2016 and was included as part of the Authority's Findings of Facts in the Authority Report.[87] It demonstrates how the NHS will be held accountable for each of its Commitments under the Commissioner's active supervision.). In addition, new Application Exhibit 17.1 lists all of the Applicants current commitments – including the original commitments that remain proposed – as well as the accountability mechanism for each under the Commissioner's active supervision. The modified scoring mechanism and ongoing evaluation mechanism ultimately adopted by the Commonwealth will include a means of evaluating the performance of the health system in implementing the annual plan for Community Health Improvement and its associated

[87] See Authority Report, pages 151-154.

spend. The plan will be dynamic, and the health system will work actively with the state and the Authority to ensure that best practice interventions for improving health will have a concerted focus on vulnerable populations.

The Authority's review of the Parties' proposed Cooperative Agreement was thorough and focused on the health care needs of the region it serves. The Revised Commitments contemplate a continuing role by the Authority in the cooperative agreement oversight. The Response to Question G-1 provides details on this role, which includes participation in a joint Task Force with the New Health System. The joint Task Force will be comprised of four members, two from the New Health System and two from the Authority. The Task Force will 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 the Task Force will report such progress to the Authority. The Task Force will be chaired by a member of the Authority. The members appointed by the Authority may not have a conflict of interest. In addition, the Authority will continue to focus on the collaborative planning and project management necessary to implement the local health improvement, access, research and academic goals collaboratively developed. The Parties believe that an oversight partnership of the Commissioner and the Authority will ensure rigorous, long-term supervision of the cooperative agreement.

The New Health System's Community Benefit/Population Health Board committee will be responsible for the oversight of compliance with the Cooperative Agreement. The New Health System will ensure than not less than thirty percent (30%) of the composition of this committee will reside in Virginia, thereby providing for focused internal oversight of the Cooperative Agreement by representatives of Virginia and Tennessee.

The Parties have worked with the Authority to develop measures to ensure the long-term oversight of the Cooperative Agreement. Based on the revised commitments, before the end of calendar year 2026, the New Health System and the Commissioner will review how well the formation and operation of the New Health System has served the overall interests of Virginians and Virginia businesses in the area. That review will consider all the elements set forth in Section 15.2-5384.1, Code of Virginia, and will also consider New Health System's profitability. It is the expressed 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.

As part of its application process for a Tennessee COPA, the Parties are currently in discussion with the Tennessee Department of Health regarding active supervision and the Terms and Conditions under which the COPA will operate. We anticipate that detail identified in Tennessee will be valuable in similar discussions with the Commissioner about active supervision in Virginia, and we will share this information at the earliest appropriate time.

The Parties strongly believe that the detailed system of commitments and accountability they have proposed will provide rigorous and principled governmental oversight by the Commonwealth and the Authority with long-term benefits to the region and in a manner that will not make the cooperative agreement susceptible to challenge on the basis of federal antitrust laws**.**

Regarding the reporting of financial information, MSHA and Wellmont both currently report their IRS Form 990s annually, but they are not filed until 10 ½ months after the end of the fiscal year. In connection with outstanding bond issues, each institution also supplies specific financial information to the public markets, which is available on the website EMMA. The Parties are open to designing an information package that is suitable for the commitments and terms and conditions of the COPA. The Parties request financial information provided to the State be subject to a CID to the extent it goes beyond the Parties' public filings.

V.N.13.

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

JOINT RESPONSE: Virtually all of the New Health System's significant Commitments are designed and made to assure that the Parties do not leverage any market power gained as a result of the Cooperative Agreement to attempt to exclude, harm, or prevent the competitive operation of any actual or potential competing hospitals, services, physician practices, third party payer or facilities within the Parties' geographic service area. In accordance with the Cooperative Agreement Regulations,[88] the Applicants have made substantial, wide-ranging commitments to specifically adress any potential adverse impact resulting from the Cooperative Agreement. As required by the Cooperative Agreement Regulations, the Applicants have proposed benchmarks and metrics to measure achievement of the proposed Commitments and consequences for failing to meet a commitment.

Application Section 17, pages 129-134, contains the New Health System's original commitments to improve community health; enhance health care services; expand access and choice; improve health care value by managing quality, cost and service; and invest in health education and research, and demonstrate its commitment to the workforce. Throughout discussions during the Authority's review of the Application, most of the original Application commitments were revised based upon feedback from Authority members to ensure potential adverse impacts were more fully mitigated. Revised commitments were submitted to and approved by the Authority in October 2016. Each of the Revised Commitments includes the metric for demonstrating compliance with the commitment, and the Revised Commitments were submitted with these responses as **Exhibit G-1A**. In addition, new Application Exhibit 17.2 contains the New Health System's modified Proposed Achievement Scoring Mechanism developed in consultation with the Authority, which modified the original accountability mechanisms outlined by the Applicants in the Application.[89] The modified Proposed Achievement Scoring Mechanism outlines the Authority's recommendation for how the NHS will be held accountable for each of the Revised Commitments under the Commissioner's active supervision.[90] The Authority recommended that the Application for a Cooperative Agreement be

[88] 12VAC5-221-70.B.17. A description of any commitments the parties are willing to make to address any potential adverse impacts resulting from the cooperative agreement. Each such commitment shall at a minimum include: a. The parties' proposed benchmarks and metrics to measure achievement of the proposed commitments; b. The parties' proposed plan to obtain and analyze data to evaluate the extent to which the commitments have been met, including how data shall be obtained from entities other than the parties; and c. The parties' proposed consequences if they do not meet a commitment.

[89] Application Section 15.d, pages 97-127.

[90] The NHS modified Proposed Achievement Scoring Mechanism was also attached as **Exhibit P-7** to these Responses.

approved by the Commissioner with the revised commitments and revised scoring system.[91] New Application Exhibit 17.1 lists all of the Applicants commitments under the Cooperative Agreement – including the original Application commitments that remain unchanged, and revised and new commitments made in consultation with the Authority – and the proposed accountability mechanism for each under the Commissioner's active supervision.

Below is a summary of each of the NHS Commitments, the details of which are contained in **Exhibit G-1A** or the Application as noted.

- **Revised Commitment 1**: Rate cap mechanism for Principal Payers.[92]
- **Revised Commitment 2:** For negotiated rates, limit on pricing growth tied to Consumer Price Indices.
- **Revised Commitment 3:** Negotiate in good faith with Principal Payers to include NHS in health plans offered in the Geographic Service Area on commercially reasonable terms and rates and 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. This includes the commitment of NHS to resolve through mediation any disputes as to whether this commitment applies to the proposed terms of a health plan contract.
- **Revised Commitment 4:** No requirement that NHS must be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer.
- **Revised Commitment 5:** Participate meaningfully in a health information exchange for the local physician community to share needed information.
- **Revised Commitment 6:** 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.
- **Revised Commitment 7:** Include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and NHS.
- **Revised Commitment 8:** Enhanced quality reporting, including timely posting of quality measures and actual performance on New Health System's website accessible to the public, which will allow the public to easily evaluate the performance of the NHS as compared to its competitors, and ensure consumers retain the option to seek services where the quality is demonstrably the highest.

[91] Authority Report, page 167. The revised commitments and the modified scoring system were included as part of the Authority's Findings of Facts in the Authority Report.
[92] See Revised Commitments contained in **Exhibit G-1A** to these Responses.

- **Revised Commitments 9 and 10:** Enhanced charity care and related policies to ensure low income patients who are uninsured are not adversely impacted due to pricing, including full write-off of amounts owed for services by patients with incomes at or below 225% of the federal poverty level and a discount off hospital charges for uninsured or underinsured individuals who do not qualify under the charity care policy based on their ability to pay.

- **Revised Commitments 13-17:** Commitments to the workforce including (i) honoring prior service credit for eligibility and vesting under the employee benefit plans maintained by WHS and MSHA and crediting all employees for accrued vacation and sick leave; (ii) as quickly as practicable addressing differences in salary/pay rates and employee benefit structures between WHS and MSHA and investing up to $70 million over 10 years to address these differences; (iii) offering competitive compensation and benefits for its employees; (iv) within 2 months of closing adopting a severance policy to address how employees will be compensated if they are not retained by NHS, which policy will include factors to be considered and outplacement support; (v) career development programs to ensure maximum opportunity for career enhancement and training; (vi) developing with 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; and (vii) contingent on continued funding, not reducing or eliminating any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility.

- **Revised Commitment 18:** Create research opportunities and work closely with current academic partners to develop and implement a 10-year plan for investment in research and growth in the Virginia and Tennessee service area.

- **Revised Commitment 19:** Adopt a Common Clinical IT Platform and make access to the IT Platform available on reasonable terms to all physicians in the service area and grant reasonable access to data collected to researchers.

- **Revised Commitment 20:** Maintain all hospitals in operation at the effective date of the merger operational as clinical and health care institutions for at least five years. After this time, the NHS 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 theNHS, and continued investment in health care and preventive services based on the demonstrated need of the community. NHS may adjust scope of services or repurpose hospital facilities. In the event that the NHS 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”:

    - Emergency room stabilization for patients;

    - Emergent obstetrical care;

    - Outpatient diagnostics needed to support emergency stabilization of patients;

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

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

- **Revised Commitment 21:** For the Virginia and Tennessee service areas, maintain a minimum of the three full-service tertiary referral hospitals located in Johnson City, Kingsport, and Bristol, to ensure higher-level services are available in close proximity to where the population lives, as exists currently.
- **Revised Commitment 22:** Maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility, with exceptions that may be made for certain hospital departments or services as determined by the NHS Board or the applicable hospital board.
- **Revised Commitment 23:** Not require independent physicians to practice exclusively at NHS hospitals and other facilities.
- **Revised Commitment 24:** Not take steps to prohibit independent physicians from participating in health plans and health networks of their choice. [93]
- **Revised Commitment 25**: Develop a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by NHS and consult with the Authority in development of the plan. NHS 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

[93] See Revised Commitments contained in **Exhibit G-1A** to these Responses.

or expanding. NHS will promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.

- **Revised Commitment 26**: Enhance health care services: (i) create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee; (ii) 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; and (iii) 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.

- **Revised Commitment 27**: Invest not less than $75 million over ten years in population health improvement for the service area. NHS 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. This includes 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.

- **Revised Commitment 28**: Support the Authority's role in promoting population health improvement under the Cooperative Agreement by reimbursing the Authority for costs associated with the various planning efforts cited above in an amount up to $75,000 annually, with CPI increases each year.

- **Revised Commitment 29**: Adopt governance to reflect the region, including: (i) no later than 3 months after closing, appointing an additional resident of Virginia to serve on the NHS Board; (ii) ensuring membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce; (iii) ensuring than not less than 30 percent of the composition of the Community Benefit/Population Health committee will reside in Virginia (committee will be the Board committee responsible for the oversight of the compliance of the Cooperative Agreement); and (iv) within 5 years, ensuring that not less than 3 members of the Board of Directors will reside in the Commonwealth of Virginia, and such composition will be sustained.

- **Revised Commitment 32:** Adhere to the Alignment Policy (Application 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.

- **Revised Commitment 33:** Together with the Authority, create a Joint Task Force comprised of four members, two from NHS and two from the Authority. The Task Force shall meet at least

annually to guide the collaboration between the Authority and the NHS and to track the progress of the NHS 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.

- **Continuing Application Commitment**: The New Health System will not engage in "most favored nation" pricing with any health plans.[94]

- **Continuing Application Commitment:** The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health System's Board of Directors.[95]

In **Exhibit T-5**, the Applicants have evaluated potential disadvantages of the proposed merger along with the commitments and mechanisms we have set forth to address and mitigate them. This evaluation applies overall to the New Health System and individually to its component entities, including the Virginia hospitals. **Exhibit T-5** demonstrates the ways in which the Commitments will prevent the NHS from leveraging any market power gained and creating anticompetitive affect.

In addition to the Applicants' extensive Commitments described above, existing market and competitive dynamics for health care services in the region (outlined in Section 14 of the Application, pages 54-67) will substantially limit the ability of the NHS to leverage any market power gained as a result of the Cooperative Agreement to the detriment of competition, or exclude, harm, or prevent the competitive operation of any actual or potential competing hospitals, services, physician practices, third party payer or facilities within the Geographic Service Area. There is a varied payer mix, with high volumes of Medicaid and uninsured patients in the Geographic Service Area. There is a robust presence of independent providers in the Geographic Service Area, including inpatient, outpatient and physician services.[96] The Parties' provision of general inpatient services, physician services, and outpatient services are also currently offered or capable of being offered by other providers in the service area. In fact, independent providers offer the majority of physician services (70%) and outpatient services (over 50%). As described in Application Section 14 and below, there are meaningful competitors for health care in the Geographic Service Area. Application Section 14.c (pages 59-66) and its accompanying exhibits demonstrate the extensive independent providers of physician, inpatient and outpatient services in the Geographic Service Area that will remain independent after the Cooperative Agreement is approved. These independent providers include the majority of all practioners in the Geographic Service Area, several general acute care hospitals in the Geographic Service Area and nearby that compete for patients in

[94] Continuing Application Commitments were made in the Application, were not revised by the Authority, and remain unchanged and continuing commitments. See Application Section 14.c, pages 65-66, and Section 17, page 131-132.
[95] *Id.*
[96] The data included in the Application does not reflect the acquisition by WHS of Takoma Regional Hospital in Greeneville, TN as of January 1, 2017.

the Geographic Service Area, and numerous outpatient service providers, such as urgent care facilities, CT/MRI facilities, and ambulatory surgical centers.[97] Revised Application Section 14 provided in response to request V.N-4 (see **Exhibit N-4** to these responses) further demonstrates the significance of independent providers when considering only the Virginia service area.

Payers. Currently, 100% of the principal payers in the New Health System's service area have both WHS and MSHA as contracted providers for inpatient, outpatient, and physician services. Once merged, it is the New Health System's intention to continue to be contracting providers to all principal payers. The outpatient and physician market is and will remain competitive. In addition, the New Health System's pricing commitments apply to outpatient and physician services rates as well as inpatient rates. Typically, the principal payers want to contract for all of Wellmont's and Mountain States' services, and the NHS assumes that would be the case going forward. If a principal payer should want to contract for inpatient and emergency hospital services only, and the NHS is unwilling to do so, this negotiation would be subject to the mediation under Revised Commitment 3.

For purposes of the payer rate cap (Revised Commitment 1) and pricing (Revised Commitment 2) Commitments, all Medicare Advantage plans, Medicaid managed care plans, and TriCare plans will be considered as Principal Payers. 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.

The NHS has taken steps to protect the large numbers of Medicaid and uninsured patients in the region from negative pricing harm. In addition to the commitments regarding the payer rate cap and limit on pricing growth, the NHS commits to adopt charity and related policies that provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred twenty-five percent (225%) of the federal poverty level (Revised Commitment 9) and discounts

[97] See descriptions of these services in Application Section 14.c: All Outpatient facilities – page 60 and Application Exhibit 14.1 (Section A); Urgent Care facilities – pages 60-61 and Application Exhibit 14.1 (Section B); CT/MRI facilities – pages 61-62 and Application Exhibit 14.1 (Section C); Ambulatory Surgical Centers – pages 62-63 and Application Exhibit 14.1 (Section D); Physician Services – pages 63-64 and Application exhibit 14.1 (Section E).

based on ability to pay for patients who do not qualify under the charity policy (Revised Commitment 10).

Independent Physicians. Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Even in overlap specialties between the systems, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. Application Table 14.3 (Application page 56) provides share estimates for independent physicians, and WHS and MSHA physicians in the specialties in which there is an overlap. Application Table 14.4 (Application pages 57-58) reports shares for specialties in which there is not an overlap – that is, where MSHA and WHS do not each employ physicians.

A large number of independent physicians in the Geographic Service Area offer the physician services currently offered by WHS and MSHA through their respective employed (or affiliated) physicians.

Application Exhibit 14.1 (Section E) provides data on the number of physicians employed by WHS and employed by or affiliated with MSHA in each of several specialties (e.g., family practice). It also reports data on the number of independent physicians in each of these specialties; the total counts of physicians are based on all physicians with privileges at either or both of MSHA and WHS.

The majority of physicians in the Geographic Service Area with privileges at WHS or MSHA are independent. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. WHS employs nine percent (9%); MSHA employs seventeen percent (17%); and four percent (4%) of physicians are affiliated with MSHA through staffing arrangements for certain hospital-based services. Independent competitive alternatives exist in all nineteen physician specialties in which the Parties overlap. The combined share of independent physicians exceeds sixty-five percent (65%) in all specialties except Family Medicine, Orthopedic Surgery, Psychology, Psychiatry, Pain Management, Cardiothoracic Surgery, Pulmonology, Occupational Medicine, Hematology/Oncology, Cardiology, and Hospital Medicine, and is at least fifty percent (50%) in most specialties. Nearly sixty-five percent (65%) of Family Practice and Orthopedic physicians are independent.

Each physician specialty where there is an “overlap” between WHS and MSHA has competition from independent physicians. There are relatively few specialties where the combined number of MSHA and WHS employed physicians exceeds thirty-five percent (35%) of the total number of area physicians in that specialty. As is common across the country, certain specialties tend to have higher shares of employed physicians due to the nature of that medical practice. This includes hospitalists, cardiologists and hematologists/oncologists, although these specialties have a number of independent alternatives.

The NHS has committed 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.[98] 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 NHS will support this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding. The NHS will (and both MSHA and WHS currently do) provide recruiting assistance to independent physician practices and in some cases provide income support.

The Applicants acknowledge that federal payment reforms have put significant pressure on independent physicians to move toward employment. But other models exist as alternatives. For example, MSHA's subsidiary, Integrated Solutions Health Network (ISHN), operates an accountable care organization (ACO), AnewCare, with a network of independent and employed physicians governed by a board composed largely of physicians. ISHN provides contracting, credentialing and enrollment, quality improvement, care management and analytics services to the ACO and other entities. As described in other responses, the NHS will transform from the traditional fee-for-service model to other innovative and value-based models such as the accountable care model.

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

Inpatient Services. The general inpatient services currently offered by WHS and MSHA are offered by, or capable of being offered by, other hospitals located in the Geographic Service Area, with the exception of certain high-level tertiary care services such as trauma and neonatal intensive care.

Seven general acute care hospitals in the Geographic Service Area are not operated by WHS or MSHA: Clinch Valley Medical Center (Richlands, VA), Wythe County Community Hospital (Wytheville, VA), Carilion Tazewell Community Hospital (Tazewell, VA), Lakeway Regional Hospital, Buchanan General Hospital (Grundy, VA), Morristown-Hamblen Healthcare System, and Newport Medical Center, four of which are in Virginia as indicated.[99]

[98] Revised Commitment 25.

[99] Takoma Regional Medical Center in Greene County, TN was acquired by WHS as of January 1, 2017. MSHA has entered into an agreement to acquire Laughlin Memorial Hospital in Greene County, TN.

In Virginia, the merger of WHS and MSHA would eliminate competition for inpatient services between the two only in Wise County. Of the seven hospitals in Southwest Virginia operated by WHS or MSHA, four operate as the sole community provider (three of these hospitals face competition from unaffiliated hospitals located outside immediate community area, and such competition will remain post-merger). The three hospitals in Wise County (two in Norton and one in Big Stone Gap) have a combined average daily census of approximately 50. Even with the elimination of competition in Wise county between WHS and MSHA, it is important to note that competition for residents of Wise County will remain from Pikeville Medical Center in Kentucky. Aided we understand by significant subsidies from the Commonwealth of Kentucky, Pikeville Medical Center deploys substantial marketing efforts to attract patients as well as staff from Wise County**.**

Outpatient Services. A large number of independent providers of outpatient services compete in the Geographic Service Area. For many outpatient services, including imaging, surgery and urgent care, independent providers account for at least a fifty percent (50%) share. Application Table 14.5 (Application page 59) presents counts and share numbers for categories of outpatient services based on the affiliation of the providers. Application Exhibit 14.1 shows numbers and shares of all outpatient facilities serving the Geographic Service Area (Section A), urgent care facilities (Section B), CT/MRI facilities (Section C), and ambulatory surgical centers (Section D). The data show that independent providers in the Geographic Service Area operate 50% of all urgent care facilities, over 70% of all imaging facilities, and 57% of all ambulatory surgical facilities. WHS and MSHA together account for less than 50% of the outpatient facilities in 21 of the 32 categories provided in Exhibit 14.1 (Section A), including physical therapy (6.6%) and nursing homes (7.6%).

Continued Competition. Because of the substantial commitments made by the NHS and the existing market and competitive dynamics in the Geographic Service Area, market power will not be gained by the NHS as a result of the Cooperative Agreement. The NHS will be actively supervised by Virginia and Tennessee officials. This supervision will ensure that the NHS will act in furtherance of the public policies that underlie Virginia's Cooperative Agreement statutory and regulatory provisions and Tennessee's COPA. Moreover, as noted above, the NHS will face competition from several independent general acute care hospitals, outpatient facilities, post-acute care facilities and physicians in the Geographic Service Area. These competitors will not be a party to the Cooperative Agreement, and the Parties anticipate that the independent providers will continue to operate independently and competitively if the Letter Authorizing Cooperative Agreement is granted. Most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. WHS and MSHA are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

We believe the effects of any loss of competition may be less anticipated for several reasons: (1) the combined system will have incentive to reach agreement with payers to sustain important

commercial revenues, which are limited; (2) market shares overstate issues because a large part of market share comes from numerous small hospitals which are not a strong competitive constraint; (3) without the merger, substantial cost pressures will limit the Applicants' ability to lower rates materially; (4) there are numerous benefits unlikely to be accomplished but for the merger, and (5) finally, the specific commitments of the Parties limit adverse outcomes.

V.P.1.

P. Population Health

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

   JOINT RESPONSE: Below is the Ballad Health strategy for developing an integrated health system that will impact the agreed upon population health issues in the Virginia service area.

Ballad Health Plan for Community Partnership and Collaboration

Executive Summary: In this response, we outline the plans for community partnership and collaboration which complement Ballad Health's transformation from two individual and traditional health care delivery systems to a fully integrated and aligned health care delivery system responsible for providing value-driven community health improvement. A key component of that transformation is new kinds of partnership and collaboration efforts with providers of care and community stakeholders through the development of the Accountable Care Community together with a Community Health Improvement Plan and regionally coordinated and scaled efforts around common objectives. We envision that state or regional Department of Health leaders will serve in key roles for the Accountable Care Community.

Building the Key Partnerships and Collaborations

This response focuses on Ballad Health's plans for community partnership and collaboration. Aligning existing organizations and resources for community health improvement provides an important underpinning for community health improvement within the Geographic Service Area.

As mentioned in the Overview, the establishment of the Accountable Care Community will allow Ballad Health to work with its partners to meaningfully and measurably impact the health of the whole population. This model extends the benefits of the critical transformation within the healthcare delivery system into specific partnerships and affiliations in the immediate community to address the agreed upon population health needs.

A. The Community Health Improvement Framework

Our over-arching model for community collaboration and partnership is defined by the **Community Health Improvement Framework** outlined below and the interface of its components—the three environments of prevention activity (clinical settings, personal settings, and community settings), the three types of prevention (primary, secondary, and tertiary), and the engagement of essential cross-sector partners through an Accountable Care Community with utilization of the right resources to improve health proactively.

It is important to note that we include the clinical setting in the Community Health Partnership Framework even though we make a clear distinction between population medicine and community

health improvement. These strategies can and should be connected, and the engagement of physicians with their patients is absolutely essential to improving the overall health of the community. Physicians, nurses, and other clinical professionals have a significant ability to influence their patients to make sound decisions which will affect their health outcomes.

Prevention Environment Strategies

1. Clinical Settings - Increase the use of clinical preventative services with provider partners (optimize clinical engagements)
2. Personal Settings - Provide services that extend outside the clinical setting with community partners and patients (mobile and community based screenings, immunizations, educational programs, and home-based programs)
3. Community Settings - Implement interventions that reach whole populations with community partners and patients (policy, environment, behavior)

In order to effectively impact the three areas of the Triple Aim comprehensively across a diverse population, it is essential to create strategies that reach into each of these environments. Auerbach describes these environments as The Three Buckets of Prevention in the *Journal of Public Health Management Practice* (2016).[127]

It is also essential to impact all three types of prevention—with a significant focus on primary prevention strategies:

Prevention Type Strategies

1. Employ primary prevention strategies to keep disease from developing. Examples:
    - Population Medicine Strategy: In order to fully advance primary prevention practice, clinical providers must be engaged and informed of the strategies necessary to address prevention issues within the clinical context. Clinicians often do not grasp how they can have an impact on the factors that lead to many illnesses and injuries in the first place.[128] Part of the plan will include trainings on community prevention for clinical providers and other health care organizations to build a team of individuals that are deeply versed on community prevention principles and strategies.

    - Community Health Improvement Strategy: In order to reach people effectively, especially those in rural or underserved populations, we will use mobile health resources and partnerships with community organizations to enact elements of the Community Health Improvement Plan, including screenings for risk factors, immunizations, preventative dental services, and risk assessments to connect individuals to primary care and social supports. We will also enact community based

[127] John Auerbach, *The 3 Buckets of Prevention*, 22:3 J. PUB. HEALTH MGMT. AND PRAC. 215 (2016).
[128] *See* PREVENTION INST., *Opportunities for Advancing Community Prevention in the State Innovation Models Initiative* (Feb. 2013), *available at* https://www.preventioninstitute.org/sites/default/files/editor_uploads/images/stories/Documents/CMMI_SIM_Initiative_Memo_February_2013.pdf.

health education and interventions to increase health literacy and engage people in behavior change such as healthy eating and moving more.

2. Employ secondary prevention strategies to slow or stop the progression of disease. Examples:
    - Population Medicine Strategy: Through the implementation of the Common Clinical IT Platform, protocols and alerts will be embedded in the IT system to identify individuals with health risks who need intervention or lifestyle changes to prevent the progression of heart disease, behavior related cancers, and diabetes.

    - Community Health Improvement Strategy: Mobile and community based screenings will allow the identification of high risk individuals who need educational resources, connection to primary care, or specific tools to enact lifestyle changes to avoid the progression of high-blood pressure to heart disease or high AIC levels to type II diabetes, for example.

3. Employ tertiary prevention strategies through population medicine strategies and community health improvement strategies to manage disease effectively and mitigate negative effects. Examples:
    - Diabetes Management: Effective clinical management of diabetes will allow the avoidance of complication and hospitalization
    - Heart Failure Management: Effective heart failure management strategies, shared between cardiologists and primary care physicians will allow the avoidance of re-hospitalization and disease progression
    - Intensive Cardiac Rehab: Intensive cardiac rehabilitation opportunities such as the Pritikin program will allow individuals to slow or reverse the progression of heart disease through lifestyle change and to also influence the behavior of family and friends in support networks
    - Community Health Improvement Strategy: We will work to connect community partners that address social factors with discharged or chronically ill patients in way that positively impacts the health. Programs like Meals on Wheels and organizations that offer assistance with housing and utilities can offer resources in the community setting that will have a significant impact on the health status of disease patients.

Finally, the right resources will need to be developed to inform strategy, drive actions, and ensure effective evaluation within the framework. By mobilizing resources around a specific goal, the opportunity to coordinate services across the community and limit duplication of parallel or competing efforts is improved.[129] To that end, the Accountable Care Community will conduct an inventory of resources to identify gaps and strengthen connections between prevention resources with a specific focus on the following:

<u>Prevention Resources</u>

1. Human Resources. Examples:
    - Ballad Health staff members and physicians
    - Independent physicians

[129] *See* FAEGREBD CONSULTING, AUSTEN BIOINNOVATION INST., *Healthier By Design: Creating Accountable Care Communities* (Feb. 2012), *available at* http://www.faegrebdc.com/webfiles/accwhitepaper12012v5final.pdf.

- Community partners
- Community service boards
- School systems
- Faith-based organizations
- Resource agencies such as housing departments, courts, and non-profits (e.g. Meals on Wheels)

2. Financial Resources. Examples:
    - Eliminating the duplication in medical care delivery to free up resources that can be redeployed to upstream activities that address underlying behavioral, environmental and social determinants of health
    - Pursuing value-based and risk-based payment arrangements that reward population health management/medicine
    - Using financial capital to increase the community's social capital through the development of effective partnerships
    - Utilizing the funding set forth in the COPA commitments to empower activities and plans
    - Identifying common funding and activities within the Accountable Care Community membership that can be better leveraged if coordinated
    - Identifying public and private grant opportunities to support and advance the community goals

3. Health IT Resources. Examples:
    - Implementing a Common Clinical IT Platform to coordinate health care across the region
    - Utilization of a Health Information Exchange to share community health data with health care providers across the region
    - Using electronic health record and data analysis capabilities to promote linkages with other sectors' data and create a dashboard to track progress on community health indicators

4. Education/Training/Communication Resources. Examples:
    - Partnering with local organizations, including faith-based and educational institutions, to educate individuals on disease prevention and health screening opportunities
    - Educating and training local healthcare providers in prevention strategies in the clinical context
    - Supporting important local and state public health initiatives, such as opioid abuse prevention efforts and water fluoridation programs, through communications campaigns and advocacy efforts
    - Establishing communications platforms to coordinate resources and initiatives across the multi-sector partnerships, increase buy-in amongst the partners, recruit new members, and attract grant investment to support the Accountable Care Community, as well as share best practices across the multi-sector partners

5. Best Practice Intervention Resources. Examples:
    - Utilizing inter-professional teams including, medicine, pharmacy, public health, nursing, social work, mental health, and nutrition, to align care management and improve patient access and care coordination
    - Coordinating community-wide immunization programs and educational efforts
    - Adopting evidence-based screening assessments by clinical partners
    - Implementing screening programs by healthcare and social service providers to improve referral policies and services for mental health and substance abuse patients
    - Establishing health coaching programs
    - Utilizing transition programs and acute care networks to reduce hospital readmissions
    - Exploring programs such as Centering Pregnancy and Nurse Family Partnership

B. Recruiting and Organizing the Members

By serving as a central organizer in the Accountable Care Community, Ballad Health can improve efficiency and reduce redundancy in community efforts by strengthening the links between existing programs, capitalizing on current resources, and building novel solutions to all health issues. Through the inclusion of these broad-base community-wide partnerships, the interconnections can be strengthened and duplication of efforts will be reduced. By mobilizing the coalition in coordinated and collaborative efforts, the goal of the ACC to improve the physical, social, intellectual, emotional, and spiritual health of the community will be realized.

Ballad Health will identify essential accountable partners across the region and engage them in the establishment of the Accountable Care Community focused on the Community Health Improvement Plan using the following steps:

1. Surveying Interest and Capabilities

Part of the process of establishing the Accountable Care Community will be the development of a survey or other assessment or response tool which will allow regional organizations to outline their capabilities and interest in participation. This will be followed up with one on one interaction and assessment of interest. Though we have not yet conducted this survey, our interactions with regional organizations and their participation in the Community Work Groups led by ETSU are a strong indication of support and interest. Many relationships exist but will have to be strengthened and become more interdependent to achieve success.

2. Identification and Recruitment of Members

Members of the Accountable Care Community will be recruited based on their multi-sector leadership and their willingness to commit to be an accountable partner in the development of cohesive regional community health improvement efforts. This includes identifying common goals and building each organization's contribution to these goals into organization-specific workplans.

This coalition is a multi-sector partnership with robust participation from the community with a diverse membership including representation from: public health, medicine, health systems, higher education, secondary education, safety-net health services, academic researchers,

practicing health care providers, alcohol/drug/mental health services, local chapters of national health organizations, the faith and service community, local issue-focused coalitions and multiple community-based programs.

Fortunately, the leaders of Wellmont and Mountain States have cultivated strong working relationships over the last several decades with numerous community organizations. These relationships will provide the foundation for the Accountable Care Community partnerships. Ballad Health will utilize mutually accountable covenant commitments to establish the responsibilities and expectations for the Accountable Care Community partnerships. Both existing health systems have strong relationships with regional organizations which need to be further developed under the Accountable Care Community model.

C. Defining Common Objectives.

Based on the Community Health Improvement Plan, Ballad Health and its partners will articulate the common vision of community health, identify stewardship priorities, and develop an action and investment agenda around shared goals and measures. This step will be essential to the broad aim of impacting all of the factors leading to improved health outcomes including behavioral and social determinants of health. One of the major premises of this approach is to activate community-based prevention, particularly interventions that look upstream to address the root causes of disease and affect proactive change through prevention activities in environments that are typically outside of the clinical realm and the traditional clinical environments.

D. Creating Accountability.

A leadership council or board will govern the work of the Accountable Care Community and sub-committees may be developed based on sub-regional designations such as cities, counties, or other connected geographies.

The Partners, including Ballad Health, will adopt mutually accountable covenant commitments and focus comprehensive efforts around common objectives. Each partner commits to building their specific contribution to the Accountable Care Community goals into their own organization's goals and objectives. The partners will include the breadth of organizations that are able to help the Accountable Care Community fulfill its charge of implementing comprehensive efforts to improve the health of the entire population in the Geographic Service Area.

Ballad Health will provide financial investments to accountable partners to focus on priority efforts with clear, contractual expectations for how those funds will be used and a clear system for evaluating compliance, evaluation, and success.

Through these efforts, Ballad Health intends to align the components of the Accountable Care Community and aim them effectively to target health improvement in our region in a way that creates clear advantage for payers (individuals, insurance companies, government payers, and employers), providers (physicians, hospitals, ancillary services), and the people and communities we serve—including underserved populations or those experiencing health disparities.

V.T.1.

T. Additional Questions

1. **Provide information on the structure of Virginia physician practices to calculate the appropriate physicians' market share of the patient population. The bargaining power of a single physician is not equal to the bargaining power of a physician group. Therefore, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required. The applicants should include a certification from an appropriately credentialed professional with each analysis submitted in response to this question that the analysis provided is accurate.**[146]

   JOINT RESPONSE: Information on the structure of physician practices is attached as **Exhibit T-1**. The Parties have attempted to identify physicians by employment status (employed versus independent), and to aggregate physicians into their relevant practice groups. The Parties reiterate the difficulty calculating data for independent physicians:

   - There is little publicly reported, and therefore available, data for outpatient services. Inpatient volumes are reported to the Virginia Hospital and Healthcare Association (VHHA) for purposes of market share calculation, but the calculation of comparable market share measures for physician practice volumes is not possible because those volumes are not uniformly reported to an independent resource.
   - The geographic scope of service for many physician specialties goes well beyond counties and prescribed geographic areas. For example, some advanced specialties may serve very broad service areas, and patients may travel out of the area to see specialists for services that could be obtained in locations near the Parties' three tertiary facilities. As a result, shares at the county level, or even at the service area level, may overstate concentration and competitive concerns.

   Updated Application Exhibit 14.1 (Section E) (attached as **Exhibit N-4** to these Responses) provides physician share data based on counts of physicians developed by identifying MSHA and WHS employed and affiliated physicians and allocating physicians to independent groups, which independent physicians account for a large proportion of physicians in the Geographic Service Area. The Parties have made their best efforts to calculate independent physician services based on the limited publicly available data and their general industry knowledge of the region's health care providers.

   Since the time the Application was submitted in February 2016, a number of WHS employed and MSHA employed and affiliated physicians have been hired, have left employment, and have retired. The information included in **Exhibit T-1** includes updated physician information as of July 25, 2016,

[146] This question was modified In the letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017 with proposal to respond to this request.

and therefore excludes 60 physicians and physician extenders who are now employed by WHS as a result of the acquisition by WHS of Takoma Regional Hospital in Greene County, Tennessee as of January 31, 2017. The Parties also note that updated Application Exhibit 14.1 (Section E), which is included in **Exhibit N-4** to these Responses, reflects changes in employment and affiliation of physicians with WHS and MSHA as of July 25, 2016.

As modified and agreed by the Commissioner,[147] Included with **Exhibit T-1** is a certification from the appropriately credentialed professional regarding the analyses submitted with this Response T-1.

INDEX OF DOCUMENTS:

- Exhibit T-1 Information on the Structure of Physician Practices and Certification about Analysis in T-1 and T-2

[147] In letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017 with proposal to respond to this request.

V.T.2.

2. Recalculate market shares using appropriate geographic market and output measures for the Virginia geographic market. The applicants should include a certification from an appropriately credentialed professional with each analysis submitted in response to this question that the analysis provided is accurate.[148]

JOINT RESPONSE: **Exhibit N-4**, previously referenced, includes a revised Application Exhibit 5.2 "B. Inpatient" updated to show inpatient discharges for patients residing in the Virginia counties of the Geographic Service Area, an area served by other hospitals physically located in the 11-county Virginia area as well as hospitals located outside of this area. Revised Exhibit 5.2B shows shares for general acute care inpatient services, which were calculated using calendar year 2014 discharge data for all Virginia and Tennessee hospitals using the Virginia Health Information's patient level database system and the Tennessee Hospital Discharge Data System. We believe revised Application exhibit 5.2B provides the data requested.

In revised Exhibit 5.2B:

- WHS hospitals are highlighted in blue, and MSHA hospitals are highlighted in orange. There are a number of independent hospitals located in the Geographic Service Area, and these are highlighted in green. There are a number of hospitals located outside of the Geographic Service Area used by patients in the Virginia counties of the Geographic Service Area; the top several of these hospitals are shown without highlighting.
- Shares were calculated for general acute care services excluding normal newborns (DRG 795) and excluding MDC 19 and 20 and for all payers.
- Hospital and health system shares were calculated using a denominator of the total number of discharges of residents in the 11-county Virginia area.[149] An individual hospital's share is its total discharges of residents from the 11-county area divided by the total number of 11-county area discharges. Health system shares are calculated as the sum of all of its hospitals' shares.
- To estimate the share that a given Wellmont or Mountain States hospital accounts for of the combined system share, its total discharges are shown as a percentage of the combined systems' discharges. These percentages are shown in the column labeled Shares of Wellmont and Mountain States Discharges.

The data illustrate that there are a number of non-party hospitals that currently serve large numbers of patients from the Virginia service area. The combined share of WHS and MSHA, however, obscures the fact that the majority (60%) of their combined share is accounted for by three hospitals – Johnston Memorial Hospital, Bristol Regional Medical Center, and Holston Valley Medical Center.

[148] This question was modified In the letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017 with proposal to respond to this request.

[149] The 11-county Virginia area includes the independent cities of Bristol and Norton, Virginia.

Each of the other Wellmont and Mountain States hospitals, most of which are very small and located in outlying areas,[150] *individually* has very low patient volume and contributes very little to the Parties' combined shares. The collective volume of these hospitals obscures their very small size and patient volumes thereby overstating any competitive significance.

As modified and agreed by the Commissioner,[151] Included with **Exhibit T-1** is a certification from the appropriately credentialed professional regarding the analysis submitted with this Response T-2.

[150] The next largest share contributors are Johnston Memorial Hospital and Indian Path Medical Center, which contribute 8.7% and 6.4% respectively.

[151] In letter dated January 30, 2017 from Ms. Allyson Tysinger, Senior Assistant Attorney General, to the Applicants in response to the Applicants' letter dated January 13, 2017, with proposal to respond to this request.

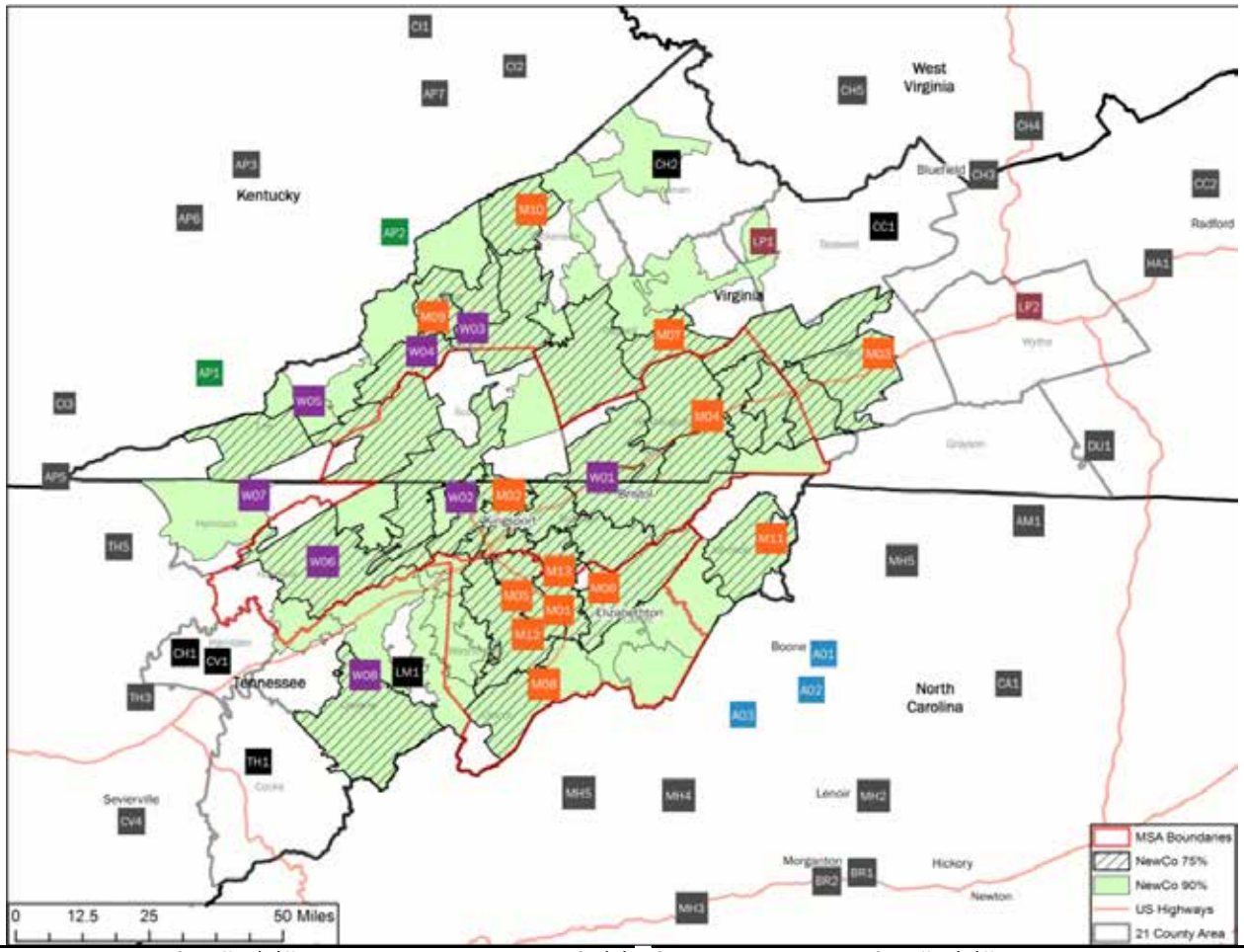
LIST OF EXHIBITS

SECTION V

Exhibit Number	Description
Amended N-1A	AMENDED Map of Hospitals In and Out of 75% and 90% Service Areas
Amended N-4	AMENDED Updated Application Section 14 and Exhibits 14.1 and Exhibit 5.2
T-1	Information on the Structure of Physician Practices and Certification about Analysis in T-1 and T-2

AMENDED Exhibit N-1A. 75% (PSA) and 90% (SSA) Service Areas (Map) Based on New Health System Discharges

(Mountain States + Wellmont)



System	State	Hospital Name	Symbol
Mountain States Health Alliance	TN	Johnson City Medical Center	M01
	TN	Indian Path Medical Center	M02
	VA	Smyth County Community Hospital	M03
	VA	Johnston Memorial Hospital	M04
	TN	Franklin Woods Community Hospital	M05
	TN	Sycamore Shoals Hospital	M06
	VA	Russell County Medical Center	M07
	TN	Unicoi County Memorial Hospital	M08
	VA	Norton Community Hospital	M09
	VA	Dickenson Community Hospital	M10
	TN	Johnson County Community Hospital	M11
	TN	Woodridge Hospital	M12
	TN	Quillen Rehabilitation Hospital* * *	M13

System	State	Hospital Name	Symbol
Wellmont Health System	TN	Wellmont Bristol Regional Medical Center	W01
	TN	Wellmont Holston Valley Medical Center	W02
	VA	Mountain View Regional Medical Center	W03
	VA	Wellmont Lonesome Pine Hospital	W04
	VA	Lee Regional Medical Center *(Closed)* *	W05
	TN	Wellmont Hawkins County Memorial Hospital	W06
	TN	Wellmont Hancock County Hospital	W07
	TN	Takoma Regional Hospital *(Independent)* * *	W08

**The data provided include Takoma Regional Hospital as an independent hospital. Wellmont's acquisition of Takoma Regional Hospital, located in Greene County, Tennessee, was recently completed as of January 1, 2017.

PARTY HOSPITAL	Party	PSA or SSA
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	SSA
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	PSA
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	PSA
WELLMONT LONESOME PINE HOSPITAL	Wellmont	PSA
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	PSA
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	PSA
TAKOMA REGIONAL HOSPITAL	Wellmont	PSA
DICKENSON COMMUNITY HOSPITAL	Mountain States	PSA
JOHNSON COUNTY COMMUNITY HOSPITAL	Mountain States	PSA
QUILLEN REHABILITATION HOSPITAL	Mountain States	PSA
UNICOI COUNTY MEMORIAL HOSPITAL	Mountain States	PSA
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	PSA
RUSSELL COUNTY MEDICAL CENTER	Mountain States	PSA
NORTON COMMUNITY HOSPITAL	Mountain States	PSA
SYCAMORE SHOALS HOSPITAL	Mountain States	PSA
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	PSA
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	PSA
INDIAN PATH MEDICAL CENTER	Mountain States	PSA
JOHNSTON MEMORIAL HOSPITAL	Mountain States	PSA
JOHNSON CITY MEDICAL CENTER	Mountain States	PSA

Amended Exhibit N-4

Updated Application Section 14 and Exhibits 5.2B and 14.1

Exhibit 5.2

B. Inpatient (Excluding MDCs 19 and 20)

Hospital Name	Hospital Affiliation	Total	Shares of total Discharges	Shares of Wellmont and mountain States Discharges
Total		**47,811**	**100.0%**	
Total VA GSA Hospitals		**25,158**	**52.6%**	
Total All Other Hospitals		**22,653**	**47.4%**	
Share Outside VA GSA		**47.4%**		
WELLMONT HAWKINS COUNTY MEMORIAL HOSPITAL	Wellmont	4	0.0%	0.0%
WELLMONT HANCOCK COUNTY HOSPITAL	Wellmont	13	0.0%	0.0%
MOUNTAIN VIEW REGIONAL MEDICAL CENTER	Wellmont	1,167	2.4%	3.3%
WELLMONT LONESOME PINE HOSPITAL	Wellmont	1,708	3.6%	4.8%
WELLMONT HOLSTON VALLEY MEDICAL CENTER	Wellmont	4,937	10.3%	13.9%
WELLMONT BRISTOL REGIONAL MEDICAL CENTER	Wellmont	8,362	17.5%	23.5%
DICKENSON COMMUNITY HOSPITAL	Mountain States	5	0.0%	0.0%
QUILLEN REHABILITATION HOSPITAL	Mountain States	14	0.0%	0.0%
SYCAMORE SHOALS HOSPITAL	Mountain States	33	0.1%	0.1%
FRANKLIN WOODS COMMUNITY HOSPITAL	Mountain States	80	0.2%	0.2%
WOODRIDGE PSYCHIATRIC HOSPITAL	Mountain States	346	0.7%	1.0%
INDIAN PATH MEDICAL CENTER	Mountain States	1,569	3.3%	4.4%
SMYTH COUNTY COMMUNITY HOSPITAL	Mountain States	1,774	3.7%	5.0%
RUSSELL COUNTY MEDICAL CENTER	Mountain States	1,932	4.0%	5.4%
JOHNSON CITY MEDICAL CENTER	Mountain States	2,533	5.3%	7.1%
NORTON COMMUNITY HOSPITAL	Mountain States	3,122	6.5%	8.8%
JOHNSTON MEMORIAL HOSPITAL	Mountain States	7,922	16.6%	22.3%
CLINCH VALLEY MEDICAL CENTER	Other	4,127	8.6%	
WYTHE COUNTY COMMUNITY HOSPITAL	Other	1,807	3.8%	
BUCHANAN GENERAL HOSPITAL	Other	1,048	2.2%	
CARILION TAZEWELL COMMUNITY HOSPITAL	Other	546	1.1%	
CARILION MEDICAL CENTER	Other	1,220	2.6%	
CARILION NEW RIVER VALLEY MEDICAL CENTER	Other	793	1.7%	
UNIVERSITY OF VIRGINIA MEDICAL CENTER	Other	781	1.6%	
TWIN COUNTY REGIONAL HOSPITAL	Other	654	1.4%	
LEWISGALE MEDICAL CENTER	Other	240	0.5%	
MORRISTOWN-HAMBLEN HEALTHCARE SYSTEM	Other	8	0.0%	
TAKOMA REGIONAL HOSPITAL[1]	Other	6	0.0%	
LAUGHLIN MEMORIAL HOSPITAL, INC.[2]	Other	1	0.0%	
ALL OTHER	Other	1,059	2.2%	

[1] Takoma Regional Medical Center was acquired by WHS as of January 1, 2017.
[2] MSHA has entered into an agreement to acquire Laughlin Memorial Hospital.

Exhibit 14.1

Outpatient analyses of the Geographic Service Area were conducted using counts of facilities for a variety of types of outpatient providers serving the area; these include out-of-area facilities. Facility-level data included the name, address, affiliation and type of service (e.g., ASC). A summary table for all categories of outpatient services is provided below and shows that for many services there is little or no overlap and that for the majority of services, independent providers account for a large share of total providers. In the few services in which there is higher share, there is no overlap. More detailed analyses were also conducted for three outpatient categories: urgent care, imaging facilities, and ambulatory surgery centers; and the tables below show that competing facilities account for 50% or greater share for each of these services. Maps show that these alternatives are located near those affiliated with Mountain States and Wellmont.

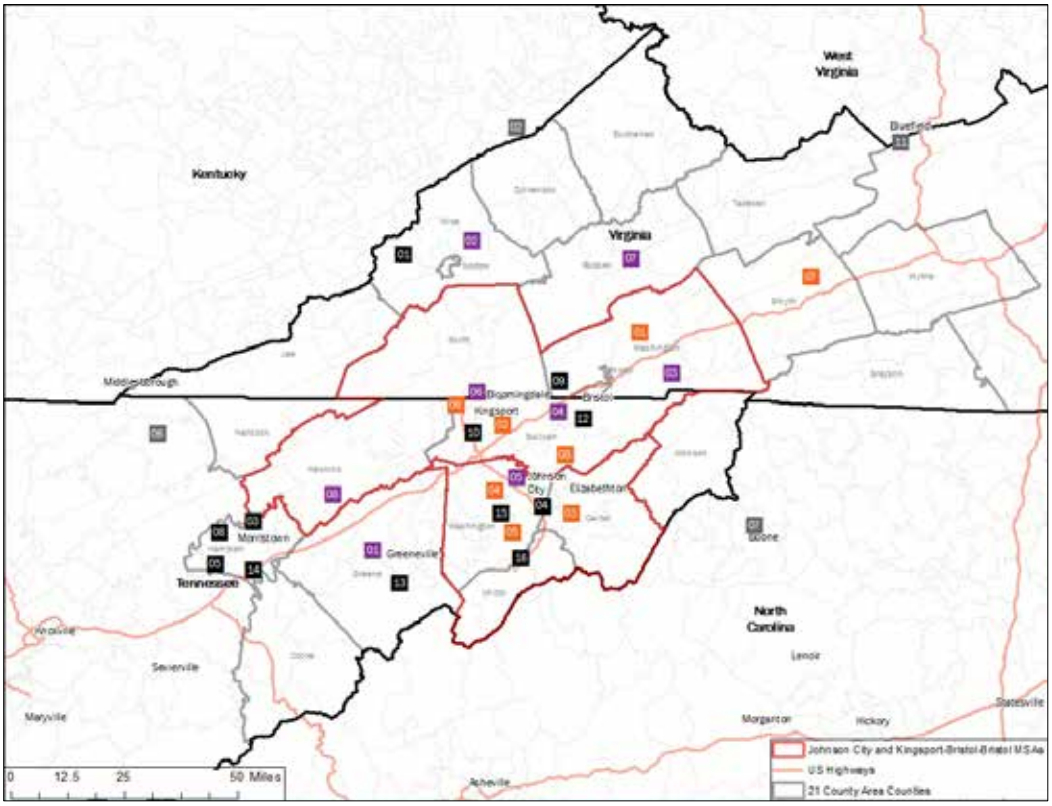
For the following exhibits, the tables show results limited to the Virginia counties of the Geographic Service Area. That includes Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe (including the Independent Cities of Bristol and Norton).

A. All Outpatient Facilities

Service Type	WHS & MSHS Combined %	Mountain States	Wellmont	All Other*	Total
Pharmacy	2.2%	2	0	87	**89**
Home Health	19.0%	4	0	17	**21**
Fitness Center	0.0%	0	0	20	**20**
X-RAY	52.9%	6	3	8	**17**
CT	64.3%	5	4	5	**14**
Nursing Home	16.7%	1	1	10	**12**
Surgery - Hospital Based	54.5%	4	2	5	**11**
MRI	54.5%	4	2	5	**11**
Physical Therapy	10.0%	1	0	9	**10**
Rehabilitation	55.6%	2	3	4	**9**
Surgery - Endoscopy	75.0%	4	2	2	**8**
Urgent Care	71.4%	2	3	2	**7**
Chemotherapy	80.0%	2	2	1	**5**
Rehabilitation & Physical Therapy	40.0%	0	2	3	**5**
Dialysis Services	0.0%	0	0	5	**5**
Wellness Center	0.0%	0	0	5	**5**
Weight Loss Center	0.0%	0	0	2	**2**
Cancer Center	100.0%	1	1	0	**2**
Radiation Therapy	100.0%	1	1	0	**2**
Surgery - ASC	100.0%	1	0	0	**1**

*All Other may include competing facilities located outside of the Geographic Service Area yet serving patients from the Geographic Service Area.

B. Urgent Care



Urgent Care Outpatient Facilities

Wellmont

01	Greeneville Urgent Care
02	Wellmont Extended Hours Clinic - Norton
03	Wellmont Urgent Care - Abingdon
04	Wellmont Urgent Care - Bristol
05	Wellmont Urgent Care - Johnson City
06	Wellmont Urgent Care - Kingsport
07	Wellmont Urgent Care - Lebanon
08	Wellmont Urgent Care - Rogersville

MSHA

01	First Assist Urgent Care - Abingdon
02	First Assist Urgent Care - Colonial Heights
03	First Assist Urgent Care - Elizabethton
04	First Assist Urgent Care - Johnson City
05	First Assist Urgent Care - Jonesborough
06	First Assist Urgent Care - Kingsport
07	First Assist Urgent Care - Marion
08	First Assist Urgent Care - Piney Flats

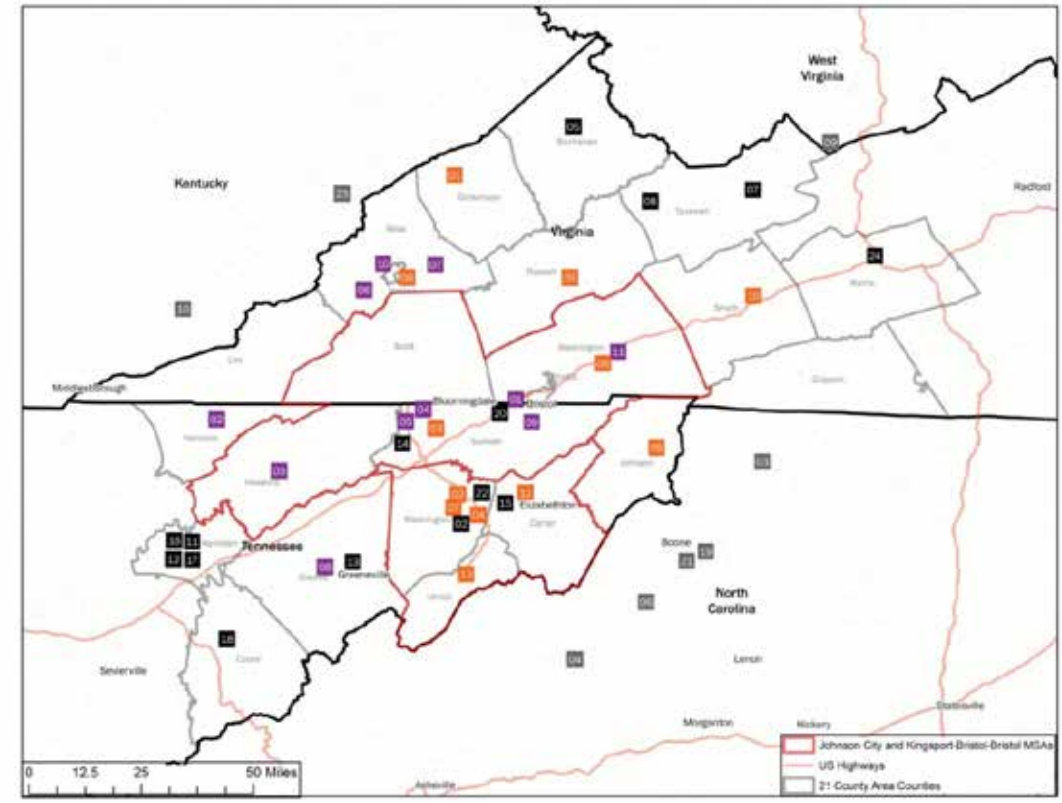
All Other Facilities

01	Appalachian After Hours Care
02	AppUrgent Care
03	College Park Medical Clinic
04	Doctors Care
05	Express Health Clinic-Morristown
06	Express Health Clinic-Newport
07	FastMed Urgent Care
08	HealthStar Urgent Care Clinic
09	Holston Medical Group Urgent Care-Bristol
10	Holston Medical Group Urgent Care-Kingsport
11	MedExpress Urgent Care-Bluefield
12	MedExpress Urgent Care-Bristol
13	Patmos EmergiClinic
14	Prompt Family Care
15	State of Franklin Healthcare Associates Walk-in Clinic
16	Urgent Care of Erwin

Urgent Care Facility Locations and Counts, by System

Affiliation	Facility Name	County	State
Total	**Total**	**7**	**100.0%**
Wellmont	Wellmont Extended Hours Clinic - Norton	Wise	VA
Wellmont	Wellmont Urgent Care - Abingdon	Washington	VA
Wellmont	Wellmont Urgent Care - Lebanon	Russell	VA
Wellmont	**Total**	**3**	**43%**
Mountain States	First Assist Urgent Care - Abingdon	Washington	VA
Mountain States	First Assist Urgent Care - Marion	Smyth	VA
Mountain States	**Total**	**2**	**29%**
All Other	Appalachian After Hours Care	Wise	VA
All Other	MedExpress Urgent Care-Bluefield	Tazewell	VA
All Other	**Total**	**2**	**29%**

C. CT/MRI



CT/MRI Capabilities

	Wellmont
01	Bristol Regional Medical Center
02	Hancock County Hospital
03	Hawkins County Memorial Hospital
04	Holston Valley Imaging Center, LLC
05	Holston Valley Medical Center
06	Lonesome Pine Hospital
07	Southwest Virginia Cancer Center
08	Takoma Regional Hospital *(Independent)**
09	Volunteer Parkway Imaging Center
10	Wellmont Mountain View Regional Medical Center
11	Wellmont Urgent Care Abingdon

	MSHA
01	Dickenson Community Hospital
02	Franklin Woods Community Hospital
03	Indian Path Medical Center
04	Johnson City Medical Center
05	Johnson County Community Hospital
06	Johnston Memorial Hospital
07	Mountain States Imaging at Med Tech Parkway
08	Norton Community Hospital
09	Russell County Medical Center
10	Smyth County Community Hospital
11	Sycamore Shoals Hospital
12	Unicoi County Memorial Hospital, Inc.

	All Other Facilities
01	Appalachian Orthopaedic Associates, PC**
02	Appalachian Orthopaedic Associates
03	Ashe Memorial Hospital
04	Blue Ridge Regional Hospital
05	Buchanan General Hospital
06	Cannon Memorial Hospital
07	Carilion Tazewell Community Hospital
08	Clinch Valley Medical Center
09	Community Radiology Of Virginia, Inc.
10	Harlan ARH Hospital
11	Healthstar Physicians, PC
12	Lakeway Regional Hospital
13	Laughlin Memorial Hospital, Inc.
14	Meadowview Outpatient Diagnostic Center
15	Medical Care, PLLC (Elizabethton)
16	Medical Care, PLLC (Johnson City)
17	Morristown-Hamblen Hospital
18	Newport Medical Center
19	Ortho-Carolina - Boone
20	Sapling Grove Outpatient Diagnostic Center
21	Watauga Medical Center
22	Watauga Orthopaedics, PLC
23	Whitesburg ARH Hospital
24	Wythe County Community Hospital

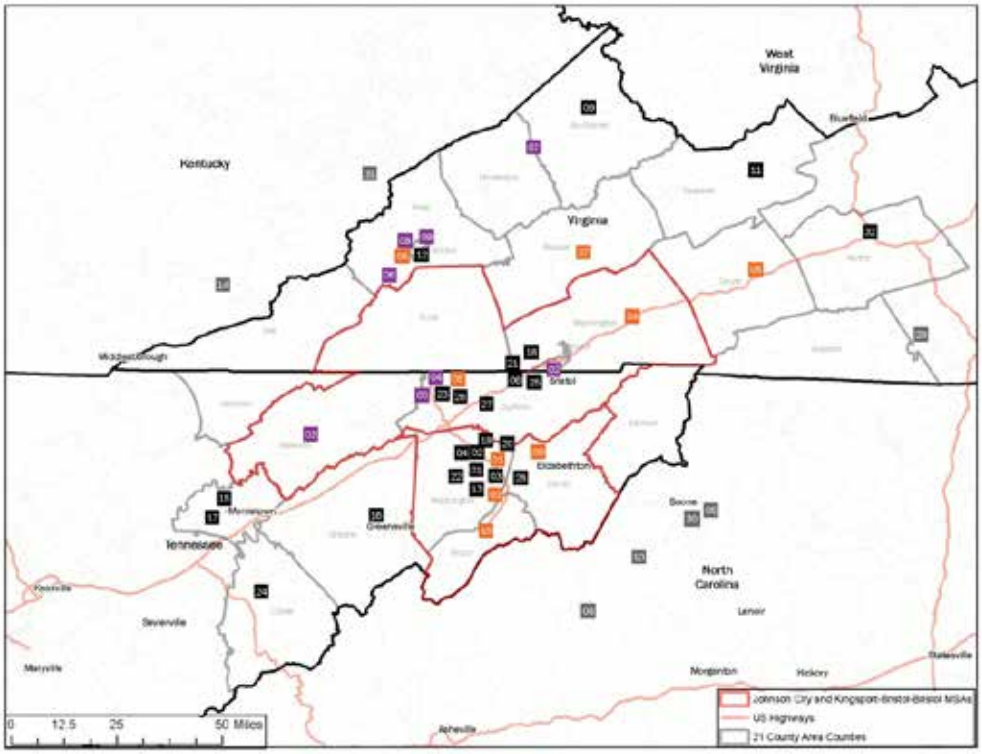
* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Appalachian Orthopaedic Associates, PC is co-located with Bristol Regional Medical Center and is therefore not visible on the map

Imaging Capabilities Locations and Counts, by System

System Affiliation	Facility Name	County	State	CT Facilities
Total	**Total**	**14**	**100%**	**14**
Wellmont	Lonesome Pine Hospital	Wise	VA	X
Wellmont	Southwest Virginia Cancer Center	Wise	VA	X
Wellmont	Wellmont Mountain View Regional Medical Center	Wise	VA	X
Wellmont	Wellmont Urgent Care Abingdon	Washington	VA	X
Wellmont	**Total**	**4**	**28.6%**	**4**
Mountain States	Dickenson Community Hospital	Dickenson	VA	X
Mountain States	Johnston Memorial Hospital	Washington	VA	X
Mountain States	Norton Community Hospital	Wise	VA	X
Mountain States	Russell County Medical Center	Russell	VA	X
Mountain States	Smyth County Community Hospital	Smyth	VA	X
Mountain States	**Total**	**5**	**35.7%**	**5**
All Other	Buchanan General Hospital	Buchanan	VA	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA	X
All Other	Clinch Valley Medical Center	Tazewell	VA	X
All Other	Community Radiology Of Virginia, Inc.	Tazewell	VA	X
All Other	Wythe County Community Hospital	Wythe	VA	X
All Other	**Total**	**5**	**35.7%**	**5**

D. Ambulatory Surgical Centers[3]



Ambulatory Surgical Centers Outpatient Facilities

Wellmont

01	Bristol Regional Medical Center
02	Bristol Surgery Center
03	Hawkins County Memorial Hospital
04	Holston Valley Medical Center
05	Holston Valley Surgery Center, LLC
06	Lonesome Pine Hospital
07	Sapling Grove ASC
08	Takoma Regional Hospital *(Independent)**
09	Wellmont Mountain View Regional Medical

MSHA

01	Franklin Woods Community Hospital
02	Indian Path Medical Center
03	Johnson City Medical Center
04	Johnston Memorial Hospital
05	Kingsport Ambulatory Surgery Center**
06	Norton Community Hospital
07	Russell County Medical Center
08	Smyth County Community Hospital
09	Sycamore Shoals Hospital
10	Unicoi County Community Hospital

All Other Facilities

01	East Tennessee Ambulatory Surgery Center, LLC***
02	Johnson City Eye Surgery Center***
03	Mountain Empire Surgery Center, LP***
04	TriCities Laser Center***
05	Appalachian Gastroenterology
06	Appalachian Orthopaedic Associates, PC
07	Ashe Memorial Hospital
08	Blue Ridge Regional Hospital
09	Buchanan General Hospital
10	Cannon Memorial Hospital
11	Carilion Tazewell Community Hospital
12	Clinch Valley Medical Center
13	Endoscopy Center of Northeast Tennessee, PC
14	Harlan ARH Hospital
15	Lakeway Regional Hospital
16	Laughlin Memorial Hospital
17	Morristown-Hamblen Healthcare System
18	Mountain Empire Cataract and Eye Surgery Center
19	PMA Surgery Center, LLC
20	Reeves Eye Surgery Center
21	Renaissance Surgery Center
22	State of Frankin OB/GYN Specialists
23	Sullivan Digestive Center
24	Tennova Healthcare - Newport Medical Center
25	The Endoscopy Center of Bristol
26	The Regional Eye Surgery Center
27	Tri Cities Gastroenterology
28	Tri-Cities Outpatient Surgery, LLC
29	Twin County Regional Hospital
30	Watauga Medical Center
31	Whitesburg ARH Hospital
32	Wythe County Community Hospital

* Wellmont sold Takoma Regional Hospital ("Takoma") to Adventist Health System in 2014. Wellmont has publicly announced its plan to repurchase Takoma. However, as of the date of this filing, the transaction has not yet closed and may not close. The Parties anticipate that, if Takoma is acquired by Wellmont before the COPA is granted, that Takoma would be included in the COPA.

** Managed Joint Venture

*** Non-Managed Joint Venture

[3] ASCs include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities; these facilities are included in map and table.

Ambulatory Surgical Center Locations and Counts, by System
(continues on following page)

System Affiliation	Facility Name	County	State	Surgery - ASC	Surgery - Endoscopy	Surgery - Hospital-based
Total	**Total**	**11**	**100%**	**1**	**8**	**11**
Wellmont	Lonesome Pine Hospital	Wise	VA		X	X
Wellmont	Wellmont Mountain View Regional Medical	Wise	VA		X	X
Wellmont	**Total**	**2**	**18.2%**	**0**	**2**	**2**
Mountain States	Johnston Memorial Hospital	Washington	VA	X	X	X
Mountain States	Norton Community Hospital	Wise	VA		X	X
Mountain States	Russell County Medical Center	Russell	VA		X	X
Mountain States	Smyth County Community Hospital	Smyth	VA		X	X
Mountain States	**Total**	**4**	**36.4%**	**1**	**4**	**4**
Non-Managed Joint Venture	**Total**	**0**	**0.0%**	**0**	**0**	**0**
All Other	Buchanan General Hospital	Buchanan	VA		X	X
All Other	Carilion Tazewell Community Hospital	Tazewell	VA			X
All Other	Clinch Valley Medical Center	Tazewell	VA		X	X
All Other	Twin County Regional Hospital	Grayson	VA			X
All Other	Wythe County Community Hospital	Wythe	VA			X
All Other	**Total**	**5**	**45.5%**	**0**	**2**	**5**

Replacement Application Exhibit 14.1 (Section E). Physician Status by Specialty/Employment[4]

Specialty	Overlay Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)	**X**	**797**	**67.6%**	**12.5%**	**13.0%**	**6.8%**
PEDIATRICS & NEONATOLOGY	X	30	83.3%	10.0%	0.0%	6.7%
OTHER SPECIALTIES	X	58	77.6%	5.2%	13.8%	3.4%
OBSTETRICS & GYNECOLOGY	X	30	73.3%	6.7%	6.7%	13.3%
PRIMARY CARE	X	285	69.1%	20.7%	3.9%	6.3%
PSYCHIATRY, PSYCHOLOGY & SOCIAL SERVICES	X	24	66.7%	8.3%	20.8%	4.2%
GENERAL SURGERY	X	22	63.6%	4.5%	9.1%	22.7%
CARDIOVASCULAR	X	24	62.5%	20.8%	12.5%	4.2%
ONCOLOGY & HEMATOLOGY	X	29	48.3%	31.0%	6.9%	13.8%
HOSPITALIST	X	71	42.3%	14.1%	31.0%	12.7%
PULMONOLOGY	X	12	33.3%	33.3%	16.7%	16.7%
URGENT CARE	X	27	18.5%	3.7%	70.4%	7.4%
RADIOLOGY		15	100.0%	0.0%	0.0%	0.0%
RHEUMATOLOGY		1	100.0%	0.0%	0.0%	0.0%
PATHOLOGY & LABORATORY MEDICINE		2	100.0%	0.0%	0.0%	0.0%
EMERGENCY MEDICINE		97	95.9%	0.0%	2.1%	2.1%
ENT		8	87.5%	12.5%	0.0%	0.0%
UROLOGY		8	62.5%	0.0%	37.5%	0.0%
ORTHOPEDICS		40	57.5%	0.0%	37.5%	5.0%
GASTROENTEROLOGY		7	57.1%	0.0%	42.9%	0.0%
NEPHROLOGY		2	50.0%	0.0%	50.0%	0.0%
NEUROSCIENCES		4	25.0%	0.0%	75.0%	0.0%
ENDOCRINOLOGY, DIABETES & METABOLISM		1	0.0%	0.0%	100.0%	0.0%

[4] Data were developed by specialty to identify physicians employed by Wellmont, employed by Mountain States (or affiliated with Mountain States) and independent physicians. Data on independent physicians were developed using names and specialties for physicians with admitting privileges at Wellmont and/or Mountain States hospitals. The Overlap Flag identifies specialties in which both systems employed physicians. The Specialty categories included in this table may differ slightly from those included in the original Application Exhibit 14.1 (Section E). The information available to the Parties on employed, affiliated and independent physicians in the area utilizes different categories of specialties (e.g. Family Medicine may be a specialty category in one list and Primary Care may be a specialty category in another list). The individual categories were aggregated to ensure specialties from various data sources could be combined to provide shares. Physician data include physicians and licensed mid-level healthcare professionals such as Physician Assistants and Nurse Practitioners.

14. MARKET AND COMPETITIVE DYNAMICS

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

REQUEST: The identity of any nonparty hospital located in the PSA and SSA and any nonparty hospital outside of the PSA and SSA that also serves patients in the parties' PSA and SSA;

RESPONSE: As discussed in Section 5, the Geographic Service Area consists of the following twenty-one counties: Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe (including the Independent Cities of Bristol and Norton), in Virginia; and Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee. For this response, we will be concentrating only on the Virginia counties within the GSA.

There are eight general acute care hospitals in the Geographic Service Area that are not operated by WHS or MSHA: Clinch Valley Medical Center (Richlands, VA), Wythe County Community Hospital (Wytheville, VA), Carilion Tazewell Community Hospital (Tazewell, VA), Lakeway Regional Hospital, Buchanan General Hospital (Grundy, VA), Morristown-Hamblen Healthcare System, Newport Medical Center, and Laughlin Memorial Hospital four of which are in Virginia as indicated.[1] Some residents of the Geographic Service Area leave the region to receive specialized care. The three service lines with the largest proportion of outmigration volume from the Virginia Geographic Service Area are Myeloproliferative Disorders, Mental Diseases and Disorders, and Multiple Significant Trauma. When patients leave the Geographic Service Area for medical care, they most frequently go to the Holston Valley Medical Center, Bristol Regional Medical Center, Johnson City Medical Center, Indian Path Medical Center, and Carilion Medical Center.

REQUEST: Estimates of the share of hospital services furnished by each of the parties and any nonparty hospitals;

RESPONSE: The Parties estimate their current share in the Geographic Service Area's Virginia counties for general acute care inpatient services based on Calendar Year 2014 ("CY2014") discharge data[24] as follows:

[1] Takoma Regional Medical Center in Greene County, TN was acquired by WHS as of January 1, 2017. MSHA has entered into an agreement to acquire Laughlin Memorial Hospital in Greene County, TN.

[24] Shares for general acute care inpatient services were calculated using CY2014 discharge data for all hospitals in the Virginia portion of the Geographic Service Area. Shares were calculated defining general acute care services excluding normal newborns (DRG 795) and including (excluding) MDC 19 (Mental Diseases) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). Tables detailing discharges by hospitals serving the Virginia Geographic Service Area, and hospitals located within the Virginia Geographic Service Area,are in **Exhibit 5.2**.

Table 14.1 – Share of Virginia GSA CY2014 Discharges, Current Systems[25]

System	Total	Share of Total Discharges
Mountain States	19,330	40.4%
Wellmont	16,191[26]	33.9%
Other	12,290	25.7%

Table 14.1 identifies the percentage of total discharges in the Geographic Service Area's Virginia counties (exclusive of DRG 795) that are accounted for by Mountain States, Wellmont, or other health care systems. Share analyses demonstrate that three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center, and Johnson City Medical Center) make up sixty percent (60%) of the combined system's discharges.[27]

If the Letter Authorizing Cooperative Agreement is granted and volumes coming from Virginia remain consistent with CY2014 trends, then the Parties estimate the projected shares for general acute care inpatient services would be as follows in **Table 14.2**:

Table 14.2 – Share of Virginia GSA CY 2014 Discharges, New Health System

System	Total	Share of Total Discharges
New Health System	35,521	74.3%
Independent Competitors	12,290	25.7%

Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent; in Virginia GSA alone, that figure is 68%. Even in overlap specialties, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 14.3**[28] provides share

[25] Shares for **Table 14.1** were calculated based on general acute care services excluding normal newborns (DRG 795).
[26] Because WHS acquired Takoma Regional Medical Center as of January 1, 2017, if Tables 14.1 and 14.2 were modified to reflect Takoma's current affiliation with WHS instead of its affiliation as of CY2014, the percentages reported in the Tables would not change. This is due to the small number of discharges at Takoma coming from patients in the Virginia service area..
[27] These three hospitals account for 44.4% of discharges by Virginia hospitals in the Geographic Service Area.
[28] **Tables 14.3 and 14.4** are based on data and information provided by the Parties regarding physicians with admitting privileges at

estimates for independent physicians, and Wellmont and Mountain States physicians in the specialties in which there is an overlap. **Table 14.4** reports shares for specialties in which there is not an overlap – that is, where Mountain States and Wellmont do not each employ physicians.

Table 14.3 – Shares of Physicians in Overlapping Specialties, by System (VA GSA)

Specialty	Overlay Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)	X	797	68%	13%	13%	7%
PEDIATRICS & NEONATOLOGY	X	30	83%	10%	0%	7%
OTHER SPECIALTIES	X	58	78%	5%	14%	3%
OBSTETRICS & GYNECOLOGY	X	30	73%	7%	7%	13%
PRIMARY CARE	X	285	69%	21%	4%	6%
PSYCHIATRY, PSYCHOLOGY & SOCIAL SERVICES	X	24	67%	8%	21%	4%
GENERAL SURGERY	X	22	64%	5%	9%	23%
CARDIOVASCULAR	X	24	63%	21%	13%	4%
ONCOLOGY & HEMATOLOGY	X	29	48%	31%	7%	14%
HOSPITALIST	X	71	42%	14%	31%	13%
PULMONOLOGY	X	12	33%	33%	17%	17%
URGENT CARE	X	27	19%	4%	70%	7%

Table 14.4 – Shares of Physicians in Non-Overlapping Specialties, by System (VA GSA)

Specialty	Overlay Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)		797	68%	13%	13%	7%
RADIOLOGY		15	100%	0%	0%	0%
RHEUMATOLOGY		1	100%	0%	0%	0%
PATHOLOGY & LABORATORY MEDICINE		2	100%	0%	0%	0%
EMERGENCY MEDICINE		97	96%	0%	2%	2%
ENT		8	88%	13%	0%	0%
UROLOGY		8	63%	0%	38%	0%
ORTHOPEDICS		40	57%	0%	38%	5%
GASTROENTEROLOGY		7	57%	0%	43%	0%
NEPHROLOGY		2	50%	0%	50%	0%
NEUROSCIENCES		4	25%	0%	75%	0%
ENDOCRINOLOGY, DIABETES & METABOLISM		1	0%	0%	100%	0%

their hospitals and employed or affiliated physicians and the specialty of the physicians.

A large number of independent providers of outpatient services compete in the Geographic Service Area's Virginia counties. For many outpatient services, independent providers account for at least a fifty percent (50%) share. **Table 14.5**[29] presents counts and share numbers for categories of outpatient services based on the affiliation of the providers.

Table 14.5 – Shares of Outpatient Facilities by System (VA GSA)[30]

Service Type	WHS & MSHS Combined %	Mountain States	Wellmont	All Other*	Total
Pharmacy	2.2%	2	0	87	**89**
Home Health	19.0%	4	0	17	**21**
Fitness Center	0.0%	0	0	20	**20**
X-RAY	52.9%	6	3	8	**17**
CT	64.3%	5	4	5	**14**
Nursing Home	16.7%	1	1	10	**12**
Surgery - Hospital Based	54.5%	4	2	5	**11**
MRI	54.5%	4	2	5	**11**
Physical Therapy	10.0%	1	0	9	**10**
Rehabilitation	55.6%	2	3	4	**9**
Surgery - Endoscopy	75.0%	4	2	2	**8**
Urgent Care	71.4%	2	3	2	**7**
Chemotherapy	80.0%	2	2	1	**5**
Rehabilitation & Physical Therapy	40.0%	0	2	3	**5**
Dialysis Services	0.0%	0	0	5	**5**
Wellness Center	0.0%	0	0	5	**5**
Weight Loss Center	0.0%	0	0	2	**2**
Cancer Center	100.0%	1	1	0	**2**
Radiation Therapy	100.0%	1	1	0	**2**
Surgery - ASC	100.0%	1	0	0	**1**

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

a. **REQUEST**: Identification of whether any services or products of the proposed cooperative agreement are currently being offered or capable of being offered by any nonparty hospitals in the PSA and SSA and a description of how the nonparty proposed cooperative agreement will not exclude such nonparty hospitals from continued competitive and independent operation in the PSA and SSA;

[29] **Table 14.5** depicts the counts and shares for categories of outpatient services and is based on a listing provided by the Parties of outpatient facilities by type including names, locations, and affiliations.
[30] When including only Virginia facilities, the following service types no longer had any facilities and were omitted from the table: Community Center, Cancer Support Services, and Women's Cancer Services.

RESPONSE: As described in more detail below, the Parties' provision of general inpatient services, physician services, and outpatient services are also currently offered or capable of being offered by other providers in the service area.

Inpatient Services. The general inpatient services currently offered by Wellmont and Mountain States are offered by, or capable of being offered by, other hospitals located in the Geographic Service Area, with the exception of certain high-level tertiary care services such as trauma and neonatal intensive care.

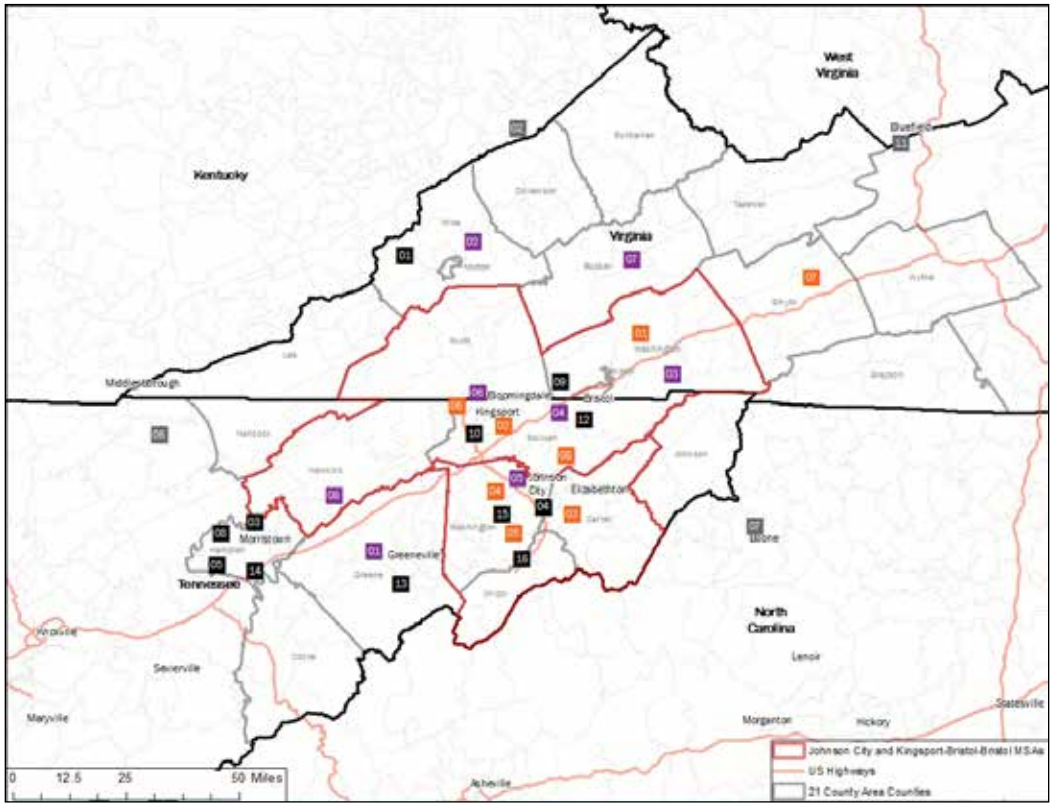
Eight general acute care hospitals in the Geographic Service Area are not operated by WHS or MSHA: Clinch Valley Medical Center (Richlands, VA), Wythe County Community Hospital (Wytheville, VA), Carilion Tazewell Community Hospital (Tazewell, VA), Lakeway Regional Hospital, Buchanan General Hospital (Grundy, VA), Morristown-Hamblen Healthcare System, Newport Medical Center, and Laughlin Memorial Hospital, of which Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, and Buchanan General Hospital are in Virginia as indicated.[1]

Outpatient Facilities. The Geographic Service Area also contains a number of competing, independent outpatient facilities, along with independent nursing homes, assisted living facilities and skilled nursing facilities. **Exhibit 14.1 (Section A)** provides the numbers and shares of outpatient facilities serving the VA Geographic Service Area as organized in broad categories. Wellmont and Mountain States together account for less than fifty percent (50%) of the outpatient facilities in nine of the twenty categories provided, including Physical Therapy (10.0%) and Nursing Homes (16.7%). Outpatient services, including urgent care, imaging, and ambulatory surgery centers, have many independent alternatives, which are identified in **Exhibit 14.1** and whose locations are shown on maps in **Figures 14.1-14.3**.

Urgent Care Facilities. Of the seven urgent care centers in the Virginia portion of the Geographic Service Area, Mountain States and Wellmont collectively operate five of them; twenty-nine percent (29%) of the urgent care centers are competitor facilities. **Exhibit 14.1 (Section B)** contains a list of all urgent care facilities serving the Geographic Service Area's Virginia counties.

[1] Takoma Regional Medical Center in Greene County, TN was acquired by WHS as of January 1, 2017. MSHA has entered into an agreement to acquire Laughlin Memorial Hospital in Greene County, TN.

Figure 14.1 – Map of Locations of Urgent Care Facilities[31]



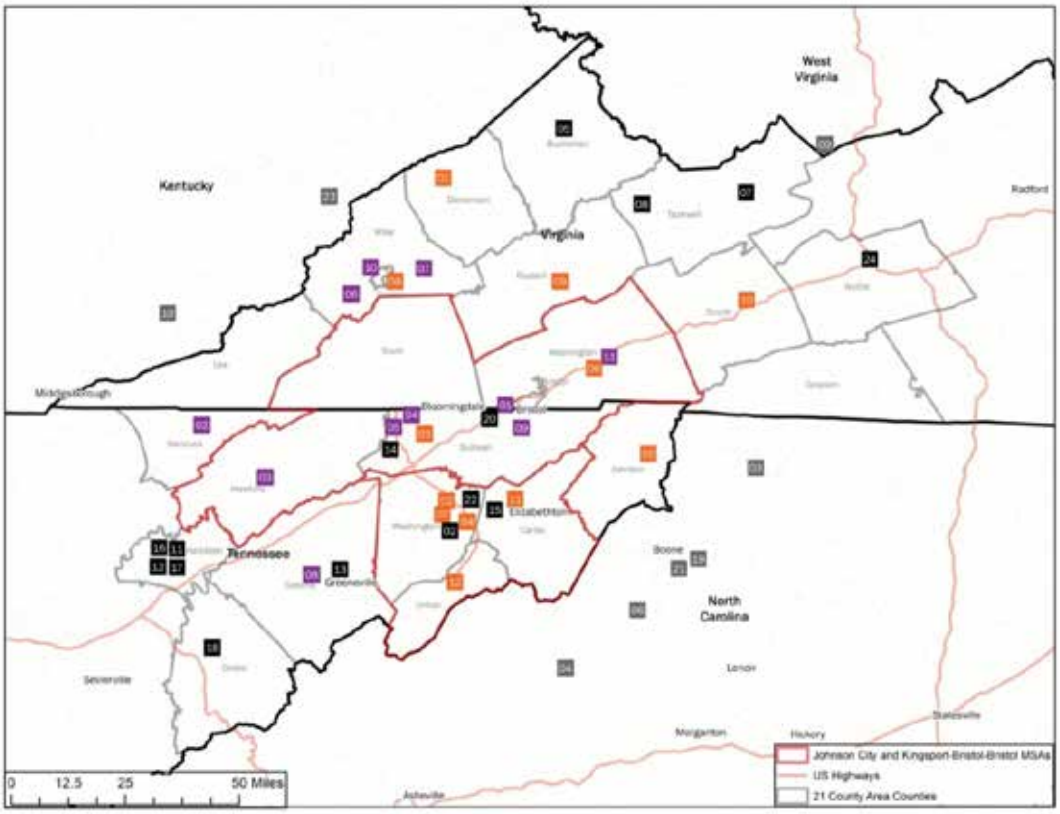
CT/MRI Facilities. The Geographic Service Area contains imaging facilities, including providers of CT, MRI, and X-Ray services. Wellmont and Mountain States each offers at least one type of these imaging services, but nearly thirty-six percent (36%) of all imaging facilities in the Virginia portion of the Geographic Service Area are operated by competitors. Wellmont and Mountain States together account for about half of the CT and MRI capabilities in the area, and a much smaller percentage of X-Ray capabilities. A breakdown is provided in **Table 14.6**, and locations are depicted on the map in **Figure 14.2**. **Exhibit 14.1 (Section C)** lists all CT/MRI capabilities in the Geographic Service Area's Virginia counties.

[31] An enlarged version of the map and legend is included in **Exhibit 14.1 (Section B).**

Table 14.6 – Medical Imaging Facilities/Capabilities and System Affiliation in Virginia GSA

System Affiliation	Total Facilities[32]	% of Total	CT Capabilities	MRI Capabilities	X-Ray Capabilities
Total	25		14	11	17
Wellmont	6	24.0	4	2	3
Mountain States	6	24.0	5	4	6
All Other	13	52.0	5	5	8

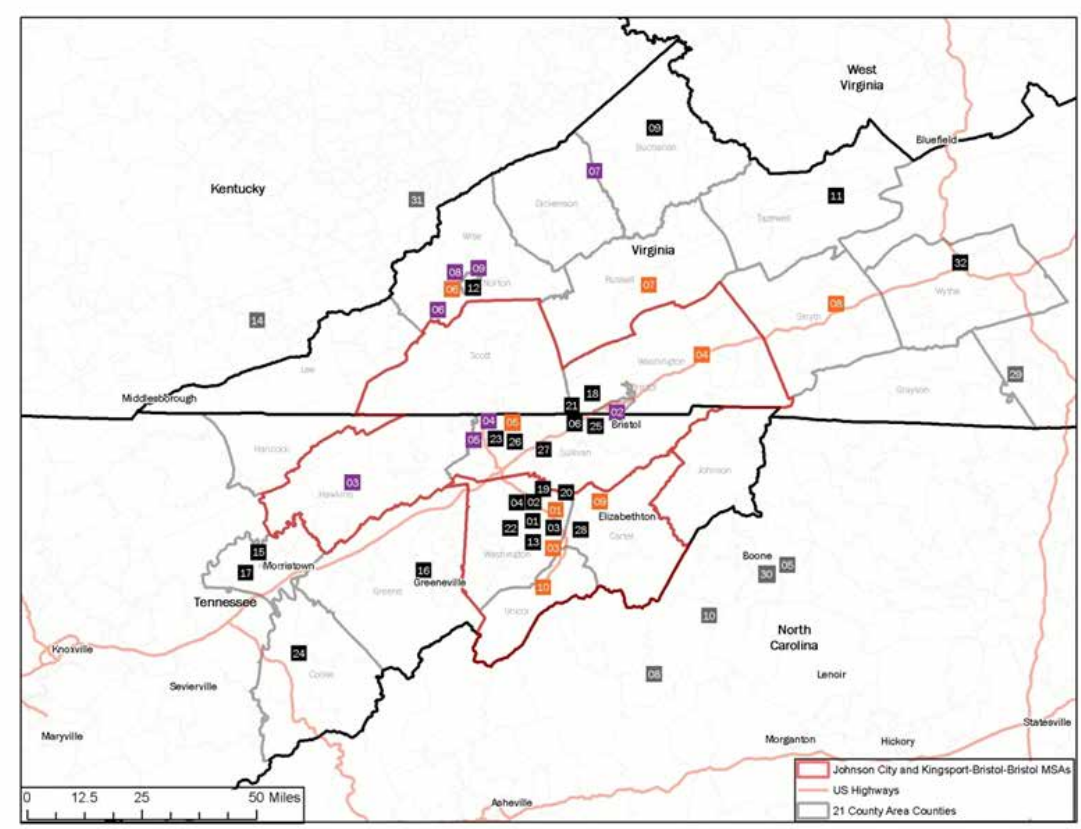
Figure 14.2 – Map of Locations of CT/MRI Facilities[33]



Ambulatory Surgical Centers. Wellmont and Mountain States each have ambulatory surgical centers ("ASCs")[34] in the Virginia portion of the Geographic Service Area, but forty-five percent (45%) are competing facilities. The locations of all area ASCs are shown in **Figure 14.3** below. **Exhibit 14.1 (Section D)** lists all ASCs serving the Geographic Service Area's Virginia counties.

[32] Facilities may have CT, MRI and/or X-ray capabilities co-located at a single location that are counted separately.
[33] An enlarged version of the map and legend is included in **Exhibit 14.1 (Section C).**
[34] "ASCs" include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.

Figure 14.3 – Map of Locations of Ambulatory Surgical Centers[35]



Physician Services**.** A large number of independent physicians in the Geographic Service Area offer the physician services currently offered by Wellmont and Mountain States through their respective employed (or affiliated) physicians.

Exhibit 14.1 (Section E) provides data on the number of physicians employed by Wellmont and employed by or affiliated with Mountain States in each of several specialties (e.g., family practice). It also reports data on the number of independent physicians in each of these specialties; the total counts of physicians are based on all physicians with privileges at either or both of Mountain States and Wellmont.

The majority of physicians in the Virginia portion of the Geographic Service Area with privileges at Wellmont or Mountain States are independent. Approximately sixty-eight percent (68%) of all practitioners in the Geographic Service Area's Virginia counties are independent. Wellmont employs thirteen percent (13%); Mountain States employs thirteen percent (13%); and seven percent (7%) of physicians are affiliated with Mountain States through staffing arrangements for certain hospital-based services. Independent competitive alternatives exist in all twelve physician specialties in which the Parties overlap. The combined share of independent physicians exceeds sixty percent (60%) in all specialties except Oncology & Hematology; Hospitalist; Pulmonology; Urgent Care; Orthopedics; Gastroenterology; Nephrology; Neurosciences;

[35]An enlarged version of the map and legend is included in **Exhibit 14.1 (Section D).**

and Endocrinology, Diabetes, & Metabolism. The share of independent practitioners is at least fifty percent (50%) in most specialties. Nearly sixty-nine percent (69%) of Primary Care Physicians are independent.

Each physician specialty where there is an "overlap" between Wellmont and Mountain States includes competition from independent physicians. No overlap between the Parties exists in a large number of specialties and all of them have numerous competitive alternatives. There are relatively few specialties where the combined number of Mountain States and Wellmont employed physicians exceeds thirty-five percent (35%) of the total number of area physicians in that specialty. As is common across the country, certain specialties tend to have higher shares of employed physicians due to the nature of that medical practice. This includes hospitalists, cardiologists and hematologists/oncologists, although these specialties have a number of independent alternatives.

Continued Competition. Market power will not be gained as a result of the Cooperative Agreement. The New Health System will be actively supervised by Virginia and Tennessee officials. This supervision will ensure that the New Health System will act in furtherance of the public policies that underlie Virginia's Cooperative Agreement statutory and regulatory provisions and Tennessee's Certificate of Public Advantage. Moreover, as noted above, the New Health System will face competition from several independent general acute care hospitals, outpatient facilities, post-acute care facilities and physicians in the Geographic Service Area. These competitors will not be a party to the Cooperative Agreement, and the Parties anticipate that the independent providers will continue to operate independently and competitively if the Letter Authorizing Cooperative Agreement is granted. Most outpatient medical services are delivered outside the hospital setting by independent physicians and other independent providers such as home health, lab, imaging, occupational medicine, hospice, long-term care services, skilled nursing, physical therapy, occupational therapy, pharmacy, counseling, and surgery centers. Wellmont and Mountain States are required to ensure patient choice when selecting these services and will continue these policies as a merged organization.

In order to ensure continued competitive and independent operation of the services and products of entities not a party to the Cooperative Agreement, the Parties are willing to enter into the following commitments.

COMMITMENTS

- 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.

- The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.

- The New Health System will not engage in "most favored nation" pricing with any health plans.

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two

As noted, a large number of independent physicians in the community will not be a party to the Cooperative Agreement. Both Wellmont and Mountain States continue to value a robust and successful independent physician community. The New Health System intends to collaborate where possible with the independent physician community in procompetitive arrangements to build an array of service offerings that will be accessible throughout the region. To remove barriers to patient choice and promote open physician practice, the New Health System is prepared to make the following commitments.

COMMITMENTS

- 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.

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

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

- The New Health System will not require independent physicians to practice exclusively at the New Health System’s hospitals and other facilities.

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

b. **REQUEST**: A listing of the physicians employed by or under contract with each of the parties' hospitals in the PSA and SSA, including their specialties and office locations;

RESPONSE: The listing of the physicians employed by or under contract with Mountain States, including their specialty and office location(s), is attached as **Exhibit 14.2**. The listing of the physicians employed by or under contract with Wellmont, including their specialty and office location(s), is attached as **Exhibit 14.3**.

c. **REQUEST**: The identity of any potential entrants in the parties' PSA and SSA and the basis for any belief that such entry is likely within the two calendar years immediately following the date of the Letter authorizing cooperative agreement is issued by the department; and

RESPONSE: Other than the efforts described below, the Parties have no knowledge of any potential entrants in the Parties' Geographic Service Area.

- SBH-Kingsport, LLC applied for a Certificate of Need with the Tennessee Department of Health to operate an in-patient behavioral health center in Kingsport, Tennessee. The Tennessee Department of Health initially denied the application on June 25, 2014, but, on appeal, an administrative law judge recently ruled in favor of SBH-Kingsport, LLC's CON application.
- Lee County Hospital Authority owns the building where the former Lee Regional Medical Center was once located. The Parties are aware that the Lee County Hospital Authority has plans to open an acute care hospital as an independent facility at that location.

d. **REQUEST**: A list of each party's top 10 commercial insurance payers by revenue within the PSA and SSA.

RESPONSE: The listing of the commercial insurance payers by revenue is considered to be competitively sensitive information under federal antitrust laws. As such, each Party submits a list in alphabetical order of its top 10 commercial insurance payers within the Geographic Service Area. Mountain States' list is attached as **Exhibit 14.4**, and Wellmont's list is attached as **Exhibit 14.5**.

CERTIFICATION
V.T-1 and V.T-2

This Certification is submitted in connection with the Virginia Department of Health's Request for Additional Information dated December 22, 2016 (the "Request") submitted to Mountain States Health Alliance ("MSHA") and Wellmont Health System ("WHS," collectively with MSHA, the "Parties") regarding the application of MSHA and WHS for a letter authorizing cooperative agreement from the Virginia State Health Commissioner (the "Application"). This Certification is provided solely for the purpose of fulfilling the certification requirements for the responses to Request numbers V.T-1 and V.T-2 as described in the letter dated January 30, 2017 from Ms. Allison Tysinger, Senior Assistant Attorney General/Chief, to counsel for WHS and MSHA.

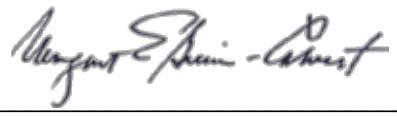
The undersigned hereby certifies as follows:

1. I am a Senior Consultant at Compass Lexecon, an independent economic consulting firm, in their office located at 1101 K Street, NW, Washington, DC 20005, and I performed analysis of data in connection with the response to Request numbers V.T-1 and V.T-2.

2. The information about physician practices in the Geographic Service Area (as that term is defined in the Application) presented in Exhibit T-1 to the Request responses is accurate in all material respects based on (i) the information available to me when it was analyzed on July 25, 2016, and (ii) the Parties' representations to me as of July 25, 2016 about the characterization of practices as independent.

3. Exhibit N-4 to the Request responses makes use of these same data on physician practices and is accurate in its presentation of physician share data in the Virginia counties within the Geographic Service Area as of September 8, 2016.

4. Updated Application Exhibit 5.2B provided in Exhibit N-4 to the Request responses is accurate in its presentation of inpatient share data for patients from the Virginia counties within the Geographic Service Area using available inpatient discharge data as of September 8, 2016.



Margaret E. Guerin-Calvert
Senior Consultant
Compass Lexecon

March 3, 2017