COMMONWEALTH OF VIRGINIA

APPLICATION FOR A

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: February 16, 2016

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IDENTIFICATION OF THE PARTIES

Legal Name of Applicant #1.

Mountain States Health Alliance
FEIN: 62-0476282

Address of Principal Business Office for Applicant #1.

Alan Levine, President & CEO
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604

Legal Name of Applicant #2.

Wellmont Health System
FEIN: 62-1636465

Address of Principal Business Office for Applicant #2.

Bart Hove, President & CEO
1905 American Way
Kingsport, Tennessee 37660

Throughout this Application, Mountain States Health Alliance is referred to as "Mountain States," and Wellmont Health System is referred to as "Wellmont." Mountain States and Wellmont are also referred to individually as a "Party" and collectively as the "Parties."

VERIFIED STATEMENT

REQUEST: All supplemental information submitted to the commissioner shall be accompanied by a verified statement signed by the chairperson of the board of directors and chief executive officer of each party; or if one or more party is an individual, signed by the individual attesting to the accuracy and completeness of the enclosed information.

RESPONSE: The undersigned hereby verifies that the information included in this Application is accurate and complete to the best of our knowledge and belief and that it is our intent to carry out the proposed agreement.

Mountain States Health Alliance Chairman of the Board		**Wellmont Health System** Chairman of the Board
_____ Barbara Allen		_____ Roger Leonard
Mountain States Health Alliance President & Chief Executive Officer		**Wellmont Health System** President & Chief Executive Officer
_____ Alan Levine		_____ Bart Hove

1. REPORT(S) USED FOR PUBLIC INFORMATION

REQUEST: A report or reports used for public information and education about the proposed cooperative agreement prior to the parties' submission of the application. The applicants shall document the efforts used to disseminate the report or reports. The report or reports shall include, but are not limited to:

a. A description of the proposed primary service area (PSA) and secondary service areas (SSA) and the services and facilities to be included in the cooperative agreement;

b. A description of how health services will change if the letter authorizing cooperative agreement is issued;

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

d. A description of any plans by the parties regarding existing or planned facilities that will impact access for patients to the services currently offered by the parties at their respective facilities, including expansions, closures, reductions in capacity, consolidation, and reduction or elimination of any services;

e. A description of the findings from community or population health assessments for the service areas regarding major health issues, trends, and health disparities, including comparisons to measures for the state and similar regional areas, and a description of how the health of the population will change if the letter authorizing cooperative agreement is issued; and

f. A description of the impact on the health professions workforce including long-term employment, wage levels, recruitment, and retention of health professionals.

RESPONSE: The Parties prepared the Pre-Submission Report attached as **Exhibit 1.1** to educate the public on the proposed merger and seek additional community input, and the Pre-Submission Report includes the information requested above. The Pre-Submission Report was posted on the Parties' website on January 7, 2016, and the Parties publicized the release of the report through various news outlets. The community has been invited to submit comments and questions through the Parties' website: http://becomingbettertogether.org.

2. RECORD OF COMMUNITY STAKEHOLDER AND CONSUMER VIEWS

REQUEST: A record of community stakeholder and consumer views of the proposed cooperative agreement collected through a public participatory process including meetings and correspondence. Transcripts or minutes of any meetings held during the public participatory process shall be included in the report.

RESPONSE: The Parties have conducted extensive community meetings and created wide-ranging opportunities for community stakeholders and consumers to express their views. **Exhibit 2.1** contains a detailed summary and record of stakeholder meetings and outreach efforts and community stakeholder and consumer views of the proposed Cooperative Agreement.

3. SUMMARY OF THE PROPOSED COOPERATIVE AGREEMENT

REQUEST: A summary of the nature of the proposed cooperative agreement between the parties.

RESPONSE: The Parties are formally submitting this Application to the Southwest Virginia Health Authority, and simultaneously submitting copies to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia to request the issuance of a Letter Authorizing Cooperative Agreement under Virginia Code Section 15.2-5384.1 *et seq*. and the regulations promulgated thereunder (12VAC5-221-10 *et seq.*).

The Process.

Two years ago, Wellmont began an internal evaluation of Wellmont's strategic and financial position, industry trends, and the organization's goals for the future of health care within its service area. Wellmont entered the process from a position of clinical strength and relative financial stability, but recognized that it needed to be prepared for financial pressures, regulatory mandates, and imperatives for change. The important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with continued downward pressure on reimbursement from government and commercial payers compelled the Wellmont Board to thoroughly evaluate its strategic options. Wellmont's Board evaluated all reasonable options with the objective of sustaining community assets vital to the region while achieving high quality patient care at the lowest possible cost. Wellmont was not alone. Hospital systems throughout the nation have undergone strategic options reviews, with many choosing a traditional merger or consolidation in hopes of surviving in this challenging environment – an environment which has seen more than sixty rural hospitals close since 2010.[1] Four of Wellmont's six hospitals are rural, and have below fifty staffed beds, each with a daily census ranging from3 to 13. Seven of the Mountain States hospitals are rural, and have below 50 staffed beds, each with a census ranging from 1 to 35. The overwhelming number of assets between the two systems are rural, and all of the Parties' hospitals in Virginia are in rural areas.

Providers throughout the nation, including Wellmont and Mountain States, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, higher patient out-of-pocket costs due to increased copayments and deductibles (resulting in additional declining revenue to the hospitals as the deductibles are increasingly uncollectable by hospitals), and a variety of other pressures stemming from an understandable frustration with the cost of health care. The challenges are intensified in the Parties' service area of Southwest Virginia and Northeast Tennessee, a

[1] *66 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, available at https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (accessed January 25, 2016).

rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, and significant health care challenges.

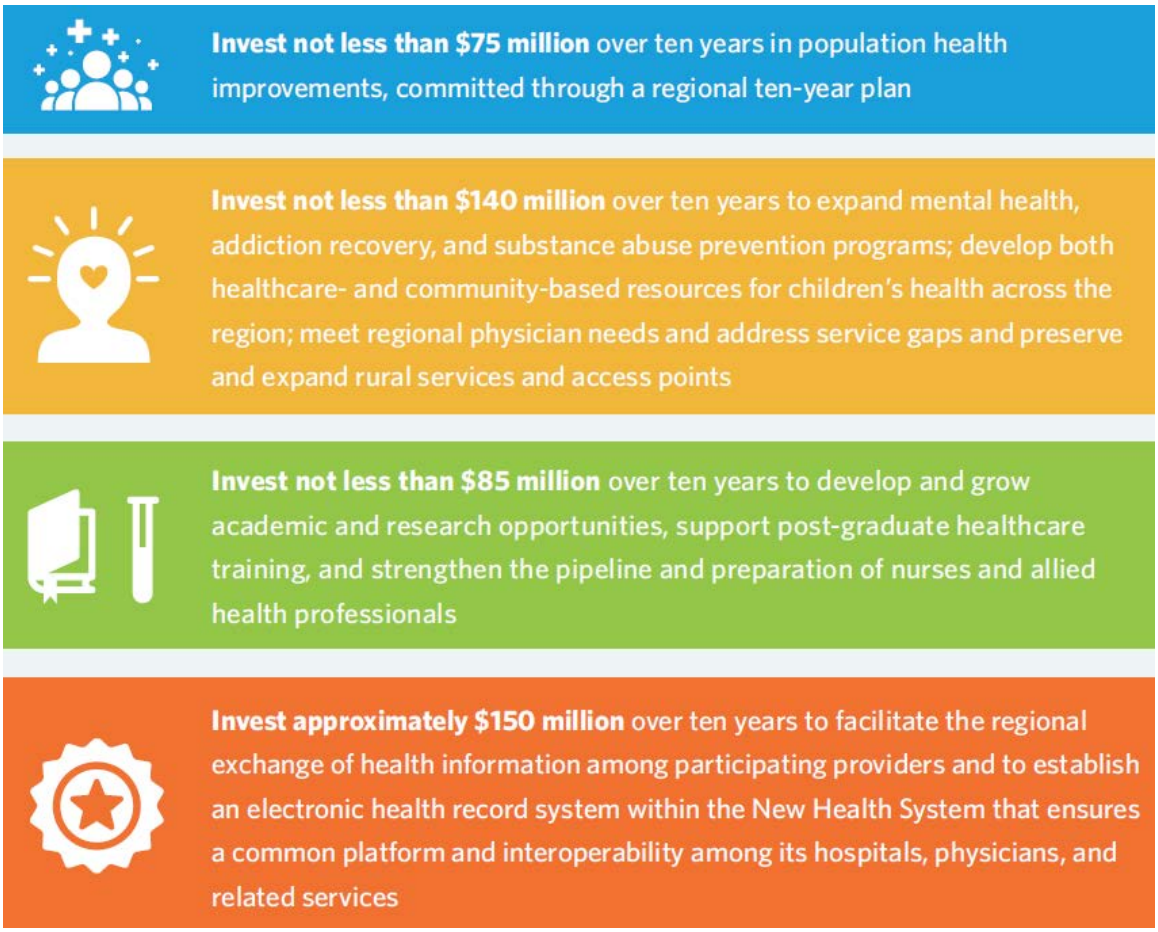
After a thorough evaluation, Wellmont's Board of Directors and leadership team ultimately determined that Wellmont's future would be best served through a strategic alignment with another health care system. In April 2014, Wellmont began a strategic options process to further consider alternatives to fulfill its long-term health care mission through potential alignment options. Wellmont issued requests for proposals from organizations interested in strategic alignment and received substantial interest and a number of proposals from a variety of sophisticated health systems, including Mountain States. Based on inquiries, Wellmont issued twenty-two requests for proposals and received nine proposals from other health systems. After more than a year of merger discussions, internal analysis within each system, thoughtful conversations in the community and unanimous votes by both boards to examine this option, Wellmont entered into a term sheet with Mountain States in April, 2015 to exclusively explore the creation of a new, integrated and locally governed health system (the "New Health System").

Wellmont and Mountain States have a history of competition dating back to the formation of the two health systems in the late 1990s, and the decision to form the New Health System is not based on a traditional merger approach. This merger is contingent on the granting of a Letter Authorizing Cooperative Agreement by the Commonwealth of Virginia and a Certificate of Public Advantage by the State of Tennessee (collectively, the “State Agreements”). Without the State Agreements, the proposed consolidation of Wellmont and Mountain States would likely be challenged under state and federal antitrust laws. The Parties believe that this merger is the only model that effectively maintains local governance, provides a unique opportunity to sustain and integrate health care delivery for residents into a high quality and cost-effective system, provides an enforceable commitment to limit pricing growth, keeps hundreds of millions of dollars in the region, and invests those dollars in the improved health of this region while also preserving local jobs.

The Goals to be Achieved by the Cooperative Agreement.

The Parties’ goals in pursuing the merger are to reduce cost growth, improve the quality of health care services and access to care, including the patient experience of care, and enhance overall community health in the region. Under approved State Agreements, savings realized through the merger, by reducing duplication and improving coordination, will remain within the region and be reinvested in ways that significantly benefit the community through the addition of new services and capabilities, improved choice and access, effective management of costs and investment in improving the quality of health care and economic development in the region. All of these investments will be devoted to Southwest Virginia and Northeast Tennessee to focus on

improving the health of this region's residents and the economy of its communities. As examples, the New Health System will:



The Benefits and Advantages of the Cooperative Agreement.

- Population Health. The New Health System is committed to creating a new integrated delivery system designed to significantly enhance community health through the investment of not less than $75 million over ten years in population health improvement. The New Health System would commence the population health improvement process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for its focus over the next decade. The health improvement plan would be prepared in conjunction with the public health resources available at East Tennessee State University ("ETSU"). The funding may be committed to the following initiatives, as well as others, based upon the 10-year action plan for the region:

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low birthweight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.[2]

- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

- Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will allow the hospitals the opportunity to continue to offer programs and services that are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. The New Health System will commit to spending at least $140 million over ten years pursuing specialty services. Specifically, the New Health System will create new capacity for residential addiction recovery services, 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, ensure recruitment and retention of pediatric sub-specialists, and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

[2] Improving performance on third grade reading assessment is identified as a population health priority goal for Southwest Virginia in the *Blueprint for Health Improvement & Health-Enabled Prosperity,* update approved January 7, 2016 by the Southwest Virginia Health Authority; *available at* :http://swvahealthauthority.net. In May 2010, the Annie E. Casey Foundation published *Early Warning: Why Reading by the End of Third Grade Matters*, which summarized the research basis for focusing on grade-level reading proficiency as an essential step toward increasing the number of children who succeed academically, graduate from high school on time and do well in life and the workforce. *Available at*: http://www.aecf.org/resources/early-warning-confirmed/. Eight of the 11 Virginia counties in the Geographic Service Area perform below the Virginia state average for low birthweight babies. *County Health Rankings for Virginia*, Robert Wood Johnson Foundation, *County Health Ranking and Roadmaps*, 2015. *Available at*: http://www.countyhealthrankings.org.

- Improving Health Care Value. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thereby contributing to the overutilization of costly inpatient services. The merger offers the New Health System the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. To ensure that merger-derived savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community through new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices, all of which are described in more detail in this Application.

- Investment in Health Research and Graduate Medical Education. The New Health System will work with its academic partners to commit not less than $85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program. Partnerships with academic institutions will enable research-based and academic approaches to the provision of these services. These initiatives would not be sustainable in the region without the financial support created by the merger.

- Avoidance of Duplication of Hospital Resources. Combining these two health systems in an integrated delivery model is the only effective way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services moving forward. These efforts will produce savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy by adding research opportunities. The coordination, integration, sustainability and development of new models of care delivery made possible by the merger will lead to better health for local residents and a stronger local economy.

- Improvements in Patient Outcomes. The region served by the Parties faces significant health care challenges. A key goal of the Cooperative Agreement is to enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes. The New Health System is committed to implementing a common clinical information technology platform (the "Common Clinical IT Platform") that will promote efficiency, transparency and higher-quality care for patients and their providers. In particular, the Common Clinical IT Platform will allow providers in the New Health System the ability to obtain full access to patient records quickly at point of care, will support the regional exchange of health

information to encourage and support patient and provider connectivity to the New Health System's integrated information system, will support a system-wide physician-led clinical council responsible for implementing quality performance standards across the New Health System, and will publicly report extensive quality measures with respect to the performance of the New Health System. These commitments will result in the investment of approximately $150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.

- Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over $19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. To ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain rural hospital operations in these areas and thus enhance access to quality care in our rural communities.

- Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant gaps exist in the continuum of care devoted to these issues. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems.

How the Cooperative Agreement Best Positions the Parties to Address Anticipated Future Changes in Health Care Financing, Organization and Accountability Initiatives.

Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act, which was enacted in 2010, is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. However, the movement to value-based payment requires comprehensive

provider networks to form and contract for the total care of patients for a defined population. The formation of the New Health System will align the Parties' hospitals and related entities into one seamless organization, working together to enter into value-based contracts. As evidence of its commitment to move towards risk-based payment, the New Health System is willing to: include provisions for improved quality and other value-based incentives for all Principal Payer[3] contracts; discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business; and commit to having a risk-based model in place within two years after the closing of the transaction (the "Closing"), subject to payer interest.

Potential Disadvantages of the Cooperative Agreement.

The Parties do not foresee any adverse impact on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement. Rather, the Parties foresee the Cooperative Agreement resulting in significant benefits as detailed in this Application.

A Unique Solution for a Unique Region.

Southwest Virginia and Northeast Tennessee disproportionately suffer from serious health issues.[4] The cost of this poor health is not sustainable. This region is a unique geographic area that requires a unique solution. With the approvals of Virginia and Tennessee under the State Agreements, savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community. These benefits will include new services and capabilities, improved choice and access, more effective management of health care costs, and strategic investments to address the region's most vexing health problems while spurring its economic development.

The merger of Wellmont and Mountain States is a unique opportunity to create a long-lasting legacy of improved health for this region with positive effects on the local economy.

[3] For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Heath System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

[4] The Southwest Virginia Health Authority's original *Blueprint for Health Improvement & Health-Enabled Prosperity* stated "[The LENOWISCO and Cumberland Plateau] planning districts have higher rates of health risks than the Commonwealth in obesity, blood pressure and cholesterol levels." The Authority's recently updated (Jan. 7, 2016) Blueprint goals for the region included these ongoing health issues. Virginia data is available at University of Wisconsin Population Health Institute, County Health Rankings & Roadmaps, *available at*: http://www.countyhealthrankings.org/. Tennessee county-level data for the region is available at "2015 Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015; *available at*: https://www.tn.gov/health/topic/specialreports/.

4. SIGNED COPY OF THE COOPERATIVE AGREEMENT

REQUEST: A signed copy of the cooperative agreement:

RESPONSE: A signed copy of the Cooperative Agreement (referred to by the Parties as the "Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance") is attached hereto as **Exhibit 4.1**

REQUEST: and a copy of the following:

a. **REQUEST**: A description of any consideration passing to any party, individual or entity under the cooperative agreement including the amount, nature, source, and recipient;

RESPONSE: No consideration will pass between the Parties under the Cooperative Agreement. In order to preserve the assembled workforce, the Parties intend to pay retention consideration to key employees. The executive officers of the New Health System will enter into employment agreements consistent with their duties and responsibilities. Their compensation will be fair market value as confirmed by an independent valuation firm and consistent with IRS guidelines, and a significant portion of compensation will be based on performance. At the commencement of the strategic options process, Wellmont instituted a retention policy for its key executives. Likewise, Mountain States adopted a retention policy as it commenced negotiation of the Cooperative Agreement. As a result of the Cooperative Agreement, some positions will be eliminated. Those positions will be entitled to customary severance associated with that position. The New Health System anticipates executing new employment agreements, service agreements, and vendor agreements once the Letter Authorizing Cooperative Agreement has been granted, but none have been executed to date.

The Cooperative Agreement involves no brokers or finders fees. No professionals advising Wellmont, Mountain States, or the New Health System on matters related to the Cooperative Agreement are being compensated on a contingency basis.

b. **REQUEST**: A detailed description of any merger, lease, operating or management contract, change of control or other acquisition or change, direct or indirect, in ownership of any party or of the assets of any party to the cooperative agreement;

RESPONSE: The Parties plan to cause a new, independent, public benefit, not for profit, tax-exempt corporation to be incorporated in Tennessee. The New Health System would be governed by a Board of Directors composed of

representatives from each legacy board, as well as new community members. The Parties would amend their respective articles and bylaws to designate the New Health System as the sole corporate member of each of the Parties.

The New Health System will be governed exclusively by its board of directors, which is the fiduciary board responsible for the delivery of quality care in consideration of the needs of the communities served by the system. The New Health System's management team will be composed of current executives from both organizations. The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System. Wellmont and Mountain States will jointly select two members of the New Health System's initial board, who will not be incumbent members of either Party's board of directors. The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then-current President of ETSU. The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer). Other senior management positions will be determined at a later date.

After the Closing, the Wellmont and Mountain States entities will continue in existence and the boards of both of those entities will be identical to the New Health System board. The New Health System board will oversee all of the assets and operations of the previously separate Parties and all of their respective Affiliates on the terms and conditions set forth in the Cooperative Agreement for the purpose of enhancing the provision of high quality and cost effective health care that such a unified structure will facilitate, and for the purpose of positioning the combined systems to adapt effectively to the changes taking place locally and nationally in the health care delivery and financing systems.

c. **REQUEST**: A list of all services and products and of all hospitals and other service locations that are a subject of the cooperative agreement including those not located or provided within the boundaries of the Commonwealth of Virginia, and including, but not limited to, hospitals or other inpatient facilities, insurance products, physician practices, pharmacies, accountable care organizations, psychiatric facilities, nursing homes, physical therapy and rehabilitation units, home care agencies, wellness centers or services, surgical centers or services,

dialysis centers or services, cancer centers or services, imaging centers or services, support services, and any other product, facility, or service; and

RESPONSE: The Parties intend for the Cooperative Agreement to include all services, products, and service locations under the control of Mountain States and Wellmont at the time of execution of the Cooperative Agreement and for so long as those entities remain under the control of the New Health System.

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

RESPONSE: The Parties intend for the Cooperative Agreement to include all assets, ownership interests, subsidiaries and controlled affiliated businesses currently owned or operated, in whole or in part, directly or indirectly, by the respective Parties at the time the Letter Authorizing Cooperative Agreement is granted. An organizational chart identifying all of the subsidiaries and affiliates of Mountain States is attached as **Exhibit 4.2**. An organizational chart identifying all of the subsidiaries and affiliates of Wellmont is attached as **Exhibit 4.3**.[5]

[5] Wellmont has publicly announced its plan to repurchase Takoma Regional Hospital ("Takoma") in Greeneville, Tennessee. 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 Letter Authorizing Cooperative Agreement is granted, Takoma would be included in the Cooperative Agreement.

5. PROPOSED GEOGRAPHIC SERVICE AREA

REQUEST: A detailed description of the current and proposed PSA and SSA for the parties, including the PSA and SSA of each party's hospitals, not limited to the boundaries of the Commonwealth of Virginia. If the proposed PSA and SSA differ from the service areas where the parties have conducted business over the five years preceding the application, a description of how and why the proposed PSA or SSA differs and why changes are proposed.

RESPONSE: The proposed geographic service area takes into consideration the counties principally served by the Parties, including the following counties: Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise, and Wythe in Virginia; Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington in Tennessee; Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina; and Harlan and Letcher in Kentucky. These counties represent the service areas where the Parties have conducted business over the five years preceding the Application. These counties are inclusive of the areas from which the Parties draw and serve the majority of patients. While the Parties serve patients from twenty-nine counties in Virginia, Tennessee, North Carolina, and Kentucky, the patients only receive services from Wellmont and Mountain States at facilities and locations in Virginia and Tennessee, as the Wellmont and Mountain States physical facilities and provider locations are all in those two states and are subject to state regulations only in these states. To the extent the Parties draw some patients from adjacent North Carolina and Kentucky counties, these patients are served at the Parties' facilities and provider locations in Virginia and Tennessee.

In defining the primary geographic service area for purposes of this Application and specifically for responses to a broad range of questions that request a single geographic area, the Parties believe it appropriate to focus on an area of the twenty-one counties in Virginia and Tennessee.[6] This is inclusive of the Virginia and Tennessee counties in which the Parties have locations and facilities and serve residents, and all locations and providers that will be under the control of the Parties and subject to any regulation under the State Agreements. This area is inclusive of most of the population, whether commercial, Medicare, Medicaid, or uninsured, served by the Parties.

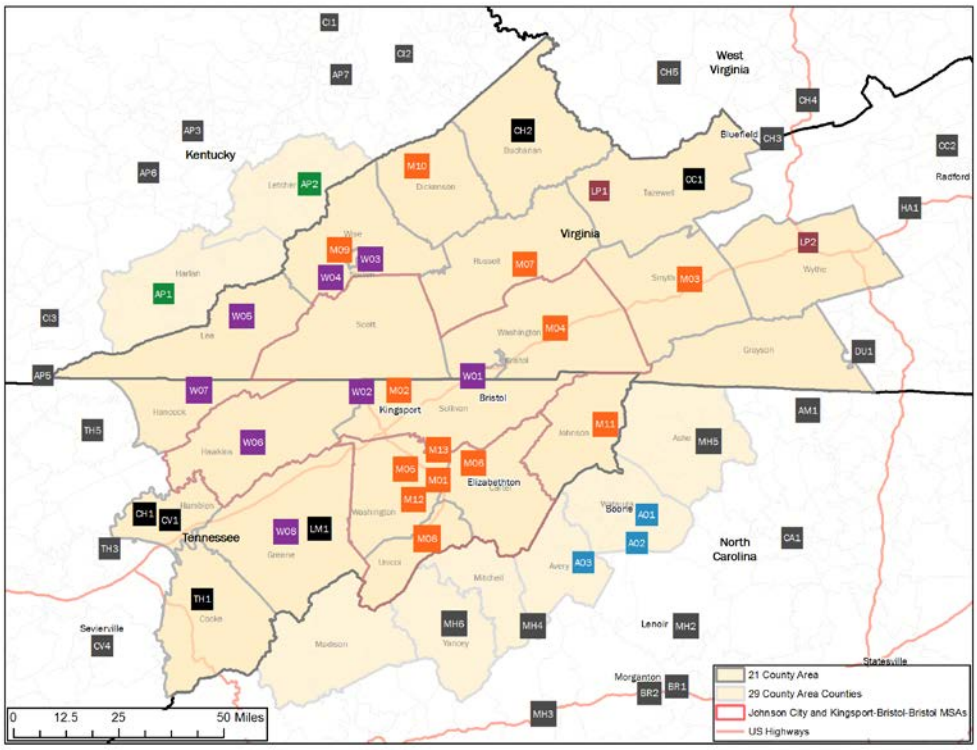
The Parties expect that the benefits of the transaction will primarily accrue in the Virginia and Tennessee counties and will likely extend to residents and communities in the adjacent North Carolina and Kentucky communities primarily through their access of services in Virginia and Tennessee. These benefits are likely to derive substantially from the changes made possible by the merger at the facilities and provider locations of the

[6] These 21 counties are: 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.

New Health System located in Virginia and Tennessee, as well as the investments made by the New Health System in this region.

For purposes of the analyses in this Application, including share analysis and identification of competitors, the Parties focus on the twenty-one county area in Virginia and Tennessee principally served by the Parties, including the Independent Cities of Bristol and Norton in Virginia (the "Independent Cities"), and refer to this area throughout the Application as the "Geographic Service Area." **Figure 5.1** is the map of the Geographic Service Area and indicates the location of hospitals and highlights the twenty-one counties in Virginia and Tennessee.

Figure 5.1 – Map of the Geographic Service Area[7]



Rural Population: The Geographic Service Area has a population over 960,000. Its largest cities are Bristol, Kingsport, and Johnson City, Tennessee. In the Geographic Service Area, over 500,000 residents (52%) live in areas defined as rural. **Table 5.1**

[7] An enlarged version of the map and the legend are included in **Exhibit 5.1 (Section A)**. Wellmont closed Lee Regional Medical Center ("LRMC") in 2013. The Lee County Hospital Authority purchased the LRMC building from Wellmont in 2015 with plans to reopen the hospital as an independent facility. LRMC is no longer a Wellmont facility and, if reopened, it would not be included in the Cooperative Agreement. 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 Letter Authorizing Cooperative Agreement is granted, that Takoma would be included in the Cooperative Agreement. For purposes of this map, Takoma (W08) is counted as one of the independent hospitals. The Mountain Home VA Medical Center is also located in the Geographic Service Area but is not shown on this map. The Parties compete with this facility for the recruiting and hiring of staff, but do not compete with this facility for patients. The patients that may seek treatment at the Mountain Home VA Medical Center are limited to those individuals that meet certain government-established criteria.

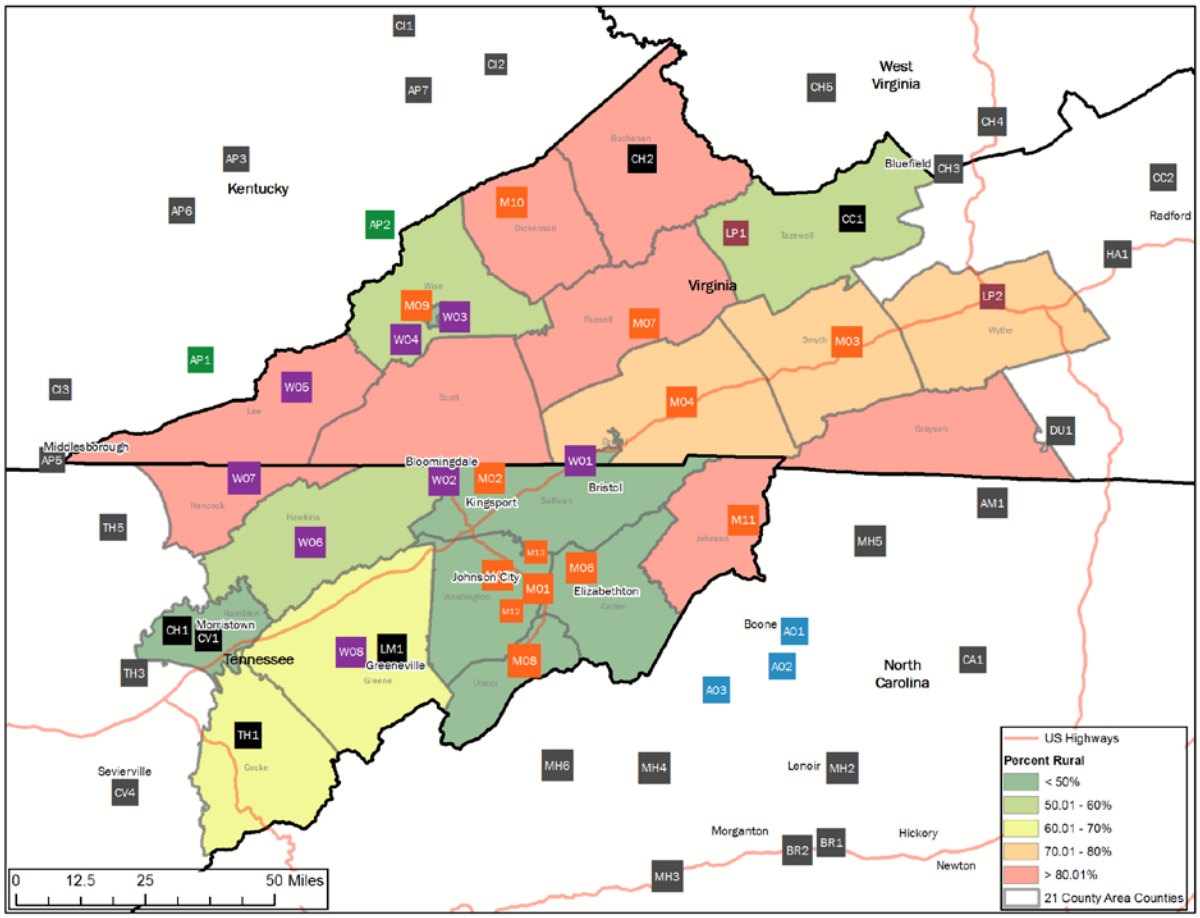
provides data on population, the proportion of the counties/Independent Cities in the Geographic Service Area classified as rural, and the total "rural" population.[8] The data reveal that many of the counties in the Geographic Service Area served by Wellmont and Mountain States are predominantly rural. Even in the two most populous counties (Washington and Sullivan Counties in Tennessee), a quarter or more of the populations resides in rural areas. In total, sixteen of the counties in the Geographic Service Area (excluding the Independent Cities) are more than 50% rural, and in five counties virtually all of the population is classified as rural. **Figure 5.2** is a map with counties shaded by proportion of the population that is rural; it indicates that most of the Virginia counties are predominantly rural, as are all but a few counties in and around Sullivan and Washington Counties in Tennessee.

Table 5.1 – Geographic Service Area Statistics[9]

County Name	Total Population	Percent Rural	Rural Population
Grand Total	***962,309***	***52.0%***	***500,270***
Hancock, TN	6,819	100.0%	6,819
Buchanan, VA	24,098	100.0%	24,098
Dickenson, VA	15,903	100.0%	15,903
Grayson, VA	15,533	99.9%	15,514
Lee, VA	25,587	99.6%	25,475
Russell, VA	28,897	88.2%	25,483
Johnson, TN	18,244	85.2%	15,546
Scott, VA	23,177	82.1%	19,034
Smyth, VA	32,208	75.3%	24,248
Wythe, VA	29,235	75.3%	22,023
Washington, VA	54,876	71.7%	39,333
Cocke, TN	35,662	67.5%	24,083
Greene, TN	68,831	65.2%	44,874
Hawkins, TN	56,833	57.9%	32,884
Wise, VA	41,452	56.7%	23,491
Tazewell, VA	45,078	51.9%	23,390
Unicoi, TN	18,313	44.7%	8,180
Carter, TN	57,424	41.0%	23,524
Washington, TN	122,979	26.4%	32,493
Sullivan, TN	156,823	25.6%	40,086
Hamblen, TN	62,544	21.9%	13,680
Norton City, VA	3,958	2.6%	102
Bristol City, VA	17,835	0.0%	7

[8] All reported measures were obtained from the US Department of Health and Human Services' Area Health Resource File, a dataset that compiles data collected by other entities; *available at*: http://ahrf.hrsa.gov/. Total Population is from the U.S. Census Bureau's 2010 Census Redistricting Data (Public Law 94-171) Summary File. Rural residency is available from the Census of Population and Housing: Summary File 1 (SF1) Urban/Rural update.
[9] Norton and Bristol, VA are Independent Cities.

Figure 5.2 – Percentage of Population in Rural Areas



Characteristics of Hospitals: Many of the Parties' hospitals are small, rural, have only a few beds and experience a very small average daily census. The Geographic Service Area and comparative statistics for Wellmont and Mountain States hospitals are included in **Exhibit 5.1 (Section B).** The Exhibit illustrates that many Wellmont and Mountain States hospitals have a narrow service area (defined as comprising relatively few zip codes from which the hospital draws 75-90% of its patients), low staffed bed count and very low average daily census. Several of these hospitals have experienced declines in admissions, occupancy rates and average daily census over the last few years. Moreover, there is very little overlap in the service areas of the smaller Wellmont hospitals and the smaller Mountain States hospitals.

Tables 5.2 and 5.3 demonstrate that licensed bed capacity is a poor measure of actual bed utilization. Most Mountain States and Wellmont hospitals have staffed beds that are well below their licensed bed capacity, and some of those hospitals have relatively low occupancy rates for staffed beds.

- **Wellmont Bed Size and Average Daily Census**: As of 2013[10], four of the six operating Wellmont hospitals have fewer than fifty staffed beds, and an average daily census from only three to thirteen patients per day. The largest of these small hospitals (Hawkins County Memorial Hospital) has an occupancy rate of only nineteen percent (19%).
- **Wellmont Occupancy Rates:** Occupancy rates fell over the period FY10-FY13 at both Holston Valley and Mountain View Regional. The average daily census and patient days have declined by more than fifty percent (50%) since FY10 at Lonesome Pine.

Table 5.2 – Wellmont Hospitals (2013)

Hospital	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Holston Valley	339	505	66.4%	44.6%	225
Bristol Regional	261	312	65.0%	54.4%	170
Hawkins County	46	50	18.7%	17.2%	9
Lonesome Pine	21	60	49.6%	17.4%	10
Mountain View Regional	18	74	69.5%	16.9%	13
Hancock County	10	10	30.9%	30.9%	3

- **Mountain States Bed Size and Average Daily Census**: As of 2013, seven Mountain States hospitals have fifty or fewer staffed beds (three have fewer than ten staffed beds) and an average daily census ranging from thirty-five to less than one patient per day on average. Four other Mountain States hospitals have between seventy-four and one hundred twelve staffed beds and an average daily census ranging from forty-two to sixty-five patients.
- **Mountain States Occupancy Rates**: Several Mountain States hospitals have low staffed bed occupancy rates. The average daily census at the Dickenson Community and Johnson County Community hospitals has been less than one each year since FY10.

[10] These numbers do not include Takoma Regional Hospital in the Wellmont numbers. Takoma was sold by Wellmont in 2014.

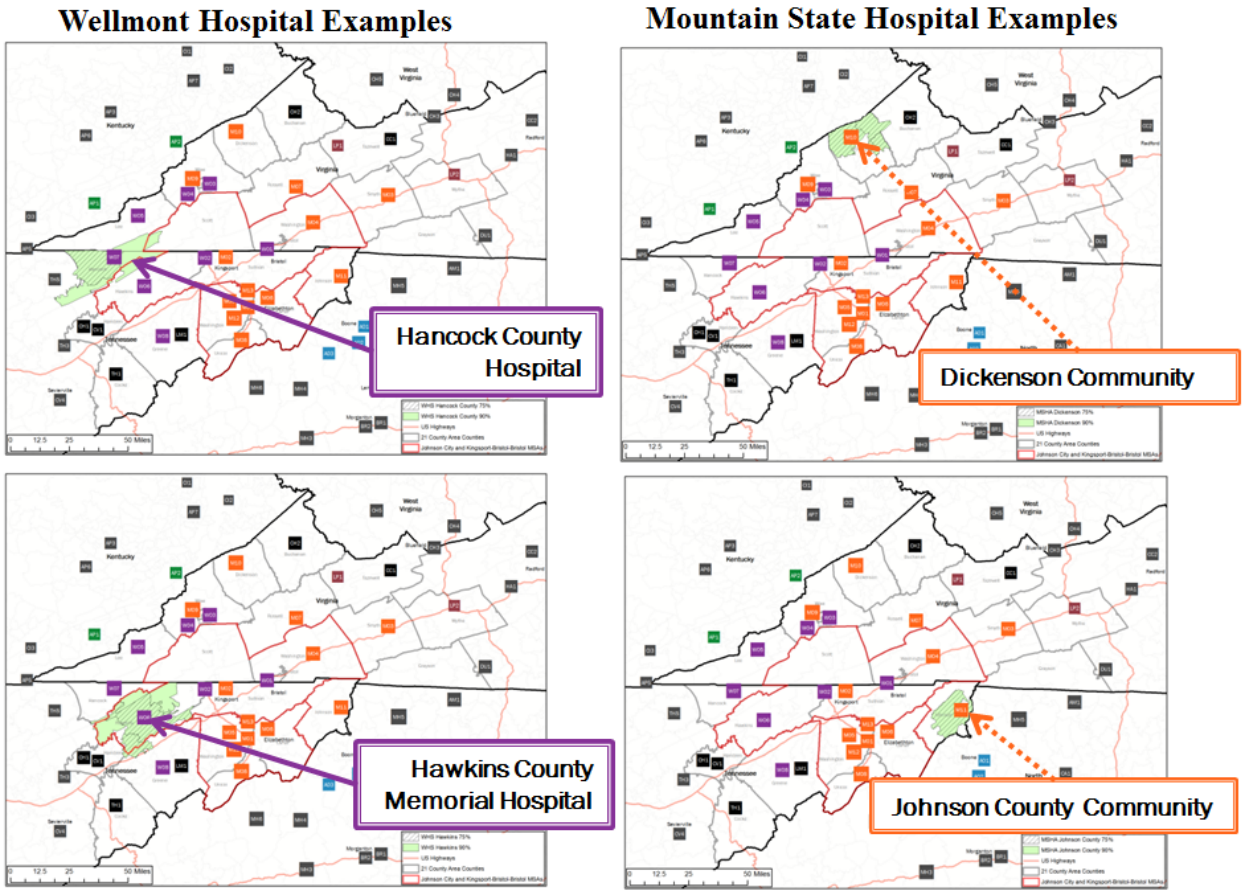
Table 5.3 – Mountain States Hospitals (2013)

Hospital	Staffed Beds	Licensed Beds	Staffed Beds Occupancy	Licensed Beds Occupancy	Average Daily Census
Johnson City[11]	497	501	69.3%	68.7%	344
Indian Path	168	239	37.4%	26.3%	63
Johnston Memorial	112	116	58.3%	56.3%	65
Woodridge Psychiatric	80	84	76.0%	72.4%	61
Franklin Woods	77	80	54.1%	52.1%	42
Sycamore Shoals	74	121	57.0%	34.9%	42
Norton Community	50	129	70.5%	27.3%	35
Russell County	49	78	58.5%	36.7%	29
Smyth	44	44	48.1%	48.1%	21
Quillen Rehabilitation[12]	26	26	77.8%	77.8%	20
Unicoi County	7	48	169.7%	24.7%	12
Dickenson Community	2	25	1.6%	0.1%	<1
Johnson County	2	2	6.0%	6.0%	<1

Service Areas: Several of the smaller Wellmont and Mountain States hospitals have narrow, non-overlapping service areas. The maps in **Figure 5.3** below show the 75% and 90% draw areas for certain Wellmont and Mountain States hospitals.[13] Dickenson Community's 75% and 90% draw areas comprise only three zip codes and Johnson County Community's 75% and 90% draw areas consist of only a single zip code. In general, Wellmont hospitals tend to be in the western portion of the Geographic Service Area and Mountain States hospitals tend to be in the northeast, south and southeast portions.

[11] Niswonger Children's Hospital operates as a unit of Johnson City Medical Center and its data are included in the Johnson City Medical Center reported data.
[12] Mountain States has a minority interest in a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital, which is currently licensed for 26 beds.
[13] **Exhibit 5.1 (Section B)** contains the methodology and maps for the 75% and 90% draw areas for each of the Parties' hospitals, based on CY2014 discharge data for all payers for Virginia and Tennessee; the 75% area is depicted by cross-hatched areas.

Figure 5.3 – Draw Area Maps



Assessment of Inpatient Services in the Geographic Service Area

Wellmont and Mountain States obtain the majority of their inpatient discharges from the Geographic Service Area, an area served by other hospitals physically located in the area as well as by hospitals located outside of the area. Share analyses of general acute care inpatients in the Geographic Service Area were calculated for the New Health System and for competing hospitals and are shown in **Exhibit 5.2**.[14] There are numerous competing hospitals that collectively account for approximately twenty-five percent (25%) of current discharges of residents in the Geographic Service Area.

The combined share of Wellmont and Mountain States, however, obscures the fact that the majority (58%)[15] of their combined share is accounted for by three hospitals – Bristol Regional, Holston Valley, and Johnson City Medical Center. Each of the other Wellmont and Mountain States hospitals, most of which are very small and located in outlying areas,[16] *individually* has very low patient volume and contributes very little to

[14] Share analyses are based on discharges by hospitals for the Geographic Service Area. **Exhibit 5.2** provides shares calculated excluding DRG 795 and inclusive or exclusive of MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). The percentage holds for both.
[15] This percentage is lower when MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders) are excluded from the calculation.
[16] The next largest share contributors are Johnston Memorial Hospital and Indian Path Medical Center, which contribute 8.7% and 6.4% respectively.

the Parties' combined shares – typically just one to two percent (1-2%) per hospital. The collective volume of these hospitals obscures their very small size and patient volumes thereby overstating any competitive significance.

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 Geographic Service Area are Mental Diseases, Circulatory, and Musculoskeletal. When patients leave the Geographic Service Area for medical care, they most frequently go to the University of Tennessee Medical Center in Knoxville and Carilion Medical Center in Roanoke, Virginia. Peninsula Hospital in Louisville, Tennessee, receives the largest outmigration for Mental Diseases.

As a result of the Cooperative Agreement, the Parties plan to provide new and enhanced services that will better serve local patients who currently leave the Geographic Service Area for health care and encourage in-migration by patients who reside outside the area. The proposed merger will produce savings that will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density. These are discussed more fully below.

6. PRIOR HISTORY OF APPLICANTS

REQUEST: A description of the prior history of dealings between the parties for the last 5 years, including but not limited to, their relationship as competitors and any prior joint ventures, affiliations or other collaborative agreements between the parties.

RESPONSE:

Description of Mountain States Health Alliance

Mountain States Health Alliance ("Mountain States") is a Tennessee non-profit corporation based in Johnson City, Tennessee. It traces its roots back over one hundred years, and became a system in 1998 when the then Johnson City Medical Center Hospital, Inc., a one-hospital organization, acquired from the former Columbia-HCA six hospitals located in upper East Tennessee, thus forming Mountain States. In 2006 Mountain States acquired a membership interest in Smyth County Community Hospital in Marion, Virginia, which began Mountain States' journey as a multi-state health care system. Since 2006, Mountain States has acquired or become a member of four other hospitals in the Southwest Virginia region.

Throughout its multi-state service area, Mountain States functions as an integrated delivery system. Its thirteen hospitals collectively offer a range of services from the most basic primary level of care through two critical access facilities to highly advanced tertiary levels of care such as Level I trauma, open heart and radiation oncology. Through its for-profit subsidiaries, Mountain States employs approximately four hundred physicians and mid-level providers throughout the region. Also, Mountain States, either directly or through its for-profit subsidiaries, provides an array of outpatient and/or post-acute care services, including: pharmacy; home health; hospice; durable medical equipment; diagnostics; skilled nursing/nursing home; and rehabilitation. Additionally, Mountain States owns and operates the region's only children's hospital: Niswonger Children's Hospital.

Mountain States' hospitals provide services with a total licensed bed complement of 1,669[17] beds but with an average daily census of 734 for FY2013. The Tennessee hospitals owned and/or operated by Mountain States are: Johnson City Medical Center; Niswonger Children's Hospital;[18] Indian Path Medical Center; Franklin Woods Community Hospital; Sycamore Shoals Hospital; Unicoi County Memorial Hospital; Johnson County Community Hospital; and Woodridge Hospital.[19] Mountain States also has a joint venture with HealthSouth to operate Quillen Rehabilitation Hospital, which is currently licensed for 26 rehab beds. In Virginia, Mountain States owns and/or

[17] This number includes Mountain States' general acute care beds, psychiatric beds, rehab beds, nursing home beds and skilled nursing beds.
[18] Niswonger Children's Hospital is licensed under Johnson City Medical Center.
[19] Woodridge Hospital is also licensed under Johnson City Medical Center.

operates: Johnston Memorial Hospital; Smyth County Community Hospital; Russell County Medical Center; Norton Community Hospital and Dickenson Community Hospital. Mountain States also holds an ownership interest in a number of joint venture entities, primarily for the purpose of providing ambulatory surgical services. None of these joint ventures include Wellmont Health System.

Description of Wellmont Health System

Wellmont Health System ("Wellmont") is a Tennessee non-profit corporation based in Kingsport, Tennessee, and provides health care services in Southwest Virginia and Northeast Tennessee. Wellmont was formed in July 1996 with the merger of Bristol Memorial Hospital, now known as Bristol Regional Medical Center, in Bristol, Tennessee and Holston Valley Medical Center in Kingsport, Tennessee. Since that time, Wellmont has grown to include four additional rural hospitals, an integrated physician network and several ambulatory sites. Wellmont hospitals offer a broad scope of services, including community-based acute care to highly specialized tertiary services including two trauma centers, comprehensive heart care and cancer care.

Wellmont owns and operates an integrated health care delivery system providing inpatient, outpatient and other health care services at multiple locations in Southwest Virginia and Northeast Tennessee. Currently, Wellmont owns and operates five acute care hospital facilities and one critical access hospital with a total of 1,011 licensed beds but with an average daily census of 430 for FY2013. The hospitals owned/operated by Wellmont in Tennessee include: Holston Valley Medical Center, Bristol Regional Medical Center, Hawkins County Memorial Hospital and Hancock County Hospital. In Virginia, Wellmont owns and/or operates Mountain View Regional Medical Center and Lonesome Pine Hospital.

Wellmont also, directly or indirectly, controls, owns or is affiliated with various nonprofit and for-profit corporations and other organizations that currently provide health care and health care-related services throughout the Geographic Service Area.

History of Dealings between the Parties

Wellmont and Mountain States have competed with each other in certain areas and with other health care providers since the formation of the two systems in the late 1990s. Prior to the merger of Holston Valley and Bristol Regional into Wellmont and the acquisition of HCA hospitals by Johnson City Medical Center, which formed Mountain States, those three tertiary facilities were viewed largely as serving their individual cities and adjacent areas. Since the formation of the two systems, each system subsequently acquired smaller primary and secondary facilities, and has served a region composed of twenty-one counties in southwestern Virginia and northeastern Tennessee. The two systems offer essentially equivalent levels of services in their respective tertiary and secondary hospital facilities. In addition, both systems have historically affiliated with

separate air ambulance services and operate competing Level I Trauma Centers. In addition, Wellmont has a Level II Trauma Center located in Northeast Tennessee. This is the only region of Tennessee having more than one Level I Trauma Center. Although there is some overlap in the primary market areas of the three large tertiary facilities, the main overlap in competitive services has occurred in two areas: (1) Wise County, Virginia, where Wellmont owns two secondary acute care hospitals and Mountain States owns one hospital; and (2) Kingsport, Tennessee, where Mountain States' secondary acute care facility Indian Path Medical Center competes with Holston Valley Medical Center, Wellmont's largest tertiary facility.

In the early 2000s, Wellmont applied for and initially was awarded a certificate of need ("CON") to construct a secondary hospital facility in Johnson City, but that CON was overturned following a challenge to the CON by Mountain States. Wellmont's 2007 CON application for a free-standing Emergency Room to be located on the northern boundary of Johnson City was denied following opposition by Mountain States. Beginning in 2012, Wellmont and Mountain States competed in a public contest for the acquisition of Unicoi County Memorial Hospital; ultimately, Mountain States acquired that facility in 2013.

The Parties have attempted to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.

There have also been examples of cooperative arrangements between the Parties as follows:

- In 2004, the foundations for the two systems worked together to start the first regional Susan G. Komen affiliate.

- For several years now, hospitals from both systems have been members of the Northeast/Sullivan Healthcare Coalition to utilize annual grant funds from the Tennessee Department of Health to prepare the region for disasters and health emergencies. The two health systems are currently alternating annually as fiscal agents for the $250,000 per year in grant funds for this project.

- Since 2008, Wellmont provided blood services to certain Mountain States facilities through its blood bank, the Marsh Regional Blood Center.

- The two systems collaborated in 2014 in their joint responses to the Ebola awareness and preparedness campaigns and have jointly sponsored other community health awareness efforts, such as the Healthy Kingsport initiative.

- Recently, Wellmont has added Indian Path Medical Center as a satellite site to its Orthopedic Residency Program and has allowed Mountain States/Norton Community Hospital Internal Medicine residents the opportunity to complete their endocrinology rotations at Bristol Regional Medical Center.

- Also, the two systems are currently working together to provide an Antibiotic Stewardship educational program for providers and the community.

In addition, in cooperation with the College of Public Health at ETSU and in connection with the Parties' goal to improve health care services through a cooperative agreement, the Parties have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups have been created to specifically focus on the health needs in the region, including Mental Health and Addiction, and Healthy Children and Families. Numerous public meetings have been held to seek community input. Mutual efforts directly related to this proposed merger are discussed more fully in Section 15.

7. FINANCIAL PERFORMANCE

REQUEST: Documents sufficient to show the financial performance of each party to the transaction for each of the preceding five fiscal years including tax returns, debt, bond rating, and debt service, and copies of offering materials, subsequent filings such as continuing disclosure agreements and material event disclosures, and financial statements prepared by external certified public accountants, including management reports.

RESPONSE: **Exhibit 7.1** is a summary description of the financial performance of Mountain States for the preceding five years, and the accompanying **7.1 Exhibits** provide supporting financial performance information. **Exhibit 7.2** is a summary description of the financial performance of Wellmont for the preceding five years, and the accompanying **7.2 Exhibits** provide supporting financial performance information. The Parties, respectively, believe that the Mountain States Covenant Compliance Certificates (**Exhibit 7.1D**), the Mountain States Officer's Certificates accompanying Independent Auditor's Reports (**Exhibit 7.1E**), and the Wellmont External Auditor Management Letters (**Exhibit 7.2D**), which are submitted in response to this Request, are proprietary, confidential documents. Each Party, individually, will submit the proprietary Exhibit(s) pertaining to it to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.

8. ANNUAL BUDGETS

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

RESPONSE: Each of Mountain States and Wellmont believes that its current annual budgets and its budgets for the last five years (**Exhibit 8.1** for Mountain States and **Exhibit 8.2** for Wellmont) are proprietary, confidential documents and competitively sensitive under federal antitrust laws. Each Party, individually, will submit the proprietary, competitively sensitive Exhibit pertaining to it to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.

9. PROJECTED FINANCIAL INFORMATION

REQUEST: Projected budgets, including projected costs, revenues, profit margins, and operating ratios, of each party for each year for a period of five years after a letter authorizing cooperative agreement is issued. The budgets shall be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used shall be documented.

RESPONSE: A five-year projected budget for the New Health System is attached as **Exhibit 9.1**.

10. PROJECTED EFFECTS

REQUEST: A detailed explanation of the projected effects including expected change in volume, price, and revenue as a result of the cooperative agreement, including:

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

RESPONSE: Please see attached **Exhibit 10.1** identifying all insurance contracts and payer agreements in place at the time of the Application for Mountain States. Please see attached **Exhibit 10.2** identifying all insurance contracts and payer agreements in place at the time of the Application for Wellmont.

While some of the payer agreements held by both Parties permit the termination of the agreement by the payer upon a change of control, the Parties do not intend to amend their current insurance and payer agreements in connection with completing the affiliation except as set forth herein. Going forward, the Parties intend the New Health System will negotiate with the payers in the ordinary course of business as each managed care contract comes up for renewal after the Closing.

b. **REQUEST**: A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties to the cooperative agreement, if the letter authorizing cooperative agreement is issued including changes in percentage of risk-bearing contracts; and

RESPONSE: Like other health systems across Virginia and the nation, the Parties negotiate with commercial health insurance providers for inclusion in the health insurance plans they offer to employers and individuals. Wellmont and Mountain States each approach these negotiations with the basic goal of agreeing on rates and terms that will enable the health systems to cover the cost of providing high quality health care while earning a reasonable margin to invest in maintaining and improving their facilities and expand their service offerings.

Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is projected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay. Unregulated merged systems do not provide for limitations on commercial payment increases, which can negatively impact self-insured employers, employees and insurers who are managing risk. Conversely, the New Health System has committed to a reduction in price increases and set a new, lower cost trend for many third party payers. These pricing commitments are proposed so as to pass

savings on to consumers through their chosen insurers resulting from the efficiencies the New Health System expects to achieve.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health System agrees to mediation as a process to resolve any disputes.

*For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

In addition, as a result of the merger, the Parties project that the merger will result in improved quality of care and enhanced clinical coordination. This capability will enable the system to participate meaningfully in various federal and commercial efforts to share risk and take advantage of the scalable ability of the New Health System to better manage the care for high cost, high utilization patients. Through this effort, these changes will result in fewer hospitalizations and reduced lengths of stay when patients are hospitalized. Insurers and insured consumers will benefit through lower expenditures for inpatient care when patients spend less time in the hospital or are able to avoid hospitalizations altogether.

The Parties' intend to manage population health through the deployment of a research-based ten year plan that is focused on reducing the variables leading to chronic disease, improved clinical coordination, higher quality facilitated by the consolidation of services, and a shared information technology platform, among other things. All of these benefits strengthen the ability of the Parties to engage in risk-based contracting to a far greater extent than is currently the practice in the region. It is, therefore, the intent of the New Health System that future contractual arrangements with payers will be more focused on identification of the drivers of cost, with a shared objective of reducing unnecessary cost, and sharing the benefit of such successful initiatives.

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

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

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

RESPONSE: Each of the Parties believes that its existing and future business plans (**Exhibit 10.3** for Mountain States and **Exhibit 10.4** for Wellmont) are proprietary, confidential documents and competitively sensitive under federal antitrust laws. Each Party, individually, will submit the proprietary, competitively sensitive Exhibit pertaining to it to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, the Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.

11. POLICIES

REQUEST: A copy of the following policies under the proposed cooperative agreement:

a. A policy that assures no restrictions to Medicare and/or Medicaid patients;

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

c. Policies for bad debt write-off; and

d. Policies that require the parties to the cooperative agreement to maintain or exceed the existing level of charitable programs and services.

RESPONSE: Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid is housed within Mountain States. The New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. The current charity care and other related policies for both Mountain States and Wellmont are attached as **Exhibits 11.1 and 11.2**. If the Letter Authorizing Cooperative Agreement is granted, the Parties intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rules. As evidence of this commitment, the Parties have committed in the Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Parties.[20] Specifically, the Parties intend to address each category of patients as follows:

Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.

Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the

[20] *See* **Exhibit 4.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance, Section 1.02 "Community Benefit."

program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model that optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.

Uninsured Population. As described in Section 15.a.G of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the Letter Authorizing Cooperative Agreement is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the Geographic Service Area. The Parties intend to work with charitable clinics in the Geographic Service Area to improve access for the uninsured population to patient-centered medical homes, Federally Qualified Health Centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

All Categories of Payers and the Uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.

- Develop with the Commonwealth and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer, and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

12. SERVICES INTEGRATION

REQUEST: A description of the plan to systematically integrate health care and preventive health services among the parties to the cooperative agreement in the proposed geographic service area that addresses the following:

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

RESPONSE: The Response to Section 4.b. contains a description of the streamlined management structure of the New Health System, including its single Board of Directors, centralized leadership and operating structure.

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

RESPONSE: A well-executed merger provides multiple opportunities to enhance care delivery and patient outcomes through the consolidation, integration, realignment and/or enhancement of clinical facilities and services (collectively the "Clinical Consolidation"). Clinical Consolidation can involve both concentration of services of a particular type in fewer locations and/or establishment of common protocols and systems across a common set of services with an ultimate goal of yielding improved outcomes, sustaining the most effective levels of services at the right locations, reducing costs of care, and achieving related efficiencies. Where appropriate, these Clinical Consolidations are a standard and widely accepted mechanism for reducing unnecessary cost in health care, improving quality, and ensuring the services and programs offered by a health care delivery system are continuously evaluated to ensure efficiency and the best outcome for patients.

As a means to ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy that will allow the New Health System to utilize a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients and to make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. Additionally, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. A copy of the Alignment Policy is attached as **Exhibit 12.1**.

A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefit and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as those proposed by the New Health System and outlined in this Application.

c. **REQUEST**: Clinical standardization;

RESPONSE: A well-executed merger can also improve patient outcomes if it results in improved performance management processes to help leaders in identifying where (and why) problems are occurring and how to implement best practices to coordinate care across the system. The New Health System is firmly committed to standardizing its management and clinical practice policies and procedures to promote efficiency and higher standards of care throughout the New Health System. As evidence of this commitment, the New Health System will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce clinical variation and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow the New Health System to share the clinical and financial information needed to integrate this process across the range of inpatient, outpatient, and physician services. The Clinical Council will be composed of independent, privately practicing physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates as more fully described in Section 15.a.A.iii. It would not be possible for the two competing systems to standardize procedures and policies for clinical best practices as effectively, or to develop such new care models, absent the merger.

Many of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. This approach to value-based purchasing will truly harness the intent of the changes in federal policy that encourage improved population health. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and then to collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

d. **REQUEST**: Alignment of the cultural identities of the parties to the cooperative agreement;

RESPONSE: There are many specific steps the Parties will take to align the cultural identities of the two organizations, including merging the executive leadership, establishing a board made up of equal representation from both legacy systems, agreeing on the appointment of new, independent board members with expertise in integration, implementation of a Clinical Council, bringing together key providers of both systems and implementing a single information technology platform that will be used to promote system-wide communication, cultural integration, and implement common clinical standards for improvement of patient quality.

The New Health System's board of directors and management team will be composed of current executives from both Wellmont and Mountain States.

- The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System.

- Wellmont and Mountain States will jointly select two members of the initial New Health System board, who will not be incumbent members of either Party's board of directors.

- The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then-current President of ETSU.

- The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer).

- All Board committees of the New Health System will be established with initial membership of equal representation from both legacy organizations. Likely committees will include: Executive, Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Workforce; Community Benefit; and Governance/Nominating.

Promptly after Closing, the New Health System will establish a physician-led Clinical Council (see Section 15.a.A.iii) to establish common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States.

As discussed in Section 15.a.A.i, the New Health System will adopt a Common Clinical IT Platform that will allow all providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care.

The New Health System is committed to its current workforce and will honor prior service credit, address any differences in salary/pay rates and benefits, offer competitive salaries, and combine the best of each hospital's career development programs as described more fully in Section 12.f.

Cultures will be further aligned by the increased emphasis on quality through the use of a common set of measures and protocols and the timely public reporting of many quality measures, as discussed in Section 15.a.A.iv. This combined emphasis on quality and public reporting of quality measures will significantly contribute to promoting a common culture emphasizing quality in the New Health System.

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

RESPONSE: Through the Cooperative Agreement, the two health systems will be able to avoid unnecessary duplication of services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these services more efficiently and with better quality and enhanced patient outcomes. One example of duplicative services the New Health System can potentially consolidate is the area's two Level I Trauma Centers, which are expensive to maintain and redundant in a region with low population density. No other region in Tennessee operates two Level I centers. Consolidation of these programs into a single facility is projected to result in cost savings. Significantly, studies have shown that higher volume trauma centers result in better patient outcomes.[21] Thus, a consolidation would likely result in lower cost and improved outcomes. Other cost-saving and efficiency opportunities include consolidation

[21] *High-volume trauma centers have better outcomes treating traumatic brain injury,* Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and Acute Care Surgery, January 2013, *available at*: http://www.ncbi.nlm.nih.gov/pubmed/23271089. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, *available at*:: http://jama.jamanetwork.com/article.aspx?articleid=193615.

of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities.

To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. Additionally, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. A copy of the Alignment Policy is attached as **Exhibit 12.1**.

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

RESPONSE: It is the objective of the New Health System to become one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. In order to achieve this objective, the Parties will conduct frequent employee and physician satisfaction and engagement assessments benchmarking with national organizations to achieve at least top quartile performance. The Parties will also build substantial partnerships beyond what currently exist with regional colleges and universities in Virginia and Tennessee that train physicians, nurses, and allied health professionals to ensure there is a strong pipeline of regional health professionals.

The Parties recognize that their workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for their team members. Thus, competitiveness of pay and benefits is critical to the New Health System's success. The New Health System is committed to its existing workforce. Therefore, when the New Health System is formed:

COMMITMENTS

- The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.

- The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.

- The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

The New Health System will achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by volume and varies across the market from time to time. Health care workers are in great demand in the region, and retaining and developing excellent health professionals in the region will be of utmost importance to ensure the highest clinical quality. Wages must remain competitive to attract top regional and national talent.

Further, significant investments must be made in the development of infrastructures and human resources for community health improvement, population health management, academics and research, and new high-level services. In addition to the significant ongoing base of clinical personnel, support staff, and physicians, all of these initiatives will serve to further develop the region's health care workforce and support the regional economy.

A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical center aligned in important ways with the New Health System in its efforts to transform health care delivery and to address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of an enhanced academic medical center to bring specific health care and economic benefits to the community. For example, the

Parties, with their academic partners, plan to create new specialty fellowship training opportunities, build an expanded research infrastructure, add new medical and related faculty, and attract research funding, especially translational research, to address regional health improvement objectives. These efforts will benefit the community directly and indirectly, with expanded efforts to develop research specific to the local communities' health care needs and issues. The Parties intend for the enhanced academic medical center to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Virginia and Tennessee to focus on strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities with overall health and economic well-being.

In the current environment, Wellmont and Mountain States have been reducing the number of residency slots due to financial constraints. It is a goal of the New Health System to reverse this trend. Using savings obtained from merger-derived efficiencies, the New Health System will work with its academic partners and commit not less than $85 million over ten years to increase residency and training slots, create new specialty fellowship training opportunities, build and sustain research infrastructure, and add faculty. These are all critical to sustaining an active and competitive training program. New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest quality and resourced labs and scientists. Specifically, the Parties commit to the following:

COMMITMENTS

- With academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.
- The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

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

RESPONSE: Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. CMS has stated that its goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients for a defined population. The formation of the New Health System will align the region's hospitals and related entities into one seamless organization, working together to enter into value-based contracts. The scale created by the merger will foster opportunities for cost-savings and quality-enhancement through risk contracting to a degree neither system could come close to achieving independently.

The New Health System intends to discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business. Those discussions would address both New Health System's and Principal Payer's willingness and ability to successfully implement risk-based models and over what time period. Additionally, the New Health System will commit to having at least one risk-based model in place within two years after Closing. No payer has historically expressed an interest in a global spending cap for hospital services in this region. However, after completing its clinical integration/alignment, the New Health System is willing to engage in those discussions if requested by a reputable payer, and assuming the New Health System is extended an actuarially sound proposal.

As further evidence of its commitment to move towards risk-based payment, the New Health System is willing to commit to the following:

COMMITMENTS

- For all Principal Payers,* the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the system.

- Adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

13. ANTICIPATED EFFICIENCIES

REQUEST: A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services that can be gained only through the cooperative agreement including:

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

b. Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term Population health improvements; and

c. Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: Funding the population health, access to care, enhanced health services, and other commitments described in this Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Parties have analyzed the anticipated efficiencies in three categories and calculated the anticipated savings described below.

The Parties commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies. The economies analysis is divided into three major segments. Segment One is the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two is the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three is the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are more fully discussed below.

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include:

- Harmonization to a Common Clinical IT Platform;
- Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.);
- Reductions in unnecessary duplication of call pay;
- Reductions in Locum Tenens and use of “Registry Staff”;
- Renegotiations of service, maintenance, and other contracts;
- Reductions in the duplication of subscriptions, memberships, licenses and other similar payments; and
- Added economies and efficiencies gained from the larger size of the New Health System.

The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately $70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in Section 14.c. below, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in Section 12.f, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from the merger in labor expenses totaling approximately $25 million annually. These savings could extend across a variety of departments and areas:

   - Administration;
   - Biomedical Engineering;
   - Patient Access/Registration;
   - Finance and Accounting;
   - Health Information Management;
   - Human Resources;

- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 12.b,, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the State Agreements, and the Parties do not believe it is appropriate to delegate the process without the full and complete participation of community stakeholders after the Cooperative Agreement is approved.

3. Clinical Efficiencies. The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in Section 12.b.) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of

the area's two Level I Trauma Centers, consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in Section 12.b., the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the State Agreements, and the Parties do not believe it is appropriate to delegate the process without the full and complete participation of community stakeholders after the Cooperative Agreement is approved.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations that for access to care that will directly benefit these communities.

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

RESPONSE: To ensure that savings and benefits are passed on from the merged system to patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health System agrees to mediation as a process to resolve any disputes.

*For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

b. **REQUEST**: Proposed use of cost savings to fund low or no-cost services designed to achieve long-term population health improvements; and

RESPONSE: The New Health System is committed to improving community health through investment of not less than $75 million over ten years in science and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy by adding research opportunities. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others, based upon the 10-year plan for the region.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low birthweight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the Geographic Service Area already have achieved noteworthy performance in specific prevention areas. For example, several of the Tennessee counties in the Geographic Service Area[22] rank among the best in Tennessee in immunizations. However, as a general rule, the health status of the Geographic Service Area's population is in need of significant improvement.[23] Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships ("MAPP") community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in Section 15.a.H. of this Application. It is anticipated that input from the Community Health Work Groups, the Technical Advisory Panel appointed by the Commissioner, and the Authority will help define the agreed-upon Quantitative Measures (as discussed in Section 15.d.), which will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States owns and operates drop-by Health Resources Centers that support chronic disease prevention and management in Kingsport and Johnson City, Tennessee, and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health information technology strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call

[22] These counties are Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges in Tennessee from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. *See* https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf *accessed* February 4, 2016.

[23] The Southwest Virginia Health Authority's *Blueprint for Health Improvement and Health-Enabled Prosperity* lists improved immunizations for children among its goals.

centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

c. **REQUEST**: Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least $140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; 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; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Improving Health Care Value. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. To ensure that savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community through new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices which are described in more detail in this Application.

Investment in Health Research and Graduate Medical Education. The New Health System will commit not less than $85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to

sustaining an active and competitive training program. These funds will enhance the Parties' academic partners' abilities to invest in additional research infrastructure, a significant benefit to the Commonwealth of Virginia and State of Tennessee. Additionally, partnerships with academic institutions in Virginia and Tennessee will enable research-based and academic approaches to the provision of the services the New Health System intends to invest to improve overall population health. These initiatives would not be sustainable in the region without the financial support created by the merger.

Avoidance of Duplication of Hospital Resources. Combining the region's two major health systems in an integrated delivery model is the best and most effective way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. These efforts will provide resources that can be invested in more value-based spending in the region – spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy by adding research opportunities. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

Improvements in Patient Outcomes. The region served by the Parties to the Cooperative Agreement faces significant health care challenges. In this environment, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes in the region. The New Health System will adopt a Common Clinical IT Platform to allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care, supporting the regional exchange of health information to encourage and support patient and provider connectivity to the New Health System's integrated information system, establishing a system-wide, physician-led clinical council responsible for implementing quality performance standards across the New Health System, and publicly reporting extensive quality measures with respect to the performance of the New Health System to promote transparency and further incentivize the provision of high quality care. These commitments will result in the investment of up to $150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.

Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the

proposed merger would create. Continued access to appropriate hospital-based and clinical services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over $19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain hospital operations in these areas across the region to preserve and enhance access to quality care in these rural communities.

Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant gaps exist in the continuum of care related to these services. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems. The New Health System will invest in the development of new capacity for residential addiction treatment with the goal of reducing the incidence of addiction in our region.

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:

a. **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.

There are nine general acute care hospitals in the Geographic Service Area that are not operated by Wellmont or Mountain States: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, Newport Medical Center, Takoma Regional Medical Center, and Laughlin Memorial Hospital. 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 Geographic Service Area are Mental Diseases, Circulatory, and Musculoskeletal. When patients leave the Geographic Service Area for medical care, they most frequently go to the University of Tennessee Medical Center in Knoxville and Carilion Medical Center in Roanoke, Virginia. Peninsula Hospital in Louisville, Tennessee, receives the largest outmigration for Mental Diseases. Section 5 contains additional information about the Geographic Service Area.

b. **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 for general acute care inpatient services based on Calendar Year 2014 ("CY2014") discharge data[24] as follows:

[24] Shares of the Geographical Service Area for general acute care inpatient services were calculated using CY2014 discharge data for all Virginia and Tennessee hospitals in 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 Geographic Service Area, and hospitals located within the Geographic Service Area,are in **Exhibit 5.2**.

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

System	Total	Share of Total Discharges
Mountain States	58,441	45.6%
Wellmont	35,075	27.4%
Other	34,584	27.0%

Table 14.1 identifies the percentage of total discharges in the Geographic Service Area (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 fifty-eight percent (58%) of the combined system's discharges.[26] Other Mountain States and Wellmont hospitals individually contribute less than one to two percent (1-2%) to the total discharge volume accounted for by their respective parent system.

If the Letter Authorizing Cooperative Agreement is granted and volumes in the Geographic Service Area 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 CY 2014 Discharges, New Health System

System	Total	Share of Total Discharges
New Health System	93,516	73.0%
Independent Competitors	34,584	27.0%

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, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 14.3**[27] provides share estimates for independent physicians, and

[25] Shares for **Table 14.1** were calculated based on general acute care services excluding normal newborns (DRG 795).
[26] These three hospitals account for 42.3% of discharges by all hospitals in the Geographic Service Area.
[27] **Tables 14.3 and 14.4** are based on data and information provided by the Parties regarding physicians with admitting privileges at

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

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate[28]
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Emergency Medicine	X	141	95%	1%	1%	3%
Neurology	X	75	91%	3%	4%	3%
Otolaryngology	X	21	90%	5%	5%	0%
Pediatrics	X	87	87%	3%	9%	0%
General Surgery	X	57	70%	7%	19%	4%
Internal Medicine	X	178	67%	19%	13%	1%
OB/GYN	X	81	67%	10%	23%	0%
Neurosurgery	X	20	65%	5%	25%	5%
Family Medicine	X	183	63%	16%	20%	1%
Orthopedic Surgery	X	68	63%	3%	32%	1%
Psychology	X	5	60%	20%	20%	0%
Psychiatry	X	30	57%	10%	33%	0%
Pain Management	X	6	50%	17%	17%	17%
Cardiothoracic Surgery	X	21	43%	38%	19%	0%
Pulmonology	X	37	38%	38%	19%	5%
Occupational Medicine	X	5	20%	40%	40%	0%
Hematology/Oncology	X	34	15%	44%	35%	6%
Cardiology	X	70	14%	49%	36%	1%
Hospital Medicine	X	123	14%	10%	58%	15%

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

[28] Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 14.4 – Shares of Physicians in Non-Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate[29]
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

[29] Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

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

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Nurse Practitioner	-	89	98%	0%	2%	0%
CRNA	-	75	97%	0%	0%	3%
Anesthesiology	-	65	97%	0%	0%	3%
Nephrology	-	16	94%	0%	6%	0%
Gastroenterology	-	30	90%	0%	10%	0%
Unknown	-	9	89%	0%	11%	0%
Urology	-	23	87%	0%	13%	0%
Physical Medicine and Rehabilitation	-	11	82%	18%	0%	0%
Infectious Disease	-	10	80%	20%	0%	0%
Dermatology	-	6	67%	0%	33%	0%
Pediatric Critical Care	-	3	67%	0%	0%	33%
Palliative Care	-	2	50%	50%	0%	0%
Pediatric Cardiology	-	4	50%	50%	0%	0%
Pediatric Neurology	-	2	50%	0%	0%	50%
Surgical Oncology	-	2	50%	50%	0%	0%
Radiation Oncology	-	11	36%	64%	0%	0%
Oncology	-	7	29%	43%	0%	29%
Trauma Surgery	-	29	21%	0%	38%	41%
Critical Care	-	15	7%	0%	80%	13%
Behavioral Health	-	8	0%	0%	50%	50%
Endocrinology	-	4	0%	0%	50%	25%
Pediatric Endocrinology	-	1	0%	0%	0%	100%
Pediatric Hospital Medicine	-	6	0%	0%	0%	100%
Sleep Medicine	-	2	0%	0%	50%	50%
Urgent Care	-	58	0%	0%	86%	14%

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. **Table 14.5**[30] presents counts and share numbers for categories of outpatient services based on the affiliation of the providers.

[30] **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.

Table 14.5 – Shares of Outpatient Facilities by System

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other	Total
Pharmacy	1.4%	5	0	0	0	349	**354**
Fitness Center	0.0%	0	0	0	0	98	**98**
XRAY	28.3%	14	0	12	0	66	**92**
Nursing Home	7.6%	3	0	2	0	61	**66**
Physical Therapy	6.6%	1	0	3	0	57	**61**
Home Health	16.7%	8	0	2	0	50	**60**
Rehabilitation	39.5%	9	0	8	0	26	**43**
CT	51.2%	12	0	10	0	21	**43**
MRI	43.9%	11	0	7	0	23	**41**
Surgery - Endoscopy	45.2%	9	0	5	0	17	**31**
Urgent Care	50.0%	8	0	8	0	16	**32**
Surgery - Hospital-based	46.7%	9	0	5	0	16	**30**
Dialysis Services	0.0%	0	0	0	0	25	**25**
Wellness Center	14.3%	2	0	1	0	18	**21**
Surgery - ASC	50.0%	2	0	3	4	9	**18**
Chemotherapy	55.6%	4	1	5	0	8	**18**
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	**16**
Radiation Therapy	54.5%	3	0	3	0	5	**11**
Cancer Center	54.5%	3	0	3	0	5	**11**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	6	**6**
Cancer Support Services	0.0%	0	0	0	0	1	**1**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**

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

c. **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;

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. In fact, independent providers offer the majority of physician services (70%) and outpatient services (over 50%).

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.

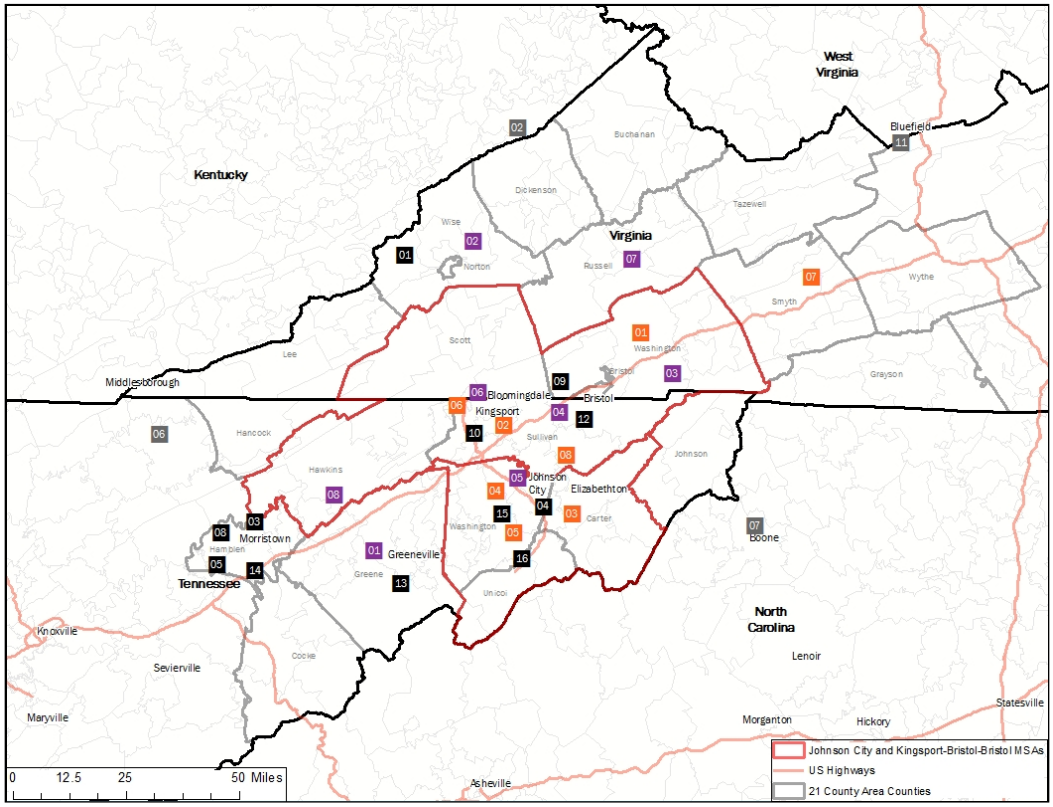
Nine general acute care hospitals in the Geographic Service Area are not operated by Wellmont or Mountain States: Clinch Valley Medical Center, Wythe County Community Hospital, Carilion Tazewell Community Hospital, Lakeway Regional Hospital, Buchanan General Hospital, Morristown-Hamblen Healthcare System, Newport Medical Center, Takoma Regional Medical Center, and Laughlin Memorial Hospital.

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 Geographic Service Area as organized in broad categories.[31] Wellmont and Mountain States together account for less than fifty percent (50%) of the outpatient facilities in twenty-one of the thirty-two categories provided, including Physical Therapy (6.6%) and Nursing Homes (7.6%). Outpatient services, including urgent care, imaging, and ambulatory surgery centers, have many independent alternatives, which are identified in **Exhibit 14.1 (Section A)** and whose locations are shown on maps in **Figures 14.1-14.3**.

Urgent Care Facilities. Of the thirty-two urgent care centers in the Geographic Service Area, Mountain States and Wellmont collectively operate sixteen of them; fifty percent (50%) 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.[32]

[31] The outpatient facilities listed in **Exhibit 14.1 (Section A)** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.
[32] The outpatient facilities listed in **Exhibit 14.1 (Section B)** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

Figure 14.1 – Map of Locations of Urgent Care Facilities[33]



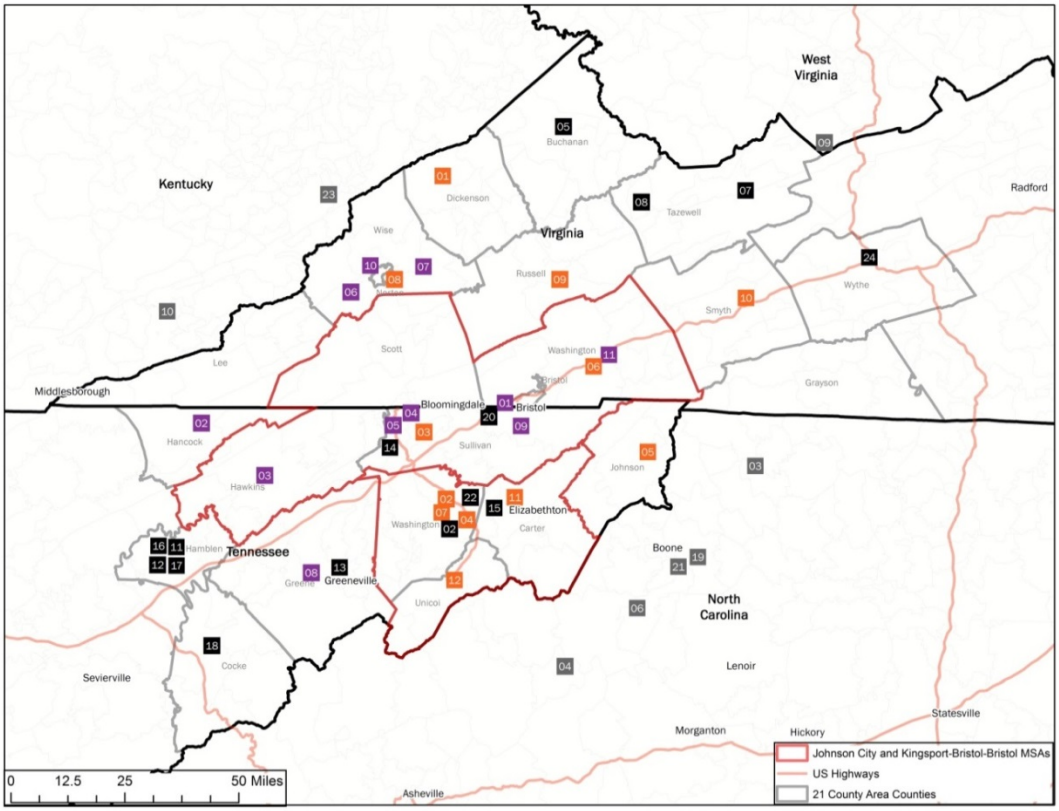
CT/MRI Facilities. The Geographic Service Area contains imaging facilities, including providers of CT, MRI, and X-Ray services. Wellmont and Mountain States each offers at least one type of these imaging services, but over seventy percent (70%) of all imaging facilities in the Geographic Service Area are operated by competitors. Wellmont and Mountain States together account for about half of the CT and MRI capabilities in the Geographic Service 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.[34]

[33] An enlarged version of the map and legend is included in **Exhibit 14.1 (Section B).**
[34] The outpatient facilities listed in **Exhibit 14.1 (Section C)** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

Table 14.6 – Medical Imaging Facilities/Capabilities and System Affiliation in the Geographic Service Area

System Affiliation	Total Facilities[35]	% of Total	CT Capabilities	MRI Capabilities	X-Ray Capabilities
Total	119		43	41	92
Wellmont	18	15.1%	10	7	12
Mountain States	15	12.6%	12	11	14
All Other	86	72.3%	21	23	66

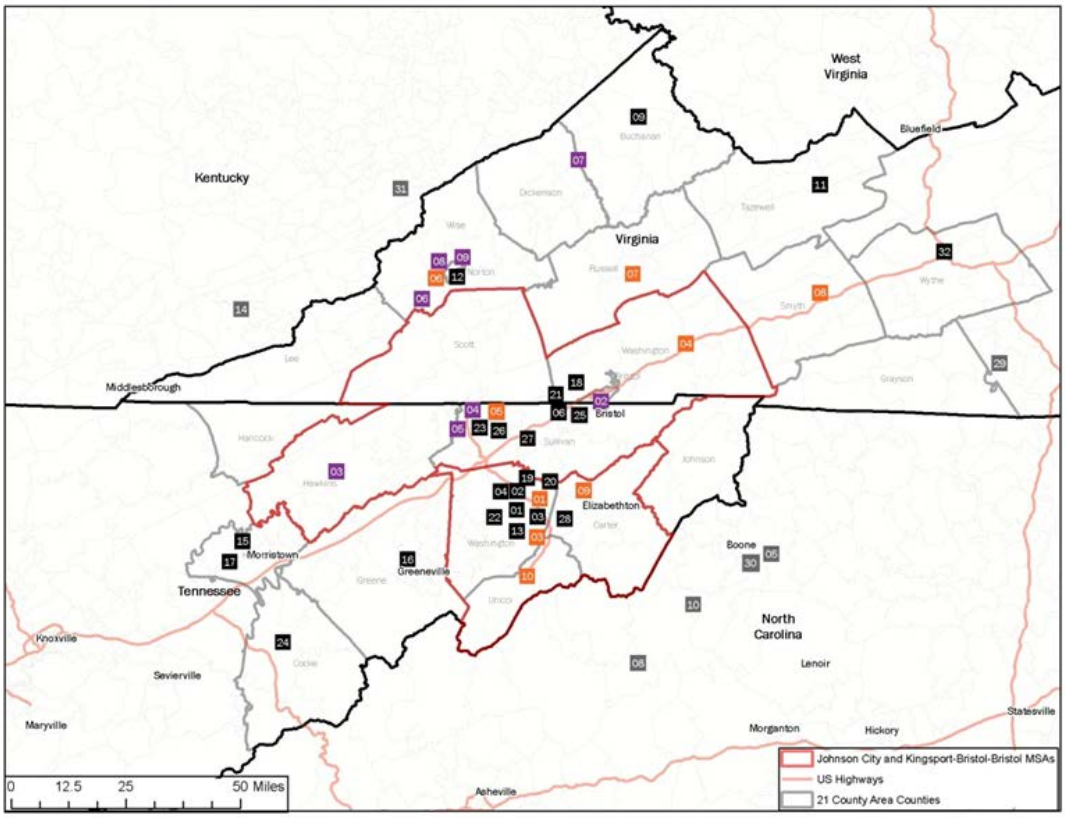
Figure 14.2 – Map of Locations of CT/MRI Facilities[36]



Ambulatory Surgical Centers. Wellmont and Mountain States each have ambulatory surgical centers ("ASCs")[37] in the Geographic Service Area, but fifty-seven percent (57%) 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.[38]

[35] Facilities may have CT, MRI and/or X-ray capabilities co-located at a single location that are counted separately.
[36] An enlarged version of the map and legend is included in **Exhibit 14.1 (Section C).**
[37] "ASCs" include ambulatory surgical center facilities, hospital-based outpatient surgical facilities, and surgery-endoscopy facilities.
[38] The outpatient facilities listed in **Exhibit 14.1 (Section D)** include the outpatient facilities located in the Geographic Service Area and serving the Geographic Service Area.

Figure 14.3 – Map of Locations of Ambulatory Surgical Centers[39]



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 Geographic Service Area with privileges at Wellmont or Mountain States are independent. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Wellmont employs nine percent (9%); Mountain States employs seventeen percent (17%); and four percent (4%) of physicians are affiliated with Mountain States 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

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

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 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 percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

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.

d. **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**.

e. **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.

f. **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**.

15. DESCRIPTION OF BENEFITS

REQUEST: A detailed description of each of the benefits that the parties propose will be achieved through the Cooperative Agreement. For each benefit include:

a. **REQUEST**: A description specifically describing how the parties intend to achieve the benefit;

RESPONSE: The Parties foresee significant benefits that they propose will be achieved through the Cooperative Agreement, which are described in detail below and how the Parties intend to achieve these benefits.

BENEFITS

A. Enhancement of the quality of hospital and hospital-related care provided to Virginia citizens.

The region served by the Parties to the Cooperative Agreement faces significant, wide-ranging health care challenges. The 2015 America's Health Rankings report[40] finds that the State of Virginia ranks 31st in the nation in smoking. Virginia counties in the Geographic Service Area exceed the national average for smoking and range from a low of 21 percent (21%) to a high of 33 percent (33%). Virginia counties within the Geographic Service Area also have obesity rates that exceed the Virginia state levels, ranging from 29 percent (29%) to 35 percent (35%). Teenage pregnancy rates in the Virginia counties within the Geographic Service Area exceed the national average of 26.5 births per 1,000 adolescent females,[41] and four of those counties have rates that exceed double the national average (Dickenson, Lee, Smyth, and Wise). Low birthweight is also an issue of concern. Only three of the Virginia counties in the Geographic Service Area – Grayson, Russell and Wythe – have low birthweight rates that are better than the state average. Of the eleven Virginia counties in the Geographic Service Area, all eleven exceed the state average for mortality rate due to drug poisoning. Dickenson County's rate is the highest in either Tennessee or Virginia. The Southwest Virginia Health Authority's *Blueprint for Health Improvement and Health-Enabled Prosperity* (updated January 7, 2016)[42] identifies these issues and others in the Authority's goals for its region's health.

The health challenges faced by residents of the Geographic Service Area are illustrated in **Table 15.1**, which reports key statistics on the population of all counties in the Geographic Service Area, including metrics for obesity, smoking,

[40] *Virginia State Data*, America's Health Rankings, United Health Foundation, Annual Report 2015, *available at*: http://www.americashealthrankings.org/VA.
[41] *Trends in Teen Pregnancy and Childbearing*, Office of Adolscent Health, U.S. Department of Health & Human Services, *available at::* http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html and search "Trends in Teen Pregnancy and Childbearing."
[42] *Goals Update, available at*: https://swvahealthauthority.net.

childhood poverty, and death rates due to drug poisoning. Full County Health rankings for all Tennessee and Virginia Counties and Independent Cities located in the Geographic Service Area are attached as **Exhibits 15.1A and 15.1B**.

Table 15.1 – Geographic Service Area Health Rankings

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Tennessee	43rd	19%	32%	23%	27%	16
Carter	48/95	23%	29%	31%	34%	20
Cocke	88/95	27%	31%	21%	41%	21
Greene	59/95	21%	32%	29%	30%	22
Hamblen	54/95	26%	30%	23%	29%	27
Hancock	93/95	29%	30%	40%	45%	42
Hawkins	64/95	26%	35%	26%	31%	26
Johnson	44/95	26%	31%	28%	38%	11
Sullivan	36/95	22%	33%	26%	28%	17
Unicoi	68/95	26%	30%	23%	29%	24
Washington	19/95	19%	31%	24%	24%	17
Virginia	21st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

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

The State of Tennessee has identified the "Big Three plus One" health issues (physical inactivity, obesity, tobacco abuse and substance abuse) as major health challenges for the state.[43] These health issues disproportionately impact residents of the Geographic Service Area and are associated with other health challenges and conditions. **Table 15.2**, reports key statistics on the population in all Counties in the Geographic Service Area and Virginia and Tennessee state-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. Red shading indicates that the county scores are worse than the applicable state average for that particular metric. The reported data show that all of the Virginia Counties in the Geographic Service Area exceed the state average in all four categories.

[43] Information about the *Big Three plus One* prevention initiatives can be found in the 2014 Update to the State Health Plan, Division of Health Planning, Tennessee Department of Health, *available at:* https://www.tn.gov/assets/entities/hsda/attachments/2014_State_Health_Plan_FINAL.pdf.

Table 15.2 – County-Level Data for Physical Inactivity, Obesity, Tobacco Abuse, and Substance Abuse in the Geographic Service Area

	Physical Inactivity Score[44]	Obesity[45]	Tobacco Abuse[46]	Substance Abuse Score[47]
Tennessee Average	30%	32%	23%	16
Carter County	32%	29%	31%	20
Cocke County	36%	31%	21%	21
Greene County	36%	32%	29%	22
Hamblen County	33%	30%	23%	27
Hancock County	39%	30%	40%	42
Hawkins County	35%	35%	26%	26
Johnson County	34%	31%	28%	11
Sullivan County	35%	33%	26%	17
Unicoi County	37%	30%	23%	24
Washington County	30%	31%	24%	17
Virginia Average	22%	28%	18%	9
Buchanan	28%	29%	30%	37
Dickenson	32%	29%	32%	53
Grayson	30%	32%	22%	Not reported
Lee	27%	29%	25%	14
Russell	36%	35%	25%	32
Scott	35%	34%	28%	14
Smyth	23%	31%	22%	15
Tazewell	31%	30%	21%	37
Washington	30%	32%	24%	13
Wise	38%	32%	33%	38
Wythe	27%	30%	24%	18

The Parties share the Commonwealth's concern about these significant health issues and are aware of the acute challenges present in this region. The Parties intend for the issues described in this Section to be among the key areas of focus within the scope of the current Community Health Work Groups, as well as the Technical Advisory Panel that will work to define the ongoing Quantitative Measures (as defined below) for the Cooperative Agreement.

[44] Physical Inactivity: Percentage of adults aged 20 and over reporting no leisure-time physical activity. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.
[45] Adult Obesity: Percentage of adults that report a BMI of 30 or more. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.
[46] Adult Smoking: Percentage of adults who are current smokers. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.
[47] Substance Abuse: Drug Poisoning Mortality Rate per 100,000 Population Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

These variables impose increased costs on employers, the government and society in general because the cost to manage the health of these populations is much higher and often reactive and acute, rather than proactive. Poor health leads to higher inpatient utilization. A major component of the change the New Health System seeks to impact is to improve the determinants of poor health that lead to unnecessary inpatient utilization, better manage the "super-utilization" of health resources and, through collaboration with payers, align the incentives to ensure appropriate utilization.

The region is materially affected by the federal policy of paying local hospitals based on one of the lowest Medicare Wage Indices in the nation. This leads to substantially lower reimbursement than peer hospitals in other states and in Virginia for the exact same services. The low rates, combined with the expensive, unnecessary and inefficiently allocated duplicative health care resources currently existing in the region, make it difficult for the two systems to independently invest the resources required to meaningfully influence the variables that contribute to poor health. These factors confine the region's health systems to the model that has led to higher cost in the first place.

Furthermore, there is projected continued downward pressure on reimbursement by government payers, as costs for labor and supplies, many of which are unnecessarily duplicative, continue to grow. By better coordinating the two systems, eliminating unnecessary duplicative cost, and creating a better focus on the drivers of poor health, the New Health System will make a material positive impact on the region's health care.

Thus, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and health outcomes in the region. The specific initiatives of the Cooperative Agreement are summarized below, followed by a description of the Parties' specific commitments to achieve these goals and the resulting benefits:

- A fully integrated and interactive Common Clinical IT Platform will be implemented to enable ready access to patient records by physicians from any location in the New Health System. Implementation of this Common Clinical IT Platform requires sharing of highly proprietary information and commitment of significant resources by both systems, which would not be accomplished in the absence of a merger.

- The New Health System will participate meaningfully in an existing or new health information exchange to promote coordination among community providers, including those providers not part of the New Health System. The regional health information exchange will facilitate the sharing of information, including highly proprietary information to

the extent feasible, and a commitment of significant resources, which would not be accomplished in the absence of a merger.

- Management and clinical practice procedures and policies will be standardized to promote efficiency and higher standards of care on a consistent basis throughout the New Health System through a system-wide Clinical Council. It would not be possible for the two competing systems to standardize procedures and policies for best practices absent the merger. Such standardization to improve health care requires sharing of proprietary information and significant contribution of resources by both parties, as discussed below.

- Best practices will be used to develop standardized clinical protocols for care ("Clinical Pathways") to reduce clinical variation and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow sharing of the clinical and financial information needed to integrate this process.

- The integration and coordination of clinical services made possible by the merger will free up resources that can be directed to develop new health care services and to enhance existing services, discussed more fully below. Clearly, the resources needed to achieve these goals would not be available in the absence of the merger.

- The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.

- The New Health System's services and staff will be optimally located to improve productivity and ensure access.

- Clinical programs will be integrated to establish centers of excellence that coordinate and optimize care throughout the New Health System. The three tertiary hub hospitals will serve not only as training sites for new physicians and allied health professionals, but will also utilize effective technology and cutting edge treatment in concert with translational research.

To enhance the quality of health care services provided in the region to achieve the above benefits, the Parties are willing to commit to the following:

i. Migrate to a Common Clinical Information Technology Platform

(a) The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.

(b) The Common Clinical IT Platform will allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care.

(c) The Common Clinical IT Platform will also facilitate the increased adoption of best practices and evidence based medicine implemented by the New Health System.

(d) The New Health System intends to use the Common Clinical IT Platform to provide immediate, system-wide alerts and new protocols to improve quality of care.

(e) The New Health System expects the Common Clinical IT Platform to be utilized in ways that will help reduce the risk of clinical variation and lower the cost of care by decreasing duplication of health care services.

ii. Support Regional Efforts For Establishment of a Region-Wide Health Information Exchange

(a) The New Health System will support development and operation of a region-wide health information exchange (the "Health Information Exchange") that will include independent providers, medical groups and facilities.

(b) The Health Information Exchange will encourage and support patient and provider connectivity to the New Health System's integrated information system.

(c) The New Health System will coordinate with third-parties to establish the technology platform vendor for the Health Information Exchange and to provide key data security and relevant protocols to all users.

(d) The New Health System will utilize the Health Information Exchange to further facilitate better patient care and coordination of care, and to decrease the unnecessary duplication of health care services.

iii. Establish System-Wide Clinical Council

(a) The New Health System will establish a system-wide, physician-led clinical council (the "Clinical Council").

(b) The Clinical Council will be composed of independent physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates. The Clinical Council will include representatives of management but the majority will be composed of physicians.

(c) The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.

(d) The Chair of the Clinical Council will be a physician member of the active medical staff(s) of one or more New Health System hospitals. The Chair will serve on the Quality, Service and Safety Committee of the Board of Directors of the New Health System and will provide ongoing reports on the activities of the Clinical through the Quality, Service and Safety Committee of the Board.

(e) The Clinical Council will be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review where appropriate and quality performance standards and best practices requirements for the New Health System.

(f) The Clinical Council will also provide input on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System.

(g) The Clinical Council will report to the Chief Medical Officer of the New Health System.

iv. Quality Reporting

(a) The Parties affirm the need for complete transparency on quality measures with respect to the performance of the New Health System. The Parties will report on a common and comprehensive set of measures and protocols that will be part of the integrated delivery of care across the entire New Health System, as well as track and monitor opportunities to improve health and access to care at the right place and right time for consumers. Timely information will be available to the public, which will impact choice and further incentivize the provision of high quality of care. Increased transparency will provide consumers with information for their use to make better health care decisions.

(b) The New Health System will commit to publicly reporting on its website the New Health System's CMS core measures[48] for each facility within thirty days of reporting the data to CMS. The New Health System will also provide benchmarking data against the most recently available CMS data so the public can evaluate and monitor how the New Health System facilities compare against hospitals across the state and nation in a manner that is more "real time" than currently available. Publicly reported CMS Hospital Compare measures, by category, along with the number of measures in each respective category are presented in **Table 15.3** below. These demonstrate the breadth of commitment by the Parties to provide comprehensive and timely information for benchmarking and for consumers.

[48] CMS Hospital Compare metrics are publicly *available at*: https://data.medicare.gov/data/hospital-compare. As indicated in **Table 15.3**, there are seventeen categories of measures and each category contains a set of measures. For example, Readmissions & Deaths is one of the 17 Hospital Compare measure categories. This category contains fourteen individual measures including, for example, AMI 30-day mortality rate, Pneumonia 30-day mortality rate, and the Rate of readmission after discharge (hospital-wide).

Table 15.3 – CMS Hospital Compare Measures

Measure Category	Number of Measures
Healthcare-associated infections(HAI)	6
Inpatient Psychiatric Facility Quality Reporting(IPFQR)Program	6
Outpatient Imaging Efficiency	6
Payment & value of care	4
Readmissions & deaths	14
Surgical Complications	7
Survey of patients' experiences(HCAHPS)	11
Timely and effective care- Blood Clot Prevention and Treatment	6
Timely and effective care- Children's Asthma	3
Timely and effective care- Emergency Department	7
Timely and effective care- Heart Attack or Chest Pain	9
Timely and effective care- Heart Failure	3
Timely and effective care- Pneumonia	1
Timely and effective care- Pregnancy and Delivery Care	1
Timely and effective care- Preventive Care	2
Timely and effective care- Stroke Care	8
Timely and effective care- Surgical Care Improvement Project	9

- The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public. Currently, there is an approximate six-month lag between when core measures are reported to CMS and when CMS posts the information for the public. The New Health System intends to empower patient decision making by reporting core measures in advance of the federal agency reporting.

- CMS periodically changes the core measures it requires hospitals to report. To ensure patients have information on the latest CMS core measures, the New Health System will commit to include all current CMS core measures in its public reporting on the website, rather than a pre-defined set of measures chosen by the Parties.[49]

[49] The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those core measures that would not be reported by CMS (e.g. too few patients for the metric to be statistically significant, protected health information concerns with the metric being reported, etc.).

(c) The New Health System will commit to publicly reporting on its website measures of patient satisfaction for each facility within thirty days of reporting the data to CMS via the Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") reporting. The New Health System will also provide benchmarking data against the most recently available CMS patient satisfaction scores so the public has access to how the New Health System facilities compare against hospitals across the state.

- The New Health System's results will be available on its website and reported several months earlier than CMS customarily makes the information available to the public.

(d) The New Health System will commit to publicly reporting on its website specific high priority measures for each facility annually, with relevant benchmarks. The high priority measures are set by CMS[50] and the Joint Commission and have in the past included:

- Central Line-Associated Bloodstream Infections,
- Catheter-Associated Urinary Tract Infections, and
- Ventilator Associated Pneumonia Infection Rates.

(e) The New Health System will commit to publicly reporting on its website surgical site infection rates for each facility annually.

(f) The New Health System will commit to publicly reporting on its website the ten most frequent surgical procedures performed (by number of cases) at each Ambulatory Surgery Center in the system annually. Studies have shown that facilities performing high volumes of a procedure may have better outcomes than those performing low volumes. The New Health System intends to be transparent about the volume of procedures it performs and the outcomes related to those procedures.

[50] The New Health System will commit to using the same standards of reporting as CMS and reserves the right to not report those high priority measures that would not be reported by CMS (e.g. too few patients for the metric to be statistically significant, etc.).

(g) The New Health System will commit to improved transparency and reporting on high priority measures for quality and cost by reporting annually on its website the following information by facility, aggregated for the facility across the DRGs that comprise eighty percent (80%) of the discharges from the New Health System facilities:[51]

- Severity adjusted cost/case;
- Length of stay;
- Mortality rate; and
- Thirty-day readmission rate.

(h) The New Health System will also commit to report these quality measures on its website for the top ten DRGs aggregated across the system annually. By reporting on these quality measures specific to each of the top 10 DRGs for the system as a whole, the New Health System is committing to a new level of transparency and accountability for care in the service lines that account for greatest usage by the population. The top 20 DRGs by system for 2014 are listed in **Table 15.4** below:

[51] Cost and utilization metrics could include broad measures such as: total medical cost per member per year, inpatient admissions per 1000, average length of stay, percentage of readmissions within 30 days, ER visits per 1000, Evaluation and Management per 1000, Scripts per 1000. More detailed expenditure and utilization statistics could be presented for inpatient by treatment type (Medical , Surgical, Psychiatric/Substance Abuse, Maternity/Newborn, Non Acute & LTC), outpatient by treatment type (Surgery, ER, Home Health, DME, Lab, Radiation, Pharmacy, Other) and Providers (PCP, Specialist, Transportation, DME & Supplies, Spec Drugs & Injections, and Other). The report could include costs for the top 10 DRGs by volume, evaluation and management visits by group, Rx Utilization, top 20 Clinical Conditions by Medical Cost, and top 10 patients (identified by clinical condition) by cost.

Table 15.4 – Top DRGs by Health Systems, 2014

Top 20 Discharge DRGs for Combined MSHA and Wellmont, 2014			
No.	DRG	DRG Description	Total Discharges
1	885	PSYCHOSES	5,320
2	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	3,627
3	775	VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	3,283
4	470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	2,820
5	189	PULMONARY EDEMA & RESPIRATORY FAILURE	1,965
6	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	1,950
7	603	CELLULITIS W/O MCC	1,716
8	194	SIMPLE PNEUMONIA & PLEURISY W CC	1,651
9	193	SIMPLE PNEUMONIA & PLEURISY W MCC	1,619
10	872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	1,535
11	690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	1,423
12	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	1,413
13	766	CESAREAN SECTION W/O CC/MCC	1,402
14	683	RENAL FAILURE W CC	1,342
15	291	HEART FAILURE & SHOCK W MCC	1,174
16	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	1,147
17	292	HEART FAILURE & SHOCK W CC	1,063
18	247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	1,026
19	378	G.I. HEMORRHAGE W CC	966
20	765	CESAREAN SECTION W CC/MCC	948
Note: The table excludes normal newborns (DRG 795).			
Source: Combined all-payor IP discharge data from Virginia State & Tennessee State, calendar year 2014			

(i) The New Health System will select a third-party vendor and provide the data for the vendor to analyze the severity adjusted measures and post them to the New Health System's website.

B. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.

Health care services offered by rural hospitals in the United States are at increasing risk of closure. According to the University of North Carolina Sheps Center, sixty-six rural hospitals have closed since 2010, including one in Virginia and six in Tennessee.[52] Wellmont and Mountain States each make substantial investments in order to maintain access to health care services in their rural communities. As presented in **Tables 5.2 and 5.3**, many of the Parties' rural hospitals have an average daily census of 20 patients or less.

Because of decreasing reimbursements and the other challenges mentioned

[52] *66 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, available at https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/ (accessed January 25, 2016).

earlier, it will be increasingly difficult to continue to sustain these facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement.

Currently, most rural hospitals operated by Wellmont and Mountain States operate with negative or very low operating margins, representing challenges to the capitalization and, ultimately, the survival of these hospitals. Last year alone, Mountain States and Wellmont collectively invested more than $19.5 million to ensure that inpatient services would remain available at the following rural hospitals: Smyth County Community Hospital, Russell County Medical Center, Unicoi County Memorial Hospital, Johnson County Community Hospital, Dickenson Community Hospital, Norton Community Hospital, Johnston Memorial Hospital, Hawkins County Memorial Hospital, Hancock County Hospital, Lonesome Pine Hospital, and Mountain View Regional Medical Center. In the current resource-constrained, status-quo environment, these hospitals face an uncertain future with respect to their viability. The existing threat to these hospitals is substantial, which affects not only access to care, but also the economic vitality of these communities.

The proposed Cooperative Agreement is a thoughtful mechanism for ensuring that the efficiencies from a merger that is actively supervised will be used to ensure sustained access to care for these communities. Without the Cooperative Agreement, there is no comparable assurance. Specifically, the Parties commit to the following:

COMMITMENTS

- All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.

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 commit to the development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference. The Parties expect the combined system to facilitate this goal by employing physicians 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.

C. Gains in the cost containment and cost efficiency of services provided by the hospitals involved.

Federal and state regulatory agencies impose significant cost constraints on all hospital providers. Medicare and Medicaid payment rates are non-negotiable and are often applied as benchmarks by other payers. Medicare costs are regulated through the Medicare Wage Index. In Southwest Virginia and Northeast Tennessee, payment rates remain lower because the local Medicare Wage Index is one of the lowest in the nation. With a payer mix for the regional health systems that is approximately 70% Medicare, Medicaid, and Medicare managed care, this wage index serves as a fundamental regulator of health care costs.[53]

The proposed Cooperative Agreement complements federal and state efforts to contain costs and promote cost efficiency in several ways.

Through the Cooperative Agreement, the two health systems will be able to avoid unnecessary duplication of services. By integrating their efforts in key service areas, the Parties will avoid duplicative costs and will be able to operate these facilities and services more efficiently, with better quality and with enhanced patient outcomes. One example of duplicative services the New Health System can potentially consolidate is the area's two Level I Trauma

[53] See **Exhibit 15.1** for a breakdown of payers in the Geographic Service Area.

Centers, which are expensive to maintain and redundant in a region with low population density. No other region in Tennessee operates two Level I centers. Consolidation of these programs into a single facility is projected to result in cost savings. Significantly, studies have shown that higher-volume trauma centers result in better patient outcomes.[54] Thus, a consolidation would likely result in lower cost and improved outcomes. Other cost-saving and efficiency opportunities include consolidation of specialty pediatric services, repurposing acute care beds and consolidation of certain co-located facilities.

The New Health System will also achieve greater cost efficiencies through various organizational and administrative efficiencies. Such efficiencies include, among other things, non-labor efficiencies, labor efficiencies, clinical efficiencies, and the opportunity to consolidate technology resources on a Common Clinical IT Platform as described in Section 15.a.A.i.

Specifically, the Parties commit that the New Health System will achieve at least $95 million in annual efficiencies by the end of the fifth year of operation. The potential savings identified here are limited to the estimated dollar savings from the realignment of resources and certain clinical efficiencies, but do not include the potentially significant benefits that the Parties expect to achieve through improved access, quality, and care in the best locations that will directly benefit these communities. Importantly, that work must be done only after significant study and assessment along with input from key stakeholders and physicians, guided by the Alignment Policy set forth in this document. The work must be orderly, methodical, and well-communicated. While the efficiency numbers set forth above were established and validated by independent outside experts, only certain sample initiatives have been set forth in this document.

D. Improvements in the utilization of hospital resources and equipment.

In addition to reduced costs through improved efficiency and avoidance of waste and duplication, the New Health System will reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. Currently, the admissions rate for the Virginia counties in the Geographic Service Area is 139 per 1,000 people compared to a state average of 94 admissions per 1,000 people.[55] The Parties believe the creation of a regionally integrated health system with a comprehensive regional health information exchange will help reduce unnecessary utilization.

[54] *See High-volume trauma centers have better outcomes treating traumatic brain injury,* Tepas, Joseph J. III MD; Pracht, Etienne E. PhD; Orban, Barbara L. PhD; Flint, Lewis M. MD, Journal of Trauma and see Acute Care Surgery, January 2013, *available at:* http://www.ncbi.nlm.nih.gov/pubmed/23271089. *Relationship between trauma center volume and outcomes*, Avery B. Nathens, MD, PhD, MPH; Gregory J. Jurkovich, MD; Ronald V. Maier, MD; David C. Grossman, MD, MPH; Ellen J. MacKenzie, PhD; Maria Moore, MPH; Frederick P. Rivara, MD, MPH, Journal of American Medical Association, March 2001, *available at:* http://jama.jamanetwork.com/article.aspx?articleid=193615.

[55] These estimates were calculated using hospital admissions data from VHHA, THA, and NC state data bases; and population data from Virginia Cooper Center Research.

The proposed merger will result in a Common Clinical IT Platform for electronic medical records among the combined nineteen hospitals, employed physicians and related services, and will facilitate a community health information exchange between participating community providers in the region, as described above. This combination will help ensure that providers have the information they need to make high-quality treatment decisions, reduce unnecessary duplication of services, enhance documentation and improve the adoption of standardized best practices. Patient information will be more portable, removing barriers to patient choice and improving patients' access to their own health information. A more fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services resulting in a better patient experience and more effective and efficient care.

To reduce the pace of health care cost growth for patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

COMMITMENTS

- For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

COMMITMENTS

- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health System agrees to mediation as a process to resolve any disputes.

- The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.

- The New Health System will participate meaningfully in a health information exchange open to community providers.

- The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.

*For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

All of these efforts would not be undertaken in the absence of the merger due to a variety of factors, including the need to share proprietary information and the significant commitment of resources to be made by the Parties as part of the merger. Moreover, commitments relating to pricing, consolidation of services, standardization of practices, and procedures, would raise significant antitrust concerns if undertaken together by two independent hospital systems. A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefits and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as the New Health System. It would also not be subject to rigorous rate regulation by state authorities, even though there are concerns that out-of-market acquirers may raise the acquired hospital's prices.

In the event of repeal or material modification of the Virginia Certificate of Public Need law and/or the Tennessee Certificate of Need law, the Parties solely with respect to outpatient, physician, and additional non-hospital health care services (collectively, the "non-inpatient services"), reserve the right for the New Health System to enter into exclusive network and "most-favored nation" agreements with insurers, and to engage in any other competitive practices that comply with antitrust laws regarding the non-inpatient services, notwithstanding the commitments stated in this Application..

E. Avoidance of duplication of Hospital resources.

A major factor in the accumulation of nearly $1.5 billion of debt, and the redundant costs borne by the market, has been the duplication of services and programming by Wellmont and Mountain States as separate systems. Combining the region's two major health systems in an integrated delivery model is the best way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services moving forward. These efforts will provide savings that may be invested in higher-value activities in the region to help expand currently absent but necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy by adding research opportunities. These new levels of development and job creation will not be possible as long as the two health systems duplicate one another in an environment of increasingly scarce resources. While any alternative model to this proposal would likely lead to significant job displacement in the region, the proposed merger would mitigate this impact through investment in new programs as outlined in this application.

The Parties also anticipate cost savings through capital cost avoidance. This includes avoiding duplication in select clinical areas, as well as eliminating duplicative planned strategic investments for initiatives that would no longer be warranted as a combined entity.

F. Demonstration of Population health improvement of the region served according to criteria set forth in the Cooperative Agreement and approved by the Department.

Wellmont and Mountain States are committed to creating a New Health System designed to improve community health. To accomplish this, the New Health System will commit to pursuing health improvements aligned with goals contained in the current Virginia Health Innovation Plan (including the Lieutenant Governor's Quality, Payment Reform, and HIT Roundtable and Virginia's Plan for Well Being), and within the current Tennessee State Health Plan, and with regional collaborative health improvement goals such as those set forth in the Southwest Virginia Health Authority's *Blueprint for Health Improvement and Health-Enabled Prosperity* and in Healthier Tennessee.

All of these efforts recognize that ultimately, individual and community health and well-being are not primarily driven by health care services, but instead by income, education, family and community support, personal choices, genetics and the environment. As the Virginia Center for Health Innovation notes, "Much of what impacts our health depends on our environment, the decisions we make every day, and having access to quality, affordable healthcare. In Virginia, your zip code can predict your health status every bit as much as your blood pressure reading. To improve the well-being of our communities, we have to reach outside the walls of a health care provider's office and engage non-traditional partners. Initiating these new relationships and forming new partnerships is hard work. This is an opportunity and invitation to get started in your region."[56]

A Healthy Virginia, a plan for better health care in the Commonwealth of Virginia commissioned by Governor McAuliffe, notes that the Commonwealth's "needs include strengthening coverage and access for children, veterans, and pregnant women; capitalizing on innovation opportunities; and optimizing the often fragmented systems of care that are currently in place." The plan also highlights mental health needs in the State: "[H]ealth and mental health are inextricably linked. The urgency of the need for accessible mental health care for Virginians cannot be ignored…."[57]

The New Health System is committed to creating a new integrated delivery

[56] *Regional Accountable Care Communities*, Virginia Health Innovation Plan, *available at:* http://www.vahealthinnovation.org/what-we-do/the-virginia-health-innovation-plan/regional-accountable-care-communities-information.
[57] *A Healthy Virginia* Health Care Report, *available at:* https://governor.virginia.gov/media/3096/a-healthy-virginia-report-final.

system designed to significantly improve community health through investment of not less than $75 million over ten years in population health improvement. The New Health System would commence the population health improvement process with the preparation of a comprehensive community health improvement plan that identifies the key health issues for its focus over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The population health improvement funding may be committed to the following initiatives, as well as others, based upon the 10-year action plan for the region.

i. ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low birthweight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

ii. ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

iii. ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

iv. ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The New Health System will also provide financial support to develop and sustain an Accountable Care Community effort across state lines for the region that will help address these and other issues identified by the community health improvement plan. As described in the section below, some of this work is already underway. Wellmont and Mountain States have worked with the College of Public Health at ETSU to organize four Community Health Work Groups to focus on the root causes of poor health in the region and identify actionable interventions for a generational shift in health trends. It is expected that the membership of these Community Health Work Groups could form the initial core of the Accountable Care Community structure.

G. The extent to which medically underserved population have access to, and are projected to utilize, the proposed services.

In cooperation with the College of Public Health at ETSU, the Parties have launched the region's most substantial community health improvement assessment effort to date. Four Community Health Work Groups have been 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 above, the Parties have jointly sponsored and funded these Four Work Groups only as part of the Parties' goal to improve health care services through the Cooperative Agreement.

The four Community Health Work Groups and the eight community leaders who are serving as chairpersons are set forth below:

- Mental Health & Addiction: Dr. Teresa Kidd, president and CEO of Frontier Health, and Eric Greene, senior vice president of Virginia services for Frontier Health;

- Healthy Children & Families: Dr. David Wood, chair of the department of pediatrics at ETSU, and Travis Staton, CEO of United Way of Southwest Virginia;

- Population Health & Healthy Communities: 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: Dr. Wilsie Bishop, vice president for health affairs and chief operating officer of ETSU, and Jake Schrum, president of Emory & Henry College.

These Community Health Work Groups are jointly funded by the Parties. The charters and membership lists of each Work Group are attached as **Exhibit 15.2A and Exhibit 15.2B**[58].

The Community Health Work Groups met during the Fall of 2015 in public meetings throughout Southwest Virginia and Northeast Tennessee to seek community input. The meetings were led by subject matter experts and included business and community leaders from throughout the region who represent a broad variety of experience and perspectives. The meetings were also staffed by members of Mountain States and Wellmont along with master's and doctoral

[58] The membership list reflects all members of each Work Group as of January 25, 2016.

level students from ETSU. The extensive schedule of public meetings already conducted by these four Work Groups is included in **Exhibit 2.1**.

ETSU has been engaged jointly by the Parties to analyze the community input received at these Community Health Work Group meetings and to develop a 10-year plan for addressing these community health opportunities for improvement.

Specifically, the 10-year plan will utilize the input received in the Community Health Work Group sessions in the following ways:

- Mental Health & Addiction: The Mental Health and Addiction Work Group is charged with evaluating the inventory of mental health and addiction services for adults and children in the area. An important objective is to provide data and analysis that will assist the New Health System in developing an optimal structure to combat addiction and substance abuse, reduce the number of newborns born into addiction, and to reduce dependency on drugs and alcohol through improved access and support. The New Health System will use findings from this group to partner with the medical and social service community to combat addiction and support the next generation to achieve its potential.

- Healthy Children & Families: The Healthy Children and Families Work Group is charged with exploring the opportunities and necessary actions for structuring a comprehensive regional approach to child well-being in Southwest Virginia and Northeast Tennessee. The work group will produce a report that identifies the most prominent physical, behavioral, and social health problems affecting children in the region and explores their causes, taking into account the social and family support necessary to equip children to make the strongest possible start in their journey to adulthood.

- Population Health & Healthy Communities: The Population Health and Healthy Communities Work Group is charged with exploring opportunities and necessary actions to improve the overall health and well-being of Southwest Virginia and Northeast Tennessee by aligning and mobilizing public and private sector resources – schools, businesses, civic and faith groups; health care providers; government – around a core set of community health improvement goals in the areas of both health care delivery and social determinants of health. The New Health System will utilize the findings from this group to identify health care delivery goals that could be improved, including, but not limited to: increased vaccinations and screenings, improved

integration of primary care, dental and mental health services, improved access to preventive and treatment services for persons with addictive disorders, and reductions in hospital acquired conditions.

- Research & Academics: The Research and Academics Work Group is charged with exploring the opportunity to improve health and economic growth in Southwest Virginia and Northeast Tennessee by enhancing professional recruitment and research-based funding under a new research and academics partnering strategy between the New Health System and regional academic institutions. The findings from this Work Group will be used by the New Health System and its research partners to interface with an effort to create an accountable care community – in particular, analyze what infrastructure is needed to use the benefit of research to support the initiatives and priorities identified in the accountable care community model.

In addition to utilizing the Community Health Work Groups to identify the services most needed by the medically underserved population, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. The charity care policy and related policies for Mountain States are attached as **Exhibit 11.1.** The charity care policy and related policies for Wellmont are attached as **Exhibit 11.2**. If the Letter Authorizing Cooperative Agreement is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rule.

H. Any other benefits that may be identified.

Behavioral Health and Substance Abuse. Behavioral health and substance abuse issues are a major health factor in the geographic area served by the Parties, and there are currently significant gaps in the continuum of care related to these issues. As part of the public benefit associated with the merger, the New Health System is prepared to make major investments in programs and partnerships that will help to address these issues. The societal cost associated with mental illness and substance abuse is extensive, and, given that the single largest diagnosis related to regional inpatient admissions is psychoses, these issues merit priority attention.

According to the American Hospital Association, one in four Americans experiences a behavioral health issue or substance abuse disorder each year, with the majority of those also experiencing physical health conditions or chronic

diseases that complicate care needs.[59] Thus, these patients typically have higher levels of health care utilization. It has been estimated that medical costs for treating those patients with chronic medical and comorbid mental health/substance use disorder conditions can be 2-3 times as high as for those who do not have a mental health/substance abuse disorder.[60]

Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region and contributes to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and a regionally integrated delivery model to help support the development of effective behavioral health and substance abuse resources to provide high-quality, well-coordinated, and more proactive care. The Parties recognize that important relationships must be developed across a continuum of community-based resources, primary care, intensive outpatient care, and inpatient care. In fact, effective systems of care and provider resources in the outpatient environment and the community go a long way in reducing the need for acute hospitalization or emergency department use. Though the New Health System will work to ensure appropriate inpatient resources exist, the main focus of development in this area will be outpatient systems of care, coordinated systems of care in the community, sufficient provider and specialized counseling resources, and residential recovery services.

The New Health System will work within the existing framework of resources and partnerships across the region to identify needs associated with this area as well as gaps in service offerings. In fact, this is a major focus of the assessment being performed with ETSU through one of the priority Community Health Work Groups. The Parties expect to identify a more integrated care model similar to what is outlined by the Agency for Healthcare Research and Quality ("AHRQ") for the region through the efforts of the Community Health Work Groups. That model includes primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care addressing mental health, substance abuse conditions, health behaviors, life stressors and crisis, stress-related physical symptoms, and ineffective patterns of health care utilization.

The work of AHRQ and other evidence-based best practices will be used as a guide to support the development of regional services in a model that is coordinated, co-located, and integrated to overcome the disparate and disconnected manner in which individuals are currently treated. The New Health System will have tremendous opportunities to support a network of care

[59] Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Cost and Outcomes. Trendwatch. Chicago, IL: American Hospital Association (January 2012). *Available at*:: http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf
[60] Economic Impact of Integrated Medical-Behavioral Healthcare. Milliman, Inc. April 2014. *Available at*:: http://integrationacademy.ahrq.gov/node/5950

resources across the region in partnership with agencies such as Frontier Health, Highlands Community Services, the regional rural health centers and Federally Qualified Health Centers, faith-based organizations, and health departments. Together with these partnership networks, the care resources associated with the New Health System, including primary care networks, emergency department networks, and inpatient behavioral health, will position the system to positively impact the development of this continuum of resources in an unprecedented way.

Common Clinical IT Platform. The Cooperative Agreement will allow the New Health System to leverage its integrated technology systems, combined with data from within the community to better coordinate population health efforts. By creating a "single team" approach, the combined system will promote collaboration across inpatient and outpatient care environments, engage patients, and manage health care data to promote healthier living and manage chronic care conditions. Specifically, the Parties are willing to commit as follows:

COMMITMENTS

- The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.
- The New Health System will commit to participate meaningfully in a health information exchange open to community providers.

Quality and Availability. The quality and availability of health care services will improve under the proposed Cooperative Agreement. Wellmont and Mountain States have been developing quality measurement systems independently of one another. Working together, the Parties believe they will be able to improve how quality is measured not only at their respective hospitals, but also throughout the region. Specifically, the Parties commit to the following:

COMMITMENT

- The New Health System will collaborate with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Parties intend to maintain community outreach programs, such as programs for the elderly and the very young, and be able to better afford to attract and retain top quality specialists in areas either not now offered or at risk of out-migration from either one or both hospital systems. For example, the proposed merger will produce savings which will be used to support specialty services such as behavioral health and pediatric subspecialties that otherwise could not be supported in a region of this size, geography and population density.

The Cooperative Agreement will allow the hospitals the opportunity to continue to offer programs and services that are now unprofitable and otherwise may have to be reduced or cancelled due to lack of funding. Specifically, the New Health System will commit to spending at least $140 million over ten years pursuing specialty services, including those outlined in the commitments below. The initiatives would not be sustainable in the region without the financial support created by the merger.

COMMITMENTS

- The New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
- 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.
- The New Health System will ensure recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.
- 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.

The Parties, the Authority and the Commonwealth share a common interest in ensuring that the financial commitments set forth in this Application are maintained to achieve the longer-term population health goals for the region served by the New Health System. In the event of a natural disaster or other extraordinary circumstance beyond the New Health System's control that would materially risk the financial or operational stability of the New Health System, the Parties may file an amended schedule and investment plan for the commitments to the State for approval. Such amended schedule or contingency plan will specify the financial or operational issues that warrant an amended schedule or contingency plan, and detail how the amended plan or contingency plan is consistent with the intended goals and priorities of the original commitments.

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

RESPONSE: The Parties have attempted to collaborate with respect to quality improvement methodologies and related projects but have been unsuccessful due to the competitive environment, the inability to share proprietary information, and the lack of a common clinical information system.

Examples of cooperative arrangements between the Parties in recent years are:

- In 2004, the foundations for the two systems worked together to start the first regional Susan G. Komen affiliate.

- For several years now, hospitals from both systems have been members of the Northeast/Sullivan Healthcare Coalition to utilize annual grant funds from the Tennessee Department of Health to prepare the region for disasters and health emergencies. The two health systems are currently alternating annually as fiscal agents for the $250,000 per year in grant funds for this project.

- Since 2008, Wellmont provided blood services to certain Mountain States facilities through its blood bank, the Marsh Regional Blood Center.

- The two systems collaborated in 2014 in their joint responses to the Ebola awareness and preparedness campaigns and have jointly sponsored other community health awareness efforts, such as the Healthy Kingsport initiative.

- Recently, Wellmont has added Indian Path Medical Center as a satellite site to its Orthopedic Residency Program and has allowed Mountain States/Norton Community Hospital Internal Medicine residents the

opportunity to complete their endocrinology rotations at Bristol Regional Medical Center.

- Also, the two systems are currently working together to provide an Antibiotic Stewardship educational program for providers and the community.

The Cooperative Agreement will allow the Parties to achieve much more. For example, under the Cooperative Agreement, the New Health System will be able to use the Common Clinical IT Platform and Clinical Council to develop and share the clinical and financial information needed to standardize procedures and policies for clinical best practices and to develop new, improved care models.

As long-standing providers of health care services in the Geographic Service Area, the Parties have vast knowledge of and experience with the unique and vexing health care needs of the region and recognize the pressing need to improve health care services in the region. In addition to the efforts listed above, the Parties, in cooperation with the College of Public Health at ETSU, have jointly sponsored and funded the region's most substantial community health improvement assessment effort to date. This community health improvement assessment effort was launched 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.

c. **REQUEST**: An explanation of why the benefit can only be achieved through a cooperative agreement and not through other less restrictive arrangements; and

RESPONSE: The significant ongoing duplication of services and costs cannot be avoided without a consolidation. Funding the population health, access to care, enhanced health services, and commitments described in this Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost-savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services as further described in Section 13.

Many of the health challenges of the Geographic Service Area are multi-layered and require significant resources and commitments to effectively address them – resources and commitments that no system or hospital alone has been able to devote. The extensive commitments described throughout this Application (which are detailed in Section 17) to improve access to health care and quality of health care could not be achieved without the combination and would not be effectively enforced absent active state supervision programs mandated by Virginia and Tennessee law. Under approved State Agreements, savings realized through the merger, by reducing duplication and improving coordination, will

remain within the region and be reinvested in ways that significantly benefit the community through the addition of new services and capabilities, improved choice and access, effective management of costs and investment in improving the quality of health care and economic development in the region. A merger by Wellmont or Mountain States with a different entity would fall well short of the New Health System's potential for realizing the major integrative efficiencies described herein, which, in turn, will help fund and sustain the Parties' unprecedented and enforceable commitments to health care cost-control and quality improvement in the Geographic Service Area. The proposed consolidation of Wellmont and Mountain States without the State Agreements would likely implicate state and federal antitrust laws. As a result, the potential efficiencies and benefits identified in this Application could not be achieved in the existing market without the approval of the Cooperative Agreement.

d. **REQUEST**: A description of how the parties propose that the commissioner measure and monitor achievement of the proposed benefit including:

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

(2) The current and projected levels, and the trajectory, for each measure that would be achieved over the next five years under the cooperative agreement;

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

(4) A plan for how the requisite data for assessing the benefit will be obtained.

RESPONSE: The region served by the Parties to the Cooperative Agreement faces significant, wide-ranging health care challenges. Virginia counties in the Geographic Service Area exceed the national average for smoking and range from a low of 21 percent (21%) to a high of 33 percent (33%). Virginia counties within the Geographic Service Area also have obesity rates that exceed the Virginia state levels, ranging from 29 percent (29%) to 35 percent (35%). Teenage pregnancy rates in the Virginia counties within the Geographic Service Area exceed the national average of 26.5 births per 1,000 adolescent females,[61] and four of those counties have rates that exceed double the national average (Dickenson, Lee, Smyth, and Wise). Low birthweight is also an issue of concern. Only three of the Virginia counties in the Geographic Service Area – Grayson,

[61] *Trends in Teen Pregnancy and Childbearing*, Office of Adolescent Health, U.S. Department of Health & Human Services, *available at*: http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html and search "Trends in Teen Pregnancy and Childbearing."

Russell and Wythe – have low birthweight rates that are better than the state average. Of the eleven Virginia counties in the Geographic Service Area, all eleven exceed the state average for mortality rate due to drug poisoning. Dickenson County's rate is the highest in either Tennessee or Virginia. The Southwest Virginia Health Authority's Blueprint for Health Improvement and Health-Enabled Prosperity (updated January 7, 2016)[62] identifies these issues and others in the Authority's goals for its region's health. **Table 15.1** reports key statistics on the population of the counties in the Geographic Service Area, including metrics for obesity, smoking, death rates due to drug poisoning and childhood poverty.

The Parties share the Commonwealth's concern about health disparities in the region and are aware of the acute challenges present in the individual counties across the Geographic Service Area. As a result, the Parties propose that ongoing evaluation of the public advantage resulting from the merger take into consideration the New Health System's pursuit of the Institute of Health Improvement's Triple Aim goals, commonly considered the national standard for evaluation of health care effectiveness. The Triple Aim objectives are to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of health care. In this application, the Parties have organized the necessary actions by the New Health System to pursue the Triple Aim objectives as follows:

- Improving Community Health
- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Research and Graduate Medical Education
- Attracting and Retaining a Strong Workforce

In order to evaluate the benefits provided by the New Health System on a continuous basis, the Parties propose that the Department adopt a set of "Quantitative Measures" to be used to evaluate the proposed and continuing benefits of the Cooperative Agreement and that the Quantitative Measures be comprised of five major categories:

A. Commitment to Improve Community Health
B. Enhanced Health Care Services
C. Expanding Access and Choice
D. Improving Health Care Value: Managing Quality, Cost and Service
E. Investment in Health Research/Education and Commitment to Workforce

[62] *Goals Update available at:* https://swvahealthauthority.net.

A description of each category and the accountability mechanisms the Parties propose the Commonwealth consider for each category are outlined in detail in the following sections.

A. Commitment to Improve Community Health

Community health is affected by a complex variety of factors including genetic predisposition, behavioral patterns, social circumstances, environmental exposures, and access to quality health care. Because of the complex set of influences that shape community health and well-being, effective improvement strategies must be developed through a combination of evidence-based approaches and an understanding of local and regional culture, capacity and resources. Plans that are adopted "off the shelf" from elsewhere, without community buy-in and adaptation, have less chance of success. Although there are similarities with other parts of Virginia and Tennessee, the southern Appalachian mountain region of Southwest Virginia and Northeast Tennessee has a distinct culture, capacity and resource base that results in a unique set of health issues.

There are tremendously valuable assets, organizations and individuals highly motivated to address the underlying factors that affect the poor health status of our region. ETSU's College of Public Health and Quillen College of Medicine are both nationally recognized for their contributions to rural community health improvement, along with a host of other academic institutions throughout the region. In addition, municipalities, community organizations such as local United Way agencies and YMCAs, Healthy Kingsport, chambers of commerce, and health departments are highly motivated to work in new, focused ways to improve community health.

Much of the work and investment devoted to these efforts in the past, however, has lacked unified focus in combination with sustainable funding. While the Parties believe that motivated leadership and substantial investment from the New Health System will be transformational, they also believe that a sustainable collective impact model of community health improvement stands the best chance of creating long-standing health improvements.

To make sustained improvements in health, a portfolio of investments, interventions and performance improvements designed to impact specific long-term goals at a variety of intervention and prevention levels is necessary. **Figure 15.1** depicts the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships ("MAPP") process for community health improvement. MAPP suggests that it is critical for the New Health System, the Commonwealth and local Departments of Health and the broad community of stakeholders to work together in an Accountable Care

Community arrangement to formulate the appropriate investments, interventions and performance improvements to populate a robust and dynamic community health improvement portfolio. This process includes (1) defining a common vision and goals; (2) conducting comprehensive assessments of community health status and well as community and public health systems culture, capacity and resources; (3) prioritizing health issues; (4) formulating goals and strategies; and (5) evaluation and monitoring.

Figure 15.1 – Mobilizing for Action through Planning and Partnerships

Some progress has already been made. Several local, state and national analyses have identified the key health issues in our region, and there is considerable overlap in their findings. Groups such as the Southwest Virginia Health Authority, Healthier Tennessee, and Healthy Kingsport have organized to collectively address these findings, and important relationships have been formed.

Additionally, in cooperation with the College of Public Health at ETSU, the Parties launched the region's most substantial community health improvement assessment effort in August 2015. Four Community Health Work Groups have been 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. These workgroups are co-chaired by regional community leaders from both Virginia and Tennessee and are organized by Healthy Children and Families, Mental Health and Addiction, Population Health

and Healthy Communities, and Research and Academics. The charters and membership lists for the Community Health Work Groups can be found in **Exhibits 15.2A and 15.2B**.

Analyzing the most current findings of the Virginia Health Innovation Plan, the Southwest Virginia Health Authority's *Blueprint for Health Improvement and Health-Enabled Prosperity*, the Tennessee State Health Plan, and Healthier Tennessee, as well as initial feedback from the Community Health Work Groups organized by Mountain States and Wellmont, the Parties have identified five Key Focus Areas and several related Health Concerns in which the New Health System is committed to investing at least $75 million over ten years in population health improvement.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

- ***Improve Access to Behavioral Health Services*** through new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region; as well as community-based mental health resources, such as mental 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.

For the first category of the Quantitative Measures, the Parties propose an accountability mechanism for the commitment to improve community health that the New Health System has set forth in this Application. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) in **Table 15.6**.

Table 15.6 – Proposed Commitment to Improve Community Health Measures

Quantitative Measures of Continuing Benefit **A. Commitment to Improve Community Health Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than $75 million over ten years in population health improvement.	Annual report to Commissioner attesting to progress towards compliance until $75 million is invested.
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the Virginia State Agreement.	Commitment to Community Health Annual Report to Commissioner will attest to progress on the accountability mechanisms for each Key Focus Area as outlined in the Virginia State Agreement.
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to Commissioner attesting to compliance with reporting obligations as outlined in the Virginia State Agreement.

In addition to the Commitment to Community Health Annual Report, mentioned in **Table 15.6** above and described in more detail below, the Parties will submit a yearly report to the Commissioner attesting to progress toward the creation of a new integrated delivery system through investment of not less than $75 million and an annual report to the Commissioner attesting to compliance with the quality reporting obligations as outlined in the Virginia State Agreement.

The annual report to the Commissioner attesting to progress on the achievement of accountability mechanisms for each Key Focus Area (the "Commitment to Community Health Annual Report") would be developed as follows:

Proposal for Development of the Commitment to Community Health Annual Report

- As part of the Cooperative Agreement approval process, the Commissioner and the Parties will agree on the Key Focus Areas of the commitment to improve community health.

- After the Application is deemed complete and during the Cooperative Agreement approval process, the Parties and the Commissioner, with input from community stakeholders (including the Authority and the Department's Technical Advisory Panel) will agree on a limited number of Health Concerns, Tracking Measures and relevant baselines within each Key Focus Area. Agreement on these specific Health Concerns for inclusion in the Commitment to Community Health Annual Report will serve as the guide for on-going development with the Commonwealth and stakeholder community for the specific investments, interventions or performance improvements by the New Health System to improve community health in the region over the duration of the Virginia State Agreement.

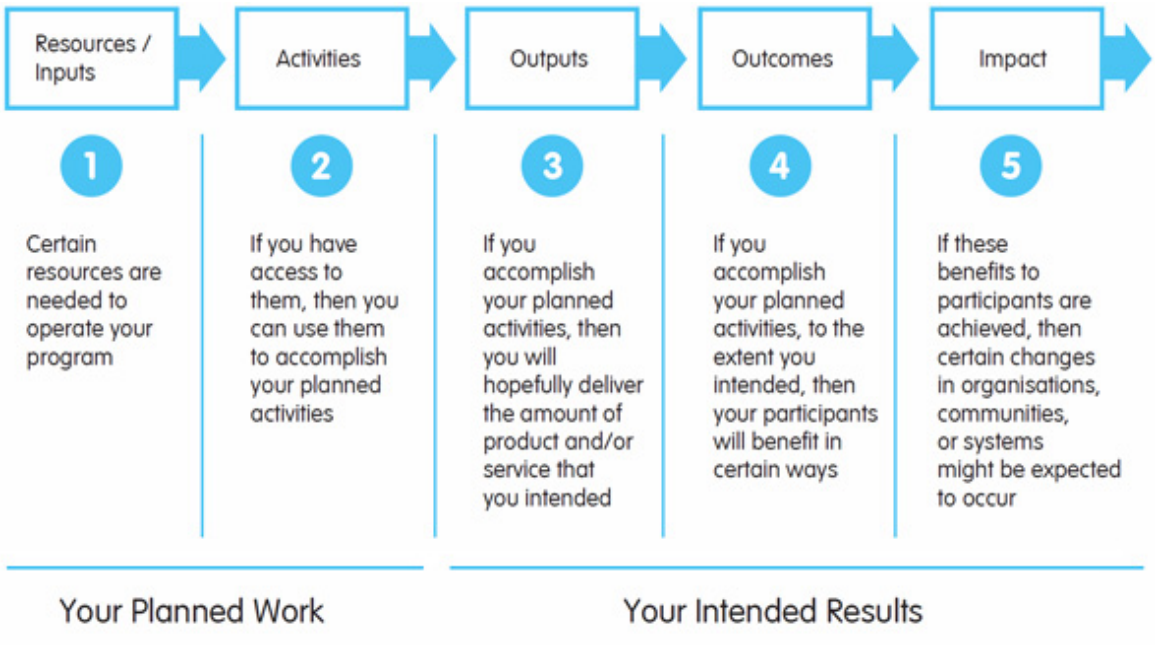
- The Virginia State Agreement will outline the specific Key Focus Areas, the individual Health Concerns, the Accountability Mechanisms, the Tracking Measures, and relevant baselines within each area agreed upon by the Department and the New Health System to be included in the Commitment to Community Health Annual Report.

Recognizing the complex interplay of inputs and activities in reaching desired population health outcomes, the Parties propose to use the Kellogg Foundation's Logic Model displayed in **Figure 15.2** for development of the Commitment to Community Health Annual Report Measures.

The evaluation of improvement in community health is complex and involves many factors, both short-term and long-term. Population health improvement programs can be characterized by their inputs, activities, outputs, outcomes, and impact. *Inputs* are the resources dedicated to or consumed by the program, including the human, financial, organizational, and community resources a program has available to direct toward doing the work. *Activities* are what the program does with its inputs to fulfill its mission. These include the processes, tools, events, technology, and actions that are an intentional part of the program implementation. *Outputs* are the direct products of program activities and may include types, levels and targets of services to be delivered by the program. *Outcomes* are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. *Impact* is the fundamental change

occurring in organizations, communities or systems as a result of program activities often with longer term time frames of 7 to 10 years.

Figure 15.2 – Logic Model for Evaluation



Under this model, the Commonwealth could evaluate progress toward *long-term* community health improvement outcomes under the State Agreement by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The Commonwealth and the New Health System could track participation or service levels related to these programs and performance improvements (Outputs). Over time, the cumulative effect of these efforts is expected to result in the intended population health improvement (short and medium-term Outcomes and long-term Impact).

Table 15.7 below identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Parties propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Parties have identified specific Health Concerns (column one) that pose an important challenge and priority for health in this region; these are aligned with health challenges and priorities identified by the states. The second column identifies a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas

in the states or nationally.

Column three provides a *representative* investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the Commonwealth and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area.

The fourth (highlighted) column provides the relevant Accountability Mechanism the Parties believe reflects the New Health System's performance related to the investment, intervention, or performance improvement.

Column five provides a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern.[63] The final two columns – six and seven – reference county-level disparities as measured by the Tennessee and Virginia counties in the Geographic Service Area that have the lowest/poorest measure. This recognizes Virginia's (and Tennessee's) concerns that specific counties within the Geographic Service Area may warrant particular attention or intervention.

[63] In addition to consideration of Triple Aim objectives, the Parties also have considered the categories of health measures for access, cost, health, and quality identified in the Institute of Medicine ("IOM") Vital Signs Core Measures; each of the several areas that these investment, intervention, or performance improvement would target are aligned with specific IOM Core Measures.

Table 15.7 – Sample Commitment to Improve Community Health Annual Report

Health Concern		*Health Concern **Tracking Measures** in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest Ranking Virginia Counties in Geographic Service Area*
Key Focus Area #1: Ensure Strong Starts for Children							
1.	Low Birth-Weight Babies	Low-birth weight rate per 100,000 population	Establish evidence-based Home Visitation Programs in certain high-risk counties[64]	Establish agreed upon number of evidence-based Home Visitation Programs in specific counties by set date	Percentage of eligible women in high risk communities participating in evidence-based home visitation programs.	Johnson, Carter, Cocke[65]	Tazewell, Buchanan, Smyth[66]
2.	Neonatal Abstinence Syndrome	Percent of Births in New Health System with NAS	Establish residential treatment for pregnant woman with addiction in certain high-risk communities[67]	Establish agreed-upon number of residential treatment programs for pregnant woman with addiction in specific counties by set date	Number of women in high-risk communities initiating residential treatment	Hancock, Hamblen, Hawkins[68]	Dickenson, Wise, Tazewell, Buchanan[69]
3.	Childhood Obesity	Percent children w/ BMI >= 95th percentile of the sex-specific CDC BMI-for-age	Expand "Morning Mile" Program in certain high-risk communities[70]	Expand "Morning Mile[71]" Program through investment of an agreed-upon amount by set date	Number of children participating in Morning Mile in high-risk communities	Hawkins, Sullivan, Greene[72]	Russell, Scott, Grayson, Washington, Wise[73]

[64] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,4,5,8, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[65] Tennessee: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.
[66] Virginia: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.
[67] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,4,8,and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[68] As county-level NSA data is not currently available, adult drug poisoning deaths is used as a proxy measure. Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.
[69] As county-level NSA data is not currently available, adult drug poisoning deaths is used as a proxy measure. Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.
[70] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[71] The Morning Mile is a before-school walking/running program that gives children the chance to start each day in an active way while enjoying fun, music and friends. The Morning Mile is currently sponsored in the Geographic Service Area by Mountain States. Additional Information is *available at*:: https://www.mountainstateshealth.com/medical-services/kohls-morning-mile
[72] As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Tennessee: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.
[73] As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Grayson, Washington, and Wise are in a three-way tie having the third highest obesity rate among the counties in the service region. Virginia: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

Health Concern		*Health Concern **Tracking Measures** in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest Ranking Virginia Counties in Geographic Service Area*
		growth charts					
4.	Third Grade Reading Ability	Percent 3rd graders reading at grade level	Expand "Bear Buddy" program[74]	Expand "BEAR Buddies[75]" program through investment of an agreed-upon amount by set date	Number of children participating in BEAR Buddies in TN & VA in high-risk communities	Hancock, Cocke, Carter[76]	Bristol City, Buchanan, Wythe[77]
Key Focus Area #2: Help Adults Live Well in the Community							
1.	Premature death from Cardiovascular Disease	Age Adjusted Death Rates for Diseases of the Heart per 100,000	Expansion of community-based smoking cessation programs in certain high-risk communities[78]	Expansion of community-based smoking cessation programs through investment of an agreed-upon amount by set date	Number of participants in smoking cessation programs in high-risk communities	Unicoi, Cocke, Hancock[79]	Tazewell, Smyth, Scott[80]
2.	Premature death from Diabetes	Age Adjusted Death Rates for Diabetes Mellitus per 100,000	Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications[81]	Establish Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications by set date	Number of Physicians participating in quality improvement project	Hamblen, Carter, Greene, Sullivan[82]	Scott, Smyth, Tazewell[83]

[74] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[75] The BEAR (Being Engaged to Achieve Reading) Buddies program is a partnership between Niswonger Children's Hospital and local schools designed to help children achieve early reading proficiency. BEAR Buddies pairs high school mentors with students in first, second or third grade who are six months or more behind in their reading level.
[76] Tennessee: TCAP District Level Results – 3rd through 8th Grade Reading Level. Percent Basic through Percent Advanced. Tennessee Department of Education. Accessed February 4, 2016.
[77] Virginia: SOL Assessment – 3rd Grade English Reading Pass Rate for 2014 - 2015. Virginia Department of Education. Accessed February 4, 2016.
[78] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,7,8,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[79] "Ischemic Heart Disease in Tennessee." US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/
[80] "Ischemic Heart Disease in Virginia." US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/
[81] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,7,8,9,10, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[82] Tennessee: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/. Greene and Sullivan counties tie for having the third highest rate among counties in the Geographic Service Area.
[83] Virginia: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/

Health Concern		*Health Concern **Tracking Measures** in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest Ranking Virginia Counties in Geographic Service Area*
3.	Premature death from Breast, Cervical, Colon and Lung Cancer	Age Adjusted Death Rates for Select Cancers per 100,000	Establish Faith-based screening campaigns for selected cancers (e.g. mammograms, prostate cancer) in specific high-risk counties[84]	Establish agreed-upon number of Faith-based screening campaigns in certain counties by set date	Number of parishioner screenings in high-risk counties	Hawkins, Cocke, Johnson[85]	Bristol City, Smyth, Buchanan[86]
Key Focus Area #3: Promote a Drug-Free Community							
1.	Addiction to Prescription Pain-killers and illicit drugs	Addiction death rate per 100,000	Establish a regional residential addiction treatment program[87]	Establishment of a regional residential addiction treatment program by a set date	Number of individuals participating in residential addiction treatment	Hancock, Hamblen, Hawkins[88]	Dickenson, Wise, Tazewell, Buchanan[89]
2.	Tobacco use in Teens	Percent of teens currently smoking	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco in certain high-risk counties[90]	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco through an agreed-upon investment by set date	Number of anti-smoking impressions in high-risk communities	Hancock, Carter, Greene[91]	Wise, Dickenson, Buchanan[92]

[84] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,7,8,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[85] Tennessee: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer 2014. CDC Wonder Database. Accessed February 3, 2016.
[86] Virginia: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer, 2014. CDC Wonder Database. Accessed February 3, 2016.
[87] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,8,10,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[88] Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.
[89] Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.
[90] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 11,2,4,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3**.
[91] As county-level data on teen smoking was not available, adult smoking rates were used as a proxy. Tennessee: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.
[92] As county-level data on teen smoking was not available, adult smoking rates were used as a proxy measure. Virginia: Percent of Adult Smoking. County Health Rankings. Accessed, February 3, 2016.

Health Concern		*Health Concern* ***Tracking Measures*** *in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest Ranking Virginia Counties in Geographic Service Area*
Key Focus Area #4: Decrease Avoidable Hospital Admission in the High-Utilizing Uninsured							
1.	Avoidable inpatient admission among the uninsured	PQI Admissions per 1,000 uninsured	Establish Integrated Care Management Program for Uninsured Community Super-Utilizers[93]	Establish agreed-upon number of Integrated Care Management Programs for Uninsured Community Super-Utilizers by set date	Number of Uninsured Community Super-Utilizers in Active Care Management	Hancock, Unicoi, Cocke[94]	Buchanan, Russell, Lee[95]
Key Focus Area #5: Access to Behavioral Health Services							
1.	Access to community-based mental health treatment	Psychiatric Admissions through ER per 1,000 ER visits	Establish Crisis Receiving Centers in hospitals serving specific high-risk counties[96]	Establish an agreed-upon number of Crisis Receiving Centers in specific by set date	Number of individuals managed in Crisis Receiving Centers.	Hancock, Cocke, Hamblen[97]	Wise, Dickenson, Tazewell[98]

Representative Example:

If the Commonwealth and the New Health System agree that one of the Key Focus Areas in the Commitment to Improve Community Health Annual Report should be Ensuring Strong Starts for Children, one Health Concern the Parties suggest targeting is low birth-weight babies. The baseline for tracking this health concern would be the Low Birth Weight Rate per 100,000 population for specific counties within the Geographic Service Area. One investment, intervention, or performance improvement that the New Health System could undertake to address this Health

[93] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,6,7,8,9,10,11,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3A**.
[94] As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Tennessee." County Health Rankings. Accessed February 3, 2016.
[95] As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Virginia." County Health Rankings. Accessed February 3, 2016.
[96] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3, and 8. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 15.3.**
[97] As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Tennessee: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.
[98] As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Virginia: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

Concern would be to establish evidence-based Home Visitation Programs in certain high-risk counties. The Representative Quantitative Measures would reflect the New Health System's commitment to the Commonwealth to establish an agreed-upon number of evidence-based Home Visitation Programs in certain counties by agreed-upon dates. The Quantitative Measures that could be used by the Commonwealth and the New Health System to measure progress in addressing this Health Concern would be the percentage of eligible women in high-risk communities participating in evidence-based Home Visitation Programs.

Periodic Review of the Commitment to Community Health Annual Report

The Parties recognize that population health is dynamic and the health challenges of a region will change over time. The Commitment to Community Health Annual Report established when the Virginia State Agreement is approved should be periodically reviewed and updated to reflect these changes. The Parties propose that the initial Commitment to Community Health Annual Report and its associated plan be established with the issuance of the Letter Authorizing Cooperative Agreement. On the fifth anniversary of the Cooperative Agreement, the New Health System and the Commissioner will evaluate the Commitment to Community Health Annual Report to determine what adjustments, if any, need to be made to plan elements, Quantitative Measures or other accountability mechanisms. Once the New Health System and the Commissioner have agreed upon these changes, the updated elements of the Commitment to Community Health Annual Report will go into effect on the sixth anniversary of the State Agreement for a period of five years. The Parties propose that the periodic review of the Commitment to Community Health Annual Report be performed on the same intervals for as long as the Virginia State Agreement remains in effect.

B. Enhanced Health Care Services Measures

Some residents of the Geographic Service Area have acceptable access to many services, but others reside in areas that are substantially underdeveloped or that lack services altogether. This is especially true for mental health, substance abuse and specialty pediatric services. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the New Health Systems' hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding.

For the second category of the Quantitative Measures, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to enhance health care services. **Table 15.8** below indicates five areas where the Parties have made commitments to investment, performance, or conduct in the Application as the New Health

System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 15.8 – Proposed Enhanced Health Care Services Measures

Quantitative Measures of Continuing Benefit **B. Enhanced Health Care Services Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	The New Health System commits to spending at least $140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to Commissioner attesting to progress towards compliance until $140 million is invested.
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the Geographic Service Area.	Annual progress reports and One-time report to Commissioner attesting to the creation of new capacity for residential addiction recovery services when complete.
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.	Report to Commissioner attesting to compliance after the third year after formation of the New Health System.
4.	Development of 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 as close to patients' homes as possible.	Annual report to Commissioner attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the Commonwealth every three years.

C. Expanding Access and Choice Measures

Investing in the development of new and expanded services is one way to improve access and choice in the region. Preserving services currently at risk and breaking down barriers for physicians to practice and patients to receive services where they choose is another. The New Health System is committed to both. By integrating the two systems, the Parties will help ensure that communities in the Geographic Service Area continue to have access to the care they need close to home and that care options are expanded rather than reduced.

For the third category of the Quantitative Measures, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to sustain and expand access and choice. **Table 15.9** below indicates six areas where the Parties have made commitments to investment, performance, or conduct in this Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 15.9 – Proposed Expanding Access and Choice Measures

Quantitative Measures of Continuing Benefit **C. Expanding Access and Choice Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.	Annual report to Commissioner attesting to compliance for five years after formation of the New Health System.
2.	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.	Annual report to Commissioner attesting to compliance.
3.	Maintain open medical staffs 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 Board of Directors.	Annual report to Commissioner attesting to compliance.

4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to Commissioner attesting to compliance.
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to Commissioner attesting to compliance.
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to Commissioner attesting to compliance.

D. Improving Health Care Value: Managing Quality, Cost and Service Measures

In addition to achieving reduced costs through improved efficiency and avoidance of waste and unnecessary duplication, the merger will also specifically enable the New Health System to reduce overutilization of inpatient services and stem the pace of health care cost growth for patients, employers and insurers.

As evidence of their commitment to manage quality, cost, and service, for the fourth category of Quantitative Measures the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to improve health care value. **Table 15.10** below indicates ten areas where the Parties have made commitments to investment, performance, or conduct in the Application through the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 15.10 – Proposed Improving Health Care Value: Managing Quality, Cost and Service Measures

Quantitative Measures of Continuing Benefit **D. Improving Health Care Value: Managing Quality, Cost and Service Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to Commissioner after first contract year attesting to compliance.
2.	For subsequent contract years, the New Health System will	Annual report to

	commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.	Commissioner attesting to compliance.
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to Commissioner attesting to compliance.
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to Commissioner attesting to compliance.
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to Commissioner attesting to progress towards compliance until the Common Clinical IT Platform is adopted.
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to Commissioner attesting to

		compliance once health information exchange is fully established.
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to Commissioner attesting to measurement of quality measures identified in Section 15.a.A(iv) of the Application.
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the 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.	Annual report to Commissioner attesting to compliance.
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to Commissioner attesting to compliance.
10.	The New Health System will not engage in "most favored nation" pricing with any health plans.	Annual report to Commissioner attesting to compliance.
*For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.		

E. Investment in Health Research/Education and Commitment to Workforce

A cornerstone of the proposed merger is the expansion of the health-related research and academic capabilities of the region through additional funding and closer working relationships with East Tennessee State University and other academic partners in Virginia and Tennessee. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, and expanded services and training can also contribute to the economic vitality of the Geographic Service Area and the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities both with health and economic well-being.

In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by becoming one of the best health system employers in the nation and one of the

most attractive health systems for physicians and employee team members. The workforce is the lifeblood of a health care organization and the competition for the labor force will remain intense, both locally and regionally.

As evidence of their commitments to invest in health research and education and to attract and retain a strong workforce, for the fifth category of Quantitative Measures the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to achieve these goals. The table below indicates six areas where the Parties have made commitments in the Application to investment, performance, or conduct through the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) of **Table 15.11** below.

Table 15.11 – Proposed Investment in Health Education/Research and Commitment to Workforce Measures

Quantitative Measures of Continuing Benefit **E. Investment in Health Education/Research and Commitment to Workforce Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.	Annual report to Commissioner attesting compliance.
2.	With its academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to Commissioner attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
3.	The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to Commissioner attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to Commissioner attesting to compliance after the first year after formation of the New Health System.

5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to Commissioner attesting to compliance after the first year after formation of the New Health System.
6.	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to Commissioner attesting compliance.

Applying the Quantitative Measures and Measuring Achievement of Continuing Benefit

The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the Commissioner to objectively track the progress of the Cooperative Agreement over time to ensure community health improvement. The Overall Achievement Score would be used, specifically, to determine that there is Continuing Benefit. "Continuing Benefit" will mean that the Cooperative Agreement is in substantial compliance with the terms of the Letter Authorizing Cooperative Agreement and that the benefits of the Cooperative Agreement outweigh any disadvantages attributable to any reduction in competition resulting from the Cooperative Agreement.

To calculate the Overall Achievement Score, the Parties propose that the Commissioner assign a "Satisfied" or "Not Satisfied" evaluation to each of the five categories of the Quantitative Measures and that the five categories be given equal weight in the scoring process. The score for each category will be the number of measures within that category successfully satisfied divided by the total number of measures within that category. The five category scores should be combined to determine the "Overall Achievement Score" for each year of active state supervision to ensure Continuing Benefit.

Representative Example:

For each of the five categories, the Commissioner would assign a "Satisfied" or "Not Satisfied" evaluation to the individual measures agreed upon by the New Health System and the Commonwealth in the Virginia State Agreement as demonstrated in **Table 15.12** below. If the Parties agreed upon the following Quantitative Measures of Continuing Benefit, the Commissioner would evaluate each individual accountability mechanism as follows:

Table 15.12 – Demonstration of Evaluation

	Quantitative Measures of Continuing Benefit	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
A. Commitment to Improve Community Health			
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than $75 million over ten years in population health improvement.	Annual report to Commissioner attesting to progress towards compliance until $75 million is invested.	Satisfied
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the Virginia State Agreement.	Annual report to Commissioner attesting to progress on the accountability mechanisms for each Key Focus Area as outlined in the Virginia State Agreement.	Satisfied
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to Commissioner attesting to compliance with reporting obligations as outlined in the Virginia State Agreement.	Satisfied
B. Enhanced Health Care Services Measures			
1.	The New Health System commits to spending at least $140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to Commissioner attesting to progress towards compliance until $140 million is invested.	Satisfied
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	One-time report to Commissioner attesting to the creation of new capacity for residential addiction recovery services when complete.	Satisfied
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.	Report to Commissioner attesting to compliance after the third year after formation of the New Health System.	Satisfied

	Quantitative Measures of Continuing Benefit	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
4.	Development of 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.	Annual report to Commissioner attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.	Satisfied
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the Commissioner every three years.	Satisfied
C. Expanding Access and Choice			
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.	Annual report to Commissioner attesting to compliance for five years after formation of the New Health System.	Satisfied
2.	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.	Annual report to Commissioner attesting to compliance.	Satisfied
3.	Maintain open medical staffs 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 Board of Directors	Annual report to Commissioner attesting to compliance.	Satisfied
4.	Commitment to not engage in exclusive contracting for physician services, except for	Annual report to Commissioner attesting	Satisfied

	Quantitative Measures of Continuing Benefit	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	certain hospital-based physicians as determined by the Board of Directors.	to compliance.	
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to Commissioner attesting to compliance.	Satisfied
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to Commissioner attesting to compliance.	Satisfied
D. Improving Health Care Value: Managing Quality, Cost and Service			
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement..	Report to Commissioner after first contract year attesting to compliance.	Satisfied
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing	Annual report to Commissioner attesting to compliance.	Satisfied

	Quantitative Measures of Continuing Benefit	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.		
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to Commissioner attesting to compliance.	Satisfied
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to Commissioner attesting to compliance.	Satisfied
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to Commissioner attesting to progress towards compliance until the Common Clinical IT Platform is adopted.	Satisfied
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to Commissioner attesting to compliance once health information exchange is fully established.	Satisfied
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to Commissioner attesting to measurement of quality measures identified in Section 15.a.A(iv) of the	Satisfied

	Quantitative Measures of Continuing Benefit	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
		Application.	
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the 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.	Annual report to Commissioner attesting to compliance.	Satisfied
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to Commissioner attesting to compliance.	Satisfied
10.	The New Health System will not engage in "most favored nation" pricing with any health plans.	Annual report to Commissioner attesting to compliance.	Satisfied
E. Investment in Health Education/Research and Commitment to Workforce			
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.	Annual report to Commissioner attesting compliance.	Satisfied
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to Commissioner attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
3.	The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to Commissioner attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to Commissioner attesting to compliance after the first year after formation of the New Health System.	Satisfied
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and	Report to Commissioner attesting to compliance after the first year after	Satisfied

	Quantitative Measures of Continuing Benefit	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	employee benefit structures.	formation of the New Health System.	
6.	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to Commissioner attesting compliance.	Satisfied
*For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.			

In this representative example, the Overall Achievement Score would be calculated as demonstrated in **Table 15.13** below:

Table 15.13 – Demonstration of Overall Achievement Scoring

Category	**Measures Satisfied**	**Overall Achievement Score**
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	6/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	10/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	**30/30**	**100%**

Continuing Benefit

The Parties propose that an Overall Achievement Score rounded to the nearest tenth of one point that equals seventy percent (70%) or above shall be considered definitive evidence of Continuing Benefit, and the Virginia State Agreement shall continue in effect. An Overall Achievement Score rounded to the nearest tenth of one point that equals fifty percent (50%) up to seventy percent (70%) may be considered definitive evidence of Continuing Benefit depending upon the relative circumstances, and the Commonwealth, at the Commissioner's discretion, may seek a modification to the State Agreement under the terms of the State Agreement. An Overall Achievement Score rounded to the nearest tenth of one point that is below fifty percent (50%) may be considered definitive evidence, when considering the relative circumstances, of lack of Continuing Benefit, and the Commissioner, in his or her discretion, may begin action to revoke the Virginia State Agreement under the terms of the State

Agreement.

Due to the new and untested nature of the Quantitative Measures of Continuing Benefit and the significant up-front and ongoing investments required for achieving community health improvement in the Geographic Service Area, it is critical that the Commissioner use proper discretion in determining whether there is evidence of Continuing Benefit. Notwithstanding any provision to the contrary, the Commissioner shall consider any and all important public benefits, whether or not explicitly addressed in the Quantitative Measures of Continuing Benefit. Further, the Commissioner shall have discretion to determine that the Continuing Benefit standards have been achieved during a particular period even if the Overall Achievement Score falls below the parameters outlined.

Representative Examples:

Example 1. If the New Health System was able to satisfy most of the Quantitative Measures of Continuing Benefit for a particular year, the Overall Achievement Scoring might appear as follows in **Table 15.14**:

Table 15.14 – Sample Scoring for Example 1

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	5/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	9/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	**28/30**	**93.3%**

An Overall Achievement Score of 93.3% is considered evidence of Continuing Benefit and the Virginia State Agreement would continue in effect.

Example 2. If the New Health System was not able to satisfy some of the Quantitative Measures of Continuing Benefit for a particular year, the scoring might appear as follows in **Table 15.15**:

Table 15.15 – Sample Scoring for Example 2

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	4/5	
C. Expanding Access and Choice	4/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	6/10	
E. Investment in Health Research/Education and Commitment to Workforce	3/6	
Overall Achievement Score	**19/30**	**63.3%**

An Overall Achievement Score of 63.3% may be considered evidence of the Continuing Benefit, depending upon the relative circumstances considered by the Commissioner. The New Health System would be given the opportunity to explain why any Quantitative Measure has not been satisfied, and the Commissioner would consider this information in deciding whether to exercise his or her discretion in seeking a modification to the State Agreement. After considering the Continuing Benefit and the explanations for why any Quantitative Measure has not been satisfied, the Commonwealth, at the Commissioner's discretion, may seek a modification to the Virginia State Agreement under the terms of the State Agreement.

Example 3. If the New Health System was not able to satisfy several Quantitative Measures of Continuing Benefit for a particular year, the scoring might appear as follows in **Table 15.16**:

Table 15.16 – Sample Scoring for Example 3

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	2/5	
C. Expanding Access and Choice	3/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	5/10	
E. Investment in Health Research/Education and Commitment to Workforce	2/6	
Overall Achievement Score	**14/3**	**46.7%**

An Overall Achievement Score of 46.7% may be considered, depending on the relative circumstances, evidence of lack of Continuing Benefit. The New Health System would be given the opportunity to explain why any Quantitative Measure has not been satisfied, and the Commissioner would consider this information.

The Commissioner would allow a reasonable period of time for a remediation plan to be developed, presented, accepted and implemented for re-evaluation. After considering the Continuing Benefit, the explanations for why any Quantitative Measure has not been satisfied, and performance under the remediation plan, the Commonwealth, at the Commissioner's discretion, may begin action to revoke the State Agreement under the terms of the State Agreement. In deciding whether to take action to revoke the State Agreement under the terms of the State Agreement, the Commissioner would have the authority to consider important public benefits that contribute to the Continuing Benefit even if those public benefits are not explicitly addressed in the Quantitative Measures of Continuing Benefit.

Quantitative Measures of Continuing Benefit and Community Health Improvement – Conclusion

The Parties believe that the proposed Quantitative Measures of Continuing Benefit outline a process for the New Health System to align its resources and commitments with the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of health care in the region. At the same time, the Parties believe that including the Department, the Authority, the Technical Advisory Panel appointed by the Commissioner, the local departments of health, the Community Health Work Groups and other community stakeholders in finalizing the proposed Quantitative Measures Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and more efficient implementation of the population health improvement process. Ultimately, the Parties hope that this process will result in the highest chance of success for improving population health across our region.

16. NO POTENTIAL ADVERSE IMPACT

REQUEST: A description of any potential adverse impact of the proposed cooperative agreement on (i) population health, or (ii) quality, availability, cost, or price of health care services to patients or payers.

RESPONSE: The Parties do not foresee any adverse impact on population health, or quality, access, availability cost or price of health care services to patients or payers as a result of the Cooperative Agreement. The projects and commitments identified in this Application will result in significant benefits and clearly improve health care in the region.

17. COMMITMENTS

REQUEST: 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.

RESPONSE: The Parties do not foresee any adverse impacts on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement. Rather, the Parties foresee the Cooperative Agreement resulting in significant benefits as detailed in this Application.

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

With the approvals of Virginia and Tennessee under the State Agreements, savings realized, by reducing duplication and improving coordination, will remain within the region and be reinvested in ways that substantially benefit the community. All of these benefits will be devoted to Southwest Virginia and Northeast Tennessee and will include new services and capabilities, improved choice and access, more effective management of health care costs, and strategic investments to address the region's most vexing health problems while spurring its economic development.

In order to assure the Commonwealth of the overriding benefits of the proposed merger, the Parties are willing to make meaningful and significant commitments, which are evidence of the Parties' belief in the ability of the New Health System to reduce cost growth, improve the quality of health care services and access to care, including the patient experience of care, and enhance overall community health in the region. Many of the Parties' commitments can be categorized into the following areas:

- Improving Community Health

- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Education/Research and Commitment to Workforce

The Parties' commitments in each of these categories is shown in **Table 17.1** below:

Table 17.1 – Commitments

COMMITMENTS
Improving Community Health ***Enhancing Health Care Services*** ***Expanding Access and Choice*** ***Improving Health Care Value: Managing Quality, Cost and Service*** ***Investment in Health Education/Research and Commitment to Workforce***
IMPROVING COMMUNITY HEALTH
The New Health System is committed to creating a new integrated delivery system designed to significantly enhance community health through the investment of not less than $75 million over 10 years in population health improvement.
The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the Commonwealth and the New Health System in the Cooperative Agreement. Feedback from the initial community stakeholder input process provided information from which the Parties identified five potential Key Focus Areas: ensuring strong starts for children, helping adults live well in the community, promoting a drug-free community, decreasing avoidable hospital admissions and emergency room use, and improving access to behavioral health services.
The New Health System commits to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System.
ENHANCING HEALTH CARE SERVICES
The New Health System commits to spending 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. Specifically, the New Health System will create new capacity for residential addiction recovery services, 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, ensure recruitment and retention of pediatric sub-specialists, and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals.
The New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
The New Health System will ensure recruitment and retention of pediatric sub-specialists in accordance with

the Niswonger Children's Hospital physician needs assessment.

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.

The New Health System will commit to the development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference. The Parties expect the combined system to facilitate this goal by employing physicians 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.

EXPANDING ACCESS AND CHOICE

All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.

To ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol, Tennessee.

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.

IMPROVING HEALTH CARE VALUE: MANAGING QUALITY, COST AND SERVICE

For all Principal Payers,[99] the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

[99] For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer[99] are unable to reach agreement on a negotiated rate, New Health System agrees to mediation as a process to resolve any disputes.

The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers,[99] the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.

The New Health System will collaborate with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.

The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.

The New Health System will commit to participate meaningfully in a health information exchange open to community providers.

The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.

The New Health System will negotiate in good faith with Principal Payers[99] 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.

INVESTMENT IN HEALTH EDUCATION/RESEARCH AND COMMITMENT TO WORKFORCE

The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program.

With its academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.

The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.

The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.

The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

Section 15.d., identifies in detail the Parties' proposed benchmarks and metrics (or the process by which these will be identified) (Quantitative Measures) to measure the Parties' progress toward achieving the commitments and Continuing Benefits. The first category of the Quantitative Measures will involve identifying Key Focus Areas of the commitment to improve community health. As part of the Cooperative Agreement approval process, the Commissioner and the Parties will agree on the Key Focus Areas. After the Application is deemed complete and during the Cooperative Agreement approval process, the Parties and the Commissioner, with input from community stakeholders (including the Department's Technical Advisory Panel), will agree on a limited number of Health Concerns, Tracking Measures and relevant baselines within each Key Focus Area. Agreement on these specific Health Concerns for inclusion in the Commitment to Community Health Annual Report will serve as the guide for on-going development with the Commonwealth and stakeholder community for the specific investments, interventions or performance improvements by the New Health System to improve community health in the region over the duration of the State Agreement.

For the second category of the Quantitative Measures, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to enhance health care services. In the Application, the Parties

have made commitments to performance, conduct and investment of not less than $75 million toward the creation of a new integrated health delivery system, which commitments are shown in **Table 17.1** above. In Section 15.d., the Parties have proposed the accountability mechanism to track compliance with each commitment. The New Health System will submit a yearly report to the Commissioner attesting to progress toward achieving the commitments and an annual report to the Commissioner attesting to compliance with the quality reporting obligations, described in Section 15.a. and to be outlined in the State Agreement.

Section 15.d. contains detailed descriptions of the Parties' plan for obtaining and analyzing data to evaluate the extent to which their commitments have been met. The proposed Overall Achievement Scorecard, described in Section 15.d., provides the mechanism for the Commissioner's annual assessment of the Continuing Benefit of the Cooperative Agreement and the consequences to the New Health System for failing to meet commitments.

Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will produce cost savings to fund the extensive commitments described above and elsewhere in the Application and achieve the New Health System's goals of improving community health, enhancing health care services, expanding health care access and choice, improving health care value, investing in health research and medical education, and attracting and retaining a strong workforce.

18. PLAN OF SEPARATION

REQUEST: A plan of separation. The parties shall provide an independent opinion from a qualified organization verifying the plan of separation can be operationally implemented without undue disruption to essential health services provided by the parties.

RESPONSE: The Plan of Separation will focus on a divestiture of assets and operations and any other actions that would be appropriate under then-current market circumstance, to restore, to the extent practicable, competitive conditions to their pre-consolidation state or otherwise remedy the competitive concerns identified. In planning the steps needed to accomplish this, the Parties and the consultant must consider the pre-consolidation competitive state and assess the relevant competitive factors currently applicable to each individual facility's local area, including patient flow patterns, utilization volumes, shares of local rival facilities and concentration levels. This exercise will take into account, for example, the fact that approximately half of the merging systems' current combined share of inpatient services in their combined service area is volume from three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center and Johnson City Medical Center), and that each of these hospitals has an inpatient share in its own service area that is similar in size or larger. Most other hospitals in each system are in largely rural counties, offer fifty or fewer staffed beds and report an average daily census between one and three dozen patients. In only a minority of areas within the combined service area do the parties face each other with competing hospitals in close proximity to each other, and in various areas the parties have competition from third-party hospitals. Outpatient services competition has its own set of unique characteristics across different parts of the combined service area. The Plan of Separation will recommend divestitures and remedial steps, as applicable, designed to restore these competitive dynamics. Please see the Plan of Separation attached as **Exhibit 18.1**.

The Plan of Separation has been reviewed by FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm. FTI Consulting, Inc. has issued an opinion verifying that the Parties' Plan of Separation can be operationally implemented without undue disruption to essential health services provided by the Parties. A copy of the opinion is attached as **Exhibit 18.2**.

19. STATEMENT REGARDING CERTIFICATE(S) OF PUBLIC NEED

REQUEST: A statement regarding the requirements for any certificate or certificates of public need resulting from the cooperative agreement.

RESPONSE: No Certificate of Public Need will be required under the proposed Cooperative Agreement.

20. DESCRIPTION OF TOTAL COST

REQUEST: A detailed description of the total cost to the parties resulting from the application for the cooperative agreement. Cost estimates should include costs for consultant, legal and professional services; capital costs; financing costs; and management costs. The description should identify costs associated with the implementation of the cooperative agreement, including documentation of the availability of necessary funds. The description should identify which costs will be borne by each party.

RESPONSE: Commencing with the strategic options process, both Wellmont and Mountain States have incurred consultant and professional expenses in connection with the Cooperative Agreement. These services include business advisory, economist, legal, accounting and other professional services. Each Party has been responsible for its own legal and accounting services. The Parties have agreed to share certain consulting services, such as economist, public relations, and governance, and certain due diligence expenses. The Parties estimate merger-related expenses to be one-time expenses and to total in the aggregate approximately one half of one percent (0.5%) of the annual aggregate net revenue of the New Health System.

Because there is no consideration being exchanged in the transaction, there are no other fees that normally would apply, such as financing, contingency or lending fees. There are no capital expenditures required by the Cooperative Agreement. The Parties anticipate that the New Health System will make expenditures in connection with rebranding, the Common Clinical IT platform, population health, implementation of the health index, new services, and other items discussed more fully elsewhere in this Application.

21. STATEMENT OF EXCLUSION

REQUEST: An explanation of the reasons for the exclusion of any information set forth in this section. If the parties exclude an item because it is not applicable to the proposed cooperative agreement, an explanation of why the item is not applicable shall be provided.

RESPONSE: The Parties believe that the following documents to be submitted as part of the Application are proprietary, confidential documents, as noted in the applicable Responses mentioning the information. Each Party, individually, will submit the proprietary Exhibits pertaining to it to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, the Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.

Exhibit 7.1D Mountain States Covenant Compliance Certificates

Exhibit 7.1E Mountain States Officer's Certificates accompanying Independent Auditor's Reports

Exhibit 7.2D Wellmont External Auditor Management Letters

Exhibit 8.1 Mountain States Current Annual Budget and Budgets for the Last Five Years

Exhibit 8.2 Wellmont Current Annual Budget and Budgets for the Last Five Years

Exhibit 10.3 Existing and Future Business Plans of Mountain States

Exhibit 10.4 Existing and Future Business Plans of Wellmont

22. TIMETABLE FOR IMPLEMENTATION OF THE COOPERATIVE AGREEMENT

REQUEST: A timetable for implementing all components of the proposed cooperative agreement and contact information for the person or persons authorized to receive notices, reports, and communications with respect to the letter authorizing cooperative agreement.

RESPONSE: The Parties intend to follow the proposed timetable set out below for implementation of all components of the Cooperative Agreement:

Action	Date/Target Date
New Health System Articles of Incorporation Filed in Tennessee	September 11, 2015
Letter of Intent for a Letter Authorizing a Cooperative Agreement Filed in Virginia	September 16, 2015
COPA Letter of Intent Filed in Tennessee	September 16, 2015
Mountain States Board Approves Cooperative Agreement	December 15, 2015
Wellmont Board Approves Cooperative Agreement	January 6, 2016
Pre-Submission Report for Applications filed in Virginia and Tennessee	January 7, 2016
Cooperative Agreement is Executed by Both Parties	February 15, 2016
New Health System Interim Directors are Elected and Interim Bylaws are Adopted	February 15, 2016
Application for a Letter Authorizing a Cooperative Agreement filed in Virginia	February 16, 2016
COPA Application filed in Tennessee	February 16, 2016
Tax-Exemption Application filed for the New Health System	February 17, 2016 (Target Date)
Notice Of Disposition Of Assets By Nonprofit Healthcare Entity submitted to the Virginia Attorney General's Office	April 15, 2016 (Target Date)
Tennessee Public Benefit Hospital Sales and Conveyance Act Notice submitted to	April 15, 2016 (Target Date)

Action	Date/Target Date
the Tennessee Attorney General's Office	
If the Letter Authorizing Cooperative Agreement is Granted in Virginia and the COPA is Granted in Tennessee:	
New Health System Articles of Incorporation will be Amended	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Bylaws will be Amended	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Initial Directors are Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Board Officers are Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
New Health System Initial Management Team is Elected	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Wellmont Board will Adopt Amended and Restated Bylaws Making New Health System its Sole Member	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Mountain States Board will Adopt Amended and Restated Bylaws Making New Health System its Sole Member	Within 5 business days after all the conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)
Cooperative Agreement Transaction Closes	Within 5 business days after all the

Action	Date/Target Date
and New Health System Begins Operations	conditions to Closing identified in the Cooperative Agreement have been satisfied (Targeted for September 1, 2016)

RESPONSE: The individuals authorized to receive notices, reports and communications with respect to the Application are as follows:

For Mountain States:

Barbara Allen
Chairman of the Board
3300 Browns Mill Rd
Johnson City, TN 37604
423-282-4841

Alan Levine
President & Chief Executive Officer
303 Med Tech Parkway, Suite 300
Johnson City, Tennessee 37604
423-302-3423

Tim Belisle, Esq.
Senior Vice President-Compliance Officer and General Counsel
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Johnson City, Tennessee 37604
423-302-3394

Jim Daniel, Esq.
Hancock, Daniel, Johnson & Nagle, PC
Counsel to Mountain States
4701 Cox Road, Suite 400
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804-967-9604

For Wellmont:

Roger Leonard
Chairman of the Board
102 Oakview Circle
Bristol, TN 37620
423-652-2204

Bart Hove
President & Chief Executive Officer
1905 American Way
Kingsport, Tennessee 37660
423-230-8219

Gary Miller, Esq.
Senior Vice President, Legal Affairs, and General Counsel
1905 American Way
Kingsport, Tennessee 37660
423-230-8204

Richard G. Cowart, Esq.
Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C.
Counsel to Wellmont
211 Commerce Street, Suite 800
Nashville, TN 37201
615-726-5660

LIST OF EXHIBITS

Exhibit Number	Description
Exhibit 1.1	Pre-Submission Report
Exhibit 2.1	Record of Community Stakeholder and Consumer Views
Exhibit 4.1	Signed Copy of the Cooperative Agreement
Exhibit 4.2	Organizational Chart of Mountain States
Exhibit 4.3	Organizational Chart of Wellmont
Exhibit 5.1	Geographic Service Area and Draw Areas A. Geographic Service Area B. Hospital Draw Areas and Summary Statistics
Exhibit 5.2	Shares for New Health System
Exhibit 7.1	Financial Summary for Mountain States
Exhibit 7.1A	Mountain States Bonds Official Statement for 2011 bonds
Exhibit 7.1B	Mountain States Bonds Official Statement for 2012A bonds
Exhibit 7.1C	Mountain States Bonds Official Statement for 2013 bonds
Exhibit 7.1D	Mountain States Covenant Compliance Certificates for the Last Five Years ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.**
Exhibit 7.1E	Mountain States Officer's Certificate Accompanying the Independent Auditor's Reports for FY10 to FY14 ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.**
Exhibit 7.1F	Mountain States Audited Financial Statements for 2009 to 2014
Exhibit 7.1G	Mountain States EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
Exhibit 7.1H	Mountain States Rating Agencies Reports
Exhibit 7.1I	Mountain States Forms 990 for the Last Five Years
Exhibit 7.2	Financial Summary for Wellmont
Exhibit 7.2A	Wellmont 2011 Bonds Official Statement for 2011 bonds
Exhibit 7.2B	Wellmont Audits – External Audited Financial Statements for 2011 to 2014

Exhibit Number	Description
Exhibit 7.2C	Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures
Exhibit 7.2D	Wellmont External Auditor Management Letters for 2011 to 2014 ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.**
Exhibit 7.2E	Wellmont Rating Agencies Reports
Exhibit 7.2F	Wellmont Forms 990 for the Last Five Years
Exhibit 8.1	Mountain States Current Annual Budget and Budgets for the Last Five Years ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.**
Exhibit 8.2	Wellmont Current Annual Budget and Budgets for the Last Five Years ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.**
Exhibit 9.1	Five Year Projected Budget for New Health System
Exhibit 10.1	Mountain States Insurance Contracts and Payer Agreements
Exhibit 10.2	Wellmont Insurance Contracts and Payer Agreements
Exhibit 10.3	Existing and Future Business Plans of Mountain States ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's**

Exhibit Number	Description
	Procedures Governing Receipt and Review of Cooperative Agreements.
Exhibit 10.4	Existing and Future Business Plans of Wellmont ***This information will be submitted separately to the Southwest Virginia Health Authority, the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), and the Southwest Virginia Health Authority's Procedures Governing Receipt and Review of Cooperative Agreements.**
Exhibit 11.1	Mountain States Charity Care and Related Policies
Exhibit 11.2	Wellmont Charity Care and Related Policies
Exhibit 12.1	New Health System Alignment Policy
Exhibit 14.1	Outpatient Facilities and Physician Services A. All Outpatient Facilities B. Urgent Care Facilities C. CT/MRI Facilities D. Ambulatory Surgical Centers E. Physician Services
Exhibit 14.2	Mountain States Physicians
Exhibit 14.3	Wellmont Physicians
Exhibit 14.4	Mountain States List of Top 10 Commercial Insurance Payers
Exhibit 14.5	Wellmont List of Top 10 Commercial Insurance Payers
Exhibit 15.1A	Health Rankings for Virginia Counties and Independent Cities within the Geographic Service Area
Exhibit 15.1B	Health Rankings for Tennessee Counties within the Geographic Service Area
Exhibit 15.1C	Geographic Service Area Payer Mix
Exhibit 15.2A	Community Health Work Group Charters
Exhibit 15.2B	Community Health Work Group Membership Lists
Exhibit 15.3	IOM Vital Signs Core Measures
Exhibit 18.1	Plan of Separation
Exhibit 18.2	Opinion on Plan of Separation