STATE OF TENNESSEE
DEPARTMENT OF HEALTH

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September 19, 2017

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RE: Certificate of Public Advantage

Dear Mr. Levine and Mr. Hove:

As you know, Tenn. Code Ann. § 68-11-1303 vests the Tennessee Department of Health (the "Department") with the authority and responsibility to grant or deny the Application (including all supplemental submissions) for a Certificate of Public Advantage ("COPA") submitted by Wellmont Health System and Mountain States Health Alliance (the "Parties" or the "Applicants"). Pursuant to Tenn. Code Ann. § 68-11-1303(d), the Department has decided to grant the Application for a COPA **with conditions.** The Department has determined, after consultation with the Tennessee Attorney General and based on the record compiled in this matter and the applicable law and regulations, that the Application, in conjunction with the active supervision regulatory structure outlined in the Terms of Certification[1], demonstrates by clear and convincing evidence that the likely benefits resulting from the Cooperative Agreement outweigh any disadvantages attributable to a reduction in competition that may result from the Cooperative Agreement entered into by the Parties in accordance with Tenn. Code Ann. § 68-11-1303(e)(1).

I. The Applicants

Wellmont Health System ("Wellmont") is a Tennessee nonprofit corporation based in Kingsport, Tennessee and provides health care services in Northeast Tennessee and Southwest Virginia. 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. Wellmont owns and operates six acute care hospital facilities and one

[1] For purposes of this letter, the Terms of Certification shall refer to the September 18, 2017 edition of such Terms attached to the Approval Certificates delivered on September 18, 2017.

critical access hospital. The Tennessee hospitals include: Holston Valley Medical Center; Bristol Regional Medical Center; Hawkins County Memorial Hospital; Hancock County Hospital and Takoma Regional Hospital. The Virginia hospitals include: Mountain View Regional Medical Center and Lonesome Pine Hospital. Wellmont hospitals offer a broad scope of services, from community-based acute care to highly specialized tertiary services including two trauma centers, comprehensive heart care and cancer care. 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 region.

Mountain States Health Alliance ("Mountain States") is a Tennessee nonprofit corporation based in Johnson City, Tennessee. It traces its roots back over 100 years and became a system in 1998 when the then Johnson City Medical Center Hospital, Inc., acquired six hospitals located in upper east Tennessee. In 2006, Mountain States acquired a membership interest in Smyth County Community Hospital in Marion, Virginia. Since then, Mountain States has acquired or become a member of four other hospitals in the Southwest Virginia region. The Tennessee hospitals include: Johnson City Medical Center; Niswonger Children's Hospital; Indian Path Medical Center; Franklin Woods Community Hospital; Sycamore Shoals Hospital; Unicoi County Memorial Hospital; Johnson County Community Hospital; Woodridge Hospital; and Laughlin Memorial Hospital. Mountain States also has a joint venture with Health South to operate Quillen Rehabilitation Hospital. The Virginia hospitals include: Johnston Memorial Hospital; Smyth County Community Hospital; Russell County Medical Center; Norton Community Hospital; and Dickenson Community Hospital. Mountain States hospitals provide a range of services from basic primary care through two critical access facilities to highly advanced tertiary levels of care including Level 1 trauma, open heart and radiation oncology. 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. Mountain States also holds an ownership interest in several joint ventures, primarily for the purpose of providing ambulatory surgical services.

II. The Proposed Transaction

On February 15, 2016, Wellmont and Mountain States executed a Master Affiliation Agreement and Plan of Integration (as amended, the "Cooperative Agreement"). Pursuant to that Agreement, the Parties agreed to cause a new, independent public benefit, nonprofit, tax-exempt corporation to be incorporated in Tennessee, Ballad Health ("Ballad" or the "New Health System"). Ballad is to be governed by a Board of Directors composed of representatives of Wellmont and Mountain States. Ballad will be the sole member of Wellmont and Mountain States and at the closing of their proposed affiliation as contemplated by the Cooperative Agreement (the "Closing"), the Parties will amend their respective charters and bylaws to designate Ballad as such.

Ballad is to be governed exclusively by its Board of Directors, which is the fiduciary board responsible for the delivery of quality care to meet the needs of the communities served by the system. Ballad's management team will be composed of current executives from both Parties in the following agreed-upon roles: Executive Chair/President Alan Levine and Chief Executive Officer Bart Hove.

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 Ballad Board. The Ballad Board will oversee all of the assets and operations of the previously separate Applicants and all of their respective affiliates on the terms and conditions set forth in the Cooperative Agreement and the Terms of Certification.

III. The Application Process

Pursuant to Tenn. R. & Reg. Ch. 1200-38-01-.02(1), Wellmont and Mountain States submitted a Letter of Intent to apply for a Certificate of Public Advantage on September 16, 2015. Subsequently, on February 16, 2016, the Parties submitted an Application for a COPA consistent with Tenn. Code Ann. § 68-11-1303(c) and Tenn. R. & Reg. Ch. 1200-38-01-.02(2). On February 29, 2016, the Tennessee Department of Health (the "Department") requested certain additional documentation. The Parties submitted Addendum #1 to their Application on March 16, 2016.

The Department made its first request for additional information on March 28, 2016, and a subsequent request on April 22, 2016. The Parties submitted responses to these requests on April 25, July 13 and July 25, 2016. On September 12, 2016, the Parties submitted the First Amendment to Master Affiliation Agreement and Plan of Integration. Thereafter, on September 15, 2016, the Department announced that it had deemed the Application complete pursuant to Tenn. R. & Reg. Ch. 1200-38-01-.02(3).

After a meeting with the Parties, on November 22, 2016, the Department made its third request for additional information to the Parties. The Parties submitted responses to this request during December 13 – 17, 2016. On January 13, 2017, the Parties requested that the Department withdraw its previous determination that their Application was complete so that the Parties could submit additional information in support of their Application. The Department agreed to withdraw its determination that the Application was complete.

On April 7, 2017, the Parties submitted expert reports from The Advisory Board and the Healthy Communities Institute. On April 11, 2017, the Parties submitted an additional expert report from Compass Lexecon. On May 22, 2017, the Department announced that it had deemed the Parties' Application complete.

Public Hearings on the Application were held on the following dates and locations: Blountville, Tennessee – June 7, 2016; Kingsport, Tennessee – September 1, 2016; Nashville, Tennessee –

September 29, 2016; Bristol, Tennessee – October 6, 2016; Johnson City, Tennessee – November 21, 2016; and Blountville, Tennessee – July 18, 2017.

IV. Geographic Service Area

The region currently served by the Applicants is part of the Appalachian Region and includes Carter, Cocke, Greene, Hamblen, Hancock, Hawkins, Johnson, Sullivan, Unicoi, and Washington Counties in Northeast Tennessee and Buchanan, Dickenson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe Counties in Southwest Virginia, as well as the independent cities of Bristol, Virginia and Norton, Virginia (the "Geographic Service Area" or "GSA"). This region has a number of health, economic and other factors, which when combined, present a unique and challenging environment for the improvement of the quality and access of health care and health outcomes. These unique challenges were reaffirmed in a recent report issued by the Appalachian Regional Commission, Robert Wood Johnson Foundation and the Foundation for a Healthy Kentucky (*Health Disparities in Appalachia*), which found that the performance in the Appalachian Region is worse than the performance in the United States as a whole in seven of the ten leading causes of death: heart disease, cancer, chronic obstructive pulmonary disease, injury, stroke, diabetes and suicide. Additionally, the study found the "years of potential life lost", a measure of premature mortality, is 25% higher in the Appalachian Region than in the nation as a whole.

(a) **Health Factors:** The Tennessee State Health Plan outlines four priority factors (tobacco and nicotine addiction, obesity, physical inactivity and substance misuse, abuse and substance use disorders) that directly influence six of the top ten leading causes of death in Tennessee including heart disease, cancer and diabetes:

(i) **Tobacco and Nicotine Addiction**: Approximately 443,000 premature deaths in the United States annually can be attributed to tobacco and nicotine addiction. Studies have also demonstrated that tobacco and nicotine addiction cause various cancers, cardiovascular disease and respiratory conditions, as well as low birthweight and other adverse health outcomes. The percentage of adults who are current smokers is higher in all 21 counties in the GSA than in the United States as a whole. In 50% of the Tennessee GSA counties smoking is more common than in Tennessee as a whole, and in 50% of the Virginia GSA counties, smoking is more common than in Virginia as a whole.

(ii) **Obesity**: Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems and osteoarthritis. Two-thirds of the counties in the GSA have a higher percentage of adults who are obese compared to the national average. Moreover, compared to their respective states as a whole, 80% of the counties in Tennessee and 100% of the counties in Virginia have a higher percentage of adults who are obese.

(iii) **Physical Inactivity**: Evidence indicates physical activity, independent of its effect on weight, has substantial benefits for health. Decreased physical activity has been associated with an increased risk for several disease conditions such as type 2 diabetes, cancer, stroke, hypertension, cardiovascular disease and premature mortality. Physical inactivity at the county level is directly related to health care expenditures for circulatory system diseases.

Compared with the nation as a whole, in each of the counties in the GSA, fewer adults report any physical activity; compared with their respective states as a whole, in 90% of the counties in the Tennessee GSA and 100% of the counties in the Virginia GSA fewer adults report any physical activity.

(iv) **Substance Misuse, Abuse and Substance Use Disorders**: Drug overdose deaths are a leading contributor to premature death and are largely preventable. Since 2000, the rate of drug overdose deaths has increased by 137% nationwide, and there has been a 200% increase in deaths involving opioids (opioid pain relievers and heroin). The State of Tennessee, overall, has seen a statistically significant increase in the drug overdose death rate, with a 13.8% increase from 2014 to 2015.[2] Additionally, Tennessee has one of the highest opioid prescription rates. In 2016, Tennessee had an average prescription rate of 107.5 prescriptions per 100 people, while the national average was only 66.5 prescriptions per 100 people. The Tennessee GSA counties had an even higher average of 118.5 opioid prescriptions per 100 people. The Virginia GSA counties also had a higher average of 134 prescriptions per 100 people.[3] Tennessee has seen a 43.5% increase in heroin usage from 2014 to 2015 and Virginia has seen a 38.7% increase for the same period. Additionally, Tennessee has seen a 90.5% increase in synthetic opioid encounters from 2014 to 2015 and Virginia has seen a 57.1% increase during that same period. The substance abuse statistics for the 21 counties in the GSA are particularly compelling. Over 50% of the Tennessee GSA counties exceed the state average, with Hancock County having the highest rate in the state. Additionally, Sullivan County has one of the highest rates of Neonatal Abstinence Syndrome ("NAS") births in the state. Moreover, the rate of NAS births in the Tennessee GSA counties is almost four times the rate for the rest of Tennessee. 100% of the Virginia GSA counties exceed the state rate, with two counties having rates more than three times the state rate, and four counties with rates more than two times the state rate.

(b) **Other Factors Affecting Health Outcomes**: A number of other factors contribute to a unique and challenging environment in which to improve the quality and access of health care and health outcomes in the region, including: (1) the percentage of adults reporting fair or poor health, (2) the number of preventable hospital stays, (3) the ratio of population to primary care providers, and (4) the ratio of population to mental health providers.[4]

(i) **Preventable Hospital Stays**: Preventable hospital stays is the hospital discharge rate for ambulatory care-sensitive conditions per 1,000 fee-for-service Medicare enrollees. Hospitalization for diagnoses treatable in outpatient services suggests that the quality of care provided in the outpatient setting was less than ideal and may also represent a tendency to overuse hospitals as a main source of care. The rate of preventable hospital stays is often used to assess the effectiveness and accessibility of primary health care. The rate of preventable hospital stays for all of the counties in the GSA exceeds the state rates for Tennessee and

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[2] https://www.cdc.gov/drugoverdose/data/statedeaths.html.

[3] https://www.cdc.gov/drugoverdose/maps/rxcounty2016.html.

[4] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, *County Health Rankings 2017: Tennessee; County Health Rankings 2017: Virginia.*

Virginia. The rate in one Tennessee GSA county is more than double the state rate. That is, preventable hospital stays occur twice as often in this county than in all of Tennessee. Similarly, two Virginia GSA counties have rates that are three times the state rate, and another three counties have rates that are two times the state rate.

(ii) **Primary Care Physicians**: Access to care requires not only financial coverage, but also access to providers. Studies have demonstrated that sufficient availability of primary care physicians is essential for preventive and primary care, and when needed, referrals to appropriate specialty care. The statistics for the counties in the GSA reflect a compelling need for greater recruitment and retention of primary care providers. Only two counties in the Tennessee GSA have a ratio of population to primary care physicians that is better than the state. At least two Tennessee GSA counties have ratios double the statewide ratio, and one county has a ratio that is four times the statewide ratio. In Virginia, all 11 GSA counties have ratios substantially greater than the statewide ratio, with one county having a ratio three times greater and another five counties having ratios at least two times greater than the statewide ratio.

(iii) **Mental Health Providers**: Approximately 30% of the population in the United States lives in a county designated as a mental health professional shortage area. The lack of adequate access to mental health providers in the GSA is overwhelming. For example, the ratio of population to mental health providers in Tennessee is 780:1. Only two Tennessee GSA counties have ratios less than this amount. Several counties have ratios four to five times greater, and one county has a ratio that is 10 times greater than the statewide average. The ratio of county population to mental health providers in the 11 Virginia GSA counties is similarly troubling. Several counties have ratios four to five times greater than the statewide ratio, with one county having a ratio that is 22 times greater.

(c) **Economic Factors and Demographics**: A number of economic factors and the demographics of a particular region also contribute to the unique and challenging environment in which to improve the access and quality of health care and the health outcomes of that region. These factors include: (1) education, (2) percentage of children living in poverty, (3) average annual income, (4) population growth, (5) percentage of population over age 65, and (6) percentage of population considered to be rural.[5]

(i) **Education**: Studies show individuals with higher educational attainment are more likely to have better health. Specifically, higher educational attainment is linked to lower rates of premature death, smoking, obesity and inactivity. The relationship between higher education and improved health outcomes is well established, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress and healthier lifestyles. Furthermore, education can have multigenerational implications that also make it an important measure for the health of future generations. While the counties in the GSA have been somewhat more successful in achieving high school graduation rates, with only eight counties having graduation rates at or lower than the statewide average, the counties are substantially less successful in attaining any post-secondary education. Only two Tennessee GSA counties have percentages at or higher than the statewide average and the rest of the counties have percentages that are substantially lower. All of the Virginia GSA

[5] *Id.*

counties have percentages that are substantially lower than the statewide average, and in several counties by as much as 20%.

(ii) **Children in Poverty**: Poverty can result in an increased risk of mortality, morbidity, depression and poor health behaviors. Children's risk of poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. The children in poverty measure is highly correlated with overall poverty rates. Only one Tennessee GSA county has a rate of children in poverty that is less than the statewide average, while at least two counties have a poverty rate 15% to 20% greater. The children's poverty rate in the Virginia GSA counties is even direr with seven of the counties having poverty rates almost 15% greater than the state. Furthermore, the infant mortality rate is 16% higher in the Appalachian Region than in the nation as a whole.

(iii) **Per Capita Personal Income**: The per capita personal income in Tennessee was $42,069 for 2016. The per capita personal income for the ten Tennessee GSA counties ranges from a low of $23,104 to a high of $36,918, with most of the counties having an annual income $12,000 to $15,000 less than the statewide average. The per capita annual income in Virginia was $56,732 for 2016. The per capita personal income for the 11 Virginia GSA counties ranges from a low of $27,137 to a high of $37,388, with most of the counties having an average annual income $12,000 to $25,000 less than the statewide average.

(iv) **Median Household Income**: The median household income in Tennessee is $47,200. The median household income for the 10 Tennessee GSA counties ranges from a low of $27,987 to a high of $45,261, with most of the counties having a median household income $10,000 to $20,000 less than the statewide average. The median household income in Virginia is $66,300. The median household income for the 11 Virginia GSA counties ranges from a low of $32,135 to a high of $45,864, with most of the counties having a median household income $20,000 to $35,000 less than the statewide average.

(v) **Population Growth and Age of Population over 65**: The 21 counties in the GSA have experienced little population growth, with only three counties experiencing positive growth during the past decade. The remaining counties suffered population losses ranging from 1% to as much as 10%. Additionally, the percentage of the population aged 65 and older in the GSA is substantially greater than the statewide percentages in Tennessee and Virginia, with older adults comprising an additional five percentage points of the population in two-thirds of the counties.

(vi) **Percentage of Rural Population**: The vast majority of the population in the GSA is considered to be rural, with 100% of the population in six counties classified as rural and over 50% of the population in 11 counties classified as rural. [6] This factor is a significant contributor in influencing health outcomes in a population. A number of studies have demonstrated rural residents experience many difficulties in accessing health care services,

[6] According to a recent study done by iVantage Health Analytics, over 670 rural hospitals are in danger of closing. The National Rural Health Association reports that this number represents 1/3 of the rural hospitals in the United States. Since 2014, seven rural hospitals in Tennessee have either closed completely or have closed inpatient services. Thirteen of the New Health System's twenty-one hospitals in the GSA are considered hereunder as rural hospitals.

which result in higher morbidity and mortality rates compared to those of their urban counterparts. For example, in addition to the lack of health care professionals in rural areas, as discussed above, many rural residents must travel greater distances to access different points of the health care delivery system; however, due to geographic distance, extreme weather conditions, environmental and climatic barriers, lack of public transportation and challenging roads, rural residents may be limited, and in some instances, even prohibited from accessing health care services. The difficulties of access to health care facilities may impair outcomes by increasing patients' physical and emotional stress, reducing the likelihood of seeking follow-up care and limiting proximate family support. More than 50% of vehicle crash-related fatalities occur in rural areas, even though less than one-third of miles traveled in a vehicle occur there and there is an additional 22% risk of injury-related death. Residents of rural counties are 21% more likely to commit suicide than those living in the larger metro counties, and the poisoning mortality rate is 40% higher in the rural counties. Additionally, the infant mortality rate in the rural counties is 19% higher than the rate in the larger metro counties and the teen birth rate is 72% higher in the rural counties.

V. The Parties' Goals

The Parties' goals in pursuing the Cooperative Agreement and the Certificate of Public Advantage 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. As discussed in Section IV, *supra*, the GSA disproportionately suffers from serious health issues and the cost of this poor health is not sustainable. The Parties believe that, with the grant of a COPA, the savings realized by reducing duplication and improving coordination can be reinvested in ways that substantially benefit the GSA, including benefits such as 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.

Thus, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality and access of health care and health outcomes in the region. To that end, specific initiatives are set forth in the Cooperative Agreement, including, but not limited to:

- Management and clinical practice procedures and policies to be standardized through a system-wide Clinical Council to promote efficiency and higher standards of care on a consistent basis.

- Use of best practices to develop standardized clinical protocols for care to reduce clinical variation and overlap, shorten length of stay, reduce costs, and improve patient outcomes.

- Expanded quality reporting on a timely basis so that the public may easily evaluate the performance of Ballad.

- Optimal location of services and staff to improve productivity and ensure access.

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

Additionally, continued access to appropriate hospital-based services in the rural areas of the GSA is a significant priority and a driving impetus for the Cooperative Agreement. The Parties believe that in the current resource-constrained, status-quo environment, the rural hospitals operated by the Parties 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 their respective communities. Accordingly, the Parties believe that the Cooperative Agreement presents a thoughtful mechanism for ensuring that the efficiencies from their affiliation will be used to sustain the ongoing viability of these hospitals and access to care for their respective communities.

Finally, the Parties are committed to pursuing population health improvements aligned with the goals of the current Tennessee State Health Plan, the Virginia Innovation Plan and with regional collaborative health improvement goals such as those set forth in Healthier Tennessee and the Blueprint for Health Improvement and Health-Enabled Prosperity. Through the Cooperative Agreement and their Application, the Parties have proposed to commence a population health improvement process with the preparation of a comprehensive community health improvement plan, including behavioral health and substance abuse, identifying key health issues for improvement and, more importantly, understanding how to "build a culture of health" in the region. Further, the Parties have agreed to the Terms of Certification to accomplish the active supervision of their affiliation by the Department and the Attorney General.

VI. Findings

Potential Benefits

a. Benefit: Enhancement of the quality of hospital and hospital-related care provided to Tennessee citizens.

Discussion: The Applicants assert in their Application and in their subsequently submitted supporting documents (collectively, the "Application") that health care quality will be improved through a variety of efforts, including a physician-led clinical council, expanded public quality reporting and investments in a common clinical information technology ("IT") platform. The Applicants' experts opine that integrated delivery systems have been shown to improve health care quality and that the proposed combined care management teams from the two health systems will offer complementary skill sets to improve the quality of health care. The Applicants, however, as independent health care systems already have integrated delivery systems. The Department believes that additional quality of health care benefits attributable solely to a combination of the two systems is likely to be marginal at best.

Department Position: The Department believes there is mixed evidence that hospital and health care system mergers result in the provision of higher quality health care.

However, the Applicants' commitment to provide financial investments outlined in the Terms of Certification, the active supervision regulatory structure that the Department is implementing under the Terms of Certification and the specific quality measures the New Health System will monitor and on which it will be measured under the Terms of Certification will provide necessary incentives to the New Health System to continue to enhance the quality of hospital and hospital-related care to residents of the GSA. Thus, the Department believes this benefit is likely to occur.

b. Benefit: Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities.

Discussion: The Applicants committed in their Application to keep rural hospitals operational as clinical and health care institutions for at least five years after the Closing and to continue the operation of the three primary acute care hospitals located in Johnson City, Kingsport, and Bristol, Tennessee. The Applicants' experts state that if the hospital systems remain independent "expected changes will likely include closure of some facilities and downsizing or changing services offered in some facilities." The Department notes that the Application itself did not assert what services would remain at the hospitals during the five-year period described.

The Department recognizes that rural hospitals generally are currently experiencing severe economic pressures, increasingly bringing into question their future profitable operation. The Department does not believe these pressures will lessen or disappear in the near future. The Department's position is that maintaining a specific level of services at all rural hospitals is necessary in return for granting the COPA and the large market share to be held by the New Health System after the combination.

Department Position: The Terms of Certification require that the New Health System must continue to operate all rural hospitals (with only limited exceptions) and in all cases provide certain levels of services in Tennessee and Virginia rural hospitals. The New Health System must also continue the operation of the three primary acute care hospitals mentioned above (with the exception of (A) the three rural hospitals located in Wise County and the Independent City of Norton, Virginia, one or more of which the Applicants and The Southwest Virginia Health Authority have agreed can be repurposed, and (B) the two rural hospitals located in Greene County, Tennessee, one of which the Applicants and the Department have agreed can be repurposed). This requirement ensures the preservation of hospital facilities in geographical proximity to the communities traditionally served by them and the necessary access to health care services that the residents have come to depend upon and expect. The Department believes this benefit is likely to occur.

c. Benefit: Gains in cost containment and cost-efficiency of services provided by the hospitals involved.

Discussion: The analysis by the Applicants' consulting firm, FTI, states that the New Health System will realize the following efficiency-driven savings: an aggregate of $366 million in the first five years after the Closing, and $95 million in years 6–10 after the Closing. The Federal Trade Commission believes that this level of projected cost-efficiencies is unlikely. The Department believes that cost efficiency estimates are just that – estimates – and that any internal cost savings will count as a public benefit only if they are passed along to the consumer in the form of lower prices and through community reinvestment activities. Additionally, under the Terms of Certification, the Department has the ability to review all pricing data provided by the New Health System for certain procedures in order for the Department and the community to be able to assess what cost savings, if any, are passed on to the consumer.

Department Position: The Terms of Certification require the New Health System to provide at least $308 million in incremental (i.e., new) support over 10 years to fund community reinvestment activities. This requirement is not dependent upon gains in cost containment and/or cost-efficiency of services but instead is viewed as one of the costs to be paid for granting the COPA and the resulting market share that the New Health System will have. Additionally, the ability of the Department to assess the impact of the New Health System's pricing changes on the public and the managed care contract pricing limitations detailed in the Terms of Certification's Addendum 1 will ensure that cost containment and/or cost-efficiency of services are passed on to payors and consumers in the form of lower prices. With these requirements, the Department believes this benefit is likely to occur.

d. Benefit: Improvement in the utilization of hospital resources and equipment.

Discussion: The Applicants propose plans to reduce overutilization in their application, requiring an increased focus on upstream care, care coordination and population health improvement. The Applicants assert that investments in a common clinical IT platform and a regional health information exchange will allow for the provision of better coordinated health care. The New Health System would have a larger number of covered lives necessary for the performance of certain value-based contracts, and the increased scale would enable the New Health System to invest in significant fixed costs. The increased scale of operations and combination of complementary skills from each of the applicants may be able, but is not guaranteed, to provide the New Health System the ability to go to scale with risk-based contracts.

Department Position: While health systems across the country are working to reduce overutilization and to better coordinate care, the Applicants currently face barriers related to their size and scale. The Department believes that the conditions placed by the Terms of Certification on the New Health System address these concerns and that this benefit is likely to occur.

e. Benefit: Avoidance of duplication of hospital resources.

Discussion: The Applicants assert in their application that the New Health System will be able to reduce duplication of services, including closing a Level One Trauma Center, investing in IT infrastructure, combining certain clinical services/locations, and creating a physician-led clinical council, and that these reductions in duplication of services will enable the New Health System to achieve other reductions in the duplication of hospital resources. Further, given the requirement in (b), above, that certain hospitals remain open and that they provide certain levels of services, it is likely that, beyond the items mentioned above, few existing services/investments are likely to be redundant.

Department Position: While the region does have examples of seeming duplication, the Department believes that the goal of avoiding duplication perhaps may in the long run conflict with improving the availability of care and with improving quality of care. However, there is insufficient information available to permit the Department at this time to adequately assess the long term impact of the potential reduction in duplication of hospital resources. The Department does not take a position regarding this matter.

f. Benefit: Demonstration of population health improvement of the region served according to criteria set forth in the Cooperative Agreement and approved by the Department.

Discussion: The Applicants propose to invest $75 million over 10 years in population health improvement efforts. Without entering into the Cooperative Agreement and the issuance of the COPA, neither health system has a specific incentive to pursue population health improvement. Indeed, neither health system has shown a prior interest in leading significant community-wide collaboration on this matter.

Department Position: Community support and engagement in this area appears strong. Additionally, the two health systems would not pursue population health improvement efforts to the necessary degree without the funding and incentives provided by the Cooperative Agreement and the issuance of the COPA. The Population Health Improvement Sub-Index developed by the Department and included in the Terms of Certification sets out specific processes and outcome goals to be achieved, timelines for their achievement, and consequences if the goals are not timely achieved. The Department believes the New Health System will be able to demonstrate this benefit of population health improvement of the region; thus this benefit is likely to occur.

g. Benefit: The extent to which medically underserved populations have access to and are projected to utilize the proposed services.

Discussion: The Applicants proposed a charity care policy substantially similar to the existing policy of both Parties that will also provide a 100% discount for inpatient hospital and clinical services to patients with incomes below 225% of the Federal Poverty Level.

Department Position: The Terms of Certification require that the New Health System will adopt a charity care policy that is identical to, or more charitable (but in no event less

charitable) than the existing policies of both Applicants. Additionally, the Terms of Certification require the New Health System to provide Total Charity Care consistent with the Applicant's base charity care, adjusted by the Hospital Inflation Adjustment (as defined in Addendum 1 to the Terms of Certification). With these Terms of Certification requirements, the Department believes medically underserved populations will continue to have the same, if not better, access to health care services and so be as able, if not more able, to utilize the services of the New Health System. Thus, the Department believes this benefit is likely to occur.

h. Benefit: Other.

Discussion: The Department recognizes the following as other benefits that are likely to occur:

Behavioral Health and Substance Abuse. In their Application, the Applicants commit to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems, and the Terms of Certification require these commitments to be made.

Active Supervision. The Terms of Certification outline a detailed active supervision structure by the Department of the New Health System. While this structure is required by statute, it is more robust and detailed than the Applicants had suggested.

Board Governance. The Terms of Certification detail certain requirements of the Board of Directors of the New Health System that previously were not in place.

Acceleration to Risk-Based Contracts. The managed care contract pricing limitations detailed in the Terms of Certification's Addendum 1 not only will ensure that cost containment and/or cost-efficiency of services are passed to payors and consumers, it also encourages the New Health System to move more quickly to risk-based contracts that will provide incentives for cost containment.

Employee Protections. The Terms of Certification detail specific employee protections that were not included in the Application.

Partnership with East Tennessee State University ("ETSU"). The Application, as modified by the Terms of Certification, provides for specific funding and partnership activities with ETSU that should benefit the Northeast Tennessee region as a whole.

Potential Disadvantages

a. Disadvantage: The extent of any likely adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other healthcare payors to negotiate appropriate payment and service

arrangements with the hospitals, physicians, allied healthcare professionals or other healthcare providers.

Discussion: Without restrictions being placed upon the New Health System, the substantial market share over two states that will be created by the Cooperative Agreement and the issuance of the COPA makes it likely that healthcare payors will experience an adverse impact on their ability to negotiate appropriate payment and service arrangements with healthcare providers. This likelihood is only partly mitigated by the Applicants' commitments in the Application. The managed care contract pricing limitations detailed in the Terms of Certification's Addendum 1 will ensure that healthcare payors will be able to negotiate appropriate payment and service arrangements with the New Health System.

Department Position: The managed care contract pricing limitations, the active supervision structure and other conditions and requirements all set forth in the Terms of Certification will limit the adverse impact on the ability of payors to negotiate appropriate payment and service arrangements. The Department does not believe this disadvantage is likely to occur.

b. Disadvantage: The extent of any reduction in competition among physicians, allied health professionals, other healthcare providers or other persons furnishing goods or services to, or in competition with the hospitals that is likely to result directly or indirectly from the Cooperative Agreement.

Discussion: The Department recognizes that the competition among physicians and other healthcare providers, as well as among vendors and others furnishing goods and/or services to the New Health System, could be adversely affected if guidelines and restrictions are not put in place.

Department Position: The requirements in the Terms of Certification regarding limits placed on the employment by the New Health System of physicians and mid-level physician extenders, the conditions in the Terms of Certification preventing the New Health System from restricting the ability of its suppliers, vendors or other contractors from contracting with New Health System competitors, and the Terms of Certification requirement that the New Health System not oppose the award of Certificates of Need in the region should limit the reduction in competition among physicians and other healthcare providers. The Department does not believe this disadvantage is likely to occur.

c. Disadvantage: The extent of any likely adverse impact on (i) patients in the quality and availability of healthcare services and (ii) patients and payors in the price of healthcare services.

Discussion: The Terms of Certification requirements: (i) of retention and provision by the New Health System rural hospitals of specified essential services; (ii) that the New Health System retain the operation of the three primary acute care hospitals

located in Johnson City, Kingsport, and Bristol, Tennessee; (iii) that the New Health System comply with quality measures; (iv) of the active supervision structure; and (v) of the managed care contract pricing limitations, combine to greatly lessen any likely adverse impact on patients and payors and on the quality, availability and pricing of healthcare services.

Department Position: The potential adverse impacts on patients in the quality and availability of healthcare services, and the potential adverse impacts on patients and payors in the price of healthcare services, will be clearly mitigated by the Department's enforcement of the Terms of Certification. The Department does not believe this disadvantage is likely to occur.

d. Disadvantage: The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the Cooperative Agreement.

Discussion: While many of the benefits stated in the Application could possibly be achieved through alternative arrangements, the Department questions whether either health care system would actually pursue these benefits without the COPA, as they have not done so in the past. Importantly, mergers with outside entities, joint ventures, operating agreements or similar arrangements, etc. would not be guaranteed to provide the protections and benefits of the Terms of Certification regarding investments in the GSA, including among other things improvements to population health, the continued access to healthcare services in the more rural areas, and the monitoring and reporting with respect to quality of care measures.

Department Position: With the protections provided by the Terms of Certification, the Department does not believe that arrangements less restrictive to competition could provide the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the Cooperative Agreement. The Department does not believe this disadvantage is likely to occur.

VII. Conditions

The decision to grant the Application for a COPA is made subject to the following conditions:

- The Parties and the Department shall establish the Baseline Spending amounts required for Exhibit B in the September 18, 2017 final draft of the proposed Terms of Certification, within ninety (90) days after the issuance of this letter;

- At the Closing, the Parties shall execute the Terms of Certification in full in accordance with Section 9.13 of the Terms of Certification;

- At the Closing, each Party shall submit the Issuance Certificate in accordance with the requirements of Section 9.13 of the Terms of Certification; and

- The Closing shall occur by the deadline set forth in Section 9.13 of the Terms of Certification.

We look forward to working with you to assure that the Certificate of Public Advantage is timely issued and that the Cooperative Agreement is implemented in accordance with the provisions of the COPA, through the active supervision regulatory structure set forth in the COPA and the incorporated Terms of Certification.

Sincerely,

John J. Dreyzehner, MD, MPH, FACOEM
Commissioner
Tennessee Department of Health

cc: Barbara Allen, Chairman
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