September 23, 2015

John J. Dreyzehner, M.D., MPH, FACOEM
Commissioner, Tennessee Department of Health
5th Floor, Andrew Johnson Tower
710 James Robertson Parkway
Nashville, TN 37243

Re: HPI Submission Regarding the Emergency Rule Drafted by the Division of Health Planning for the Department of Health and Filed with the Department of State July 14, 2015

Dear Commissioner Dreyzehner,

Highlands Physicians Inc. (HPI) is a clinically integrated independent practice association (IPA) using a collaborative model to provide coordinated medical care to the residents of Northeast Tennessee and Southwest Virginia. Our membership includes more than 1,000 physicians and 500 other practitioners spread across 156 practices. We have operated successfully for 22 years, primarily within the geographic footprint of Wellmont Health System and Mountain States Health Alliance.

Today, HPI maintains a strategic alliance with Wellmont Health System ("WHS") through the Highlands Wellmont Health Network, a URAC accredited Physician Hospital Organization (PHO) formed over 20 years ago. Through this PHO, we support our patients and affiliated providers by establishing commercial relationships with insurance companies, other payers and managed care organizations.[1]

The proposed corporate combination of WHS and Mountain States Health Alliance (MSHA) announced September 16 in a Letter of Intent sent to you Dr. John Dreyzehner, Tennessee's Commissioner of Health, is of major concern to our members and other independent providers. Given the significant market concentration associated with the combined geographic footprint and assets of these two organizations, we want to make certain the transaction is structured and monitored to guarantee fair and balanced competition among all providers in our region. Independent physicians and other providers need meaningful protections to ensure this concentrated market power does not reduce competition or otherwise impede the innovation and entrepreneurship for which our members are known.

The drive of our members and other providers to deliver value-focused care to patients is evidenced in the formation of Qualuable, a CMS-approved accountable care organization (ACO) founded by HPI members and serving more than 20,000 Medicare beneficiaries in our region. Working collaboratively, Qualuable and HPI planned and implemented what is now one of the most successful ACOs in the country, saving more than $30 million in Medicare costs during our

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[1] It is important to note that while the majority of our members are independent physicians, we are also proud to include in our ranks a number of physicians currently employed or contracted with WHS.

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first two years of operation and outperforming competitive ACOs operated by both WHS and MSHA. Among 330 ACOs in the Medicare Shared Savings Program, our ACO was ranked in the top ten in the country with regard to savings. Qualuable also earned one of the highest scores on overall quality of care—again higher than those ACOs aligned with WHS and MSHA. Our physician owned and managed ACO clearly demonstrates that independent physicians in our region are in the forefront of delivering cost-effective, high quality care.

Indeed, our members' commitment to providing value-based healthcare services extends well beyond Medicare beneficiaries to encompass the whole community. We work actively to promote a deep and abiding dedication to the Triple Aim that stands at the heart of the reforms now underway. Beyond exemplary access and service levels to patients, HPI members have a strong tradition of operating freestanding facilities that deliver quality care at a lower price than their hospital competitors. In today's rapidly changing healthcare market, payers and employers are designing benefit plans and networks to encourage referrals to independently owned and managed facilities that generally offer highly-competitive service, quality and cost.

If hospital competition in Tennessee is reduced or eliminated through corporate combination of WHS and MSHA, it is essential that regulations protect the community from potential adverse effects. We applaud the state's efforts to evaluate the proposed merger and establish appropriate controls to protect its citizens from potential effects associated with excessive concentration of market power. We strongly recommend you create a regulatory environment that continues to encourage and protect competition to improve both efficiency and quality of care provided to area patients.

Given the strong interest of HPI members in the prospective corporate combination , we have reviewed the Emergency Rule drafted by the Division of Health Planning under the Department of Health and filed with the Department of State July 14, 2015 and would like to offer the following comments for consideration.[2]

Rule 1200-38-01-.01 Purpose and Definitions

1) We recommend modifying the current definition of "Hospital" which now reads:

   "Hospital" means an institution required to be licensed as a hospital pursuant to § 68-11-201, or defined as a psychiatric hospital in § 68-11-102; or any parent of a hospital, hospital subsidiary or hospital affiliate that provides medical or medically-related diagnostic and laboratory services or engages in ancillary activities supporting those services."

   In our view, the current definition does not adequately reflect the breadth of services offered or controlled by most hospitals or medical centers today. Increasingly (and especially with regard to WHS and MSHA), these institutions and their parent organizations operate a broad array of inpatient, outpatient and ancillary services (e.g., ambulatory surgery centers, urgent care centers, diagnostic imaging, laboratory, rehabilitation, home

[2] Note that in the comments that follow, alternative text of amendments or additions to the proposed rules and regulations are shown in **bold**.

health, infusion, durable medical equipment, medical transport and other offerings). While inpatient services represent their core business, outpatient services for many hospitals collectively now contribute comparable amounts of revenue.

Of significance as well is that across the country, hospitals are increasingly employing physicians (both specialty and primary care) and offering physician services through a network of distributed clinics, urgent care centers and medical offices. As noted earlier, this is particularly true with WHS and MSHA, who collectively employ or contract with approximately 600 physicians in their Tennessee and Virginia service areas.

What used to be labeled a "hospital" is now regularly called a "health system"--as evidenced by both Wellmont Health Systems' name and the fact the MSHA is a "health" (not "hospital") alliance. While we acknowledge there are clinical and economic benefits that accrue to hospitals that integrate across the care continuum, we also feel it's important the state recognize through its definition of "hospital" the scope and breadth of potential market power concentration across the entire healthcare system and not rely on the more traditional perception associated with this term.

To this end, we would propose an amended definition to read:

"Hospital" includes any health center and health provider under common ownership with the hospital and means any and all providers of medical, mental health and preventive health services, including all related facilities. These facilities include hospitals, nursing homes, assisted living facilities, continuing care facilities, self-care facilities, mental health facilities, wellness and health maintenance centers, medical office facilities, clinics, outpatient surgical centers, urgent care centers, treatment centers for drug and alcohol abuse, laboratories, research facilities, hospices, and facilities for the residence or care of the handicapped or the chronically ill. They also includes facilities for graduate-level instruction in medicine or dentistry and clinics that may offer free or reduced rate dental, medical, or mental health services to the public."

2) We also recommend adding a new defined term entitled "Independent Physician" to this section. Our recommendation is based on the fact that we will make reference to it in our subsequent comments and want to ensure clarity and consistency in our use. We propose the following definition:

   "Independent Physician" means a licensed physician in private practice and not employed by any Applicant providing medical services to patients residing or working in the Applicants' service areas."

Rule 1200-38-01-.02 Application Process

3) As currently drafted, Section (2) (a) 3 requests that the Applicants seeking the COPA include in the executive summary of the Application a description of the potential benefits and advantages and disadvantages of the Cooperative Agreement. The draft text asks the Applicants to highlight or include specific benefits and advantages as follows:

   "(ii) Benefits and advantages to parties and the public including but not limited to: ▯

(I) Population health;

(II) Access to health care and prevention services; and

(III) Healthcare operating costs' including avoidance of capital expenditures, reduction in operating expenditures and improvements in patient outcomes."

With regard to summarizing or itemizing potential disadvantages associated with the Cooperative Agreement, the draft text reads simply:

"(iv)Potential disadvantages of the Cooperative Agreement."

HPI believes that—just as key topics and issues were specified for benefits and advantages—Section (2) (a) 3 (iv) should present the same structure for the Applicants to follow, asking them to provide an executive summary of potential disadvantages framed against specific topics. We propose Section (2) (a) 3 (iv) be expanded to read:

"(iv) Potential disadvantages of the Cooperative Agreement, **including but not limited to:"**

(I) Closure or consolidation of programs and facilities, and the potential impact on access to services;

(II) Reducing selected administrative and clinical functions and loss of jobs;

(III) Narrowing of traditional payer networks leading to reduction of patient choice in choosing physicians and other services; and

(IV) Negative impact on Independent Physicians due to the anticipated increase market concentration in physician and medical services controlled by the Applicants."

4) In the draft text, Section (2) 9 currently reads:

"9. Explanation of how the Cooperative Agreement will assure continued competitive and independent operation of the services or products of entities not a party to the Cooperative Agreement;"

HPI considers this subsection to be one of the most critical components of the entire Application. One of the cornerstones of the COPA process is to ensure that the merger does not disrupt fair and balanced competition among all healthcare providers in the region—nor quash competitive innovation and entrepreneurship generally that can improve quality and patient access to care.

Given the foundational importance of this section, HPI believes the text should provide the Parties with additional structure and accountability in their submission. Specifically, we recommend the regulatory text ask for explanations as to how the Cooperative Agreement will ensure continued competitive and independent operation for specific stakeholder groups potentially impacted by the merger. These would include Independent Physician practices; independent diagnostic and medical treatment facilities owned; and hospitals not party to the Cooperative Agreement as well as physicians contracted or employed by the Applicants. Moreover, the explanation should reference specific policies, initiatives and commitments contained in the Cooperative Agreement that support the explanation for

each stakeholder group—including a commitment not to use Certificate of Need requirements to oppose development of new ambulatory facilities (e.g., urgent care centers, ambulatory surgery centers, imaging centers, and freestanding ED's) by entities not party to the Cooperative Agreement. As noted in our opening comments, these independent facilities are essential to providing access, quality of care and cost effectiveness called for in the Triple Aim, and we should ensure that the COPA be structured so as not to impede their development and operation.

HPI has a deep concern that granting of the COPA may irreparably compromise the vitality and diversity of the Independent Physician community in the region, given the Applicants' strategic focus on employing physicians in their system. We do not have to travel far to see the effects of unregulated expansion of hospital owned physician groups. In the northern counties of Kentucky two hospital systems merged in 2008. Prior to celebrating their 2 year anniversary they purchased the two largest primary care practices in the region. They now own an estimated 90% of the primary care physicians in the market. They also continue to expand their ancillary care services diminishing competition compounded by successfully defeating several CON applications.

Across the board, hospitals are willing to lose money on employed physicians so they can capture patient referrals to their inpatient facilities and ancillary services. As recently reported in the Journal of the American Medical Association, the average annual costs per patient hospital-owned physician groups in California were at least one-third higher than patients seen by physician-owned practices.[3] The authors suggest while there are benefits to building an integrated system of care through consolidation of physicians, "this consolidation could lead to higher patient care expenditures due to preferential use of high-priced hospitals for inpatient admissions, substitution of hospital-affiliated outpatient departments for ambulatory surgery and imaging facilities, and increased prices to insurers for laboratory tests, drugs, and other ancillary services."

Moreover, HPI members are very concerned the concentration of market power inherent in the Cooperative Agreement has the potential to result in narrow networks built around the Applicants' employed physicians and captive facilities—networks that ultimately exclude Independent Physicians and limit patient choice on which doctors they see.[4] We ask that this section require the Applicants to assess the possibility the Cooperative Agreement could disrupt current payer contracts with providers not party to the COPA, as well as what protections or policies the Applicants enable to minimize this risk.

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[3] "Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California" James C. Robinson, PhD, MPH[1]; Kelly Miller, BA *JAMA*. 2014;312(16):1663-1669 http://jama.jamanetwork.com/article.aspx?articleid=1917439&resultClick=3

[4] Unfortunately, we do not have to travel far to see the effects of unregulated hospital expansion into hospital owned physician groups. In the northern Kentucky, two hospital systems (St. Elizabeth Medical Center and St. Lukes Hospitals) merged in 2008, purchasing two largest primary care practices in the region within the first couple of years after consolidating. They now own an estimated 90% of the primary care physicians in the market spread across close to 90 PCP and specialty offices. They also continue to expand their ancillary care services—even while defeating several CON applications that would have other provided free market competition.

Finally, at the most basic level, we think it is important the Applicants articulate a clear "non-discrimination" policy for Independent Physicians that ensures fairness and transparency with regard to treatment of Independent Physicians within their organizations. This policy would cover granting medical staff privileges, access to operating and procedure rooms, participating on medical staff committees and serving in clinical and staff leadership roles.

Given these critical concerns, we strongly recommend that the Department ask Applicants to declare their intentions regarding future employment of physicians in the region. COPA agreements in other states such as North Carolina have mandated caps on physician employment by the combined hospital system—and HPI believes WHS and MSHA should cite their willingness to abide by a similar framework.

To that end, we propose that Section (2) 9 be amended and expanded as follows:

"9. Explanation of how the Cooperative Agreement will assure continued competitive and independent operation of the services or products **in the affected region overall.**

i. For each of the **categories listed below representing providers** not a party to the Cooperative Agreement, **document policies, initiatives, terms and commitments contained in the Cooperative Agreement that will ensure fair and balanced competition under the COPA:**

(a) Independent Physician practices;

ii. **Include an explanation of plans or intentions to limit additional employment of—or contracting with—physicians by the Applicants if the COPA is granted;**

iii. **Provide an overview of a current or proposed "non-discrimination" policy that ensures fairness and transparency in the Applicants treatment and relations with Independent Physicians;**

a) **Provider-owned facilities that provide diagnostic and medical services in the region such as ambulatory surgery centers; and**

b) **Other acute-care and psychiatric hospitals.**"

5) Section 12 currently asks the Applicants to provide a copy of a "report used for public information and education disseminated prior to submission of the Application." It then goes on to describe in Section 12 (i) through Section 12 (vi) components to be included in the report

HPI would like to ensure there is full understanding, consideration and transparency regarding the Cooperative Agreement and its potential impact among the communities and residents served by the Applicants. While publication and dissemination of a report discussing the potential impact of the Cooperative Agreement is appropriate, we also ask that as part of this disclosure the Applicants submit a summary of their public campaign and communication efforts to maximize community awareness and participation in this educational process. Our request is based on the assumption the Department of Health

would want to ensure the Applicants made satisfactory efforts to engage residents in their service areas in an active dialogue about the Cooperative Agreement.

To that end, we recommend the current text Section 12 (vi) be expanded to include:

""(vi) A record of community stakeholder and consumer views of the proposed Cooperative Agreement collected through a public participatory process including meetings and correspondence. **Applicants should also provide a summary of the number and location of events organized by the Applicants; number of speakers and the percentage of those speakers employed by or contracting with the Applicants; and communications used by the Applicants to maximize public involvement in the process.** Transcripts or minutes of any meetings held during these public forums shall be included in the report."

6) Section 13 (v) calls for the Applicants to provide a description of the "competitive environment" in their service areas, specifically requesting details and market share estimates on services and products likely to be affected by the Cooperative Agreement and how competition is likely to be reduced by the Cooperative agreement.

   Again, this subsection of the Application speaks to one of the foundational cornerstones of the Application—namely, how the Cooperative Agreement will change the competitive dynamics in the market. The information provided based on Section 13 (v) will be critical to the Department of Health's analysis and as such, HPI is deeply concerned about the fact that the competitive assessment and data presented originates with the Applicants themselves. The Applicants could be less than objective and understate potential competitive impact.

   To maximize the prospect that the competitive assessment and data presented are balanced and objective, HPI strongly recommends the Applicants include with their submission an independent, expert opinion that the information provided under Section 13 (v) is accurate and complete, and the description of the potential competitive impact is thorough, and objective.

   Based on this recommendation, we propose in this subsection be modified to read:

   "(v) A description of the competitive environment in the parties' geographic service area, including:

   (I) Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products:

   (II) The Parties' estimate of the current market shares for services and products and the projected market shares if the COPA is granted;

   (III) A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement;

   (IV) A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement; and

(V) An opinion from a qualified independent resource that, based on the review of descriptions, data and analysis contained in subsections (I) through (IV) above, the Applicants description of the current competitive environment and the projected impact on competition if the COPA is enacted is accurate, complete and objective."

7) Section 13 (vii) asks the Applicants to provide current and projected financial information As part of this request, Section 113 (vii) (II) reads:

"(II) 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 COPA is granted (underline added for emphasis) including changes in percentage of risk-bearing contracts".

The Emergency Rules state in multiple sections that, in evaluating the Application, the Department of Health will determine whether the advantages and benefits of granting the COPA outweigh the disadvantages. To ensure a complete inventory of advantages and disadvantages, HPI requests that the Applicants include in their response under Section 13 (vii) (II) a description of the financial disadvantages they might anticipate with regard to each of the groups listed. We also ask that the list of affected stakeholders be expanded to include "Independent Physicians and other providers in the service area" since they may be impacted adversely by changes in payer reimbursement or exclusion from payer networks based on the COPA (as referenced previously in Comment 4).

Finally, we recommend the Applicants also describe how the financial advantages of Cooperative Agreement—particularly as relates to potential bonuses associated with at-risk accountable care arrangements or performance incentives tied to specific payer contracts—are shared with their employed and contracted physicians. Consistent with our earlier comments, HPI believes that making tangible progress towards the Triple Aim requires all physicians (independent, contracted or employed) to focus their priorities, work collaboratively, and invest extra hours in improving the current system. Financial incentives and support for these efforts needs to be shared equitably among all participants. We believe the Department would want to ensure the Applicants prioritize the fair distribution of incentives to their physicians to maximize their engagement in care coordination and integration as well as the overall Public Advantage.

Given the above, we ask the current text be amended as follows:

"(II) A description of how pricing for provider insurance contracts are calculated and the financial advantages **and disadvantages impacting** insurers, insured consumers, **Independent Physicians and other providers in the service area**, and the parties to the Cooperative Agreement **(including the Applicants' employed and contracted physicians)**, if the COPA is granted, including changes in percentage of risk-bearing contracts."

A. Where financial disadvantages are identified, provide an explanation of how the Applicants will offer protections to the impacted stakeholders, through the

Cooperative Agreement and other policies and written commitments."

B. In instances where provider insurance contracts include performance bonuses or incentives associated with overall savings or clinical performance, describe how the Applicants propose to share the financial rewards with employed and contracted physicians

8) Section 13 (viii) asks for a plan "to systematically integrate health care and preventive services among the parties to the Cooperative Agreement...".

HPI supports the Department's intent to encourage clinical integration between the Applicants and ensure they have a well-considered plan for doing so. That said, virtually all hospitals and health systems regularly think and plan beyond the boundaries of their existing system, recognizing they play a critical role in maintaining and cultivating a thriving healthcare ecosystem in their region that encompasses a multitude of providers outside their system. This ecosystem draws its vitality from recognized interdependencies, synergistic relationships, and balanced circulation and distribution of resources among a set of diverse providers.

Given this perspective, we recommend the requested clinical integration plan also encompass Independent Physicians and other providers in the service area. Through the Cooperative Agreement, HPI would like to see the benefits of clinical integration (e.g., tighter care coordination, provider connectivity, operating efficiencies and improved levels of service) extended to as many patients and residents of the service area as possible—which necessitates engagement and collaboration with Independent Physicians.

To that end, we would like to propose the text in Section 13 (viii) be expanded to add a new subsection that asks the plan to address:

"(VI) Active and harmonious engagement and collaboration with Independent Physicians and other providers in the service area to ensure and support convenient community access to a full continuum of clinically integrated medical and preventive services."

9) In Section 13 (x), the Applicants are asked to provide a set of Measures that will collectively create—or be transformed—into an Index "to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department."

In the Emergency Rules, "Public Advantage" is formally defined as follow:

"...the likely benefits accruing from a Cooperative Agreement which outweigh, by clear and convincing evidence, the likely disadvantages attributable to a reduction in competition likely to result from the Cooperative Agreement."

Section 13 (x) asks the applicants to propose a set of Measures to be used for the Index, providing a set of suggestions (e.g., improvements in population health, operational savings and improvements in the quality of care) that all spotlight potential benefits of the Cooperative Agreement. Yet the definition of Public Advantage calls for an evaluation of

how advantages compare to disadvantages. The use of quantifiable Measures compiled into an Index is designed to make this evaluation as objective as possible.

If all Measures adopted only speak to the relative advantages of the Cooperative Agreement, there is no way to make a legitimate comparison between potential advantages and disadvantages to arrive at an assessment of Public Advantage as defined. In other words, we believe the Application should ask the Applicants (and ultimately the Advisory Group making the final recommendations to the Commissioner regarding Measures to be used) to propose Measures that quantify potential disadvantages of the Cooperative Agreement as well.

Similar to Comment 3 made earlier in this document, potential disadvantages of the Cooperative Agreement might include closure of facilities, loss of healthcare jobs, disruption of payer networks, exodus of Independent Physicians and other providers from the service area, and failure to recruit new providers of equal quality and/or quantity.

To compare advantages and disadvantages effectively, the Index requires a balanced set of Measures proposed by the Applicants and/or the Advisory Group (see HPI reference on the Advisory Group in Comment 11). As such, we recommend the draft text of Section 13 (x) be modified as follows:

"Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the Department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department. **Measures should include elements that reflect both the anticipated advantages and potential disadvantages if the COPA is approved. They** should include source and projected trajectory over each of the first five (5) years of the Cooperative Agreement and the trajectory if the COPA was not granted. Proposed Measures may include potential **advantages such as:**

(I) Improvements in the Population's health that exceed Measures of national and state improvement;

(II) Continuity in availability of services throughout the service area:

(III) Access and use of preventive and treatment health care services throughout the service area;

(IV) Operational savings projected to lower health care costs to payers and consumers; and

(V) Improvements in quality of services as defined by surveys of the Joint Commission.

Proposed Measures may also include potential disadvantages such as:

(I) Closure or consolidation of programs and facilities, and the potential impact on access to services;

(II) Reduction of selected administrative and clinical functions and loss of jobs;

(III) Narrowing of traditional payer networks leading to reduction of patient choice in

choosing physicians and other services; and**

(IV) Negative impact on Independent Physicians due to the anticipated increase market concentration in physician and medical services controlled by the Applicants."

1200-38-01-.03 Terms of Certification

10) Consistent with our preceding comments about the importance of identifying and tracking both potential advantages and disadvantages in granting the COPA, we suggest draft text in Section (3) (b) summarizing Measures to be used in the Index be amended to:

"(b) The Index will include measures of the cognizable **advantages and disadvantages** in the following categories:

1. population health; �
2. access to health services; �
3. economic impact **on the cost of services (unit prices and any volume increases), insurance premiums, operating expenses and the financial stability of Independent Physicians practicing in communities served**; and �
4. other cognizable benefits. �

11) Section (3) (e) describes the role and meeting responsibilities of the "Advisory Group", formally defined as:

"...the group of stakeholders from Applicants geographic service area, as specified in the Application, appointed by the Commissioner, in consultation with appropriate constituencies and government agencies, to recommend Measures to be considered for inclusion in an Index to objectively track Public Advantage of a single Cooperative Agreement."

HPI strongly advocates that the list of Advisory Group participants include at least one qualified and committed Independent Physician. Independent Physicians are a vital stakeholder group impacted by the COPA, and their perspective and participation should be involved in discussing the critically important COPA performance Index. Indeed, given the significant size and representation of Independent Physicians in the region by HPI, it would be happy to assist in identifying candidates for this role.

1200-38-01-.04 Notice and Hearing

12) As currently drafted, Section (1) states:

"(1) Prior to acting on an Application for a Certificate, the Department shall hold at least one (1) public hearing which will afford the right to any interested parties to express their views regarding an Application, and may gather additional feedback through other means from the community as needed "

In HPI's view, a single hearing is not adequate to solicit public comments for an Application covering what is potentially a very significant change in delivery and cost of healthcare services across a broad geography. There are a considerable number of stakeholders—such as patients, competitive providers, health plans, self-funded employers and others that could be impacted and might wish to exercise their right to comment and share their views. While we recognize these stakeholders can share their views in writing, we feel the visibility and audience in a public forum provides assurance that their views are heard and acknowledged by key decision-makers. Finally, we would like to ensure the hearings are held in the geographic service area of the Applicants rather than another location in the state such as Nashville, which would place a travel burden on those that might wish to be heard or observe.

Given the above, we urge the Department of Health amend the text to read as follows:

"(1) Prior to acting on an Application for a Certificate, the Department shall hold at least **two (2)** public hearing which will afford the right to any interested parties to express their views regarding an Application, and may gather additional feedback through other means from the community as needed. **These hearings will be held in the geographic area where the COPA will be in effect. Additional hearings may be scheduled upon determination of the Department that there is sufficient public interest in the impact of the Cooperative Agreement to justify additional forums.** "

1200-38-01-.06 Active Supervision by Terms of Certification

13) In Section (5), the text calls for the Department to conduct a public hearing in the geography where the COPA is effect every three years.

Because of the scope of potential changes with regard to healthcare access, employment, insurance premiums and overall competition among providers, HPI strongly advocates that the Department enable stakeholders impacted to register their views publicly on a more frequent schedule—particularly in the first few years after the COPA be granted. Specifically, we would recommend the text be modified as follows:

"(5) The Department shall conduct a public hearing in the geographic service area where a COPA is in effect at least **annually for the first four (4) years; then at least biannually for the next four (4) years, after which it shall hold a public hearing at least every three (3) years.**"

1200-38-01-.08 Hearings and Appeal

14) Section (2) addresses the process whereby an "Intervenor" (defined as a healthcare provider who provides services to—or in competition with—another hospital, medical corporation or a variety of payers) aggrieved or injured by the Department's decision to grant the COPA can appeal that decision. Under the proposed rules, the Intervenor would have to post an appeal bond if the Chancery Court of Davidson County issues a stay of the Department's decision. If the appeal is unsuccessful, the Intervenor would be responsible

for the costs of the appeal and attorneys fees of the Applicants.

HPI believes this process as proposed makes it hazardous for a smaller organization or provider entity to challenge the COPA. The Applicants combined constitute a multi-billion dollar enterprise and have the necessary deep pockets to support a broad array of legal counsel and expert resources over an extended period.

We do ask the Department to reconsider the process as outlined in the regulations to ensure it is not so onerous, as to discourage those with substantive objections.

In closing, we thank you for your consideration of our comments. In general, we believe the Department of Health has defined an exacting Application for review of the Cooperative Agreement and decision on granting the COPA. We only ask that specific consideration be given in the process to Independent Physicians and other providers in the region to ensure their long-term viability and continuing contributions to quality care.

Sincerely,

Brant Kelch
Executive Director