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April 11, 2017

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

Re: Request for Additional Information dated December 22, 2016– Response #15

Dear Mr. Bodin:

Response #15 to the questions received from your office on December 22, 2016 has been uploaded to the Citrix ShareFile platform. Responses to the following questions are submitted as part of Response #15:

Section V. Additional Information

T. Additional Questions
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Response #15 completes the Applicants' submission of responses to Request #1, with a lone exception relating to a portion of Question V.N-9. We await further instruction from the Commissioner regarding this request. We will provide shortly a complete Request #1 Final Responses document, which will include all narrative responses submitted to Request #1, and we will notify you as soon as this is available for access on ShareFile.

Please contact me if you have any questions.

Sincerely,

Jennifer Light McGrath

cc: Peter Boswell
Allyson K. Tysinger

RESPONSE #15

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: April 11, 2017

V.T.14.

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

JOINT RESPONSE: The New Health System's expenditures in population health improvements; the expansion of mental health, addiction recovery, and substance abuse prevention; and the growth of academic and research opportunities are key components of the plan to transform to a health care delivery system responsible for providing value-driven community health improvement to the communities we serve. The NHS has formally committed to make incremental expenditures in these areas. Commitments for each of these three categories are outlines below.

The $75 million investment in population health improvements

Revised Commitment provides that, to enhance population health status consistent with the regional health goals established by the Southwest Virginia Health Authority and the Virginia Department of Health, the New Health System will invest not less than $75 million over ten years in population health improvement for the service area. The New Health System will establish a plan, to be updated annually in collaboration with the Authority and the Department to make investments that are consistent with the health improvement goals established under the Cooperative Agreement and to complement resources already being expended. The New Health System also commits to pursuing establishment of an Accountable Care Community framework in partnership with various local, state and federal agencies, payers, service providers and community groups who wish to partner in such efforts. It is the desire of the New Health System for the Commonwealth and Tennessee to collaborate with the New Health System to establish a regional plan that disregards state boundaries.

In addition, revised Commitment 28 provides that up to $75,000 annually (with CPI increases each year) from the $75 million investment amount will be spent to support the Authority's role in promoting population health improvement through reimbursement of the Authority's costs associated with its various population health improvement planning efforts under the Commonwealth's Cooperative Agreement with the NHS.[152]

Additional proposed detail on this incremental investment is provided in the template Community Health Improvement Plan included separately as **Exhibit O-5B** and the annual estimate of reinvestment from efficiencies, also provided separately as **Exhibit O-5A**.

[152] See Exhibit G-1A. No reimbursable costs shall be paid toward compensation for any member of the Authority's Board or Directors.

The template Community Health Improvement Plan was developed in part through the work of the Community Health Work Groups. In the fall of 2015, the Parties launched the region's most substantial community health improvement assessment effort to date, bringing together partners from all sectors to participate. Four Community Health Work Groups were created to specifically focus on medical needs of the medically underserved, identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. As described in the Application Section 15.a.G, pages 89-91, the Parties jointly sponsored and funded these Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement. The Work Groups are listed below along with the chairpersons. The charters and membership lists of all four Work Groups are set forth in Application Exhibits 15.2A and 15.2B. [153]

- Mental Health & Addiction Work Group: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;
- Healthy Children & Families Work Group: Travis Staton, CEO of United Way of Southwest Virginia, and Dr. David Wood, chair of the department of pediatrics at ETSU;
- Population Health & Healthy Communities Work Group: Dr. Randy Wykoff, dean of ETSU's College of Public Health, and Lori Hamilton, RN, director of healthy initiatives for K-VA-T Food City;
- Research & Academics Work Group: Jake Schrum, president of Emory & Henry College, and Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of ETSU.

The initial reports of the Work Groups are attached as **Exhibit F-5**. The Work Groups' initial recommendations are still being assessed, but the reports are being used as guides for the New Health System's plans and initiatives for community health improvement, including the template Community Health Improvement Plan.

As explained in the Application, the Parties believe that including the Department, the Authority, and other community stakeholders in finalizing the NHS Community Health Improvement Plan will lead to greater community buy-in and adaptation of the population health improvement process. Once the community health improvement goals and metrics are agreed upon with the Department under the Cooperative Agreement, the exact programmatic investments – including location and timing – will be determined in order to most effectively leverage existing programs which operate successfully in the region and fill gaps in service offerings and fund needs where existing programs do not adequately cover the community health needs.

The $140 million to expand needed services

In Revised Commitment 26, the NHS commits to expending at least $140 million over 10 years pursuing specialty services which otherwise could not be sustainable in the region without the financial support offered by the New Health System. Revised Commitment 26 states:

- In an effort to enhance treatment of substance abuse in the region, the New Health System will create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee.

[153] The membership lists reflect all members of each Work Group as of January 25, 2016.

- Because improved mental health services is a priority of the Authority and the law, the New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements throughout the Virginia and Tennessee service area.

- As part of the priority of preserving hospital services in geographical proximity to the communities traditionally served by the facilities, and to ensure access to care, the New Health System will develop pediatric specialty centers and Emergency Rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes.

This Commitment includes the obligation to develop a plan for this investment no later than 24 months after closing and will include a time schedule for implementing the plan and expenditures under the plan.[154]

The $140 million commitment falls into three major categories: mental health and addiction recovery ($85 million), pediatric sub-specialty access ($27 million) and rural health access ($28 million). The latter two categories of spending in particular - pediatric sub-specialty access and rural health access - will support the provision of new services which would not otherwise generate sufficient revenue for the New Health System to offer, but which are necessary to address specific health and health care needs and reduce patient travel time. These expenditures will be guided by physician needs assessments updated every three years in each sub-market within the Geographic Service Area.[155]

Additional proposed detail on the incremental investment for these services is provided in the template Community Health Improvement Plan included separately as **Exhibit O-5B**. Annual spending estimates for these services are included in the annual estimate of reinvestment from efficiencies that is included separately as **Exhibit O-5A**.

The $85 million to develop and grow academic and research opportunities

Revised Commitments 17 and 18 commit to the expenditure of not less than $85 million over 10 years in academic medical training and research opportunities:

> **Revised Commitment 17:** In order to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop, in partnership with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee. The plan will include, but not be limited to, how it will address the Authority's goals, how training will be deployed in Virginia and Tennessee based on the assessed needs, clinical capacity and availability of programs. Contingent on continued funding for existing programs from federal and state sources, the New

[154] See Exhibit G-1A.
[155] See Revised Commitment 25, **Exhibit G-1A**.

Health System will not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area. Notwithstanding the foregoing, minor and temporary decreases in the number of full time equivalent residents working at Virginia hospitals may reflect year-to-year variations in residents applying for such training, dropping out of such training, electing to rotate to other hospitals, or transferring to another residency program, and shall not be deemed to violate this agreement.

Revised Commitment 18: In order to help create opportunities for investment in research in partnership with Virginia's academic institutions, the New Health System is committed to collaborating with the academic institutions to compete for research opportunities. The New Health System will work closely with current academic partners to develop and implement a 10-year plan for investment in research and growth in the research enterprise in Virginia and Tennessee service area. The plan will include, but not be limited to, how it will address the Authority's goals, how research will be deployed in Virginia and Tennessee based on the needs and opportunities, capacity and competitiveness of the proposals.

As acknowledged by the Authority and the Parties in Revised Commitment 17, the NHS service area extends across state boundaries, and patients, employees, and vendors freely cross those state lines. Accordingly, the Authority and the NHS recommend that the Commissioner not apply a fixed ratio to determine whether each year's expenditure under Revised Commitments 17 and 18 is appropriately allocated to Virginia. Instead, the Authority and the NHS recommend that the Commissioner annually review expenditures made pursuant to these Commitments for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses. Revised Commitment 17 includes the obligation of the New Health System to furnish to the Commissioner no later than June 30, 2018 a 10-year plan for medical residency training programs and other health care professional training.

Revised Commitment 18 obligates the NHS present a plan for research expenditures for full fiscal years two and three starting after the closing of the merger no later than the end of the first fiscal year after the merger. An annual report will be produced that should include a description of research topics, the entities engaged in the research, the principal researcher(s) who is/are responsible for each project, any grant money applied for or expected, and the anticipated expenditures. Each subsequent annual reports should report on the outcome of previously reported research projects including references to any published results. The Authority and the NHS recommend that the Commissioner review expenditures made pursuant to this Commitment for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

The Parties have already begun work toward developing a research and academics plan. Part of the planning for the NHS involved the creation of a Research & Academics Community Health Work Group to make recommendations to the NHS regarding the organization of the infrastructure necessary to grow research and academic activity in Southwest Virginia and Northeast Tennessee. **Exhibit B-9** lists the members of this Work Group, which included co-chair Jake Schrum, President of Emory and Henry College in Virginia. The Research & Academics Work Group's initial report is attached as **Exhibit C-1F**. While still under review by the Parties, the Work Group recommended creating a collaborative research

infrastructure that includes representation from member institutions in Virginia and Tennessee. The research program would be structured to reduce programmatic redundancies across institutions, where possible, better coordinate research efforts to improve the health of Southwest Virginia and Northeast Tennessee, better compete for private and federal research funds, and expand the number of research institutions serving Southwest Virginia and Northeast Tennessee. Our primary aim is to enable translational research opportunities which will ultimately improve the health of the population we serve and inform the overall body of research on the health issues faced by our region—particularly those where behaviors and socio-economic factors impact health status. In so doing, the research goals of NHS will support our community health improvement goals and will further our ability to create significant public advantage through improvement in poor health trends over time. The Work Group's initial recommendations are still being assessed, but the report is being used as a guide for the New Health System's plans and initiatives for academics and research growth.

Additional proposed detail on the spending associated with academic and research opportunities is provided in the annual estimate of reinvestment from efficiencies, provided separately as **Exhibit O-5A**. The Parties believe spending plans for research infrastructure, increasing residency and training slots, creating new specialty training opportunities, and adding faculty must be developed together with their academic partners in Virginia and Tennessee, as recommended by the Authority. This process will include the development of a ten-year plan for post-graduate training of physicians, nurse practitioners, and physician assistants along with other allied health professions. The NHS will work closely with our current academic partners and other academic institutions in Virginia and Tennessee to develop and implement a ten-year plan for investment in health research and growth in the health research enterprise within the region. It is not possible for the Parties to develop these plans without the integral involvement of their academic partners in Virginia and Tennessee, and the Parties expect this process will take at least a year for these plans to be fully developed.

Strategically, a major part of the New Health System's emphasis will be on the development of academic research infrastructure and personnel which is needed to attract additional research funding from national sources—specifically in the area of translational research. The New Health System intends to allocate resources to priority research projects identified by the New Health System and academic partners in pursuit of this goal. Translational research projects that are focused on rural health care, population health management, health care transformation, and community health improvement will offer important insights to inform the New Health System's overall efforts in the region and to create national models.

Further, the Parties will focus on developing the academic infrastructure to ensure effective training for the next generation of health professionals that are needed to address the health care needs of this region. This will require a program gap analysis and the formation of program development plans. In addition, the Parties will work to identify fellowship training opportunities to support the regional base of sub-specialty physicians along with collaboration where professors and research leaders can work together to close gaps in regional specialty services or provide clinical oversight. The Parties expect that an offshoot of these comprehensive efforts will be the development of new medically and technically oriented businesses in the region, and the Parties plan to work with municipalities and economic

development agencies to help incubate these opportunities and attract new opportunities to the region to support the regional economy.

How much of these totals are allocated to improve health care in Virginia alone?

Detailed plans for allocations have yet to be formed by the Parties. While some initiatives and investments will be targeted specifically for Virginia, many (if not most) will offer regional benefits for both Virginians and Tennesseans.

As noted by the Authority and the Parties, the NHS service area extends across state boundaries, and patients, employees, and vendors freely cross those state lines. Accordingly, the Authority and the NHS recommend that the Commissioner not apply a fixed ratio to determine whether each year's expenditures toward these investments is appropriately allocated to Virginia. Instead, the Authority and the NHS recommend that the Commissioner review expenditures made pursuant to these investment Commitments for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

Provide two (2) year historical baseline period financial data, YTD and five (5) year forecast data for each program.

In addition to the information about each program contained above in this Response T-14, historical and YTD financial data about each of the programs, as well as the NHS plans for these programs, are found in the following responses:

Program	Responses	Exhibits
Population Health Improvement	F-5 – NHS plans K-7b/d – NHS current programs and plans O-5 – NHS plans P-1 – NHS plans	O-5A – Year-by-Year Summary of Investments O-5B – NHS Template Community Health Improvement Plan Application Exhibits: 7.1I – MSHA Forms 990 for the Last Five Years 7.2F – WHS Forms 990 for the Last Five Years
Expansion of Services	L-5 O-5	L-5A – MSHA Behavioral Health Revenues and Expenses L-5B – WHS Behavioral Health Revenues and Expenses
Academics and Research	Academics/GME B-7 Research	B-7A – MSHA GME Programs [financial data] B-7B – WHS GME Programs [financial data]

	C-2	C-2A – MSHA Research Revenues and Expenses C-2B – WHS Research Revenues and Expenses

In order to provide the five (5) year forecast period, the Parties would be required to share competitively sensitive information that is not normally shared between competitors due to antitrust concerns. To date, the Parties have not shared this highly sensitive information with each other because of these concerns. Each Party risks violating federal antitrust laws if it shares this information with the other Party, other competitors or other insurers as a public document. For these reasons, we have been unable to develop detailed utilization and revenue projections.

With respect to the NHS' plans for these programs:

- Community Health Improvement Plan Program. The final community health improvement plan will address the Key Focus Areas agreed upon with the State during the application review period. The Parties believe that a collaborative planning process with the Southwest Virginia Health Authority, the Virginia Department of Health, the local departments of health, the Community Health Work Groups, and other community stakeholders is critical to effective implementation of a plan to improve community health. The Parties expect the final Community Health Improvement Plan will be developed in collaboration with these stakeholders and ready for implementation within twelve months of closing of the merger.

- Enhanced Health Care Services Program. As stated in Revised Commitment #26, the definitive plan for enhanced health care services under the NHS will be developed no later than 24 months after closing and will include a time schedule for implementing the plan and expenditures under the plan.

- Academics and Research Program. As stated in Revised Commitment #17, the NHS will develop, in partnership with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee. The plan will include, but not be limited to, how it will address the Authority's goals, how training will be deployed in Virginia and Tennessee based on the assessed needs, clinical capacity and availability of programs. The plan shall set forth the targeted number of persons to be trained by physician specialty or health care professional category, the location(s) of such training, the schedule for starting such training, and the expected gross annual expenditure relating to such training. In Revised Commitment #17, the NHS committed to furnish the academics plan to the Commissioner no later than June 30, 2018, however the New Health System's commitment to this timeframe was made to the Authority in October 2016 when the closing of the merger was anticipated to occur earlier than is now contemplated. Given the current timing anticipated for closing and the time needed to develop the comprehensive academics plan with academics partners, the Parties acknowledge that the

academics plan may not be completed by June 30, 2018 and may take additional time. The Parties anticipate discussing an appropriate timeframe with the Commissioner.

Similarly, as set forth in Revised Commitment #18, the NHS will work closely with current academic partners to develop and implement a 10-year plan for investment in research and growth in the research enterprise in the Virginia and Tennessee service area. The NHS' plan for research expenditures for full fiscal years two and three starting after the closing of the merger will be provided to the Commissioner no later than the end of the first fiscal year after the merger. Thereafter, the New Health System must update its research plan to address subsequent fiscal years no later than the end of the period for which the prior plan ends up to the end of the ninth full fiscal year after the closing of the merger. The research program plan will include, but not be limited to, how it will address the Authority's goals, how research will be deployed in Virginia and Tennessee based on the needs and opportunities, capacity and competitiveness of the proposals.

Demonstrate that the investment net revenue is incremental revenue.

The Baseline Financial Model prepared by FTI presents amounts to be expended by NHS from merger efficiencies over the next decade, including expenditures in population health, enhanced services and research and academics. **Exhibit O-5A** provides an estimate of the year-by-year timing of expenditures in these programs. Analysis of the current spending by the Parties in these programs demonstrates that the proposed expenditures are incremental.

Total community benefit expense is reported by MSHA and WHS on IRS Form 990 for population health-related programs, subsidized health services and research and academics. These expenditures are social responsibility efforts which are considered outside of "clinical core functions". The level of these expenditures in the fiscal year prior to the merger will serve as the baseline for the new incremental expenditures in population health improvement and academics and research the Parties have proposed under the Cooperative Agreement.

Tables T-14C and **T-14D** below show a breakdown of *Community Health Education and Outreach* spending in FY15 to demonstrate the amount currently expended on direct community health improvement. **Table T-14E** shows the three year trend for each system. Spending for community benefits has remained essential level for the recent years where data is available. Without the merger, it is not expected there would be any significant growth in the overall total spending on community health improvement by the two systems, although there may be reprioritization of spending. MSHA and WHS have not yet filed their Forms 990 for FY16 so the requested YTD information is not yet available.

Table T-14C – MSHA Breakdown of Community Health Education and Outreach Spending Over $100K (FY15)

Category	Amount
Physician Recruitment	2,171,079
Community Health Improvement Programs • Health Resource Centers(Education) • Perinatal Center/Peds Ground Transport/Lactation Consulting • Community Health Informational News • Pastoral Care (Parish Nurse Program) • Dispensary of Hope/Medication Assistance • Congestive Heart Center	1,773,242
Patient Advocacy Enrollment Assistance	967,604
Nurse Connection	242,765
MedFlight Dispatch	478,407
Other Programs	206,439
Total Community Health Education and Outreach Spending	**$5,839,536**

Table T-14D – WHS Breakdown of Community Health Education and Outreach Spending Over $100K (FY15)

Category	Amount
Physician Recruitment	3,033,615
Community Health Improvement Programs • Diabetes Treatment Center (Education) • Comprehensive Weight Management Center (Education) • Mobile Health Coach • Pastoral Care (Parish Nurse Program)	1,283,787
Nurse Connection	624,590
MedFlight Services	612,756
Business Health Solutions	247,825
Other Programs	411,682
Total Community Health Education and Outreach Spending	**$ 6,214,255**

Table T-14E – Gross Expenditures on Community Health Education and Outreach – Three Year Trend[156]

	MSHA FY13	**MSHA FY14**	**MSHA FY15**	**WHS FY13**	**WHS FY14**	**WHS FY15**
Community Health Education and Outreach	$5,362,626	$5,002,067	$5,839,536	$6,528,044	$6,020,948	$6,214,255

[156] MSHA numbers include facilities that report a separate Form 990: Johnston Memorial Hospital, Norton Community Hospital, Dickenson Community Hospital and Smyth County Community Hospital. WHS numbers includes facilities that report a separate Form 990, including Hawkins County Memorial Hospital, Inc. and other non-hospital entities.

How does the NHS plan to periodically demonstrate its progress in these areas and show its accountability?

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.[157]

The proposal 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 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 Parties' current proposal contemplates annual reporting to the Commissioner because we believe this will allow sufficient time for the NHS to advance goals and fulfill commitments, will allow assessment of performance over a statistically appropriate period of time, and will provide the Commissioner with frequent assessments to actively supervise the Cooperative Agreement. As a supplement to the detailed annual reports, the NHS is willing to provide interim financial "progress" reports to the Commissioner in the form of information currently reported to the Electronic Municipal Market Access system (EMMA). For all information provided to the Commissioner under her active supervision, the Parties want to agree in advance on the information that would be publicly available and the information that would be proprietary and maintained as confidential by the Commonwealth.

In addition, 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.

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

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' acknowledge that Virginia and Tennessee may want to refine accountability proposals. As part of its application process for a Tennessee COPA, we are currently in discussion with the Tennessee Department of Health regarding components of active supervision by Tennessee. 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.

V.T.18.

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

JOINT RESPONSE: Please see Response T-14 for a thorough description of current community benefit spending by MSHA and WHS and planned community benefit spending by the NHS under the Cooperative Agreement.