

RESPONSE BY APPLICANTS
TO SUBMISSIONS OF
FEDERAL TRADE COMMISSION STAFF,
AMERIGROUP TENNESSEE INC.,
PROFESSORS AND ACADEMIC ECONOMISTS,
KENNETH KIZER, M.D., MPH, AND
HOLSTON MEDICAL GROUP
TO THE TENNESSEE DEPARTMENT OF HEALTH
REGARDING
CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION

Pursuant to Tenn. Code Ann. § 68-11-1301 *et seq.*
and the regulations promulgated thereunder at Tenn. Rules & Regs. 1200-38-01-.01 *et seq.*

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: December 19, 2016

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I. INTRODUCTION

Mountain States Health Alliance and Wellmont Health System (“the Parties”) submit this response to address the submissions by the Federal Trade Commission Staff (the “staff”), Amerigroup Tennessee Inc. (“Amerigroup”), Professors and Academic Economists (the “Academics”), Kenneth Kizer, M.D., MPH (“Kizer”), and Holston Medical Group (“HMG”) (collectively, the “Commenters”) to the Tennessee Department of Health (the “Department”) regarding the Parties’ Application for a Certificate of Public Advantage (“Application”). As discussed below, these comments lack merit and do not overcome the compelling reasons for issuance of a Certificate of Public Advantage (“COPA”) in this matter.

In passing the Hospital Cooperation Act of 1993, the Tennessee General Assembly approved a policy to improve the welfare of Tennesseans by encouraging integration among health care providers, even in anticompetitive transactions, if the overall net effect is to facilitate “further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities”:

Technology and scientific developments in hospital care have enhanced the prospects for further improvement in the quality of care provided by Tennessee hospitals to Tennessee citizens. The cost of improved technology and improved scientific methods for the provision of health care is significantly responsible for increasing the cost of hospital care. Cost increases make it increasingly difficult for hospitals to offer care to Tennessee citizens. Existing law has constrained the ability of hospitals to acquire and develop new and improved equipment and methods for the provision of hospital and hospital-related care. *Cooperative agreements among hospitals in the provision of hospital and hospital-related services may foster further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities.* Hospitals are in the best position to identify and structure voluntary cooperative arrangements that enhance quality of care, improve access and achieve cost efficiency in the provision of care. Because competition is important to the health care sector and some cooperative agreements may have anti-competitive effects that would operate to the detriment of the public, oversight is necessary to ensure that the benefits of the agreements outweigh any disadvantages attributable to any reduction in competition likely to result from the agreements.¹ (emphasis added).

Nineteen months ago, the Tennessee General Assembly reaffirmed that policy in its revision to the Hospital Cooperation Act.

It is the policy of this state, in certain instances, to displace competition among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, in order to promote cooperation and coordination among hospitals in the provision of health services and to provide state action immunity from federal and state antitrust law to the

¹Hospital Cooperation Act of 1993, Tennessee Laws Pub. Ch. 331 (1993).

fullest extent possible to those hospitals issued a certificate of public advantage under this section.²

The General Assembly's action to maintain this policy is a response to its understanding of the uniqueness of various regions of the State, and its preference that solutions to these problems reflect that uniqueness. For example, a 2015 Department report³ found that all the Tennessee counties in the geographic service area (the "Geographic Service Area") of the New Health System (the "Tennessee Counties") exceed the national average for smoking, and seven of the ten Tennessee Counties exceed the State average for smoking. The State's obesity rate exceeds the national average, and several of the Tennessee Counties have obesity rates of more than 30 percent. All of the Tennessee Counties exceed the State average for physical inactivity (30 percent). Low birthweight is also an issue of concern. According to the same report, three of the Tennessee Counties are in the bottom third (worst group) for frequency of low birthweight births, and three of the Tennessee Counties are in the bottom third (worst group) for teen pregnancy rates. Physical inactivity, obesity, tobacco abuse and substance abuse are major health challenges that disproportionately impact residents of the Tennessee Counties, and are associated with other health challenges and conditions. The Parties' Application reported key statistics on the population in all Tennessee Counties in the Geographic Service Area, and Tennessee State-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. (Application, Table 8.2 at 33)

The General Assembly not only recognizes that solutions to these challenges may be regional in nature, but also that such solutions may call for immunity from state and federal antitrust law *to the fullest extent possible*. The Tennessee Counties served by the Parties face significant challenges in sustaining the health care infrastructure, and some of the hospitals in this rural area face negative operating margins. The hospitals that support these rural hospitals are facing downward pressure on their own operating margins, calling into question their ability to continue supporting these rural hospitals and access points. For instance, prior to the announcement of the merger, because of these financial challenges, each system was in the process of reducing the number of funded residency positions. The State has a compelling interest in the training of physicians in rural areas, and this region was facing a reduction in the pipeline of future physicians.

The Application submitted by the Parties directly and explicitly addresses each element of the Hospital Cooperation Act and its implementing regulations. By way of example, the Parties are proposing to guarantee that all rural hospitals will remain open as health care facilities, a promise that the Parties cannot make in the absence of the proposed merger and that directly supports the policy stated in the Hospital Cooperation Act. The proposed investment in outpatient mental health, residential addiction recovery and expansion of pediatric services, for example, improve access to needed services in this rural area—again, directly to the point at law. Incremental new investment in population health, dollars that will not be available but for the merger, to focus care management on high utilizers with chronic conditions is intended to directly address the law's requirement for fostering improvements in the quality of health care.

²Tenn. Code Ann. § 68-11-1303 (effective May 18, 2015).

³TENNESSEE DEPARTMENT OF HEALTH, DIVISION OF POLICY, PLANNING, AND ASSESSMENT, 2015 DRIVE YOUR COUNTY TO THE TOP TEN (July 2015), *available at* <https://www.tn.gov/health/topic/specialreports>.

Addressing these issues in order to improve health, access, cost, quality and outcomes are among Tennessee's highest priorities and are central to the law. The region's poor health and the associated costs are not sustainable, and approval of the Application provides a "unique solution for a unique region." (Application at 8)

The Commenters' submissions only tangentially refer to the specific geography, population, and health issues facing Northeast Tennessee area, of which the Parties have firsthand knowledge and which the Application details and addresses.⁴ For example, *the 10 counties in the Geographic Service Area served by the New Health System in Northeast Tennessee are largely rural with disproportionately low educational attainment levels and high levels of poverty.*⁵

The Application and the commitments therein are intentionally aligned with the issues that are most important for the residents of the Geographic Service Area and that are fundamental drivers of the cost of health care. The Parties share the State's and the Department's concerns about these significant health challenges. These issues are among the key areas of focus for the Community Health Work Groups formed as a result of the proposed merger which have informed the work of Mountain States and Wellmont throughout this process. The Commenters do not address, or even appear to recognize, these critical priorities that form the baseline for concerted action and investments by the Parties under the continuing supervision of Tennessee, and the Commenters lack of commentary on these issues lays bare the disconnect between the Commenters' opposition to the State's policy goals and their own goals.

Challenging health conditions combined with external factors as outlined below, create tremendous financial pressure for rural hospitals and make it difficult to sustain inpatient services. These damaging health outcomes disproportionately impact the poor and add to the substantial burden that rural facilities already bear, including disproportionate levels of uncompensated care and Medicaid, inability to recruit and retain physicians, gaps in services available external to the hospital and fixed cost structures required to keep the hospitals operating. Historically, Wellmont and Mountain States have supported their rural hospitals financially with both capital investment and operating support, and most of their rural hospitals operate with negative or very low operating margins. Staff assume that because this financial support has existed in the past, each of the systems can and will continue such support in the

⁴These challenges were addressed in more detail, for example, in Section 8 of the Application and are among the priority items for the New Health System in its plans for integrated delivery system and improving access to and coordination of care across the region. Among the many issues confronting the area are its significant prevalence of chronic conditions and health behaviors, such as diabetes, tobacco use and substance abuse in counties that are largely rural. This is even more starkly evidenced by reference to more detailed data in the Tennessee Department of Health: Division of Policy, Planning, and Assessment's "2015 Drive Your County to the Top Ten" report and confirmed further in its 2016 Report. TENN. DEP'T OF HEALTH, DIV. OF POLICY, PLANNING, AND ASSESSMENT, 2015 DRIVE YOUR COUNTY TO THE TOP TEN (July 2015), *available at* <https://www.tn.gov/health/topic/specialreports>. *See also* TENN. DEP'T OF HEALTH, DIV. OF POLICY, PLANNING, AND ASSESSMENT, 2016 DRIVE YOUR COUNTY TO THE TOP TEN (May 2016), *available at*

https://www.tn.gov/assets/entities/health/attachments/Drive_Report_2016.pdf. The Report provides health status, demographics, and other metrics on health for each Tennessee county and identifies priorities for health issues and action items to drive positive change. The Report ranks each county in Tennessee relative to other Tennessee counties and compares each to the state average and to three representative "peer" counties. The comparisons largely focus on health status and health behaviors such as tobacco use, obesity, and the residents reporting poor or fair health.

⁵The statistics for all of the counties in the Geographic Service Area may be found in Exhibit 8.1A of the Application for COPA, State of Tennessee.

future. *Without the synergies resulting from the merger, there should be no such assumption.* In 2015, Mountain States and Wellmont collectively shouldered the burden of \$19.5 million in operating losses in their small rural community hospitals. As operating margins in the larger Mountain States and Wellmont facilities continue to face downward pressure due to declining inpatient use rates, it is becoming more challenging to continue carrying these losses. This is why the commitment to continue operating these facilities as health care institutions is such an important commitment. Without such a commitment, there is no such guarantee.

Most of the Parties' Tennessee rural hospitals currently have an average daily census of twenty patients or less, with licensed bed occupancy at these hospitals ranging from 0.1 percent to 30.9 percent.⁶ The populations of the Tennessee Counties are declining or stagnant, and this trend is expected to continue. The economic strain on the Parties is serious and must be addressed, because the Parties' survival is crucial for the residents in these rural counties to have access to medical care. In addition to the operating losses of their rural hospitals, Wellmont and Mountain States have accumulated nearly \$1.5 billion of debt as a result of redundant costs for duplicating each other's services and programming. This significant duplication of costs and health care services in the region is not sustainable and places the Parties' rural hospitals in danger. The Parties are not alone in these experiences. According to the University of North Carolina Sheps Center, 78 rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia,⁷ and more than 600 could be vulnerable going forward.⁸

Despite these realities, staff and other critics try to make their case against approval of the Parties' Application by arguing that the merger is anticompetitive under a traditional antitrust analysis. This antitrust focus is misplaced and ignores the very reason the Parties are seeking active state supervision. The policy expressed in the Hospital Cooperation Act to facilitate the provision of quality, cost-efficient medical care to Tennessee's rural patients is of such high importance to the General Assembly that the law *encourages* mergers and offers "state action immunity from federal and state antitrust law *to the fullest extent possible*["] (Emphasis added) In those instances, the General Assembly's intent is "to displace competition among hospitals with regulation["]⁹ Staff make clear that they disagree with the Legislature's policy choice to institute a regulatory program that supplants competition with respect to health care transactions for Tennesseans. Repeatedly, staff's disagreement with the concept of cooperative agreements permeates their and others' commentary about the merits of the Parties' Application. *Staff's policy opinions are not relevant.* Under longstanding U.S. Supreme Court doctrine, a sovereign

⁶See Application for COPA, State of Tennessee, Tables 5.2 and 5.3.

⁷See THE CECIL G. SHEPS CENTER FOR HEALTH SERVS. RESEARCH AT THE UNIV. OF N.C. (as of December 17, 2016) ("80 Rural Hospital Closures: January 2010 – Present") (Fourteen rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.), *available at* <https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/>.

⁸See *Id.*; iVANTAGE HEALTH ANALYTICS, 2016 RURAL RELEVANCE: VULNERABILITY TO VALUE (2016) (assessing rural and Critical Access Hospital performance), *available at* http://www.chartis.com/resources/files/INDEX_2016_Rural_Relevance_Study_FINAL_Formatted_02_08_16.pdf; Alyssa Ellison, *The rural hospital closure crisis: 15 key findings and trends*, BECKER'S HOSPITAL CFO (Feb. 2016), *available at* <http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html>; and BG Kaufman et. al, *The rising rate of rural hospital closures*, 32(1) J. OF RURAL HEALTH 35-43 (2016).

⁹Tenn. Code Ann. § 68-11-1303.

state policy is beyond the reach of federal antitrust laws. See *infra* at Section III for a more detailed discussion of this point.

The merged health system would operate in a regulated program that places strong constraints on exercise of market power contrary to the commitments within the COPA. Staff take inadequate account of the substantial regulatory restrictions to which the Parties will be subject. Critics' comments regarding these and other features of the Cooperative Agreement also repeatedly ignore facts that do not support their narrative to oppose cooperative agreements at all costs. Among other things, the merged system will be subject to a cap on rate increases to reduce the pace of health care cost growth; conduct restrictions; commitments to invest hundreds of millions of dollars into initiatives for improving quality, access and population health; and regular reporting requirements and other accountability mechanisms to government officials who not only actively supervise compliance with the commitments but also can institute proceedings to terminate the Cooperative Agreement if needed.

In contrast to staff's and other critics' assessments, the Parties are aware of the many letters and statements submitted for the record to the Department by a variety of business, government and community leaders who, based on their own conclusions, support approval of the Application. These individuals represent companies, municipalities, consumers, employees and families directly affected by this decision as the actual purchasers of the services. That they have taken the time to educate themselves on the proposal, and have engaged with the State Government, speaks volumes about the level of community interest in this endeavor. It also speaks to the transparency and inclusiveness of the process. This engagement should carry significant weight in the Department's consideration.

A few examples of commentary which speak to these issues come from area employers, government officials and residents who offer their own educated views of the situation:

"In 2014, the Washington County Commission itself acknowledged the risks in the health care sector unanimously passing a resolution expressing their support for maintaining local control. I'd like to share just a small portion of the resolution:

'Whereas regional access to quality health care systems that are responsible to our local population health challenges and focus on clinical excellence is integral to the overall desirability of this region, or ability to attract employers and new investment, and to improving the quality of life for our citizens; and

Whereas health care is the largest provider of jobs in Washington County, Tennessee, providing a significant direct impact on the economy of this region; now

Therefore, be it resolved that we strongly encourage the Boards of Directors of our local health care systems to carefully consider the impact of their decisions on the quality and availability of the comprehensive health care services currently accessible in this region and the economic impact likely to result from the loss of local control.'

And so they did. I'm here this afternoon as a local elected official, very thankful to the boards of Wellmont and Mountain States for making a commitment to this region that has resulted in a planned merger that I believe is a best-case scenario."

Dan Eldridge, Mayor, Washington County
June 7, 2016 Public Hearing

"I wholeheartedly support the COPA and the potential the merger has to improve health and healthcare in our region. I am currently an active volunteer in the Wellmont system but prior to my retirement in 2011 I was the Chief Administrative Officer and President of the Eastman Foundation at Eastman Chemical Company. In those roles I had many opportunities to interact with both the Mountain States and Wellmont Health Systems and their leadership. As a company in the region with many covered lives and concerned about the growth in health care costs, it was abundantly clear to me and my Eastman team that the sub optimization and redundancies across the systems and that of other medical groups was only making it more difficult in the long run to have sustainable high quality health care in the region.

Based on all of my business and personal experiences, I believe the merger has the potential to ensure a better allocation of resources in the region with no detrimental effects on our current high quality of care. I also believe the merged entity can also develop and execute a more robust long term strategic plan to better benefit the long term health needs for our region. It is primarily for these reasons I support the merger. We live in a world of limited resources so we cannot afford to misallocate them. I just wish we could have gotten to this point several years earlier."

Norris Sneed, Retired/Former Chief Administrative
Officer, Eastman Foundation
Public Comment to Tennessee Department of Health
– August 15, 2016

"A merged health system would enable our region to increase the velocity of change necessary to address obesity and diabetes rates that are higher our region than the state and national averages."

"The path forward is clear. We, as concerned citizens, must have the courage to embrace it. I ask that you support the state. I ask that you grant a Certificate of Public Advantage to Wellmont Health System and Mountain States Health Alliance."

Kandy Childress, Executive Director, Healthy
Kingsport
June 7, 2016 Public Hearing

"I wholeheartedly believe a well-structured partnership between our two excellent local health care systems will create a healthy, viable, and sustainable local health care system, one that will retain local ownership governance and will allow the combined entity to continue to make a positive impact on our region's health and economic well-being."

Ken Maness, Commissioner, Tri-Cities Regional
Airport (Long-time Business Person/Retired)
June 7, 2016 Public Hearing

"I feel the merger between Mountain States Health Alliance and Wellmont Health System would benefit the community in many ways. One of which is having access to specialized care within our community. Today many of our patients and their families are traveling out of the area to receive the care they desperately need. This imposes hardships, greater out of pocket expenses and often they are separated from their families. When the hardships are too much for some to bear, they are faced with making unquestionable decisions as to whether they seek the care they need or not. We all heal better when we are near those who love and care for us the most. With the proposed merger and plans to expand services in our community, we will all WIN."

Sandra Bailey
Public Comment to Tennessee Department of Health
– September 7, 2016

“The combined system with expanded resources and a larger footprint will create a new opportunity and potential for real and measurable success. Combined with East Tennessee State University and the vast array of resources available through the university and the medical school, we will have access to one of, if not, the best network and system in the country to really move the needle towards creating a healthy region.”

Charles W. Glass – CEO, Greater Kingsport Family
YMCA
Statement of Support, compiled October 27, 2015

“I am fortunate to know personally many of the leaders of both health care systems. I know them as people of integrity who care deeply for our region and our people. They have arrived at the best decision for the people of our region through the proposed merger and I am happy to support it.”

Marvin Cameron – Pastor, First Baptist Church
Statement of Support, compiled October 27, 2015

“The New Health System would lead to more manageable costs for employers, while still allowing employees to get the care that they need. In order to remain competitive in the current climate shaped by the economic conditions, demographics, and government policy changes, a health care system must proactively focus on managing costs, improving quality, and finding efficient and innovative ways to improve operations and services. Eastman believes the proposed merger could allow the New Health System to continue to make available and affordable high quality health care in the region.”

David Woodmansee, Johnson City, TN, Eastman
Chemical Company, Vice President, Assistant
General Counsel & Assistant Secretary
June 7, 2016 Public Hearing

“Our executive management of the bank, our board, we’ve discussed this extensively. As an employer, we unanimously support it. We’ve evaluated the COPA and its impact on our objectives for the health and well-being of our employees and their families. We’ve evaluated the competitive aspects of multiple systems, and we’ve to the conclusion that the continued arms race of the past has produced a costly system with sub-optimal utilization.

We think that that the upside benefits of cooperation will bring us better outcomes, faster EMR adoptions, and the opportunity for the adoption of leading-edge technology that remaining separate wouldn’t bring.”

Roy Harmon, Chairman and CEO, Bank of
Tennessee
June 7, 2016 Public Hearing

“Our chamber board spent as much time as any community group could scrutinizing what we’re talking about today. And we unanimously, after our own due diligence, said that this merger would be extremely beneficial.”

Gary Mabrey, President and CEO,
Johnson City/Jonesborough/Washington County
Chamber of Commerce
June 7, 2016 Public Hearing

“I would like to offer a few comments of support for the proposed merger between Mountain States and Wellmont. As a business leader in the Bristol market, I see distinct advantages in allowing our two local health systems to combine. Below are just a few I would like to highlight:

- 1) Local control of our health care*
- 2) Combination / enhancements of specialties and the ability to develop sub-specialties not now available in our market*
- 3) Increased focus on our population health management in conjunction with ETSU*
- 4) Maintaining / enhancing our extensive regional health care delivery network*
- 5) Cost control thru elimination of duplicated services, corporate overhead and compliance with the COPA guidelines.”*

David Wagner, Market President for Bristol and
Blountville, Bank of Tennessee
Public Comment to Tennessee Department of Health
– August 5, 2016

“The merged system and its proposed investments in the region’s higher educational partners, including, but not limited to ETSU, will bring together two of the region’s strongest assets. By investing in health professional education, the merged systems will be helping to assure the quality of healthcare for the future of the region, and, at the same time, supporting one of the region’s largest employers—a true “win-win” for our region. Given the health challenges facing central Appalachia, I believe that strong region-wide health system, and an equally strong Academic Health Science Center, could position the region as a highly attractive location for health and education-related investments.”

Dr. Randy Wykoff, Dean, ETSU College of Public
Health
Public Comment to Tennessee Department of Health
– August 5, 2016

“Combining strengths, assets and liabilities would enable these systems to focus more on quality, population health management, mental health programs and other services benefiting the entire region.”

Douglas J. Springer, MD, immediate past president
of the Tennessee Medical Association
Better Together Website

“The Tennessee Nurses Association embraces the decision as one that will improve the quality of health care in our region, control spiraling costs, and better address the chronic health care issues facing this state.”

Teresa A. Martin, MSN, FNP-BC, District President,
on behalf of District 5, Tennessee Nurses Association
Better Together Website

“In a part of the state that cannot afford it, these competing hospital systems are having to spend for advertising and “keep up with the Joneses” spending on programs. Flashy items that attract patients (cardiology) receive funding and attention while needed programs in mental and behavioral health go wanting. Having one system responsible for the health of the region will provide the economies of scale we need, and it will eliminate waste while allowing for investment into effective programs in the community. I am strongly in favor of the COPA and merger.”

Dr. Jeff Summers, Internal Medicine, Mountain
States Health Alliance
Public Comment to Tennessee Department of Health
– August 9, 2016

“I am writing to support the issuing of the COPA, because I see that the health care needs of our local communities are in many ways unique and I feel that the benefit of keeping local control over how we allocate our resources will better served than if we have to merge or be purchased by some outside institution. I understand that there are risks to the concept of a monopoly but healthcare is far, far from a typical free enterprise and the pressures to keep costs/expenses controlled are greater in today's healthcare markets than they were in the past or in most other businesses.”

Dr. Glenn Birkitt, Independent Physician, Wellmont
Bristol Regional Medical Center
Public Comment to Tennessee Department of Health
– August 14, 2016

II. OVERVIEW OF THE MERGER

Two years ago, Wellmont began an internal evaluation of its 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. Four of Wellmont's six hospitals are rural and have fewer than 50 staffed beds, each with a daily census ranging from 3 to 13. Seven of the Mountain States hospitals are rural and have fewer than 50 staffed beds, each with a daily census ranging from 1 to 35. The overwhelming number of assets between the two systems are rural.

While providers throughout the nation have faced challenges that led them to merge with out-of-market entities or to be acquired, Wellmont and Mountain States face a challenge somewhat different. The region's declining inpatient use rates and a population that is projected to remain stagnant (and even decline in many of the Parties' markets), combined with the second lowest Area Wage Index in the United States (making Medicare and Medicaid reimbursement, which represent 70 percent of the payer mix, among the lowest in the nation), the region's hospitals face a scenario in which any out-of-market acquiring entity will most likely have no choice but to seek higher pricing in order to sustain operating margins. Any system acquiring Mountain States or Wellmont would need to generate the incremental revenue to offset the nearly \$1.5 billion in debt they would be absorbing, even in the face of deteriorating patient volumes, to sustain the cost of duplicative services. The only place to look would be to leverage the less than 20 percent of the payers that pay negotiated rates for additional reimbursement. Since Medicare and Medicaid reimbursement in the region is among the lowest in the nation, and since most negotiated commercial reimbursement is tied to Medicare payments, it is highly likely that any potential acquiring entity would have payment rates higher than either Wellmont or Mountain States. Certainly, it would be in Wellmont and Mountain States' interest to identify such a partner and to utilize its capacity to generate this incremental revenue in order to be assured the hospitals would have the requisite margins going forward. It should also be assumed that any entity would look to close money-losing services or hospitals, creating additional major gaps in care. This is not simply conjecture on the part of the applicants. There is a reason 78 hospitals have closed, and hundreds more are at risk.

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 engaged with twenty-two organizations, issuing requests for proposals from health systems interested in strategic alignment. Wellmont received substantial interest from a variety of sophisticated health systems, ultimately receiving nine proposals from other health systems, including Mountain States. 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 COPA by the State of Tennessee (the "State") and a Letter Authorizing a Cooperative Agreement by the Commonwealth of Virginia (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.

III. RESPONSE BY APPLICANTS
TO SUBMISSION OF
FEDERAL TRADE COMMISSION STAFF

A. Staff's Policy Objections Are Not Relevant

The Tennessee General Assembly (the “Legislature”) has clearly articulated and affirmatively expressed the policy of the State to supplant competition with regulation for cooperative agreements, including mergers, that meet the statutory requirements of the Hospital Cooperation Act (the “Hospital Cooperation Act” or “Act”). Staff clearly believe Tennessee’s policy for improving health care conditions in the State is misguided.¹ They contend “[c]ompetition is the most reliable and effective mechanism for controlling health care costs while preserving quality of care, including in rural areas facing economic challenges.” (staff comments at 2) They argue that “[c]ompetition is no less important in rural and economically stressed communities than it is in urban and more prosperous ones.” (*Id.* at 10) They provide FTC Chairwoman Ramirez’s remark that the goals of improving health care quality and cost “are best achieved when there is healthy competition in provider markets.” (*Id.* at 1 n.5) Repeatedly throughout their submission, staff interject their unwavering policy bias into comments ostensibly directed to the merits of the Parties’ Application under the Hospital Cooperation Act.

Staff’s disagreement with Tennessee’s public policy choices has no relevance to this proceeding and should be given no weight. The Legislature’s decision to enact the Hospital Cooperation Act is solely within the sovereign purview of Tennessee. Over seven decades ago, in *Parker v. Brown*, 317 U.S. 341 (1943), the U.S. Supreme Court held that Congress did not intend the federal antitrust laws to apply to states acting in their sovereign capacities. Tennessee acted in its sovereign capacity when the Legislature originally passed the Hospital Cooperation Act and the Governor signed it into law in 1993. The Legislature and the Governor reaffirmed the State’s policy choice in 2015 when they materially amended the Hospital Cooperation Act. Staff’s opinion that competition is always and forever a better policy for Tennesseans than the regulatory model encompassed in the Hospital Cooperation Act is legally irrelevant. Staff’s argument seems intended to prioritize staff’s policy views over the distinctly different sovereign policy that is clearly articulated in Tennessee law. Further, this sovereign policy is outside the scope of staff’s expertise.²

¹As staff point out, their comments do not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. (staff comments at n.1)

²A recent Federal Trade Commissioner herself recognized that the agency does not possess sufficient information to opine on non-competition-related public policy goals of state laws that restrict competition. In a January 8, 2016, dissent to a FTC and Dept. of Justice joint statement on repeal of the South Carolina Certificate of Need statute, then-Commissioner Julie Brill states:

“My concern is I do not believe the Agencies possess sufficient relevant information to opine on *non-competition*-related public policy goals of the CON laws. Our experience is broad but it does not extend to every issue. The FTC should advise South Carolina policy makers based on our area of expertise—competition—and not overstep our collective knowledge. Health care policy makers at the state level are faced with difficult issues separate and apart from the strong benefits competition brings to health care markets. These include the critically important issue of preserving access to care for the needy, and doing so in a complex market, involving informational asymmetries among patients, providers, and payers. In this context, it is important to understand that competition will not move resources from those that can afford health care to those that cannot. As the Agencies stated in 2004:

‘competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payers. Competition also will not shift resources to those who do not have them.’”

Staff's propensity to ignore this fundamental doctrinal principle is also seen in its selection of case references. Staff cite to *North Carolina State Board of Dental Examiners v. FTC*, 135 S.Ct. 1101, 1109 (2015), and the Supreme Court's statement therein that "federal antitrust law is a central safeguard for the Nation's free market structures" and is highly important to economic freedom and to the free-enterprise system. (staff comments at 5 n.18) But staff stop short of quoting to the Department the more pertinent text found in the Court's very next paragraphs:

The Sherman Act serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and the public's welfare. *The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition.* While "the States regulate their economies in many ways not inconsistent with the antitrust laws," in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. *If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate.*

For these reasons, the Court in *Parker v. Brown* interpreted the federal antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. That ruling recognized Congress' purpose to respect the federal balance and to "*embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution.*" Since 1943, the Court has reaffirmed the importance of *Parker's* central holding.³

B. Staff's Traditional Antitrust Law Analysis Does Not Respond To The Issues In The Hospital Cooperation Act

Turning to the Hospital Cooperation Act, staff contend that the Department should evaluate the Parties' Application (solely) according to the FTC's methods for merger analysis. Staff say this is appropriate because their antitrust approach is "similar to that which the Department will take when reviewing COPA applications." (staff comments at 7) Staff are incorrect. A traditional antitrust analysis does not respond to and incorporate the different Tennessee policy goals clearly articulated in the Hospital Cooperation Act.

1. State Policy, Not Antitrust Law, Governs Cooperative Agreements

The Legislature established a set of analytical factors for the consideration of cooperative agreements under the Hospital Cooperation Act distinctly different from those used by the FTC to scrutinize traditional mergers under the federal antitrust laws. The Hospital Cooperation Act

Staff's comments are an example of the agency's representatives "overstepping their collective knowledge" and clearly lack merit in this proceeding. Former Commissioner Brill's full statement is available at https://www.ftc.gov/system/files/documents/public_statements/905323/160111ftc-doj-sclaw-statement.pdf?utm_source=govdelivery (citation omitted).

³*North Carolina State Bd. of Dental Examiners v. FTC*, 135 S.Ct. 1101, 1109 (2015) (citations omitted) (emphasis added).

“promote[s] cooperation and coordination among hospitals” and authorizes *approval* of anticompetitive mergers that meet the law’s evidentiary tests. The federal antitrust laws *prohibit* anticompetitive mergers. This fundamental distinction is absent from staff’s comments. The result is a submission replete with incorrect and unhelpful analysis that is disconnected from the Tennessee policy goals and evidentiary requirements applicable to an application for a COPA under the Hospital Cooperation Act. (See *infra* for more detailed discussion of inaccuracies in staff comments.)

Staff urge the Department and Commissioner to scrutinize the Parties’ merger under the methods of the FTC-Department of Justice Horizontal Merger Guidelines (the “Merger Guidelines”).⁴ (staff comments at 7) The Merger Guidelines are designed to “identify and *challenge* competitively harmful mergers while avoiding unnecessary interference with mergers that are either competitively beneficial or neutral.” (staff comments at 7; emphasis added) That is not the right framework for considering an application for a COPA under the Hospital Cooperation Act. The Tennessee statute does not mandate a “challenge [to] competitively harmful mergers” or even the denial of an application merely for the reason that the merger is likely to be anticompetitive. Rather, under the Hospital Cooperation Act, mergers that might be anticompetitive under the federal antitrust laws can be authorized pursuant to a policy that “displace[s] competition among hospitals with regulation . . . and to actively supervise that regulation . . . **to promote cooperation and coordination among hospitals in the provision of health services.**”⁵ (emphasis added)

The Hospital Cooperation Act establishes a program of regulation combined with active State supervision to achieve pro-consumer benefits in ways other than reliance on pure competition. The Act takes into account enhancement of quality, preservation of hospital facilities, improvements in the utilization of hospital resources, avoidance of duplication, and population health improvement, in addition to the gains in the cost-efficiency made possible by the merger. It ensures that these benefits will be realized through legally enforceable commitments from the Parties to pursue high quality performance and to invest money from merger-generated cost savings into programs that will improve population health, expand access to care, and create community benefits tailored specifically to the needs of Tennessee’s patients. This is particularly important when these investments of merger-generated cost savings are helping achieve priorities of the State that would otherwise not be possible, or not be as immediate, without the merger. All of these commitments and the related actions made possible solely by the merger itself offer significant public advantage above and beyond market protections.

Active and ongoing supervision of these commitments is implemented, moreover, to ensure the New Health System’s compliance with the policy goals articulated by the Legislature in the Hospital Cooperation Act that displaces competition with regulation. The Act also allows for mechanisms such as rate restrictions to ensure reasonable prices and conduct restrictions to ensure non-exclusionary practices to guard against potential adverse impacts from the reduction

⁴U.S. DEPT OF JUSTICE AND FED. TRADE COMM., HORIZONTAL MERGER GUIDELINES (August 19, 2010) [hereinafter “MERGER GUIDELINES”], available at <https://www.ftc.gov/sites/default/files/attachments/merger-review/100819hmg.pdf>.

⁵Tenn. Code Ann. § 68-11-1303(a) (effective May 18, 2015).

in competition. Staff's antitrust/Merger Guidelines analysis does not take proper account of this carefully constructed regulatory framework.⁶

2. Efficiencies In A Cooperative Agreement Are Not An Antitrust Issue

The gap between staff's analysis, which is grounded in traditional antitrust theory, and the broader, community health-centered analysis which the Department must utilize under the Hospital Cooperation Act is perhaps most pronounced with respect to consideration of the cost efficiencies and consumer and community benefits likely to flow from the Cooperative Agreement. To be clear, this is not a traditional merger analysis. The scope of potential community and consumer benefits here are far broader.

a. Efficiencies Analysis Under The Federal Merger Guidelines Versus Community Health Benefits Analysis Under The Hospital Cooperation Act

Under the Hospital Cooperation Act, even potentially anticompetitive mergers qualify for approval if the totality of consumer and community benefits, cost-savings, synergies, and other advantages from the merger (collectively herein, "efficiencies") exceed by clear and convincing evidence any disadvantages attributable to reduction in competition likely to result from the cooperative agreement.⁷ The likelihood of any disadvantages can be minimized by mechanisms such as rate caps for pricing, restrictions on anticompetitive conduct, commitments for specific actions to improve quality measurably, and active supervision along with the powers to modify or withdraw approval of the COPA. As detailed herein, these "conduct" commitments are straightforward and easily enforceable by the State.

Staff's approach to efficiencies under its Merger Guidelines is focused solely on whether the claimed efficiencies enhance *competition* – not on other policy goals, such as Tennessee's policy to promote even anticompetitive mergers that convey net benefits to the community under the statutory conditions described above.⁸ The FTC does not credit an efficiency unless that efficiency is "merger-specific" (likely achievable only through the merger at issue or another

⁶According to staff, the Merger Guidelines, to which staff repeatedly refer in their submission, "reflect experience in analyzing a wide variety of mergers . . . as well as economic and other relevant research." (staff comments at 7) The "mergers" and "research" underlying the Merger Guidelines, however, do not include mergers subject to the unique factors and strict regulatory restrictions under cooperative agreement or COPA laws. *See* staff comments at 67-68 & n.291 (discussing the FTC's "difficulty in assessing whether the public policy goals of the Mission Health COPA have actually been met"). At a public hearing before the Southwest Virginia Health Authority on October 26, 2016, an FTC economist admitted that staff have never conducted an empirical analysis into the market effects of a merger subject to the regulatory restrictions of a cooperative agreement or COPA. Staff's effort to shoehorn the Parties' Application into the Merger Guidelines framework not only lacks foundation in case experience or empirical research, moreover, but also fails on the merits, as discussed in the section that follows.

⁷Tenn. Code Ann. § 68-11-1303(e)(1). The term "efficiencies" in the COPA context is broader than that used in traditional mergers and covers broader populations; for example, it can encompass effects that provide for financially sustainable and high quality care at hospital locations in an area serving all populations or changes that provide for realignment of clinical services to make effective use of scarce resources and enhance service delivery to improve outcomes and achieve improved health and reduced costs.

⁸Moreover, staff's analysis explicitly assumes that continued competition in the absence of the merger would lead to substantial efficiencies and quality that would be lost or reduced substantially by the merger. As noted, in this particular fact pattern, that assumption is inconsistent with the likely reality.

merger that is equally anticompetitive absent the efficiency) and is substantiated as to how it will “enhance the merged firm’s ability and incentive to compete.” (Merger Guidelines § 10) Efficiencies will persuade the FTC not to challenge a merger only if they “are of a character and magnitude such that *the merger is not likely to be anticompetitive* in any relevant market.” (*Id.*; emphasis added) To make that determination, the FTC considers only whether the efficiencies “likely would be *sufficient to reverse the merger’s potential harm* to customers in the relevant market.” (*Id.*; emphasis added)

Staff view each of these antitrust-focused efficiency restrictions in the Merger Guidelines only through a competition lens. The restrictions operate to further the federal antitrust law’s principal purpose for those mergers which are not immune, which is to *prevent* mergers and conduct that are deemed to be anticompetitive. Conversely, the purpose of the Hospital Cooperation Act, which is in full alignment with the Supreme Court’s express doctrine, is to create a pathway for *approval* of mergers by the State – including those that might be seen as anticompetitive – that further the State’s broader public policy objectives to enhance community health. Approval of cooperative agreements that satisfy the Act’s evidentiary balancing test for benefits versus disadvantages, coupled with active supervision to ensure that the balance of net benefits is maintained is the public policy of Tennessee. Efficiencies that would not be credited under the Merger Guidelines because they would not be sufficient to reverse the merger’s potential harm to competition in a specifically defined relevant market **must** be accorded weight under the Hospital Cooperation Act.⁹

Tennessee’s Hospital Cooperation Act establishes a regulatory program that mandates consideration of a broad range of positive effects resulting from cooperative agreements, coupled with substantial checks on potential anticompetitive effects. The Act identifies preservation of hospital facilities, population health improvement and access for the medically underserved as factors which must be considered in evaluating cooperative agreements.¹⁰ In addition, the Legislature required the consideration of **any** other benefits that might be identified.¹¹ The language of the Act clearly demonstrates the intent of the Legislature to give primacy to the achievement of community health benefits, broadly considered. This is in marked contrast with federal antitrust policy, with its one-dimensional focus on promoting competition.

Further, the Hospital Cooperation Act empowers the Department to establish conditions to its approval of a COPA. Under this model, mergers that may reduce competition can be regulated to limit sharply any risk of potential disadvantages, while enabling the beneficial attributes of substantially greater weight to flow to consumers. For example, the merged entity can be prevented from charging anticompetitive prices or engaging in exclusionary conduct. Active supervision by the Department ensures compliance with the conditions for approval.

In the case of the Mountain States-Wellmont merger, the benefits meet this test, and, due to the significance of the Parties’ investment commitments, there is overwhelming economic incentive for the merged system to achieve the synergies outlined in the Application. Moreover,

⁹Tenn. Code Ann. § 68-11-1303(e)(2).

¹⁰Tenn. Code Ann. § 68-11-1303(e)(2)(F),(G).

¹¹Tenn. Code Ann. § 68-11-1303(e)(2)(H).

the merger creates an integrated delivery system that is accountable to the State and the community with regard to its operations and results. This is a far broader set of benefits than those usually examined by staff in a traditional merger.

Thus, staff are incorrect when it argues, as it does repeatedly, that the Department's role under the Hospital Cooperation Act "is similar to the analysis that courts and antitrust agencies perform when assessing the competitive impact of mergers" using the Merger Guidelines. (staff comments at 28) The courts and antitrust agencies assess whether a merger is anticompetitive – and stop there. A traditional merger goes forward or gets blocked on that single determination. The Hospital Cooperation Act is different. It codifies a policy recognition that certain potentially anticompetitive health care mergers, when appropriately regulated and actively supervised, can yield substantial health and economic benefits to the community that outweigh the harm, if any, that may result from a lessening of competition. Nothing "similar" to that principle exists in staff's enforcement of federal antitrust law in the absence of state action immunity. The legal cases cited by staff reflect the federal antitrust requirement that efficiencies reverse the merger's anticompetitive effects. (See staff comments at 29 n.107 & n.108) If that were that the standard under the Hospital Cooperation Act, then the Legislature would not need to "provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section."¹² The public policy objectives of the State of Tennessee as articulated by the Legislature in the Act are distinctly different from those of federal antitrust policy.

Staff repeatedly invoke competition-based Merger Guidelines concepts when arguing why none of the community benefits and other efficiencies described in the Parties' Application warrants meaningful weight or any weight. Those arguments are factually incorrect, belied by the plain language of the Hospital Cooperation Act and should be rejected.

b. Less Restrictive Alternatives

Staff characterize as "similar" the concept of "merger-specific" efficiencies under the Merger Guidelines and that of section 68-11-1303(e)(3)(D) of the Hospital Cooperation Act. (staff comments at 25) This is not correct. Under this section, the Department is required to evaluate, among many other factors, the availability of alternative 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. The two principles are decidedly different.¹³ The federal antitrust agencies exclude from the competitive analysis any efficiency that is not merger-specific.¹⁴ The Department, on the other hand, is tasked with evaluating the availability of less restrictive alternatives that would achieve the same benefits, but only as one factor out of many in its overall balancing of advantages and disadvantages. The statute requires the Department to consider benefits even if those benefits are also available in an

¹²Tenn. Code Ann. § 68-11-1303(a).

¹³Tenn. Code Ann. § 68-11-1303(e)(1).

¹⁴MERGER GUIDELINES at 30 ("The Agencies credit only those efficiencies likely to be accomplished with the proposed merger and unlikely to be accomplished in the absence of either the proposed merger or another means having comparable anticompetitive effects. These are termed merger-specific efficiencies.")

alternative arrangement that is less restrictive to competition. Staff do not mention this important distinction.

Staff insist that “most of the benefits of the merger could be achieved through alternatives” to a merger between Mountain States and Wellmont, such as “joint ventures and other forms of collaboration” between them. (*Id.* at 25) Staff respond that the FTC has issued “extensive guidance” on how health care providers can collaborate without violating the federal antitrust laws. The only three examples they cite for such guidance – on price and cost information exchanges, joint purchasing arrangements and physician network joint ventures – are partially or wholly inapplicable as factors driving the efficiency potential of the Mountain States-Wellmont Cooperative Agreement. (*Id.* at 26 n.95) Staff do not address, for example, the elimination of unnecessary and costly duplication (including clinical realignment and integration), from which substantial savings will be achieved through the merger. Collaboration in that regard would face significant federal antitrust roadblocks if the Parties remained competitors. The FTC knows this:

“Most mergers completely end competition between the merging parties in the relevant market(s). By contrast, most competitor collaborations preserve some form of competition among the participants. This remaining competition may reduce competitive concerns, *but also may raise questions about whether participants have agreed to anticompetitive restraints on the remaining competition* (emphasis added). Mergers are designed to be permanent, *while competitor collaborations are more typically of limited duration* (emphasis added). Thus, participants in a collaboration typically remain potential competitors, even if they are not actual competitors for certain purposes (e.g., R&D) during the collaboration. The potential for future competition between participants in a collaboration requires antitrust scrutiny different from that required for mergers.”¹⁵

Notably, staff’s submission runs 72 pages (not counting appendices) and contains 298 footnotes, but staff do not identify a single hospital joint venture or collaboration short of merger anywhere in the country that involves the efficiencies potential provided by the Parties’ Application that might serve to show that its arguments are something other than theoretical and implausible. Staff have provided literally no evidence of any alternative arrangement that would generate similar benefits as those proposed by the merging Parties. Specifically, staff fail to note that the proposed merger involves an integrated delivery system, which is fundamentally different from loose affiliations or joint ventures in its nature and effects.¹⁶ Absent this evidence,

¹⁵U.S. DEP’T OF JUSTICE AND FED. TRADE COMM., ANTITRUST GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS at 5 (April 2000) [hereinafter COMPETITOR COLLABORATION GUIDELINES] (emphasis added), *available at* https://www.ftc.gov/system/files/documents/public_statements/300481/000407ftcdojguidelines.pdf

¹⁶As we discuss elsewhere, there are substantial benefits from integrated delivery networks or systems such as that proposed by the Parties; these benefits are not accounted for in the Staff analysis, which focuses on narrower traditional merger effects. For example, a Kaiser Permanente study notes the benefits of moving from independent and fragmented systems to integrated delivery systems: “Key elements of the health care delivery enterprise — physicians, hospitals, pharmacies, laboratories, and so on — are neither purposefully organized to act collaboratively across disciplines and settings nor signaled to do so by market forces. A growing body of evidence suggests that this lack of systemness contributes to documented shortfalls in quality and efficiency.” (KAISER PERMANENTE INSTITUTE FOR HEALTH POLICY, *Improving Health Care Quality Through ‘Systemness’*, Policy Brief (Jan. 2008)). Enthoven and Tollen address shortfalls of the current system:

mere theory cannot be considered evidentiary for purposes of consideration of this Application. This is one area where staff ignore the Merger Guidelines, which state: “Only alternatives that are practical in the business situation faced by the merging firms are considered in making this determination. The Agencies do not insist upon a less restrictive alternative that is merely theoretical.”¹⁷

Staff contend there are “doubts” based on alleged culture differences between the Parties that the merger will succeed so as to allow the New Health System to achieve their projected efficiencies. (comments at 33) Elsewhere, staff describe the Parties as “fierce competitors.” (*Id.* at 12) Staff’s apparent logic is that a less restrictive alternative to achieve efficiencies on the scale projected by the Parties would more likely occur if Mountain States and Wellmont remain as “fierce” rivals while also attempting to collaborate in limited ventures – each of which would carry a substantial risk of allegations of spillover into anticompetitive restraints – than if they become a unified integrated entity, governed by a unified board, subject to public scrutiny and working under active state supervision to execute the detailed plan outlined in the Application. This is not only theoretical, it is irrational. The suggestion that the Parties remain “fierce” competitors while they attempt to collaborate to achieve synergies that staff cannot identify or quantify, and for which they have provided no examples, is fantasy and speaks to why alternative arrangements will not achieve similar benefits as those proposed by the Parties. Certainly, if staff are arguing that alternatives exist which would yield similar benefits, staff could at least provide a sound example. They have not.

The Parties have pointed out that denial of their Application would present strong potential for one or both Parties to be acquired by an out-of-market health system. FTC Chairwoman Ramirez has acknowledged growing concern that out-of-market transactions may also lead to higher prices.¹⁸ An out-of-market acquisition also has substantially lower potential for realignment and cost savings in traditional efficiencies as well as in important health and other medical expenses.¹⁹ Consequently, there is a significantly higher risk that prices for hospital services in Northeast Tennessee and Southwest Virginia will be higher if the COPA is denied than if it is granted. Under a COPA, the merged system will be subject to pricing caps that will keep pricing increases at a rate below the Consumer Price Index for Hospitals as reported by the United States Bureau of Labor Statistics – the most reliable indicator of resource consumption costs for hospitals and one of the best tools for predicting pricing for the

“Many stakeholders agree that the current model of U.S. health care competition is not working...Instead, we need markets that encourage *integrated delivery systems*, with incentives for teams of professionals to provide coordinated, efficient, evidence-based care, supported by state-of-the-art information technology” (emphasis added). They go on to note that integrated delivery systems have the “ability to drive efficiency improvement and cost containment on a large scale.” Alain C. Entoven & Laura A. Tollen, *Competition in health care: it takes systems to pursue quality and efficiency*, HEALTH AFFAIRS 24 (Sept. 2005), available at <http://content.healthaffairs.org/content/early/2005/09/07/hlthaff.w5.420/suppl/DC1> Additionally, there is evidence supporting an association between integrated delivery systems and improved quality. See Hwang, et. al, *Effects of integrated delivery system on cost and quality*, 19 AMERICAN JOURNAL OF MANAGED CARE 5, 175-84 (2013).

¹⁷MERGER GUIDELINES at 30

¹⁸See U.S. DEP’T OF JUSTICE AND FED. TRADE COMM., *Workshop Transcript: Examining Healthcare Competition* (February 24, 2015), available at: https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf.

¹⁹We note that this is recognized in the economics literature cited by the FTC and in other submissions. See, e.g., David Dranove and Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22(6) J. OF HEALTH ECONOMICS, 983-997 (2003).

purchasers. Absent a COPA, however, there would be no antitrust impediment to an acquisition of Wellmont or Mountain States by a non-competitor, no Cooperative Agreement, and therefore no legal basis for rate regulation.

Staff respond that the literature “does not show that acquisitions by out-of-market health systems results in the same or greater price effects than a merger to near monopoly in a local health care market.” (staff comments at 27) The Parties never claimed differently, although this argument misses the mark. The point is that an out-of-market merger raises a tangible risk of higher prices and the Cooperative Agreement governed by a COPA does not, because the latter is subject to price regulation and the former is not.²⁰ As addressed more fully below, there is evidence that a *regulated* merger said to be a “near monopoly” has the potential to result in lower costs and gross pricing than non-regulated mergers or out-of-market acquisitions.²¹ Further, according to a 2011 report made to the North Carolina House Select Committee on the Certificate of Need Process and Related Hospital issues, Mission Health, a “near monopoly” created by a COPA, maintained pricing which was “well within the mainstream of hospital pricing” and costs that were “well within the median of current COPA peer group.” According to this presentation, Mission Health’s pricing is below comparison hospitals, and Mission Health is a “leader in health care quality and efficiency.”²² In addition to the potential pricing benefits provided through the proposed cooperative agreement, the proposed agreement, governed by a COPA provides opportunities for substantial community health benefits not achievable by an acquisition of either Party by an out-of-market health system.

3. West Virginia Recently Rejected The Same Staff Arguments

The Parties acknowledge that every proposed hospital merger – whether it is assessed under traditional antitrust law or a cooperative agreement under a law like the Hospital Cooperation Act – presents its own unique set of facts and leads to a balancing of potential benefits and disadvantages that is unique to its own circumstances. Nonetheless, and in full recognition of this principle, the Parties submit that it is instructive to review the recent detailed and carefully reasoned decision of the West Virginia Health Care Department (“WVHCA”) in approving a cooperative agreement between two West Virginia hospitals that met virtually the identical policy-based opposition from staff that is present in this record.²³

WVHCA approved that cooperative agreement pursuant to a recently enacted West Virginia cooperative agreement statute, which codifies immunity from the federal and state antitrust laws for qualified hospital mergers and includes provisions for active state supervision

²⁰Moreover, staff appears to assume that a merger with an out-of-market firm that may not be able to accomplish either the same efficiencies or improvements, or continued competition between Wellmont and MSHA would keep costs and prices at current levels. This assumption has not been demonstrated, and many factors addressed in the Application about market conditions, costs of duplication and likely declines in inpatient utilization at hospitals in the area suggest upward pressures on costs.

²¹According to public data provided by the State of North Carolina, the Mission Health System has demonstrated, for every year measured, case mix adjusted net revenue per adjusted admission, and case mix adjusted costs per adjusted admission are lower than all peer hospitals in the state.

²²See Thomas McCarthy, *The Mission Health System COPA*, Presentation to the North Carolina House Select Committee on the Certificate of Need Process and Related Hospital Issues (Oct. 20, 2011).

²³In Re: Cabell Huntington Hospital, Inc., Cooperative Agreement No. 16-2/3-001 (W. Va. June 22, 2016).

by WVHCA. The West Virginia statute requires WVHCA to weigh the advantages and disadvantages of a proposed cooperative agreement (under a preponderance standard) by taking into consideration many of the same factors that are set forth in the Tennessee statute.²⁴

WVHCA rejected staff's arguments in opposition to the hospitals' application, including staff's attempt to apply a traditional antitrust/Merger Guidelines analytical framework to the cooperative agreement. WVHCA decided that "this is not a federal antitrust case" and that the West Virginia Legislature "specifically provided an exemption from state and federal antitrust laws for any actions of hospitals and health care providers under the Department's jurisdiction when made in compliance with orders, directives, rules, approvals or regulations issued or promulgated by the board," citing W.Va. Code 16-29B-26. (W. Va. Decision at 35) According to the WVHCA, West Virginia sets forth a different standard for approval from that advocated by staff, and the WVHCA will not apply a standard reserved for an antitrust action to a state law matter. (*Id.* at 36)

Many of the WVHCA holdings with respect to staff's specific arguments are strikingly pertinent here:

- Due to increased combined volume, the merged entities have greater ability to offer sub-specialty care, because critical mass for tertiary sub-specialist level work is much more achievable and the hospitals separately lack sufficient volume to recruit physician specialists for such programs as highly complex orthopedic and cancer surgery and a kidney transplant program. (*Id.* at 10, 28-29)
- In response to staff criticism that commitments and benefits were not merger specific, the WVHCA held that the proposed cooperative agreement involves issues of health care law under the West Virginia statute, not a federal antitrust matter. (*Id.* at 13)
- With respect to improved quality, the WVHCA noted that unification of protocols and practice will bring efficiency and improve quality of care, including for example, using evidence-based medicine to have a sepsis protocol in both hospitals. (*Id.* at 30, 32)
- The hospitals have made enforceable commitments to establish a fully integrated and interactive medical record system at both hospitals, so that a patient's encounters will be more readily available. The WVHCA emphasized the importance of a modern database and fully integrated and interoperable medical records system so that patient encounters at each hospital can be readily available to treating physicians at either hospital in real time, which is particularly important for hospitals located in close proximity to each other where patients may seek services at one hospital one day and at another a different day. (*Id.* at 30)
- According to the WVHCA: "No population health strategy can succeed without robust integrated data analytics for the entire population across the entire continuum of care." (*Id.* at 30)
- The WVHCA specifically credited "numerous articles" from members of the academic community and governing specialty organizations that support the

²⁴Tenn. Code Ann. § 68-11-1303(e).

proposition that high volume is associated with better outcomes across a wide range of procedures and conditions. (*Id.* at 31)

- The WVHCA credited the efficiency estimates of the hospitals, rejecting the contention that the efficiencies must be merger specific, stating that it will not apply a standard reserved for an antitrust action to a state law matter. (*Id.* at 36)
- The WVHCA specifically noted the continued significant support by the hospitals for medical education in the region and that this level of support could be drastically reduced or eliminated if one of the hospitals was acquired by another hospital system. While objectors argued that other hospitals may be willing to make similar commitments, “[b]ased upon the importance of these programs to service area residents, the Department is unwilling to jeopardize these programs.” (*Id.* at 40, 43-45)
- The WVHCA was particularly concerned about jeopardizing these medical education programs in an area in which risk factors for cardiology services are so high, such as obesity and smoking. (*Id.* at 40) In this regard, the WVHCA noted the hospitals’ support for education of primary care physicians who will serve in rural communities, commitments which are too critical to the community to jeopardize based on speculation. (*Id.* at 17) In primary care and in specialty areas, most residents end up practicing within 50 miles of the training program. (*Id.* at 18)
- The hospitals argued that a single hospital system can better analyze community needs and formulate and implement education and other programs to engage the community. The WVHCA rejected staff’s contentions regarding lack of specific goals or timeframe, noting that the hospitals had committed to terms for developing goals for population health improvement for the next ten years and that a merger of the two hospitals would enhance quality because increased volume in specific areas has shown to lead to better outcomes. (*Id.* at 47-49)
- While staff argued that the hospitals should be more specific about the duplication to be avoided, the WVHCA stated that a merged system will clearly not be purchasing duplicative equipment. (*Id.* at 51-54)
- The WVHCA specifically focused on the fact that the population to be served has more significant health challenges than the United States generally. Specifically, the higher rates of many chronic conditions, such as obesity, diabetes, heart disease and cancer and behavioral issues such as drug use, smoking and poor nutrition have made these conditions particularly difficult for health care providers to address in a meaningful way. The WVHCA concluded that combining the two hospitals “aligned with other providers along the care continuum as well as stakeholders in the community creates a unique opportunity to marshal resources in a coordinated way and tackle these longstanding, expensive problems that reduce quality of life for so many of the state’s most vulnerable citizens and communities.” (*Id.* at 21) In this regard, the WVHCA specifically noted the philosophy and culture of the governing boards, composed of local community and consumer representatives. (*Id.* at 95)
- Constraints on increases in total costs of care – While staff argued that the hospital’s rate commitments, including a benchmark rate, were vague, the WVHCA rejected those arguments as speculative. (*Id.* at 57)

In conclusion, the WVHCA stated with respect to the cooperative agreement:

It creates an opportunity for savings which are specific to this transaction and could not be achieved by another purchaser of [Saint Mary's Medical Center (SMMC)]. It enables a fully integrated and interactive medical records system which will have far more importance for hospitals in close proximity to each other than could be achieved were SMMC to be acquired by a remotely located purchaser. It permits system wide coordination of community health initiatives. It assures local control of SMMC and continued support by SMMC for the Joan C. Edwards School of Medicine. It makes possible the implementation of common protocols and establishment of the centers of excellence through a single hospital system serving the region. It enhances the ability of the hospitals to recruit highly trained physicians. It makes possible the expansion of services locally so that the requirement for burdensome patient travel to other areas will be reduced.

[The acquiring hospital] notes that it is important to remember that [the acquired hospital] will be sold. The benefits listed above as well as many other benefits from the transaction could be lost to the community if [the latter hospital] is sold to another purchaser. (*Id.* at 100)

The Parties respectfully submit that WVHCA's rationale for rejecting staff's antitrust law arguments concerning the application for a cooperative agreement in that state has equal force in the matter now before the Tennessee Department of Health. Accordingly, staff's comments to the Parties' Cooperative Agreement should be rejected here as well.

C. Staff's Comments On The Statutory Factors Lack Merit

In their comments, staff address the individual statutory factors that the Department must evaluate when assessing the potential benefits and disadvantages resulting from the merger. Staff assess these factors under a federal antitrust law framework and do not identify a single aspect of the merger that they view to be a benefit. Staff's comments contain irrelevant antitrust arguments and unfounded criticisms of the Parties' substantial commitments to the region and their demonstration of substantial benefits resulting from the merger.

The Parties respond below to staff's specific comments, but first address a few points in the FTC's Executive Summary. Most of the claims in the Executive Summary are raised again in later sections of staff's submission, and the Parties respond to them elsewhere below.

Staff state that they recognize the challenges facing many states regarding unmet health care needs in rural communities and the regulatory and financial pressures that providers face in delivering health care services in those areas. (staff comments at 1) But nowhere in their submission do they acknowledge, let alone address, the specific, pervasive health problems confronting patients in Northeast Tennessee that the Parties have detailed in their Application and subsequent submissions to the Department (briefly mentioned above). Staff ignore the strained economic conditions that have led to the need for each system to absorb more than \$19 million in losses annually to ensure inpatient services continue to remain available in their

respective rural service areas and the high number of rural hospital closures across the country. Staff ignore that the projected decline in inpatient utilization in the region, when combined with flat or negative population trends, leads to additional losses as both Wellmont and Mountain States must absorb an expected loss of between 13,000 and 30,000 discharges annually.²⁵ These are examples of facts that underlie Tennessee's cooperative agreement policy and illustrate the rationale for the Parties' Application, but staff do not acknowledge or comment on them.

In fact, in the face of these distressed health and economic conditions, staff state without substantiation that "[c]ompetition between Mountain States and Wellmont *greatly benefits* area employers and residents."²⁶ (*Id.* at 2; emphasis added) Obviously, the Legislature has concluded that competition has not achieved the needed benefits throughout Tennessee, or at least that an active regulatory program has the potential to outperform competition. The effects of a competition policy in Tennessee include, among other things, that Tennessee has seen the second highest number of hospital closures since 2010, several rural hospitals in the region operating with substantial losses, a reduction in the number of funded residencies in the region supported by the two major health systems, a shortage of certain specialties in pediatrics and other specialties such as endocrinology in a region suffering from a high rate of diabetes, a lack of residential addiction recovery services in a region suffering among the highest rates of opioid addiction and deaths from addiction, and a lack of community based mental health services sufficient to serve the burgeoning needs in the region.²⁷ While competition has not met these needs, on the other hand, there is an abundance of certain specialties which generate revenue-producing hospital admissions, and two Level 1 Trauma Centers within a 20 minute drive and no pediatric trauma services.²⁸ The mismatch of resources with need is clear. These conditions are reflected in the overwhelming community support for the merger discussed above.

Staff express concern that a COPA for the Parties' Cooperative Agreement "would undermine" the State's goals (*id.* at 2) but do not answer, for example, where the region will find financial resources of the magnitude of the Parties' commitments for significant incremental investment in population health, addiction recovery and treatment, expansion of specialty services and the other region goals if the State denies the Parties' Application. In fact, since the

²⁵With approximately 126 discharges per 1,000 population currently, the region runs substantially higher than national use rates of between 90-110 admissions per 1,000. It is projected that discharges in the relevant market will decline to somewhere in this range in the next 5 years. The combined system generates approximately 100,000 discharges. Based on this data, the decline in discharges can be expected to be in the range of 13,000 and 30,000.

²⁶See Section I. above for comments in support of the merger from area employers.

²⁷See Ayla Ellison, *A state-by-state breakdown of 80 rural hospital closures*, BECKER'S HOSPITAL REVIEW (Dec. 13, 2016). McNairy Regional Hospital in Selmer, Tenn., part of Knoxville, Tenn.-based Tennova Healthcare, closed May 18. The hospital's admissions had dropped nearly 70 percent between 2010 and 2015, and ER visits had also plummeted. See BECKER'S HOSPITAL CFO (June 2016); see also WATE (June 17, 2016) (Scott County reacts to Pioneer Community Hospital closing), available at <http://wate.com/2016/06/17/scott-county-reacts-to-pioneer-community-hospital-closing/> June 17. Since 2010, there have been 8 rural hospital closures in Tennessee, four of which occurred in 2015 and 2016. See THE CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH AT THE UNIVERSITY OF NORTH CAROLINA, *80 Rural Hospital Closures: January 2010 – Present* (as of December 17, 2016) ("80 Rural Hospital Closures: January 2010 – Present") (Fourteen rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.), available at <https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/>.

²⁸Tennessee has 6 licensed Level 1 Trauma Centers. In each region outside the Tri-Cities, there exists one Level 1 Trauma Center and one Pediatric Trauma Center. In the Tri-Cities, there are two Level 1 Trauma Centers, one Level 2 Trauma Center, and no Pediatric Trauma Centers, leaving the Tri Cities as the only region of the state without a licensed Pediatric Trauma Center.

State has no alternative funding source for addressing these priorities, staff ignore completely the value of the resources that are being made available as a result of the Cooperative Agreement. These funds are available only through synergies generated by the merger under the Cooperative Agreement. The commitments proposed by the Parties not only do not “undermine” the State’s goals, the evidence shows they are aligned with the State’s goals as enumerated in the State Health Plan.

1. Staff's Market Share And Concentration Analyses Are Not Informative

In section IV, staff state that the merger’s benefits are unlikely to outweigh the disadvantages that would result from the loss of competition between the Parties (comments at 8), and in section IV.A that the merger “would likely lead to increased prices and reduced quality and availability of health care services in Southwest Virginia and Northeast Tennessee.” (*Id.* at 9) These statements are speculative and staff provide no evidence to support them. Staff discuss market shares and market concentration and the inferences to be drawn from structural statistics in traditional merger analysis. (*Id.* at 9-15) This discussion ignores that the merged health system will be subject to a rate cap commitment that will prevent anticompetitive prices and to commitments to improve quality and expand access that are based on actions that the Parties will be undertaking as part of the merger. Staff do not explain how the market power they predict based on the share/concentration statistics will be exercised under the watchful eye and active supervision Department officials and sophisticated bargaining abilities of commercial health plans.

Staff evaluated the Hospital Cooperation Act’s statutory factors “in conjunction with [their] standard analysis under the Merger Guidelines.” (*Id.* at 8). In other words, they conducted an antitrust law analysis that, as discussed above, is inapposite to a cooperative agreement analysis under the Hospital Cooperation Act. Staff conclude that Mountain States and Wellmont are competitors and the two largest health systems in their 21-county geographic service area in Tennessee and Virginia. This is not in dispute. Staff’s inpatient market shares and concentration statistics merely inform the Department that in staff’s view the merger may be anticompetitive. Staff’s discussion in this section does not address whether the benefits from the merger outweigh its disadvantages as required under the Hospital Cooperation Act.²⁹

Staff notes the few physician specialties where the combined Mountain States and Wellmont share of physicians would exceed 50%. These specialties include cardiovascular services, urgent care services, pulmonology services, and oncology & hematology services. Staff notes that the shares reported in the original COPA application in February differ from those in supplemental update, and they claim the Parties did not provide a rationale for any changes. They imply that changes may understate actual shares by newly including mid-level practitioners or changing categories.³⁰ Staff has once again failed to read the actual request from the Tennessee Department of Health and the response provided by the Parties.

²⁹Moreover, staff assumes rather than demonstrates the benefits and effects of continued competition in this marketplace.

³⁰Staff comments at 17-18 (“Mountain States and Wellmont have since submitted a revised table showing lower combined shares in these and other physician specialties, but they did not provide any underlying data that might explain the discrepancy between the two sets of shares. The revised table may understate the applicants’ combined physician shares by including mid-level health care practitioners, such as physician assistants and nurse practitioners, as well as by consolidating physician

The Tennessee Department of Health requested in its April 22nd correspondence that the Parties:

Revise the lists of services and products in Application Section 11, Exhibit 6, and Addendum #1 Section 3 to reflect the following changes:

i. Provide information on the structure of physician practices to calculate the appropriate market share.³¹

The Parties addressed this request in their response dated July 25, 2016.³² As noted in their response, the supplemental table was updated to take into account data on employment and affiliation from the four months since the Application was filed (February 16, 2016). It also included efforts by the Parties both to update the underlying categories of specialties to provide greater uniformity and simplicity in the categories in order to create clear, consistent categories for comparability. Specifically, the efforts resulted in categories that were more likely, rather than less likely, to result in “overlaps.” This is confirmed by the fact that the overall share of physicians that are independent remained roughly the same.

Staff expresses concern that physician shares with inclusion of mid-level health care practitioners may dilute or lower shares of the Parties’ employed or affiliated physicians.³³ In fact, the share tables provided in the original Application also contained mid-level practitioners, and as such, this was not a change in the updated tables. The inclusion of mid-level practitioners was a conservative approach and the exclusion of mid-level practitioners results in lower shares for physicians in the aggregate. If you look at physician numbers (not total provider numbers), Mountain States and Wellmont have a comparable, if not lower share, than when including mid-level practitioners.

In this section and throughout their submission, staff repeatedly claim support from economist research papers that staff say reflect “a large and growing body of empirical research finding that mergers between close competitors in consolidated health care provider markets are likely to result in substantial consumer harm, without offsetting improvements in quality.” (comments at 9) For example, notes 29, 30 and 31 on page nine of the staff submission all cite to one or more such papers co-authored by economist Martin Gaynor, as do footnotes 4, 19, 24, 31, 46 and 54 – combining for more than a dozen references. Not one of the Gaynor or other papers that staff cite analyzes the consumer effects of a merger that was subject to regulation and active supervision under a statutory framework like the Hospital Cooperation Act. Without such analysis, staff have no foundation in stating that a merger under state supervision and in compliance with the Hospital Cooperation Act will cause consumer harm or result in poor

specialty categories that were reported separately in the initial application.”).

³¹See Letter from the Department to Bart Hove, President and CEO of Wellmont, and Alan Levine, President and CEO of Mountain States (April 22, 2016), *available at* https://www.tn.gov/assets/entities/health/attachments/TDH_Request_for_Information-2_4.22.16.pdf

³²See *Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for Certificate of Public Advantage*, at 10-11 (July 13, 2016), *available at* http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_DOH_Response_1.pdf.

³³Staff comments at 17-18.

quality. To the contrary, the Parties have provided evidence that a merger under state supervision and in compliance with the State's law can lead to pricing which is lower than the peer hospitals while emphasizing high quality and efficiency.

Staff do not disclose this important fact about the literature it advances or explain how this literature could inform the Department in its decision-making process. All this touted research purports to show is that hospital mergers between close competitors in concentrated *unregulated markets* on average result in anticompetitive effects. Staff ignore the obvious wide gap that separates the ability of an unregulated firm with market power, compared to a firm with market power but also subject to regulation and active state supervision, to exercise that power. The gap is even wider in the hospital setting, because hospitals contract with highly sophisticated managed care organizations that not only have the expertise timely to spot violations of cooperative agreement commitments, but also the infrastructure and incentive to report violations to state supervisors on a timely basis.

Professor Gaynor and other academics submitted a memorandum to Commissioner Dreyzehner in which they “urge the Department of Health to reject” the Parties’ Application. The memorandum argues that hospital mergers between close competitors in highly concentrated markets are bad for consumers, and cites to “an extensive body of economic literature” that supports their view.³⁴ Just like staff, the professors do not mention that the literature they advance lacks any analysis of a regulated health system that is under active state supervision and subject to strict commitments in a cooperative agreement. The Department should accord no weight to these studies.³⁵

Finally, neither staff nor the Academics acknowledge that mergers regulated under state cooperative agreement statutes have resulted in lower costs, apparent lower pricing and in at least one case, have led to the hospital market being recognized as having among the highest value hospital systems in the nation.³⁶

³⁴Academic comments at 1. The authors identify five papers for this “extensive body” of literature, including one from Professor Gaynor.

³⁵Staff’s irrelevant policy desire for competition actually is understated compared to Professor Gaynor’s. Regarding West Virginia’s law and WVHCA’s approval earlier this year of a cooperative agreement for two local hospitals, Professor Gaynor attacked the policy as well as the public officials who established it. He said on Twitter: “Monopoly wins, patients lose. WV state government fails its citizens;” and “Ugh, WV legislators, governor should be ashamed of themselves (if they had any shame).” See Exhibit III.A. Professor Gaynor points to no empirical analysis of a hospital merger under a cooperative agreement, but nonetheless sees fit publicly to express apparent contempt not just for the sovereign policy but also for the motives and competence of the policy-makers. This undermines his credibility in opining on the objective merits of the Parties’ Application.

³⁶The Urban Institute has published a report which cites national experts referring to Mission Health in Asheville, North Carolina (“Mission”), as one of the highest value health systems in the nation. See Randall R. Bovbjerg & Robert A. Berenson, *Certificates of Public Advantage, Can they Address Provider Market Power?*, URBAN INSTITUTE, at VI (February 2015), available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf>. Further, according to the annual Independent Accountants’ Report on Applying Agreed-Upon Procedures, a report to North Carolina’s Department of Health Services Regulation by Dixon Hughes Goodman, the data released by the State of North Carolina demonstrates that for each of the 9 years the report is publicly available from 2007-2014, Mission demonstrated lower operating costs per adjusted admission and lower revenue per adjusted admission (on a case mix adjusted basis) than its peer hospitals in North Carolina. Neither staff nor the Academics credibly refute these facts. Buncombe County, North Carolina, where Mission Health resides, has a population of approximately 250,000. The population of Washington County, TN, and Sullivan County, TN, which is where the Parties’ hospitals reside which generate 60 percent of the admissions of the combined system, has a combined population of approximately 258,000.

2. Post-Merger Rate-Setting And Contract Negotiations With Insurers Will Be Transparent and Verifiable

In their comments in section IV.A.2 and A.3, staff contend, respectively, that the merger “would greatly enhance the hospital’s bargaining power” over hospital rates and over certain physician specialty rates, “which would lead to substantially higher prices for consumers.” (*Id.* at 21) Staff, cross-referencing to Section VI.A of their submission, state that the price commitments made by the Parties to the Department “are unlikely to mitigate this harm.” (*Id.* at 21) They contend that the Parties’ commitments lack transparency and are subject to the Parties’ manipulation. This reflects a fundamental misinterpretation of the facts. The Parties’ proposed commitments would create a substantial constraint on rates that keeps them at levels commensurate with a competitively bargained contract. The process is transparent and readily subject to verification by commercial payers and the Department.

Staff contend that the timing of certain of the Parties’ rate-related commitments is unclear. (comments at 57-58). The Parties have committed to reduce existing commercial contracting for fixed rate increases by 50 percent for one year (“Rate Reduction Commitment”) and to a rate cap applicable to certain payers (“Rate Cap Commitment”). With respect to the Rate Reduction Commitment, staff point to a language difference between the Parties’ submission to the Southwest Virginia Health Authority (“SVHA”) in response to staff’s comments to that agency (“Parties’ Virginia Response”)³⁷ and the Parties’ subsequent revised commitments with the SVHA (“Revised Commitments”).³⁸ (*Id.*) Staff also identify a language inconsistency on this subject within the Revised Commitments themselves. (*Id.* at 58) To clarify, the timing for the Rate Reduction Commitment to which the Parties and SVHA agreed is correctly described in the commitment’s description: “For all Principal Payers, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System.”³⁹ We note that staff never acknowledge that this commitment results in an immediate reduction relative to pre-merger negotiated rates for relevant Payers, which provides them resources to invest back in consumers or programs to benefit this area, or more directly, to reductions in costs for purchasers which are self-insured.

Staff also contend that timing of the Rate Cap Commitment is unclear (staff comments at 58), but on this staff are incorrect. The Parties’ Virginia Response states that the Rate Cap Commitment would be effective “immediately upon consummation of the merger.”⁴⁰ The Revised Commitments very similarly state that the Rate Cap Commitment would be “effective

There are distinct similarities between the North Carolina market served by Mission and the Tennessee market served by the Parties. Yet, staff and the Academics ignore these facts.

³⁷*Response by Applicants to Federal Trade Commission Staff Submission on September 30, 2016*, at 15-16 (October 14, 2016), [hereinafter “Sept. 30 Response”], available at <https://swvahealthauthority.files.wordpress.com/2016/09/response-to-ftc-comments-submitted-to-swvha.pdf>.

³⁸*Revised Commitments*, SOUTHWEST VIRGINIA HEALTH AUTHORITY (Oct. 12, 2016) [hereinafter “Revised Commitments”] available at <https://swvahealthauthority.net/commitments/>.

³⁹*Revised Commitments*. The Parties have recommended that the same revision be incorporated into the Tennessee COPA.

⁴⁰*See Sept. 30 Response* at 15.

on the closing date of the merger.”⁴¹ Contrary to staff’s assertion, language in the “Timing” section of the Revised Commitments that the commitment applies to “subsequent contract years” is not inconsistent with the Parties’ stated commitment that the proposed rate cap would apply upon closing of the merger. Staff’s other criticisms of the rate commitments do not have merit.

a. Concerns About The Proposed Rate Cap Mechanisms Are Unfounded

Staff contend that the proposed rate cap will result in rate growth trends that will exceed those likely to occur at Wellmont and Mountain States if the transaction does not occur. The concerns expressed focus on either (1) the price index used to set the rate cap, (2) the concept that the rate cap will act as a rate floor, or (3) that continued competition would have resulted in substantially different pricing.

i. The Price Index Is Appropriate For The Rate Cap

Staff charges that use of the medical CPI index as the basis for comparison with actual rate growth may result in higher rates of increase in rate growth, due to the index’s components or the fact it is a national (or regional) average across all hospitals and may not reflect local cost trends. (staff comments at 57) This argument lacks merit.

As a threshold matter, when Tennessee enacted the Hospital Cooperation Act and its pathway for qualified health care mergers under a program that replaces competition with regulation and active State supervision, it is fundamental that the Legislature also contemplated that a mechanism be established to protect consumers from unreasonable pricing. An argument that competition is a better means for ensuring fair prices is not meaningful, because the Legislature expressly contemplated that competition would be supplanted if the COPA for the Cooperative Agreement is approved. The only issue before the Department in this respect, therefore, is whether the rate protection mechanism under consideration will work effectively and in a consistent way with the broader Tennessee policy principles embodied in the Hospital Cooperation Act.

The rate caps are intended to emulate the beneficial effects of competition. The rate caps provide the mechanism by which the Parties and Department can be assured that any post-merger price increase is both reasonable and a reasonable approximation of what would likely occur with competition. This mechanism involves two parts – an actual rate increase and a measure of “competitive” or “marketplace” rate increases. The rate regulation methodology needs both to be sufficiently flexible to adapt to changing circumstances and to provide a sound means for the State reliably to test and evaluate actual rates of price increases. States and private entities in their contracts often include various measures of medical expense, cost, or some measure of price as a pre-determined reliable measure of marketplace rates or rate increases and also use similar index or measures to compare actual rate increases to some metric (*e.g.*, rate of GDP growth or an index).

The goal of rate caps is to regulate the rate of growth in prices post-merger consistent with a competitive environment, not to replicate precisely the pricing growth that Wellmont and

⁴¹See *Revised Commitments* at 2.

MSHA each would have negotiated in future years. Such rate negotiation outcomes cannot be predicted with precision, and there is no basis for concluding that recent actual price terms negotiated with payers would have been replicated across all new and future contracts.⁴² For example, absent the transaction, both Wellmont and MSHA might have faced pressures to increase rates to commercial payers to cover costs associated with spreading smaller inpatient volumes across higher fixed cost facilities with excess capacity and to achieve sufficient revenues to sustain operations across facilities.⁴³

Any concerns that use of the index will result in substantial deviations from the “competitive price” or in substantial rate inflation are immediately undermined by referring to the index itself. Examination of recent CPI trends reveals that the rates of increase are low, reflect common cost pressures across hospitals, and are very consistent and reasonable rates of change for application to all future contracts. They emulate, in other words, likely competitive trends. Moreover, rate caps are intended to be caps and not precise point estimates. Thus, it is irrelevant whether in any one year or one contract the Parties reach the cap – so long as the cap itself represents a reasonable level.⁴⁴

Concerns about the specifics of the CPI measure are unfounded, particularly since the CPI measure is determined by the United States Department of Labor, Bureau of Labor Statistics. It is a common and reliable index. No commenter has suggested a superior alternative to CPI measures. Economists considering the Mission Health index suggested that regional and other indexes work well for estimating and testing price changes, which is what is at issue here.

ii. The Proposed Rate Cap Is Not A Rate Floor

Staff contend that the proposed rate cap may operate as a rate floor. (staff comments at 58) This is speculative, unsupported by the evidence and ignores the realities of commercial negotiations. Information on the CPI is readily available to everyone, as will be the rate cap. Both insurers and the New Health System will come to negotiations with informed positions as to the likely value of the CPI based on most recent year’s data and information readily available from public sources.

The presence of a known rate cap with a relatively small range of values sets an outside value for the starting point of negotiations from the New Health System perspective that is likely to be lower – and perhaps by a significant amount – than current starting points for negotiations. Parties will be negotiating from a narrow range. Given recent changes in CPI, the rate cap is likely to be in the 2-4 percent range in upcoming years, which reflects a very modest rate of

⁴²It is common to see newly negotiated contracts have somewhat higher rates of increase, particularly where the prior contract had a longer term, due to changes in underlying costs and other factors. See Appendix for further discussion.

⁴³Commenters fail to account for the fact that competition can lead to greater capacity than efficient or optimal for a marketplace. Hospitals acting independently will choose to invest in and sustain more capacity to be able to serve the marketplace; in areas such as the GSA with its largely rural population and substantial Medicare and Medicaid population and the need to have several facilities located throughout the area to serve the population, this can result in facilities that have excess capacity and may not be financially sustainable at current payment levels. For a discussion of the economics of excess capacity, see Kathleen Carey, *Stochastic Demand for Hospitals and Optimizing “Excess” Bed Capacity*, 14 J. REG. ECON. 165 (1998).

⁴⁴Moreover, the actual rate cap represents more of a constraint and is lower due to the fact that in the first period rates will be reduced through other provisions committed to by the Parties.

change for new contracts. The rate cap is also considerably below the model-predicted (and highly unrealistic) estimate of 130 percent price increases that staff reference⁴⁵ and well below any levels that would appear likely to raise concerns about price increases. Moreover, the cap will be a cap – even if it is the floor, the floor is also the ceiling, and rate increases will be constrained to reflect measures of overall cost changes based on neutral benchmarks that in recent history have been small percentage changes. The cap provides for predictability around a relatively small range of rate changes across all contracts covered by the provision, including ones being newly negotiated from one year to the next. This provides payers, as well as self-insured employers, greater assurances about expected and future rates of change in expenditure.

iii. The Rate Cap Commitments Will Work To Protect Consumers

Staff vaguely speculate that “it is difficult, if not impossible, to foresee all of the ways” the price commitments could fail or be circumvented. (staff comments at 57) Staff misunderstand the rate cap and overall process that will occur under a Cooperative Agreement. Any attempted changes away from current customary and usual contract terms that would permit circumvention would be immediately detectable by payers and readily reported to the Department as part of the active supervision function.

The proposed rate cap approach, which includes a price cap and its application to inpatient, outpatient and physician services, is consistent with the principles espoused by two economists in North Carolina who were charged with addressing many of the same issues in the Mission Health COPA.⁴⁶ There, Drs. Capps and Vistnes recommended the form of rate cap

⁴⁵Staff provides nothing more than diversion ratios in statements regarding alleged post-merger price increases by the New Health System. These diversion ratios are calculated based on patient choice models with significant limitations for estimating predicted price increases and which importantly do not account at all for practical realities of negotiations with major payers such as BCBS of Tennessee and Anthem, which represent predominant sources of critically needed commercial revenues. In fact, staff rely without any vetting of the reliability or accuracy on the unrealistically high price increase estimates developed by consultants hired by America’s Health Insurance Plans: “Indeed, Competition Economics LLC, an economic consultant hired by America’s Health Insurance Plans to analyze the proposed merger, estimated that the price increase could be as high as 130%.” (staff comments at 12-13) That analysis also estimated very high diversion ratios between Mountain States and Wellmont. See Michael Doane & Luke Froeb, *An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance*, COMPETITION ECONOMICS LLC, at Tables 10, 12 & 13 (Oct. 29, 2015) (economic analysis funded by America’s Health Insurance Plans). It is revealing of staff’s adversarial approach to their comments that they refer the Department to an economic paper that predicts a potential price increase of 130 percent – an absurd conclusion on its face. The paper was published months before the Parties’ Application that described the rate cap formula – a development that even further accentuates the irrelevance of that paper. Moreover, staff did not advise the Department that the authors admitted that their analysis “has its limitations” and that, concerning the models they used, “[c]ritics have noted that errors in the WTP framework include the reliability of the hospital choice model (including its strong reliance on travel time as a determinant of hospital choice) and the measurement of the relationship between WTP and hospital prices.” They also admitted that “such criticisms may affect the magnitude of precise price predictions” but they stuck to their prediction of large price increase nonetheless “because this merger is so big” – a conclusion hardly grounded in robust economic analysis or thoughtful consideration of the rate cap formula. (See *id.* at 18) Issues with regard to the reliability of price prediction models are discussed in Christopher Garmon, *The Accuracy of Hospital Merger Screening Methods* (2016) and in Bryan Keating, et. al, *Comment on Farrell, Balan, Brand and Wendling* (2011), *Economics at the FTC: Hospital Mergers, Authorized Generic Drugs, and Consumer Credit Markets* (2012).

⁴⁶Reports by Dr. Greg Vistnes and Dr. Cory Capps were developed as part of the review of the performance of the Mission Health COPA; additional analyses on price levels and trends were provided by Dr. Thomas McCarthy. See Thomas McCarthy, *The Mission Health System COPA*, Presentation to the House Select Committee on the Certificate of Need Process and Related Hospital Issues (2011); Cory S. Capps, *Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System* at 32 (May 2, 2011). A Review of the Analysis of Dr. Greg Vistnes, with Additional Recommendations for Lessening Opportunities for Regulatory Evasion by Mission Health, at

regulation similar to what the Parties propose Tennessee and Virginia as a preferred form for price regulation in a COPA context. They determined that changes in the Mission Health form of regulation (tied to margin and cost levels) and in the services covered (which were inpatient only) would eliminate much of the perceived distortion in incentives and improve the effectiveness of regulation in that case.⁴⁷

Dr. Capps recommended that the cost and margin cap utilized in the Mission Health COPA be replaced with a “cap on the rate at which Mission Health’s pricing to commercial insurers can grow” and that the “price growth cap should be computed separately for inpatient and outpatient services.”⁴⁸ Dr. Capps noted that “switching to direct price regulation . . . is a more straightforward and effective approach to achieve the State’s goal of using oversight [to assure that benefits of agreements outweigh costs of reduced competition].”⁴⁹ He also proposed regulation of price levels at Mission Health using peer hospital benchmarks. (This change is not required here because the New Health System COPA will commence from current (competitive) price levels. Drs. Capps and Vistnes, in contrast, were undertaking an ex-post evaluation of pricing after the COPA was underway.)

The price cap approach that Drs. Capps and Vistnes recommended in North Carolina to address perceived incentive or compliance issues provides support for the Parties’ proposed rate cap and rate regulation features insofar as: (1) regulation of the rate of increase in price growth relative to some index; and (2) application of the regulation both to inpatient and outpatient services to avoid any alleged regulatory evasion or distortion of incentives. Here, moreover, the Parties have gone further to specify the relevant index measures, to propose immediately to cut in half any fixed escalator rate in existing contracts, and to offer specific methods for how the New Health System can verify changes in price growth on existing and on new contracts with the payer and also with the regulatory Department.

iv. Rates In New Payment Model Contracts Will Be Protected

Staff (staff comments at 59) criticize the proposed rate caps as inapplicable to risk-based contracting models, including those that include quality or outcomes adjustments or shared savings/risk models. Staff’s comments are not valid. There are many potential variations in the form of a “risk-based” contracting model based on the contracting parties’ characteristics, such as the capabilities and objectives of the health provider and payer. Most risk-based models, including in contracts now in place with certain payers in the region, commence with fee-for-

Section III (May 2011); Greg Vistnes, *An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health*, at 18-19 (February 10, 2011).

⁴⁷There were differences of opinion whether Mission Health’s prices and costs had increased at rates not consistent with effective rate regulation. *See, e.g.*, McCarthy at 2-4; Capps at 16. That issue is not relevant to the efficacy of the rate cap regulation proposed in the Application.

⁴⁸Capps at 16; *A Review of the Analysis*, at 15.

⁴⁹Capps at paragraph 25-26 (referencing Vistnes’ recommendations and presenting his views); *Review of the Analysis* at 16. Dr. Capps also did not appear to believe that regulation of price levels (in addition to rates of increase) would add substantially to the “administrative burden” for the state. Both Dr. Capps and Dr. Vistnes proposed adjusting price caps to account for case mix adjustment, by using net patient revenues from total commercial insurers by total case-weighted output for inpatient services and outpatient services separately. Their proposed rate regulation would involve only a single rate of price growth rather than one for each payer.

service pricing on hospital, outpatient, and physician services as an input into the risk-based elements.

The Parties expect this approach to continue for the foreseeable future, such that a substantial volume of risk-based contracts will involve limited risk shifting and operate with pay for performance and value-based terms.⁵⁰ The price cap will thus have an immediate impact on the most relevant forms of risk-based contracting currently in place or anticipated in the near term. In fact, the price cap regulation forms a basis and a bridge for transition to future risk models, and other commitments regarding engagement with payers on quality metrics and overall transparency will provide further support. It is envisioned that the Parties will continue to work with payers on new models, and that these can be developed in a form that can be reviewed by the Department under its active supervision role to assure that overall terms are reasonable. It is important to note in this regard that the Department will have access to detailed information about the prices charged by the New Health System. Additionally, the Department retains the authority to modify the cooperative agreement as necessary to adjust to the evolution of risk-based contracting.

Staff refuse to acknowledge the immediate benefits of the rate cap and related commitments. They involve an initial substantial “rebate” to payers and ASOs, in the form of reduced inflators in existing contracts which have fixed inflators. This reflects a substantial dollar amount to the recipients that can be shared with Tennessee (and Virginia) consumers or invested in important population health or wellness initiatives specific to the population. Another key benefit is predictability and certainty about fee-for-service increases, which redounds to the benefit of both payers and employers in making their important planning and financial decisions. The competitive market absent the Cooperative Agreement could not provide that predictability or certainty in this area. The Parties’ proposed form of rate cap regulation and its application across each of the major services (inpatient, outpatient, and physician services), along with the use of an external index that covers common trends in hospital costs, provide a compelling and decisive counter to speculative charges by staff and other commenters that price protection is incomplete or subject to evasion.

D. The Definition Of Commercial “Principal Payers” Is Appropriate

The Parties’ proposed rate cap is limited to “Principal Payers.” The Parties originally defined this term to mean “those commercial payers who provide more than 2 percent of the New Health System’s total net revenue” (Application at 46) but recently proposed to the Department a revision that would include “governmental payers with negotiated rates” along with commercial payers in this definition.⁵¹ Staff criticize the 2 percent limitation, contending that enrollees in plans offered by non-Principal Payers will have no protection in future rate negotiations, but do not propose an alternative approach. (comments at 58) The payers who fall below the 2 percent threshold have a *de minimis* presence in Northeastern Tennessee. Collectively, the approximately 200 payers in this category together account for less than 3

⁵⁰Many of these contract terms for value-based approaches are established, and the Parties have committed to transparency and further engagement with payers on these. The Parties have every incentive to continue to align incentives across their newly integrated health care delivery system and with payers to manage risk and enhance value.

⁵¹Letter from C. Haltom to A. Rajaratnam (Nov. 15, 2016) (attached Commitments Chart, no. 1).

percent of the New Health System's total net revenue. From a business perspective, application of the proposed rate cap to such *de minimis* payers could risk net losses to New Health System.⁵²

The Principal Payer limitation, contrary to staff accusations, also promotes administrative simplicity and enforcement. (See staff comments at 56-57) In their active supervision of the New Health System to ensure compliance with COPA requirements, Department officials will rely in part on key stakeholder input. The Principal Payer limitation focuses on those payers that are well-positioned to model the likely impact of negotiated rates based on their current use of such models in evaluating contracts. These payers will readily be able to demonstrate the Parties' compliance or report any potential violation of the rate cap commitments to the Department. Overall, changes made possible by the merger and increased transparency are likely to benefit smaller payers as well. In addition, smaller payers will be protected by their ability to raise concerns with the State.

1. Staff's Arguments About Quality And Access Are Unsupported

Staff's arguments regarding quality of care and access under the Cooperative Agreement are grounded in their irrelevant policy opinion that the Hospital Cooperation Act law is not in the best interest of Tennesseans, despite that the Legislature and Governor of Tennessee have made it state policy. They contend that "non-price dimensions of competition greatly benefit patients," that "competition between the systems" is responsible for many consumer benefits, that "competition-reducing mergers often reduce quality," and "[t]herefore" that "the proposed COPA is likely to have a negative impact on patients." (staff comments at 22-25) Meanwhile, staff provide no evidence from any analysis they have conducted of state regulated mergers under similar statutes. Their lack of evidence or analysis makes it impossible for staff credibly to assert that a merger under the cooperative agreement statute, with commitments supervised by the state, would lead to diminution of quality. In fact, the Parties have provided evidence to support that Mission Health's recognition as one of the highest value health systems in the nation, multiple year recognition as one of the top 100 hospitals in America by Truven Health Analytics and recognition as one of the top 15 health systems in the nation by Truven Health Analytics, implies that after 20 years operating as a merged system under a COPA, quality was in fact not impaired. Staff's argument here amounts to nothing more than second-guessing by staff of Tennessee's sovereign Tennessee policy to supplant competition with regulation for qualified health care mergers, and should be ignored.

So, too, should staff's arguments that the Parties' will not improve quality through the merger. They claim "substantial empirical literature . . . does not support the conclusion that hospital consolidation generally improves clinical quality of healthcare services." (comments at 31) Even if this were true, it is irrelevant, because the general result of hospital consolidation research says nothing about the merits of the specific merger outlined in the Application – a merger with enforceable commitments under active supervision by the State. The Application addresses the benefits to flow specifically from the integration of Mountain States and Wellmont into the New Health System.

⁵²Even very small changes in the risk profile of payers with very small numbers of covered lives could cause substantial changes in relative costs.

Staff cite only three articles from the so-called “substantial” body of literature. Upon review, the cited literature is far from comprehensive. One article, by Romano and Balan, is co-authored by a staff economist and addresses a single traditional merger that happened in 2000 in a Chicago suburb. (*Id.* at 31 n.116) Of the other two articles (*id.*), both co-authored by Professor Gaynor, one draws heavily for its conclusions from review of studies of the U.K. health system. The FTC relies on these, even though the authors concede “it is not possible to draw direct conclusions about the United States based on evidence from the United Kingdom.”⁵³ Professor Gaynor et al. point out that their studies concern “the relationship between hospital *consolidation* and quality.” They are careful to clarify what they mean by “consolidation”:

It is important to distinguish between consolidation and integration. *Consolidation* is simply bringing together two (or more) previously independent entities. *Integration* implies more—in particular, elimination of unnecessary duplication, creating systems to bring the previously separate entities together, and comprehensive management of the organization as a whole.⁵⁴

The authors’ definition of “integration” describes the proposed New Health System as detailed in the Application. But apparently the authors did not study mergers such as the proposed New Health System. They also did not evaluate mergers under a COPA/cooperative agreement arrangement. Accordingly, they warrant no weight in the record.

Staff’s assertions that quality will suffer under the merger are baseless for other reasons as well. They ignore the substantial importance of national quality measures, payment incentives and penalties, and the fact that reimbursement through value-based purchasing and similar programs are increasingly tied to these quality measures and not performance versus another hospital in a particular area. For example, the declarant from Anthem supplied by staff states, in regard to Anthem’s “Q-HIP®” quality performance program, that “Anthem reduces the base reimbursement rate of a provider that participates in Q-HIP® with the expectation that the provider has the ability to obtain a higher rate if it meets certain thresholds.” (staff comments at App. A, ¶60) Hospital reimbursement from federal and commercial payers is an increasingly important source of incentives for hospitals to improve quality, and the merger will not change that.⁵⁵

Staff attribute incentives to innovate and expand service lines to competition (staff comments at 23) but competition can also lead to unnecessary cost and duplication of core services, which reduce resources available for innovation or expansion. By reducing unnecessary duplication, the New Health System will be better positioned to invest in expanded

⁵³Martin Gaynor & Robert Town, *The Impact of Hospital Consolidation—Update*, ROBERT WOOD JOHNSON FOUND., THE SYNTHESIS PROJECT, Policy Brief No. 9, Attachment C at 3 (2012), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261. Despite this devastating admission, the authors incongruously add that the same U.K. studies “add to the growing evidence base that competition leads to enhanced quality under administered pricing.”

⁵⁴Gaynor & Town. The third article reviews other studies, with mixed findings.

⁵⁵For example, the CMS Hospital Readmission Reduction Program is part of the federal government’s announced goal to tie an increasing share of traditional Medicare payments to quality or value in the coming years. See *Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program*, KAISER FAMILY FOUNDATION (Sept. 30, 2016), available at <http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/>.

services not currently offered by either health system independently, and it has committed to make a definitive investment of \$140 million in those services. Staff also erroneously contend that the merger will result in reduced access and quality in regard to certain physician specialty services. (staff comments at 22) They ignore the Parties' commitment under the Cooperative Agreement to make large expenditures (\$140 million over ten years) to ensure ongoing physician needs assessments in the region and to work with independent and employed physicians to provide the needed services for access by rural patients.

2. The Commitments Ensure That Quality, Population Health Status, Innovation, Investment, Patient Access, And Quality Reporting Will Improve

The Department should evaluate staff's criticisms of the Parties' commitments on quality, population health status, innovation, investment, patient access, and quality reporting in the context of the Application taken as a whole, and especially in the context of the specific region in which the New Health System will operate. The Application represents an integrated set of commitments and actions by the New Health System that addresses fundamental health issues and priorities in Northeastern Tennessee (and Southwest Virginia) that take into consideration the unique features and challenges of this region, and that will be subject to active supervision by Tennessee (and Virginia). Furthermore, staff greatly overstate the complexity associated with the reporting and action requirements of the commitments. These are straightforward and enforceable commitments.

Staff's submission is premised on the mistaken belief that the current relationship between the Parties provides adequate health care services to address the critical health needs of the diverse and largely rural population in the region and that the \$450 million in additional health care investment and other commitments by the Parties are not needed in this region. The Application, however, is not a federal antitrust matter, but an important issue of state public policy, with oversight and supervision by state authorities focusing on improving health care for a local population with significant needs.⁵⁶ Staff do not dispute the principal factual justifications for the merger set forth in the Application. These include:

- Northeast Tennessee disproportionately suffers from serious health issues, with higher rates of health risks than the State overall in such areas as obesity, blood pressure, cholesterol levels and substance abuse. (Application at 8, n.4)
- There is a very high percentage of Medicare, Medicaid, Medicare managed care and uninsured patients, with continuing downward pressure on Medicare and Medicaid reimbursement, even as labor and supply costs increase. Moreover, the Medicare Wage Index is one of the lowest in the nation, which leads to substantially lower reimbursement than peer hospitals in other states and in Tennessee for the exact same services. (Application at 34, 44)
- Inpatient utilization is declining and the population in the area overall is declining, resulting in less utilization of inpatient facilities.

⁵⁶In their comments, staff rely on Dr. Kizer for support (staff comments at 37), but provide no further information about the bases of his opinions. There is no evidence Dr. Kizer has awareness of the issues in Northeast Tennessee, the consideration of these issues by the Legislature or the investments being proposed by the health system to address quality and population health issues in the region. Accordingly, staff's reliance on this individual should not be considered.

- There is a small and shrinking base of commercial patients, again with downward pressure on reimbursement.
- The Parties' small rural hospitals individually have very low patient volumes and contribute very little to the Parties' combined shares, typically just one or two percent per hospital. (Application at 21-22)
- Patients are willing to leave the Parties Geographic Service Area to obtain services elsewhere, particularly for specialty services. (Application at 22).
- The hospitals have duplicative health care resources.
- All these factors point to a declining revenue stream which does not support growth in capital investment or even sustainability of the current cost structure.

Staff challenge some of the quality commitments as unsubstantiated, speculative or modest in scope, ignoring the fact that many of the commitments will require collaboration with the Tennessee Department of Health to ensure they are aligned with the Department's and State's goals. Once established and agreed upon, the State will actively supervise to ensure these commitments are met. Importantly, there are many quality and health improvement commitments which are not challenged by staff. They include the preparation by the Parties of a comprehensive template community health improvement plan that identifies key strategic regional health initiatives, prepared in conjunction with the Department and its staff, and feedback from the Community Health Work Groups (discussed below) and academic partners.⁵⁷

The template community health improvement plan was prepared, in part, based on feedback from four Community Health Work Groups created by the Parties, comprised of community leaders and representatives. The groups held a number of town meetings throughout the region over the last year. These four groups have focused on four very important issues in the region – Mental Health & Addiction, Healthy Children & Families, Population Health & Healthy Communities, and Research & Academics. (Application at 89-91) Staff recognize the importance of this initiative (staff comments at 39-40), but misleadingly argue that the initiative shows the Parties can collaborate without a merger, ignoring the express statement in the Application that this initiative is being undertaken only in conjunction with the Cooperative Agreement and that the work and recommendations of the Community Health Work Groups cannot be implemented without the savings generated by the merger. (Application at 89)

Moreover, staff do not challenge the need for the following health improvement initiatives, which the Parties have committed to fund with an investment of not less than \$75 million over ten years under the active supervision and oversight of Tennessee and Virginia:

- **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.

⁵⁷The plan was prepared in conjunction with the public health resources at East Tennessee State University. See Application at 14; 50-3.

- **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.⁵⁸
- **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.

(Application at 49-50)

The Application provides comprehensive commitments addressing fundamental health issues and priorities in Northeast Tennessee that compel the need for highly integrated and organized solutions led by the New Health System in close collaboration with community leaders and under the direct supervision of the State. The Application describes how the development of the integrated health care delivery system will align and sustain clinical services and professionals to meet area needs, and how the \$450 million investments in health care programs, quality and best practices initiatives, infrastructure, organization, systems, and focused efforts to improve access and care, under active supervision by the State, will achieve a result for this region that negates staff's contention that the substantial benefits of the Cooperative Agreement are not needed. Importantly, the Application's objectives are closely aligned with the policy and goals of the Hospital Cooperation Act, along with the State Health Plan goals.

Staff's submission largely fails to consider any of the specific health care issues in this region, and asserts that a hypothetical construct of federal antitrust policy could work anywhere – whether urban or rural. In raising issues with regard to specific commitments or the alternatives available outside of the Application, staff do not address the specific issues facing Northeast Tennessee, and ignore the priorities that are well established by the Tennessee Department of Health and the Legislature. Staff further disregard the substantial new investments required to address the region's health needs and improve access, quality, and cost of care delivery.

a. Staff Ignore Key Facts About Northeast Tennessee

The region faces critical health issues, the resolution of which are Tennessee's highest priorities in order to improve health, access, cost, quality, and outcomes: *Southwest Virginia and*

⁵⁸As discussed below, staff does challenge the need for additional behavioral health services in the area, referring to a proposed facility in Gray, Tennessee, approximately 25 miles from Bristol, Virginia, but as much as 90 minutes from some of the Virginia markets that would be served by the New Health System.

*Northeast Tennessee disproportionately suffer from serious health issues.*⁵⁹ The cost of this poor health is not sustainable for the well-being of the region's communities.

This region is a unique geographic area that requires a unique solution to its significant health care challenges. With the approvals of Tennessee and Virginia, under the Tennessee Hospital Cooperation Act, and the corresponding Virginia statute, savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the communities there. 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. Approval of the Application provides a "unique solution for a unique region." (Application at 8)

Staff's submission only tangentially refers to the specific geography, population, and health issues facing Northeast Tennessee and ignores the substantial health care challenges of the area, of which the Parties have first-hand knowledge. The majority of residents of the counties served by the New Health System live in areas classified as rural;⁶⁰ and sixteen of the counties in the overall Geographic Service Area (excluding the Independent Cities) are more than 50 percent rural.⁶¹

The Application factually demonstrated that the region served by the Parties faces significant, wide-ranging health care challenges that are of specific concern and high priorities for Tennessee government authorities, and the Application specifically addressed those issues. As noted previously, the Tennessee counties served by the New Health System face many critical issues, including tobacco use, obesity, teenage pregnancy, low birthweight babies and substance abuse issues:⁶² Only two of the Tennessee counties rank in the top half in Tennessee for overall health. (Application, Table 8.1 at 31). The Northeast Tennessee statistics show serious issues:

- (1) Tennessee ranks 47th in the country in smoking rates.⁶³ A 2015 Tennessee Department of Health report finds that all the Tennessee counties exceed the

⁵⁹Tennessee county-level data for the region is available at TENNESSEE DEPT. OF HEALTH, DIVISION OF POLICY, PLANNING, AND ASSESSMENT, 2015 DRIVE YOUR COUNTY TO THE TOP TEN (July 2015), available at <https://www.tn.gov/health/topic/specialreports>. 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/>.

⁶⁰The majority of the New Health System's Geographic Service Area residents (over 500,000) live in areas defined as rural, and 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://ahrh.hrsa.gov/>). Total Population is from the U.S. Census Bureau, *2010 Census Redistricting Data, Summary File* (Pub. L. 94-171). Rural residency is available from the *Census of Population and Housing: Summary File 1 (SF1) Urban/Rural update*.

⁶¹The statistics for all of the counties in the Geographic Service Area may be found in Table 5.1 of the Application.

⁶²All references to "Tennessee counties" refer to counties in the New Health System's Geographic Service Area.

⁶³UNITED HEALTH FOUNDATION, *Tennessee State Data*, America's Health Ranking (Annual Report 2015), available at <http://www.americahealthrankings.org/TN>.

- national average for smoking, and seven of the ten Tennessee counties exceed the state average for smoking.
- (2) The state level obesity rate exceeds the national average, and several of the Tennessee counties have obesity rates of more than 30 percent.
 - (3) Tennessee is 42nd among states in rates of teenage birth,⁶⁴ and yet not a single Tennessee county in the Geographic Service Area has teenage pregnancy rates below the state average.
 - (4) Three of the Tennessee counties are in the bottom third (worst group) for frequency of low birthweight births
 - (5) Only a single Tennessee county in the Geographic Service Area is below the State average for deaths from drug poisoning. (Application at 31)

The Tennessee County Health Rankings submitted in the Application (Exhibit 8.1 at 31) demonstrate that physical inactivity, obesity, tobacco abuse and substance abuse are major health challenges that disproportionately impact residents of Northeast Tennessee, and are associated with other health challenges and conditions. Additionally, the County-Level Data in the Application provide key statistics on the population in all Tennessee counties in the service area, and Tennessee state-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. (Application, Exhibit 8.2 at 33) The county-level data show that most Tennessee Counties in the region exceed the state average in at least three of these categories.

The data on health conditions and issues in the Tennessee counties are repeated here to emphasize the alignment of all aspects of the Cooperative Agreement Application and commitments to the specific issues of importance for the residents of this area that are driving total cost of care now and in the future, and the critical importance of needed investments in the region to address cost, quality and access to care in a sustainable fashion. As was noted, the Parties share the State's concerns about these significant health issues. These issues are among the key areas of focus within the scope of the current Community Health Work Groups. Staff's submission does not address or even appear to recognize these critical priorities and issues that form the baseline for concerted action and investments by the Parties, under the continuing oversight and supervision of Tennessee.

b. Staff's Comments On Quality-Related Commitments Are Baseless

Staff question whether the proposed merger and certain commitments are likely to achieve outcomes superior to those of "likely" alternatives, including no merger, acquisition of one or both Parties by other entities or systems from outside the area, or collaboration or joint venture arrangements between Wellmont and MSHA in specific areas.⁶⁵ While staff suggest there may be alternative collaborative efforts short of a merger, staff provide no detail and no guarantee that either the FTC or private parties will not challenge such alternative efforts on antitrust grounds. Such alternatives would require sharing of very confidential cost and price information and require agreements between the Parties on the services that each would offer and

⁶⁴UNITED HEALTH FOUNDATION; *see also* U.S. Dept. Health and Human Services, *Trends in Teen Pregnancy and Childbearing*, Office of Adolescent Health, *available at*, <http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html> (search "Trends in Teen Pregnancy and Childbearing").

⁶⁵Many of the specific commitments made by the Parties are not challenged by staff.

not offer, agreements on which facilities to keep open, close, downside or repurpose and agreements on the number and compensation of specialists and subspecialists.

Similarly and importantly, while a merger with an out-of-market system may produce some efficiencies, as staff contend (staff comments at 45), any such synergies would likely benefit the out-of-market acquirer, not the local region, and would certainly not rise to the level of synergies achievable between the Parties through elimination of unnecessary duplication of cost. These synergies have been validated by independent analysis, and such analysis is in the possession of the State. The Parties' plan is to invest the hundreds of millions of dollars of merger savings locally in order to improve health care, as detailed in the Application.

Staff specifically challenge the benefits from consolidation of certain services and facilities that would reduce duplication, produce cost-saving efficiencies that would fund other needed services and improve patient outcomes by increasing volume. The cost of maintaining duplicative facilities in close proximity to each other, including maintaining three hospitals in Wise County, Virginia with daily censuses of 35, 13 and 10, is ignored.⁶⁶ Because of decreasing reimbursements and the other challenges mentioned earlier, it will be increasingly difficult to continue to sustain these facilities over the long-term without the savings the proposed merger would create.

As an example of the duplicative services that the New Health System can potentially integrate to generate efficiencies, the Parties referenced the area's two Level I Trauma Centers, which are redundant in a region with low population density. (Application at 38) No other region in Tennessee operates two Level I centers. Staff do not challenge the cost-savings potential from such integration, but ignore the fact that the savings generated could instead be invested in more needed services for the region such as pediatric trauma.⁶⁷ Staff also dispute the potential for clinical quality enhancement that would result, and hypothesize about potential patient inconvenience.

Citing only to one article (co-authored by a staff economist) concerning one hospital merger from 17 years ago, staff claim that the "research literature shows" that a volume/outcome relationship exists only for certain procedures and services, but allow that one such service is trauma. (comments at 32 & n.119) Staff say no quality benefit will result from merging the Mountain States and Wellmont trauma centers, because, based on a study the Parties identified in the Application, each center has already reached the volume level where the volume/outcome relationship ceases. (*Id.* at 32)⁶⁸ Staff take the unduly narrow view that enhanced clinical quality from a merger is a function only of volume.

⁶⁶Based on the 2013 data. See Application Tables 5.2 and 5.3 at 17-19.

⁶⁷No decision has been made on consolidation of any facilities; the reference to the trauma centers was merely an example.

⁶⁸Staff cite Avery B. Nathens et. al., *Relationship Between Trauma Center Volume and Outcomes*, 285 J. AM. MED. ASS'N 1164 (2001), available at <http://jama.jamanetwork.com/article.aspx?articleid=193615>). Staff make numerous errors in interpreting the results of this study. The study actually concludes that crude mortality rates continue to fall as volume increases beyond 650 cases per year for patients with shock (see Figure 2 – Panel B). The use of the term threshold was misunderstood by staff. It did not indicate that the beneficial effect of higher volumes weakened at that point, but was used to separate low-volume trauma centers from high-volume trauma centers.

The Parties provided this literature showing high-volume trauma centers produce better outcomes (Application at 45) to demonstrate the medical community's focus on trauma service, recognizing that it requires substantial capital investment, dedicated teams, and equipment. Staff's comments fail to recognize the critical resources that elimination of such duplication provides – scarce resources that can be allocated much more effectively to provide and sustain care delivery in the region which is not currently available. Many reasons explain why clinical outcomes are likely to be superior if the trauma centers are integrated, including sustained resources, greater specialization by individual teams, and the ability to maintain capacity in a single location dedicated to all these services. Moreover, there are no guarantees that either or both facilities would maintain volumes at current levels. Staff speculation about additional travel time to reach a trauma center, moreover, ignores the fact that most major trauma patients are transported by helicopter so the difference in time may not be material and that emergency room services will remain at the hospital that closes the Level I Trauma Center. Staff also fails to consider that Tennessee contains only six hospitals with Level I trauma centers, in the metropolitan areas of Knoxville, Chattanooga, Nashville, Memphis and the Tri-Cities. The Tri-Cities area is the only region in Tennessee with two Level I centers.

As noted by the Parties in the Application, health care services offered by rural hospitals are at increasing risk of closure, with 80 rural hospitals closing since 2010, including eight in Tennessee and one in Virginia.⁶⁹ The Parties collectively invested more than \$19.5 million last year alone to ensure that inpatient services would remain available in smaller communities. (Application at 43) The Parties have committed 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 and that the New Health System will continue to provide access to health care services in the community thereafter based upon the demonstrated need of the community. This commitment to maintain access in these communities does not exist without the merger.

In the same vein, staff attempt to minimize the multimillion dollar commitment to develop specialty centers and pediatric emergency rooms in Kingsport and Bristol and to add rotating pediatric specialty clinics in rural hospitals. (staff comment at 49) Staff contend that the Parties offer some of these services already and the merger “may” not be necessary to achieve these improvements. The Parties made this commitment based on a specific needs assessment that identified a lack of pediatric specialists in the rural areas of the region. (July 13 Department Responses at 35-36) A large number of children in the region are covered by Medicaid, and the Parties recognize the difficulty many families have with transportation and the impact this has on access to care. These are all elements of a coordinated plan to address specific needs and to hold the Parties accountable.

It is misleading for staff to list all hospitals that offer pediatric services when pediatric specialists *do not* exist in these areas. Contrary to what staff say, the Parties believe that pediatric specialty centers and pediatric emergency rooms with connectivity to local hospitals are clearly needed. Also misleading is staff's reference to a partnership with a children's hospital in Knoxville (staff comment at 49), ignoring the fact that these families then have to drive one and a half hours or more to Knoxville because the specialists are not available in closer proximity.

⁶⁹See THE CECIL G. SHEPS CENTER. Fourteen rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.

The reality is that there are few pediatric specialists available in the rural areas of the region. When pediatric specialists are not available in a local community within the Geographic Service Area, children and their families must currently often travel to Johnson City or even beyond to seek care. The Parties' goal is to make pediatric specialty care as least disruptive as possible for those children and their families who need it, and to make it an integral part of the new integrated health care delivery system by combining the assets and complementary capabilities of the Parties. The merger would allow the Parties to improve access to pediatric specialists for smaller communities and reduce the travel time necessary for families to utilize these services. These services are closely aligned to state priorities.

Staff's contention that quality overall may diminish as a result of the merger is also without foundation. This contention ignores the well-established fact that reimbursement is increasingly tied to quality metrics, both for government-funded programs such as Medicare and commercial insurance. (Application at 7) Similarly, the New Health System cannot afford to lag in innovation. It must keep pace with new technologies and approaches to care, particularly with regard to more specialized services where it will continue to compete with out-of-area tertiary centers. That competition is both to provide high quality care for patients and to attract to retain or bring needed physicians and specialists to the region. Further competition will continue to exist, particularly for services where there is a need as determined by the Tennessee in the Certificate of Need process, or for services that do not require a Certificate of Need.

i. The Behavioral Health Service Commitments Are Very Needed

Staff do not deny that, as stated in the Application, behavioral health needs and substance abuse are prevalent in the region and that the largest diagnosis related to regional inpatient admissions is psychoses. (staff comments at 33) The Application describes in detail the necessary steps to address this pervasive and serious problem in the region, focusing on the significant gaps in the continuum of care related to these issues. The Application notes that the majority of these patients also experience physical health conditions or chronic diseases that complicate care needs. (Application at 53-54) Accordingly, these patients typically have higher levels of health care utilization, sometimes 2 to 3 times as high as for those who do not have a mental health/substance abuse disorder. (Application at 53)⁷⁰

In recognition of this significant problem, the New Health System is committed to create new capacity for residential addiction recovery services connected to expanded outpatient services in the region and to 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. (Application at 56)

Staff attack this commitment, arguing that Mountain States and other organizations are already willing to develop new facilities, but cite a *planned* Mountain States/Frontier Health

⁷⁰This commitment on behavioral health services is part of a \$140 million commitment that also includes recruitment and retention of pediatric sub-specialists and development of pediatric specialty centers and emergency rooms in Kingsport and Bristol. (Application at 55)

facility in Gray, Tennessee, which is a significant drive from some of the areas served by the New Health System. The proposed project has been terminated. It was projected to reduce inpatient utilization for behavioral health and overall cost, but agreement could not be reached to obtain reimbursement for outpatient services. Staff also cite a July 12, 2016, news story, but that story relates to postponement of a zoning vote on a potential ETSU methadone clinic site. ETSU and MSHA agreed to let elected officials consider alternative locations to the Gray Commons site targeted by the Parties. While staff apparently recognize the serious need for behavioral health services, its hands-off and hypothetical solution ignores the needs of the region.⁷¹ Their argument also fails to recognize the magnitude of the planned investment by the Parties, which is envisioned to be the most comprehensive effort to meet regional needs to date and is far beyond the creation of a few isolated clinics of discreet and disconnected approaches. The plan is for more than a facility or a program, it is for the development of a comprehensive and organized program for which the Parties will be accountable.

ii. Common Clinical IT Platform Improves Quality And Saves Costs

The Parties have committed to a Common Clinical IT Platform to provide better coordinated care and committed to participate meaningfully in a health information exchange open to community providers. Staff's opposition lacks credibility. They argue that each hospital system has well-functioning electronic health records ("EHR") systems that are fully integrated within their respective hospitals (comments at 35), ignoring the fact that the commitment is for a Common Clinical IT Platform *between* the hospital systems.

Staff speculate that such a Common Clinical IT Platform would not benefit patients who choose to use only one hospital system (*id.* at 36), thereby conceding that a Common Clinical IT Platform would benefit the large number of patients who could now utilize all the hospitals within the new system based upon convenience and other factors. They also suggest that such a Common Clinical IT Platform should be done with an entity other than a competitor (*id.*), ignoring the fact that a Common Clinical IT Platform with an out-of-market system would be of no utility to coordinating care region-wide. Staff's skepticism of the value of a Common Clinical IT Platform is directly contrary to federal policy attempting to increase interoperability and also the benefits of common platforms.⁷²

⁷¹Staff's statement that the Parties' plans regarding behavioral health services "should be viewed skeptically in light of their efforts to prevent other providers from offering such services" is misleading and inapplicable. (staff comments at 34) MSHA has opposed construction of a for-profit inpatient psychiatric facility (which SBH admitted in its Certificate of Need ("CON") application would consist only of fewer than 5 percent TennCare and charity patients) because the facility would be detrimental to the only inpatient psychiatric institution serving the region – where 50 percent of its patient days serve TennCare and charity patients. The new facility would not focus on this needy population, and its service offerings were limited to the profitable services and not necessarily the most severe needs and demands of the region. MSHA executives testified under oath that the needs in the community are not for basic inpatient psychiatric services, but rather, investment into community-based, outpatient mental health services, which, if deployed, would actually decrease the need for additional inpatient and costly beds. The Parties' commitments are designed around investment into community based-outpatient services located closer to where individuals live and work. Staff never make these important distinctions. Moreover, the Parties plan to invest in additional capacity for residential addiction treatment, a service distinct from standard inpatient psychiatry. Such a facility does not currently exist in the region – a part of the country severely impacted by the opioid epidemic. Conflating this need with the CON application by SBH is a misappropriation of facts.

⁷²See "HHS Publishes a Roadmap to Advance Health Information Sharing and Transform Care," U.S. Department of Health & Human Services Press Release (October 6, 2015), available at <http://www.hhs.gov/about/news/2015/10/06/hhs-publishes->

Currently, there is no Common Clinical IT Platform in the region, and instead two separate platforms at Wellmont and Mountain States, with different protocols, data requirements, and approaches. A Common Clinical IT Platform yields several benefits, including better implementation of common protocols and best practices, secure collection and dissemination of key data and information, and substantial resource conservation supported by common data analytics and staffing that otherwise would be replicated by the two systems. This is particularly relevant for the Geographic Service Area which is largely rural, lower income, and facing lower reimbursements than many other areas in the country. Given the specific significant health care issues, and the large number of communities to be served by predominantly smaller hospitals, physician offices, and clinics, this common infrastructure and platform in combination with a region-wide Clinical Council discussed below, which will align capabilities and information around needed changes and reductions in clinical variation that will reduce costs and improve outcomes.

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. As described in the Application, 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 8.A.iii of the Application. 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. (Application at 77) 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.

Staff agree that clinical standardization can improve quality but contend that it can be accomplished unilaterally or through a collaboration short of a merger or an out-of-market merger. (comments at 36-37) Standardization across the New Health System, however, collaborating under common governance and the shared resources of an integrated organization, would generate substantially greater savings and quality enhancement opportunities than separate, intra-system standardization, a limited collaboration of the type identified by staff, or an out-of-market merger that cannot offer the same magnitude of merger-specific system-wide efficiencies.

Many of the initiatives to reduce variation and improve quality will be derived from or enhanced by new contracting practices designed to ensure collaboration and alignment of incentives around outcomes and costs savings between the New Health System and the payers. These practices will use the input from 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. The Common Clinical IT Platform and the Clinical Council will be used to establish and monitor compliance with these best practices. This approach to value-based purchasing is consistent with changes in federal policy that encourage improved population health. The objective is to identify opportunities for patient outcome improvement

and cost reduction, 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. (Application at 78)

The significant benefits from the Common Clinical IT Platform and supporting investments/activities include:

- Allows for best practices and actions to be focused on the region's highest health priorities and risk factors, and align the quality of care across all facilities for common services.
- Common data on a single platform provides for all to access data easily across the region. The ability to share data across all providers for a unique patient provides improved ways to reduce avoidable readmissions, and avoid unnecessary and redundant tests with important cost and quality benefits.
- Common data supports and enables new efforts to have best practices such as blood utilization or pulmonary embolism protocols across the region, which achieve superior results to fragmented approaches across multiple systems. With common IT platforms, all practitioners see same data and same information – and data can be made more robust with a common system.
- Detailed data and analytics on applying best practices and evidenced-based approaches can be accomplished at substantially lower average costs per patient if done with one system rather than with replication of two systems. These resources saved can then be allocated elsewhere. There is also the ability to apply more staff resources to dedicated analytics.
- Enhanced security and cybersecurity with one system, an important concern.
- In an area with so many independent physicians, a common IT platform reduces the costs and complexity associated with physicians needing to access two completely different systems with potentially two different protocols and best practices – and with higher costs.
- Community clinical variation is a critical issue in this region; with the Common IT Platform and Clinical Council there will be the same information and same drivers to direct evidence-based care. Significant decreases in clinical variation – across a region – will yield very substantial benefits to patients and payers.

Staff also argue that the merger is not necessary to implement a health information exchange (“HIE”) and the local HIE developed by local physicians can be a substitute for a robust regional HIE supported by the New Health System's Common Clinical IT Platform. (comments at 37) While the OnePartner HIE system is useful in reaching out to independent physicians, the system is limited in the data that it can transmit. There is a significant difference between a regional HIE supported by a Common Clinical IT Platform and the current OnePartner system, or any other HIE. The proposed Common Clinical IT Platform will be able to collect significantly more detailed patient information, including order entry, nurse notes, and medication reconciliation along with additional analytical capabilities for population health management.⁷³

⁷³See Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for

iii. Greater Transparency In Quality Reporting Is A Major Benefit

The Application describes a wide range of comprehensive quality metrics which the new system will publicly and timely report. Staff do not question the important value of this extensive quality reporting, which go well beyond what most hospitals report with regard to timeliness and completeness. Instead, staff assert that nothing prevents either hospital system from taking these steps now while they remain independent. By increasing transparency in reporting of data, the health system will hold itself to a higher standard than either system is being held to today. Staff's argument misses the purpose of reporting the extensive quality measures – to hold the new system publicly accountable for achieving and maintaining quality under a Cooperative Agreement actively supervised by the State.

The specific commitments on quality reporting are detailed, transparent and provide the ability for regulators and the public to hold the New Health System accountable. In particular, the New Health System will commit to publicly report on its website:

- The New Health System's CMS core measures⁷⁴ 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 were provided in the Application at Table 15.3. These demonstrate the breadth of commitment by the New Health System to provide comprehensive and timely information for benchmarking and accountability.
- Its results on core measures and do so 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.
- To ensure patients have information on the latest CMS core measures, all current CMS core measures, rather than a pre-defined set of measures chosen by the Parties.⁷⁵ CMS periodically changes the core measures it requires hospitals to report.

Certificate of Public Advantage, at 10-11 (July 13, 2016), available at [http://tn.gov/assets/entities/health/ attachments/ WHS-MSHA_April_22,_2016_DOH_Response_1.pdf](http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_DOH_Response_1.pdf).

⁷⁴CMS 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).

⁷⁵The 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.).

- 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.
- Specific high priority measures for each facility annually, with relevant benchmarks. The high priority measures are set by CMS⁷⁶ 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.
- Surgical site infection rates for each facility annually.
- 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.
- In an effort to improve transparency and reporting on high priority measures for quality and cost, annual reports of the following information by facility, aggregated for the facility across the DRGs that comprise 80 percent of the discharges from the New Health System facilities:⁷⁷ Severity adjusted cost/case; Length of stay; Mortality rate; and Thirty-day readmission rate.
- These quality measures 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 were provided in the Application at 15.4.

In addition, 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.

⁷⁶The 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.).

⁷⁷Cost 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.

All of these commitments demonstrate the willingness of the Parties to engage with payers, regulators, consumers, and the community to provide substantial information on quality in a usable form for use in contracting, consumer decision-making, and clarity of performance across the entire New Health System. In addition, the Parties have committed to reporting on its health initiatives and programs.

iv. Staff Ignore The Impact Of Increasing Incentive-Based Payments Which Influence Improvement In Quality And Value

Staff minimize the effect that incentive-based payment will have on sustaining improvements in quality. These new payment mechanisms are a powerful impetus for the New Health System to continue investing in enhanced quality. For instance, the American Hospital Association points out in its report *Care and Payment Models to Achieve the Triple Aim*, the AHA states that "...hospital leaders are designing new care delivery systems. Adoption of these new systems can be facilitated by new and innovative payment models that center on individual and community needs and reward high-quality care with desired individual and population health outcomes. Recent changes to Medicare reimbursements support building a care delivery system based on quality and value-based payment policies. The U.S. Department of Health and Human Services has set a goal of tying 30 percent of all traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models by the end of 2016, and tying 50 percent of payments to these models by the end of 2018."⁷⁸

As the payment system shifts to increasing use of quality incentives designed to improve value, the New Health System has significant incentive to improve, not diminish, quality. With 70 percent of the New Health System payments being derived from government programs which base the reimbursement on Medicare, it is clear that the New Health System faces great financial peril if it should permit value or quality to deteriorate. This pressure supplements regulatory oversight and aligns the Parties with commercial payers.

Staff contend without foundation that the Parties' are not more likely to engage or be more successful in value-based contracting despite the New Health System's enhanced scale. (comments at 40, 42)⁷⁹ Staff do not acknowledge that virtually every payer is investing in value-based models that reward measurable quality, and the incentive this creates for the New Health System to utilize its scale to achieve greater savings and quality. The Parties' commit to devoting significant resources to eliminating clinical

⁷⁸See American Hospital Association Committees on Research and Performance Improvement, *Care and Payment Models to Achieve the Triple Aim*, AMERICAN HOSPITAL ASSOCIATION (2016), available at <http://www.aha.org/content/16/care-payment-models-achieve-triple-aim-report-2016.pdf>.

⁷⁹Staff refer to two studies that purportedly support this contention. (staff comments at 41 n. 165) One study, by Kaul *et al.*, finds "no relationship between size and cost" for health care systems comprising multiple facilities. (*Id.*) The authors state, however, that the "primary explanation for the absence of scale economies is that healthcare systems are often run as de facto holding companies — i.e., a collection of highly autonomous hospitals — rather than as integrated organizations that have standardized procedures and systematically reduced costs." A "de facto holding company" is the precise opposite of what the New Health System will be. The Parties have committed to a process of standardizing procedures and systematic cost reduction and will be held to these commitments by the State. The other study to which staff refer (Muhlestein *et al.*) concerns ACOs — partially integrated groups and not full-scale health system mergers that offer a far greater opportunity for cost savings.

variation and establishing regional standardization in care plans developed by physicians partnering with the System in the Clinically Integrated Network. Resources are required to develop the data, the analytics, and the processes that can be implemented across the entire system.

The Parties will improve quality by using the data available through a common EHR and through strategies by the physician-led Clinical Council, which has direct linkage to the Quality Committee of the New Health System, and through deployment of quality initiatives applicable to the critical mass of patients with whom the System will have contact. These commitments, along with increased transparency and the move toward increased value based models of reimbursement that align quality goals and incentives with the payers, will have a powerful effect on quality and foster the benefits to be derived from value-based contracting.

The merger will also enable the Parties to advance toward risk-based relationships with payers. With a single balance sheet and aligned financials across the entire system, the Parties will be better positioned to take risk. It has been difficult for either system, alone, to enter into full risk based arrangements that blend quality with price. Mountain States attempted this with its own insurance plan, but Wellmont, as a competitor, never participated as a provider in the plan. As a result, Mountain States closed the insurance plan. The intent of the insurance plan was to gain enough critical mass of population to use incentive based payment to drive quality. The plan simply did not work because it could not generate the number of lives necessary to be sustainable. Combined, the Parties are more likely to be able to have the scale to accommodate risk-bearing, and some downside risk. Staff's claim (comments at 41) that certain limited pay-for-performance provisions in payer contracts today between each party and certain payers means that larger-scale value-based or risk-sharing contracts are not merger-specific is not supported by the facts.

v. Incremental Funding Of Academic And Research Opportunities Provides An Important Benefit

As detailed in the Application, the Parties will work with its academic partners and commit not less than \$85 million over ten years to develop and implement post graduate training of physicians, nurse practitioners, physician assistants and other health professionals, to increase residency and training slots, to create new specialty fellowship training opportunities, to build and sustain research infrastructure and to add faculty. (Application at 69) These initiatives are all critical to sustaining an active and competitive academic training program, which will attract additional outside investments from state and federal government research dollars and other sources, a fact not disputed by staff.

The Application specifically states that the Parties have each been reducing the number of residency slots they have been funding due to financial constraints and that the savings generated by the merger will be used to reverse this trend. (Application at 69) For example, due to financial constraints, Mountain States has cut ten funded residency slots since 2012 and Wellmont independently reduced funding for residency slots as well. Because of the significant financial investment needed to sustain these programs, this trend will continue without the merger. Funding of residencies is key to providing improved health care in the region since approximately 40 percent to 50 percent of residents stay in the region upon completion of their

residencies. Importantly, the new system will be able to attract physicians interested in research and the planned expansion of research opportunities.

Staff do not question the importance of this academic funding and the fact the Parties have been reducing funding for residency slots. Contrary to staff's assertions, this \$85 million funding is incremental and would not be possible in the absence of the savings from the merger. Staff also contend that the Parties already "invest significantly in healthcare education" (staff comments at 40), but do not dispute the importance of this additional funding. While staff complain that the commitments are not specific enough, they ignore the fact that Tennessee will actively supervise compliance with this important commitment.

vi. Staff's Claims Regarding Other Merger Benefits Are Also Unfounded

Staff's refusal to acknowledge a single benefit from the proposed merger continues well beyond the subjects discussed above. This serves only to underscore staff's disdain for the Hospital Cooperation Act and inability to evaluate the facts with objectivity.

They criticize the New Health System's preservation of hospital facilities as "only a limited commitment" that is insufficient in scope and detail. (comments at 42-43) Staff stretch to complain that the Application does not define the term "primary care services" or "commit to maintain any specific level of physician employment" at System facilities. (*Id.* at 43) To suggest, as staff do, that "primary care services" is a term of puzzlement to the Department, or that committing to a "specific" level of employed physicians would be a meaningful metric for the Application, betrays either a lack of understanding or lack of seriousness on staff's part. The Parties have spent many hours working with Tennessee (and Virginia) officials regarding the commitments, and are continuing to do so, to address any remaining concerns or open questions either State may have regarding the scope and content of the Parties' commitments.

Staff make another Merger Guidelines and antitrust-based argument in questioning whether any benefit results from the Parties' commitment to keep rural hospitals open, despite low or negative margins. (comments at 43) They argue that the Parties have not provided evidence that absent the merger they plan to close a hospital or curtail certain clinical services. This is tantamount to a rejection of a "failing company" defense – which the Parties have never made and which is not required under the Hospital Cooperation Act. The issue is not whether the hospitals are failing. It is whether hospitals are sustainable and capable of continuing to provide the same or improved levels of care absent the merger, including with its commitments. A major factor driving the merger is to preserve access to care, by utilizing the resources made available from merger-generated cost-savings to preserve facilities before they are on the brink of failure and market exit. This is the exactly the type of community benefit that the Hospital Cooperation Act reaches but antitrust law does not with respect to mergers that may be anticompetitive.

Later in their submission, staff repeat the claim that there are "less restrictive ways" than the merger to solve the economic and health problems in the Parties' Tennessee service area. Nowhere does staff provide an example from which to model an alternative strategy to achieve \$450 million over ten years to fund the commitments that will benefit the community due to the

merger. (*Id.*) They identify three transactions in which an acquiring health system reportedly committed to spend substantial sums (hundreds of millions of dollars or more) to improve conditions at acquired hospitals. (*Id.* at 44 n.178) In citing these transactions, staff are not explicit in where the “hundreds of millions of dollars or more” comes from, which is relevant, since in many such acquisitions, the funds are generated from the cash flow of the acquired entity.⁸⁰ Staff also do not point out, however, that the only transaction alternative to the merger for either Party is an out-of-market merger, which (i) would not replicate the proposed merger’s potential for efficiencies and community benefits, and (ii) would not be regulated and subject to a rate cap, such that its probable result would be higher prices.

Staff dispute the Parties’ description of the merger’s potential for efficiencies, which was aided by an independent third-party expert. Staff provide no empirical information to support its statements on this subject. (comments at 44-46) They state that “purchasing synergies and reductions in corporate overhead” from eliminating administrative duplication could be achieved by an out-of-market acquisition (*id.* at 45), which is true, but a high portion of those synergies would leave the area for the acquiring parent. More jobs would be lost by an out-of-market transaction. The New Health System will keep more jobs and keep the synergies local, and use the savings to fund programs to yield community benefits in the local area.⁸¹

With respect to improvements in utilization and the beneficial avoidance of unnecessary duplication from the proposed merger, staff offer another misguided criticism. They argue that current hospital infrastructure is the product of prior expenditures, which were possible only because the State found the expenditures necessary pursuant to the certificate of need (CON) process. From this, staff opine that the elimination of duplication is not a benefit because the duplication was determined to be needed. (comments at 46) This argument has no merit.

To the extent staff are accurate that certain duplicative resources once obtained a CON, the argument ignores the transformational changes in technology, financing and regulation in health care delivery over the last twenty years. The health care delivery landscape in our region today is far different from when many of the CONs were granted.⁸² The record is replete with evidence showing our current pervasive health problems and economic challenges that did not exist in those earlier years – and calling for new solutions. But staff deny the merger’s promise to improve utilization and benefit patients, and do so by retreating to their irrelevant policy

⁸⁰In such circumstance, the acquiring entity is not, in fact, providing any new funding to the acquired hospitals, but merely using cash flow to fund the cash or debt service required to pay the costs of future capital expenditures. Typically, incremental cash flow is derived from some combination of increased pricing, elimination of local jobs as synergies are obtained, and other synergies related to purchasing of supplies or improved operations.

⁸¹Staff also contend that the benefits of the efficiencies may not be achieved because of significant cultural differences between the parties and rely on a gross distortion of an article by Dr. Sargent of Wellmont. (staff comments at 33) Dr. Kizer also grossly distorts this article in the same fashion, as discussed below. As demonstrated in the response to Dr. Kizer’s comments, Dr. Sargent, who has practiced medicine here for 31 years and has witnessed firsthand the many significant health care challenges, strongly advocates for this merger in order to improve health care in this region, stating: “If our region doesn’t fight for and seize this opportunity, no one will do it for us.”

⁸²As an example, consider that when Certificates of Need were initially required for Open Heart Surgery, many of the interventional catheterization procedures which eliminate the need for opening a chest did not exist. Today, Open Heart volumes are much lower than they were 20 years ago, thus reducing the need for more programs. As the technology involved with orthopedic surgery evolves, it is projected that many joint replacement procedures will become outpatient, and no longer require hospitalization. This will significantly reduce the need for inpatient beds. By the staff’s argument, they are suggesting the beds are still needed, which demonstrates staff clearly have no grasp on evolving nature of health care.

choice of competition. They argue that “economic research indicates that hospital competition leads to lower costs” (*id.* at 46), that “competition is good for consumers” (*id.* at 47), and that “[e]liminating this competition could lead to a less productive allocation of resources” (*id.*). These claims are insufficient to overcome the compelling reasons to issue the COPA.

3. Summary Of Commitments

To assure the Department and the Commissioner of the overriding benefits of the proposed merger, the New Health System has made substantial commitments to the region that include the investment of hundreds of millions of dollars over the next ten years. The monetary and other commitments go well beyond any commitments made in the approved cooperative agreement/COPA that were granted in nearby states of North Carolina (Mission Health COPA) and recently West Virginia (Cabell Huntington cooperative agreement).⁸³ The monetary commitments are possible solely based on savings to be realized from merger efficiencies, and cannot be made without the merger. The commitments are evidence of the Parties’ belief in the New Health System’s ability 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. The commitments are made to demonstrate clearly that the benefits of the Cooperative Agreement are not only likely to, but will, outweigh any disadvantages likely to result from a reduction in competition from the proposed Cooperative Agreement.

The Parties described the initial commitments in the Application and explained that the commitments were made specifically to demonstrate benefits and ameliorate disadvantages described in the Hospital Cooperation Act. Many of the commitments can be categorized into the following areas, which align with the Hospital Cooperation Act’s list of potential benefits and disadvantages likely to result from a cooperative agreement:

- 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 Application provides additional details on the commitments as well as the Parties’ initial proposed benchmarks and metrics (or the process by which these will be identified) to measure the New Health System’s progress toward achieving the commitments.⁸⁴

Now that the Application has been deemed complete and the Department is reviewing the Application, the Parties have been engaged in productive dialogue with the Department about the commitments. Based on its extensive knowledge of the health care needs of the region, the Department has provided valuable input on some specific areas of focus for a set of broader commitments and ways in which achievement of these commitments can best be demonstrated

⁸³Some states like Tennessee and North Carolina have called these agreements with the state Certificates of Public Advantage (“COPAs”), while other states like Virginia and West Virginia have called them cooperative agreements. They function in the same way.

⁸⁴See Application 91-109.

and measured by the Department and the Commissioner on an ongoing basis after the Cooperative Agreement is approved. The Department and the Parties are considering potential revised commitments and achievement scoring mechanism based on these discussions. A number of the proposed revisions under discussion would make the original commitments stronger or clearer.

The discussions with Tennessee are ongoing as of this date. The Department's review of the Parties' proposed Cooperative Agreement has been and continues to be thorough and focused on the health care needs of the region it serves. Likewise, the Parties anticipate that the Commissioner, during his review of the Cooperative Agreement, may have additional input on specific focus of the commitments and how achievement of these commitments should be shown.

Staff criticize the Parties' commitments as not addressing anticompetitive effects, but, as noted in detail above, the proper analysis of the Parties' commitments under the Hospital Cooperation Act is whether the benefits accruing from the commitments in their totality outweigh any disadvantages likely to result from a reduction in competition. We emphatically believe they do and submit that the facts demonstrate this.

a. Staff Criticisms Of The Commitments Have No Merit

Staff criticize the Parties' commitments (which staff call "conduct remedies") as "not adequate substitutes for competition" (staff comments at 50) because they would not "maintain competition at the pre-merger level." (*Id.* at 50 n.206) Staff again make misplaced antitrust arguments that lose sight of Tennessee's policy, which is to supplant competition for a regulatory program in which the benefits outweigh the disadvantages from a merger that may be anticompetitive within the meaning of the federal antitrust laws.

Staff opine that the Parties' commitments "are unlikely to be successful in protecting consumers from higher prices and reduced quality." (*Id.* at 51) They offer no evidence of this, and it is not true.⁸⁵ Many of the Parties' proposed "conduct" commitments relating to payers are adapted from commitments imposed on the successful Mission Health COPA in North Carolina (*see infra*), and the Parties have added many additional commitments as well – including investing in a Common Clinical IT Platform, creating a Clinical Council to reduce variation, spending significantly on population health, all of which are measurable. These are specific and enforceable commitments.

Staff point to a Massachusetts case that dismissed conduct remedies as insufficient, but that case involved a traditional merger and not a cooperative agreement pursuant to state law that contemplates that disadvantages from decreased competition may occur so long as these disadvantages are sufficiently outweighed by benefits to the community. The merged entity in that case would have been held to compliance before a judge under a judicial consent decree; there was no active state supervision by health department executives in Massachusetts.

⁸⁵A more detailed discussion of why staff's comments regarding the Parties' rate commitments lack merit is in Section III above.

Staff contend it is too difficult to design a compliance mechanism to ensure that the combined hospital system achieves quality targets. Yet they look past a long-term example in Asheville, NC, where the state ably managed Mission Health's COPA for twenty years. In effect, staff argue that the Legislature established a policy that cannot work, and that the Department and Commissioner are unable to do what is needed to make the Cooperative Agreement successful for the region. Both opinions are flatly wrong. The Department has already begun the hard work of identifying the commitments and achievement scoring mechanisms that it thinks are necessary and important to hold the New Health System adequately accountable, and the Parties expect the same diligence by the Commissioner and his staff in their review of our Application and ultimately in the oversight of the Cooperative Agreement.

Staff repeatedly state that the Parties quality commitments do not "appear" sufficient and that it is unclear how the Department can determine achievement of quality commitments. As noted, the commitments contained in the proposed Cooperative Agreement are, to the Parties' knowledge, more extensive than any prior approved cooperative agreements or COPAs, with the potential to go even farther beyond the precedent cooperative agreements and COPAs if more commitments are agreed upon by the Parties, the Department and the Commissioner.

As for accountability, the Parties' proposal in the Application goes much farther than the Mission Health COPA, for example. There, Mission Health submitted only an annual report to the state, and a consultant on behalf of the state analyzed the cost data to determine if Mission Health was in compliance. Staff would apply a standard of accountability not contemplated by the Hospital Cooperation Act and without regard to how the Department and the Commissioner make their final determinations of compliance. As previously mentioned, the Parties have made significant progress with the Department toward making stronger and clearer commitments about achievement can be measured, and they expect this dialogue to continue with the Department and with the Commissioner and his staff during his review of the Application. As the Parties have stated many times, the accountability measures set out in the Application were representative and proposed measures, and made with full expectation that the Department will engage in the meaningful work of ensuring that the New Health System's significant commitments are achieved.

Staff state that the increased publication of quality data committed to by the New Health System is of limited value to consumers due to the end of competition between Wellmont and Mountain States. (staff comments at 61) Their argument is not true. The New Health System will have 75 percent share for inpatient services generally, with 25 percent of the population seeking care at hospitals outside the New Health System. There are other third-party hospitals in Roanoke, Wytheville, Richlands, Asheville, Boone, Pikeville, Winston-Salem, Knoxville and Nashville where patients regularly seek care. The Parties have every incentive to be competitive in the broader region and nationally and have a stated goal of performing in the top decile nationally. As importantly, provision of the quality data holds the Parties accountable. Staff also ignore that the majority of revenue for the New Health System is derived from outpatient services, and these services will continue to be highly competitive.

Staff criticize the Parties' conduct commitments⁸⁶ as not doing enough to solve the problem of lost competition. Again, the Tennessee Hospital Cooperation Act contemplates that any benefits from competition that will be lost will be outweighed by benefits to community health in the region. The conduct commitments are yet another part of the overall benefits to flow to Northeast Tennessee that outweigh any likely disadvantages of lost competition. The Parties note that their commitments go beyond those accepted in the successful Mission Health COPA. We also note that Staff ignore that many of our contractual commitments are actions, including designated investments and specific steps regarding implementation of the Common Clinical IT Platform. These are not general reporting requirements, but specific commitments to fund or undertake certain actions that are directly linked to consumer or community benefits.

4. Staff Criticisms Of The Plan Of Separation Are Speculation

Staff claim at pages 63-65 that the Plan of Separation would be an ineffective remedy were the Commissioner to terminate the Cooperative Agreement. At its root, this is merely another irrelevant staff expression of disagreement with the Legislature over the policy virtues of cooperative agreements. Staff point out that "antitrust agencies typically seek to prevent or remedy problematic mergers *before* they are consummated" because it is difficult to "unscramble the eggs" after the merged parties have integrated. (*Id.* at 64; emphasis in original) This is because the antitrust agencies seek to prevent mergers with anticompetitive effects from ever occurring. The Hospital Cooperation Act, in contrast and as discussed above, expressly authorizes approval of a merger with anticompetitive effects in Tennessee that meets the statute's evidentiary standard of a net benefit for the region.

Staff's criticisms of the Plan of Separation also take no account of the fact that the New Health System will be subject to the Commissioner's active and ongoing supervision over the lifetime of the Cooperative Agreement. Under this arrangement, once the merger consummates, the Department will have knowledge about integration actions and will be in a position to evaluate the benefits of that integration at the same time it is monitoring the New Health System's compliance with the terms of the Cooperative Agreement. The Hospital Cooperation Act gives the Department the power to initiate proceedings as needed to ensure compliance and to seek reasonable modifications to a cooperative agreement, with the consent of the Parties, in order to ensure that the Cooperative Agreement continues to meet the requirements of the Act.⁸⁷

Staff list a set of purported deficiencies in the Plan of Separation needed to, in their words, "restore pre-merger competition." (staff comments at 63) Their comments lack merit. As a threshold point, staff misstate the regulatory requirement for the Plan of Separation. The Tennessee Rules and Regulations Governing Cooperative Agreements⁸⁸ ("Cooperative Agreement Regulations") establish that a Plan of Separation is a written proposal submitted with

⁸⁶These commitments include not to engage in "most favored nation" pricing with any health plans, not to become the exclusive network provider to any commercial, Medicare Advantage, or managed Medicaid insurer, not to engage in exclusive contracting for physician services (except for certain hospital-based physicians) and not to prohibit independent physicians from participating in health plans and networks of their choice.

⁸⁷Tenn. Code. Ann. § 68-11-1303(f).

⁸⁸Tenn. R. & Regs. § 1200-38-01-.01, *et seq.*

an application to return the parties to a *preconsolidation state*.⁸⁹ Staff again insert their own view of what the policy should be, stating that "it would be unrealistic to expect that terminating a cooperative agreement following a merger's consummation would return the hospital system to their pre-merger status." (*Id.*) It is true that markets evolve over time for many reasons, but it will always be possible to divide assets of the merged system to re-create competitive dynamics, should the merger fail to produce continuing public benefits that outweigh anticompetitive effects. Such a determination would be based on a plan submitted to the Commissioner at that time, which would be based on the current reality of the market and the merged system.

It is important to note that, at the request of the Department, the Parties revised the initial Plan of Separation (submitted as Exhibit 15.1 in the Application) to provide additional details to specifically address how the separation would be handled in the first 18 months after closing. This revised Plan of Separation is attached hereto as Exhibit III.B.

5. Staff's Discussion Of COPAs/Cooperative Agreements In Other States Ignores Facts That Undermine Their Arguments

Staff assert at pages 67-70 that cooperative agreements (or COPAs) in other states have experienced "practical problems" and that staff have "some concerns" about them. They reference laws that were repealed in North Carolina, Montana and Minnesota. Here again, staff return to irrelevant policy disagreement with the Legislature and do not address the facts concerning the Parties' Application for a Cooperative Agreement. One of the states that enacted a Hospital Cooperation Act with which staff have concerns is West Virginia, where, as described above, the West Virginia Health Care Department earlier this year rejected virtually the same arguments from staff and approved a Cooperative Agreement for a merger that the FTC challenged on antitrust grounds.⁹⁰

Staff's comment that they are "pleased the North Carolina legislature no longer believes a COPA statute is necessary or beneficial and that problematic hospital mergers would no longer be allowed to proceed under such a statute" is very misleading. North Carolina repealed the law because the Mission Health System that operated under a COPA for the preceding 20 years was successful, because market dynamics had changed, and because the law was no longer needed.⁹¹ Staff fail to point out that Mission Health supported the repeal.

Staff are correct that the Parties point to Mission Health System as an example of a successful COPA. For seven consecutive years Mission Health has been named a Top 100 hospital, and for three consecutive years has been named a top 15 health system in the nation. Under its COPA, quality at Mission Health has been advanced. According to data provided by the State of North Carolina, the costs for health care services at Mission Health have been sustained at a lower level than its peers in the state, and its charges are the third lowest in

⁸⁹Tenn. R. & Regs. § 1200-38-01-.01(14).

⁹⁰See *Morrissey hails FTC decision to withdraw challenge to Huntington hospital merger*, WEST VIRGINIA RECORD (July 7, 2016), available at <http://wvrecord.com/stories/510955448-morrissey-hails-ftc-decision-to-withdraw-challenge-to-huntington-hospital-merger> (accessed October 14, 2016).

⁹¹See *Legislation Repeals COPA*, MISSION HEALTH, available at <http://scope.connectwithmhs.org/content/legislation-repeals-copa> (accessed October 14, 2016).

North Carolina despite having the highest Medicare and Medicaid Payer mix in North Carolina.⁹² Mission Health has been recognized as one of the nation’s best examples of health systems that successfully achieved higher quality while maintaining low costs.⁹³

Staff express “skepticism” over Mission Health as a successful COPA. They assert there is “difficulty [in] assessing whether the public policy goals of [that COPA] have actually been met,” and cite to three “[i]ndependent health policy experts” who studied but did not reach a conclusion about the Mission Health COPA. (*Id.* at 67) This hardly amounts to evidence that the COPA did not benefit patients, particularly in light of the contrary evidence noted above. Staff selectively cite parts of an Urban Institute report to contend that the results of the merger are uncertain. (*Id.* at 68 n.291) Staff chose not to advise the Department and Commissioner of the following statements from that study:

- “Both Medicare and private payer per-person costs have been found to be low in Asheville, while quality is good, according to independent findings using different data. Indeed, well-recognized policy experts have held up Asheville as one of the best communities for providing high value hospital care.”
- “Policymakers should consider quasi-regulatory oversight of provider consolidation like that of the Mission COPA because antitrust oversight has done little to prevent, roll back or continually discipline consolidation and its high prices for consumers.”⁹⁴

It is true the Urban Institute poses several reasoned questions about the complex nature of COPAs and leaves them open for ongoing public policy debate. But Tennessee resolved its public policy in 2015. Its policy is one that promotes the approval of cooperative agreements for health care transactions in Tennessee that meet the statutory standard.

The “difficulties” staff perceive in determining whether Mission Health was a successful COPA and the “skepticism” they place on evidence that it was a success stand in stark contrast to the certainty staff express in their advocacy against a Cooperative Agreement in Tennessee, particularly in light of the absence of substantial facts that supports their position. The simple fact is that staff have never conducted a comprehensive study of the Mission Health COPA, its effects on pricing, quality and efficiency, and staff, therefore, have no evidence to point to which refutes the very successful results of Mission Health in the last 20 years. Absent such evidence, and given the accolades Mission Health has received for quality, lower cost and high value, it is wholly inappropriate to discard such results. This is particularly true given the similarity in the primary markets of Sullivan/Washington Counties in Tennessee and Buncombe County, North Carolina.

⁹²See *Regulation vs. Ability to Compete: What is the Certificate of Public Advantage?*, MISSION HOSPITAL SCOPE (May 6, 2011), available at http://www.mission-health.org/sites/default/files/document-library/1710_0.pdf (accessed October 14, 2016).

⁹³See *Mission One of ten Hospitals Named for “Doing It Right,”* MISSION HOSPITAL SCOPE (August 7, 2009), available at http://www.mission-health.org/sites/default/files/document-library/1292_0..pdf (accessed October 14, 2016).

⁹⁴See Randall R. Bovbjerg & Robert A. Berenson, *Certificates of Public Advantage: Can They Address Provider Market Power?*, URBAN INSTITUTE, at 22 (2015), available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf> (accessed October 14, 2016).

Importantly, while staff have expressed a lack of concern for out of market mergers of the type Wellmont and/or Mountain States may need to pursue absent a Cooperative Agreement, they should consider some relevant facts about the market in North Carolina that are also informative for the Department in making its decision. First, in the 20 years Mission Health operated under a COPA, neither the FTC nor the Justice Department has accused Mission Health of unlawful behavior or behavior harmful to consumers. In fact, according to the Urban Institute, insurers have claimed that the behavior of Mission Health in negotiating contracts has been no different than other systems in North Carolina.⁹⁵ This suggests the COPA was effective at governing the behavior of Mission Health. Second, the only health system in North Carolina which has recently been accused of anti-competitive behavior by the Justice Department is Carolinas Health System.⁹⁶ This system formed over time through out-of-market mergers and acquisitions. The North Carolina system the federal government has seen fit to accuse of anti-competitive behavior is not the one formed under a COPA, but rather, one formed in the manner with which staff seem to have no concerns with respect to future transactions with our local health systems. Without any evidence to suggest Mission Health or any other system formed under a COPA has behaved in a manner to harm consumers, the Parties are left to assume all staff have done is to speculate.

The Carolinas example demonstrates another important point overlooked by staff. Should the Cooperative Agreement terminate and the New Health System no longer be under state supervision with immunity under the antitrust laws, then it will be fully subject to suit under any of those laws. Anticompetitive behavior by the New Health System in a post-Cooperative Agreement situation could be challenged by the FTC, the Department of Justice (as in the Carolinas example), state Attorneys General, and private citizens.

Staff also discuss Benefis Health in Montana, the COPA for which was terminated in 2007. (staff comments at 68-69) Staff refer to a blog site that purports to report price increases that followed repeal of the COPA statute in Montana. (*Id.* at 69 n.297) Staff provide no evidence that these alleged price increases were anticompetitive; indeed, the increases could have been market corrections following a period of overly aggressive price constraints under the COPA. In this case, this would be evidence that the COPA did, in fact, provide consumers with a benefit not enjoyed by consumers elsewhere in the state where pricing was even higher. The same blog post quotes a University of Montana professor (Larry White), who said “Benefis actually had some of the very lowest unit costs in the state of Montana for various kinds of medical services.”⁹⁷ Staff did not provide that quote in their comments. Staff also did not provide the following quote concerning Benefis Health post-COPA charges: “Benefis’ charges are 16 percent lower than . . . Montana peers for inpatient and outpatient care combined, according to the most recent data from the Montana Hospital Association.”⁹⁸ If this is true, then even after the COPA was repealed and prices increased, the prices remained 16 percent below

⁹⁵Bovbjerg & Berenson.

⁹⁶See *Impact of antitrust suit against CHS could ripple nationwide*, CHARLOTTE OBSERVER (June 12, 2016), available at <http://www.charlotteobserver.com/news/local/article83142307.html>.

⁹⁷Jimmy Tobias, *Costly Care*, MISSOULA NEWS (March 26, 2014), available at <http://missoulanews.bigskypress.com/IndyBlog/archives/2014/03/26/great-falls-hospital-merger-holds-lessons-for-missoula>.

⁹⁸Tobias.

peer hospitals. The article shared by staff provided no validated data from which to draw any conclusions. Nor, to the Parties' knowledge, has Benefis been accused of any anticompetitive behavior harmful to consumers by any federal or state agency.

E. Conclusion

Staff's application of traditional merger analysis to the cooperative agreement framework established by the Legislature is incorrect. The Hospital Cooperation Act sets forth Tennessee's policy to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Department in order to facilitate the provision of quality, cost-efficient medical care to rural patients. The Parties' Application and the commitments made therein satisfy the standards of the Hospital Cooperation Act and demonstrate that the significant benefits to the people of Tennessee will outweigh any anticompetitive effects of the merger. Staff's misplaced analysis along with the unsubstantiated claims and inaccuracies contained in their submission lead to the conclusion that the Department should disregard and reject the assertions of staff's submission.

IV. RESPONSE BY APPLICANTS
TO SUBMISSION OF
AMERIGROUP TENNESSEE INC.

Amerigroup’s overlapping arguments with those of FTC staff begin on page one of the Amerigroup comments. Like staff, Amerigroup takes issue with the sovereign policy that underlies the Hospital Cooperation Act (the “Hospital Cooperation Act” or the “Act”).¹ The Tennessee Legislature (the “Legislature”) passed this law in 1993 and overwhelmingly reaffirmed it only *nineteen months ago*, stating:

“It is the policy of this state, in certain instances, *to displace competition* among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, *in order to promote cooperation and coordination among hospitals in the provision of health services* and to provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section.”²

Amerigroup opines “that there are numerous reasons why [Certificates of Public Advantage] are a poor substitute for competition” and offers “five reasons” in support of this view that FTC Chairwoman Ramirez has previously espoused. (Amerigroup comments at 1) The policy prerogatives of Amerigroup, the FTC Chairwoman and staff, however, are not relevant in this proceeding. Tennessee’s sovereign policy is to promote health care mergers – even mergers that may be anticompetitive within the meaning of federal and state antitrust laws – where the benefits outweigh the disadvantages resulting from the loss of competition between the merging parties.

Amerigroup does not, just as staff does not, acknowledge the hard facts about the very difficult health and economic conditions facing the citizens of the mostly rural region of Northeast Tennessee. Amerigroup conducts business in this region, making its silence in this regard even less understandable than that of the Washington, D.C.-based staff. It is therefore not surprising that Amerigroup, like staff, cannot show how the status quo that each endorses better serves Northeast Tennesseans or offers a better solution to the problems in the region than the Cooperative Agreement outlined in the Parties’ Application.³

The Parties find irony in Amerigroup’s opposition to this sovereign Tennessee policy, given that it conducts its business in Tennessee under much the same construct. The State limits the number of health plans that may offer its products in the TennCare market, such that

¹When it unanimously reaffirmed the Hospital Cooperation Act of 1993, the State of Tennessee clearly articulated and affirmatively expressed a policy to improve the welfare of Northeast Tennesseans by encouraging integration among healthcare providers, even in anticompetitive transactions, if the overall net effect is to facilitate better care:

It is the policy of this state, in certain instances, to displace competition among hospitals with regulation to the extent set forth in this part and to actively supervise that regulation to the fullest extent required by law, *in order to promote cooperation and coordination among hospitals in the provision of health services* and to provide state action immunity from federal and state antitrust law to the fullest extent possible to those hospitals issued a certificate of public advantage under this section. (emphasis added).

Tenn. Code Ann. § 68-11-1303, *et seq.* (effective May 18, 2015) [hereinafter the “Hospital Cooperation Act”].

²Hospital Cooperation Act (emphasis added).

³Amerigroup, the only payer that submitted comments into the Tennessee record opposing the merger, accounts only for approximately 3 percent of claims and 2 percent of charges at Wellmont, and 3.7 percent of claims and 3.5 percent of charges at Mountain States.

consumers have limited choices and providers have few choices, or no choices, in determining whether to contract with Amerigroup, and under what conditions. Amerigroup benefits from this policy, and despite weakness in its own plan (for instance, Amerigroup is the only health plan the Parties are aware of which does not have its own provider network), faces no threat to competitive entry in its space once it has been deemed by the State to be a protected health plan in a region. The State permits Amerigroup to offer its product and actively supervises Amerigroup through a contract, presumably because the State has determined it is in the interest of the State and public to limit competition in favor of efficiency and management of the program.

The remainder of Amerigroup's Introduction is a summary of points made later in the Amerigroup comments. The Parties respond to those points in the sections that follow.

A. Response To Amerigroup Discussion Of "The Loss Of Competition From The Merger"

In this section, Amerigroup presents the same antitrust arguments found in the Staff Submission, relying on statistics calculated from draw area shares and concentration, and evaluating the merger using the analytical steps set forth in the FTC-Department of Justice Horizontal Merger Guidelines (the "Merger Guidelines"). (Amerigroup comments at 7-11)⁴ As the Parties noted about staff's virtually identical structural antitrust analysis, the discussion of market shares and concentration merely informs the Department that staff, or in this case Amerigroup, believes the merger is anticompetitive under Section 7 of the Clayton Act. The structural analysis does not address whether the merger meets the different balancing test and evidentiary standards of the Hospital Cooperation Act.⁵

Amerigroup speculates and misunderstands the law in stating that Mountain States' proposed acquisition of Laughlin Memorial Hospital and Wellmont's proposed acquisition of Takoma Regional Hospital "is evidence that the Parties plan to expand their dominant position in the market by acquiring independent hospitals," and that "[i]f the Department grants this COPA there would be nothing to prevent the New Health System from purchasing additional providers and expanding even further—something that is not prohibited by the proposed COPA." (Amerigroup comments at 9) Laughlin Memorial Hospital and Takoma Regional Hospital are examples of hospitals that reside in a county contemplated as part of the Geographic Service Area and under the regulatory scope of the COPA if it is granted. Moreover, while the Parties have no plans for expansion of the New Health System through acquisition, any out-of-market acquisitions would not eliminate competition. Amerigroup's comments are without merit.

⁴In addition to the Merger Guidelines, Amerigroup relies in this section on a letter from the FTC's Director of Policy Planning, staff's (rejected) comments to the West Virginia Healthcare Authority ("WVHCA") regarding a cooperative agreement application before that body, and an economic paper by Michael Doane and Luke Froeb. (Amerigroup comments at 9-11 & notes 26-39) In their Response to the Staff Submission, the Parties describe WVHCA's instructive reasoning in rejecting staff's comments and approving the cooperative agreement filed by two competing hospitals. *Response to FTC Staff Submission* at 9-12. The Parties also point out the unrealistic conclusions and significant economic flaws contained in the Doane and Froeb paper. *Response to FTC Staff Submission* at 20, n. 45.

⁵*Response to FTC Staff Submission* at 4-6.

B. Response To Amerigroup Claim That Benefits Are “Illusory And Unsubstantiated”

Amerigroup argues that the Department “should focus principally on merger-specific benefits – those that could only be obtained absent the merger and not through an alternative means that are less restrictive to competition” – because, Amerigroup continues, “according to the statute one of the disadvantages to be weighed against the potential benefits is “the availability of arrangements that are less restrictive to competition.” (Amerigroup comments at 12, citing Tenn. Code Ann. § 68-11-1303(e)(3)(D)). Amerigroup neglected to quote the full provision, which goes on to state “. . . 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 agreement.”⁶ This omission is consistent with Amerigroup’s pattern of either ignoring or grossly undervaluing the benefits to be obtained by the merger.

Amerigroup has not identified a single alternative arrangement that would meet this standard. The Department must evaluate this factor along with many others in making the determination whether the transaction’s benefits outweigh the disadvantages caused by the loss of competition between the merging parties.⁷

As the Parties previously described, in this respect, the Hospital Cooperation Act is very different from how the FTC assesses a merger’s efficiencies (or benefits) under the Merger Guidelines.⁸ Amerigroup’s claim that the two frameworks are “substantially similar” is flatly wrong. (Amerigroup comments at 12) The reason for the difference is that the FTC assesses mergers only for their effect on *competition*. The Hospital Cooperation Act, in contrast, creates a pathway for qualified mergers *even if they may be anticompetitive*. The FTC gives no credit whatsoever in a merger antitrust analysis to efficiencies that are not merger-specific.⁹ The Hospital Cooperation Act requires only that the availability of other transactions that would generate the same benefits be considered as a factor among others in an overall balancing of benefits versus disadvantages. The FTC evaluates efficiencies only insofar as they enhance the merged firm’s “ability and incentive to compete” and to the extent they “reverse the merger’s potential harm.”¹⁰ It will refrain from challenging an otherwise anticompetitive merger only if the efficiencies “are of a character and magnitude such that the merger is *not likely to be anticompetitive* in any relevant market.”¹¹ None of these concepts are embedded in the Hospital Cooperation Act.

Amerigroup’s arguments also fail to heed the core principles of state-action immunity. As the Supreme Court recently stated:

The Sherman Act serves to promote robust competition, which in turn empowers the States and provides their citizens with opportunities to pursue their own and

⁶Tenn. Code Ann. § 68-11-1303(e)(3)(D) (2016).

⁷Tenn. Code Ann. § 68-11-1303(e) (2016).

⁸*Response to the Staff Submission* at 4-6.

⁹*Merger Guidelines* at § 10.

¹⁰*Merger Guidelines* at § 10.

¹¹*Merger Guidelines* at § 10.

the public's welfare. *The States, however, when acting in their respective realm, need not adhere in all contexts to a model of unfettered competition.* While “the States regulate their economies in many ways not inconsistent with the antitrust laws,” in some spheres they impose restrictions on occupations, confer exclusive or shared rights to dominate a market, or otherwise limit competition to achieve public objectives. *If every duly enacted state law or policy were required to conform to the mandates of the Sherman Act, thus promoting competition at the expense of other values a State may deem fundamental, federal antitrust law would impose an impermissible burden on the States' power to regulate.*

For these reasons, the Court in *Parker v. Brown* interpreted the federal antitrust laws to confer immunity on anticompetitive conduct by the States when acting in their sovereign capacity. That ruling recognized Congress' purpose to respect the federal balance and to “*embody in the Sherman Act the federalism principle that the States possess a significant measure of sovereignty under our Constitution.*” Since 1943, the Court has reaffirmed the importance of *Parker's* central holding.¹²

Amerigroup, like staff, tries to promote its own policy preference over that of the Legislature and to shoehorn antitrust law enforcement concepts into the evaluation of cooperative agreements. They are completely different frameworks, and Amerigroup's arguments fail.¹³

¹²*North Carolina State Bd. of Dental Examiners v. FTC*, 135 U.S. 1101, 1109 (2015) (citations omitted)(emphasis added).

¹³A recent Federal Trade Commissioner herself recognized that the agency does not possess sufficient information to opine on non-competition-related public policy goals of state laws that restrict competition. In a January 8, 2016, dissent to an FTC and Dept. of Justice joint statement on repeal of the South Carolina Certificate of Need statute, then-Commissioner Julie Brill states:

“My concern is I do not believe the Agencies possess sufficient relevant information to opine on noncompetition-related public policy goals of the CON laws. Our experience is broad but it does not extend to every issue. The FTC should advise South Carolina policy makers based on our area of expertise—competition—and not overstep our collective knowledge. Health care policy makers at the state level are faced with difficult issues separate and apart from the strong benefits competition brings to health care markets. These include the critically important issue of preserving access to care for the needy, and doing so in a complex market, involving informational asymmetries among patients, providers, and payors. In this context, it is important to understand that competition will not move resources from those that can afford health care to those that cannot. As the Agencies stated in 2004:

‘competition is not a panacea for all of the problems with American health care. Competition cannot provide its full benefits to consumers without good information and properly aligned incentives. Moreover, competition cannot eliminate the inherent uncertainties in health care, or the informational asymmetries among consumers, providers, and payors. Competition also will not shift resources to those who do not have them.’”

The Staff's comments are an example of the agency's representatives “overstepping their collective knowledge” and clearly lack merit in this proceeding. Former Commissioner Brill's full statement can be found at https://www.ftc.gov/system/files/documents/public_statements/905323/160111ftc-doj-sclawstatement.pdf?utm_source=govdelivery (citation omitted).

1. Response To Amerigroup Claim That The Proposed Benefits Do Not Reflect Significant Investments Different From What They Are Doing Currently

In questioning the Parties' specific commitments totaling \$450 million, Amerigroup quotes language from the Application that the merger is motivated in large part by "the important and increased need for investment in population health, management of information and measurable improvement in cost and quality, combined with the continued downward pressure on reimbursement from government and commercial payers." (Amerigroup comments at 13, quoting Application at 1) Amerigroup does not challenge the "important and increased need for investment in population health, management of information and measurable improvement in cost and quality" and the other stated motivations for the merger. Instead, Amerigroup attempts to belittle the Parties' specific commitments totaling \$450 million for various important programs needed in the region, arguing that despite this "soaring language," the Parties are already making investments which could total over \$450 million over ten years.¹⁴

In response to Amerigroup's criticisms, the Parties have expressly stated that the \$450 million commitment is **incremental**, specifically that the "investments are intended to be incremental and constitute additions to current spending costs."¹⁵ As the Application states, funding the population health, access to care, enhanced health services and commitments would be impossible without the efficiencies and savings created by the merger. (Application at 57, *see* Amerigroup comments at 13)¹⁶ The Department can and will monitor and enforce the Parties' commitment of this \$450 million incremental investment to provide additional important health care services in the region.

The Parties' specific commitments are based on review of the Tennessee State Health Plan and the regional collaborative health improvement goals such as those set forth in Healthier Tennessee, and extensive feedback received over many months from the people the Parties serve across the region—direct feedback from hundreds of people ranging from regional leaders to health care consumers, including feedback from the four Community Health Work Groups. That feedback revealed strong support for local governance and control because local governance and control works hand-in-hand with local input. These commitments, shaped by local input, address the unique needs and goals of this region because they are developed by local people who live, work, and raise families in this region. The commitments provide solutions to address an epidemic of behavioral health and addiction problems with new resources to help turn the tide of

¹⁴Amerigroup does not dispute the importance of these programs and identifies the programs to include expanding mental health, addiction recovery and substance abuse prevention programs; developing and growing academic and research opportunities supporting post-graduate health care training; developing programs for children's health and preserving and expanding rural services and access points. (Amerigroup comments at 14-15) Importantly, Amerigroup also concedes that some of the Parties' commitments, if met "could offer substantial value to northeast Tennessee and southwest Virginia." (Amerigroup comments at 21)

¹⁵*See Responses to Questions Submitted April 22, 2016 by Tennessee Department of Health in Connection with Application for Certificate of Public Advantage*, at Exhibit. 20 (July 13, 2016) [hereinafter "*July 13 Department Responses*"], available at http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_DOH_Response_1.pdf.

¹⁶Importantly, the Amerigroup comments shows the extent to which these two local hospital systems are already making substantial expenditures to improve health care in the region, based on the Parties' first-hand knowledge of the needs of this region. It is unlikely that any out-of-market acquirer would be willing to continue this level of funding. Further, the Amerigroup comments assumes that the hospital systems will be able to continue their current level of funding if they remain independent, but given the documented financial pressures, there is no assurance this level of funding will continue.

poor community health and chronic disease, invest in services not currently available, and create economic opportunity through academics and research.

In addition, since the Application was deemed complete by the Department, the Parties have proposed revised and broadened commitments to the Southwest Virginia Health Authority and have presented these revised commitments to the Department for consideration (the “Revised Commitments”). Revised Commitments also include more specific ways in which achievement of those commitments can best be demonstrated and measured on an ongoing basis.¹⁷

Coming from an organization based outside the area, Amerigroup’s criticism that local control and governance is only “a nice sound bite” (Amerigroup comments at 4) is both dismissive of and disrespectful to the people of the region and to the local government entities that have expressed their support, made it clear that local solutions are needed to solve the serious challenges facing the region, and invested significant effort in identifying those challenges and formulating proposed solutions. Beyond seeking profit from the State’s taxpayers through the TennCare program under a regulatory system which protects Amerigroup from “unfettered competition” in the open market, the Parties are unaware of a single effort by Amerigroup or its parent to invest time, resources or effort into addressing these critical issues in the region. Conversely, these issues are top of mind to the local governance of the health systems based in the region. Therefore, local governance is not merely a “sound bite.” It is uniformly a relevant and critical issue to the political and business leadership of the entire region – a fact consistently revealed for the record through multiple public hearings and comments by business and political leaders since announcement of the proposed merger.

2. Response To Amerigroup Claim That The Benefits Could Be Achieved Without The Merger

Building upon its mistaken and uninformed argument that the investments “may reflect nothing little more than the Parties’ current activities” (Amerigroup comments at 16), Amerigroup argues that out-of-market acquisitions may provide similar benefits to the region.¹⁸ Amerigroup provides no basis for this speculation other than to cite self-serving press releases posted by the out-of-market acquirers. Importantly, even a cursory review of these releases demonstrates that they do not involve areas with similar characteristics to this region. Specifically, the out-of-market mergers cited do not involve rural regions with high poverty rates, higher rates of serious health problems, very high percentages of Medicare, Medicaid, Medicare managed care and uninsured patients, a declining population, a small and shrinking base of commercial patients and rural hospitals with very low patient volumes requiring substantial financial investment to ensure that important services remain available in smaller rural communities.

¹⁷SOUTHWEST VIRGINIA HEALTH AUTHORITY, *Proposed Revised Commitments*, [hereinafter “*Revised Commitments*”] available at <https://swvahealthauthority.net/commitments/>.

¹⁸As the Parties pointed out in the *Response to the Staff Submission*, the West Virginia Health Care Authority (“WVHCA”) recently rejected a similar argument when it approved a cooperative agreement between two West Virginia hospitals under a law very similar to the Tennessee Hospital Cooperation Act. The WVHCA held that it was unwilling to jeopardize important programs for the region based on speculation that another purchaser may offer similar programs. *See In Re: Cabell Huntington Hospital, Inc., Cooperative Agreement No. 16-2/3-001* (W. Va. June 22, 2016).

For example, Amerigroup references Novant building a 60-bed hospital in Prince William County in Northern Virginia, a much more affluent and growing area than the Southwest Virginia and Northeast Tennessee area.¹⁹ In fact, the press release cited states the hospital will serve the “growing” northern Virginia community. As pointed out in the Application, many of the Parties’ hospitals in Southwest Virginia have an average daily census of less than 30 patients with significant excess capacity and a declining area population, while the rural hospitals in Northeast Tennessee have an average census ranging from 1 to 30.²⁰ Similarly, the other examples involve situations where new hospitals and facilities were being built to serve growing demand, not situations where out-of-market acquirers were committing to maintain low occupancy or struggling rural hospitals in areas with high poverty and serious health challenges.

Further, since Amerigroup references the Novant acquisition of Prince William Health System, which occurred in 2009, it may prove educational to review the publicly available data regarding the outcome of this out-of-market acquisition. From the date of acquisition in 2009 through 2012, the hospital consumer price index increased by a compounded annual growth rate (“CAGR”) of 3.4 percent.²¹ According to the publicly filed hospital cost report data over that same time period, the Novant-acquired hospital’s case mix index remained flat, but Gross Revenue per Adjusted Admission grew by a CAGR of 8 percent, or 30 percent over three years. Net Revenue per Adjusted Admission grew by a compounded annual growth rate of 7 percent. This revenue growth per adjusted admission was in excess of expense growth of 3.5 percent CAGR. This revenue growth per adjusted admission is roughly twice the growth of the hospital Consumer Price Index. While the specific pricing at Prince William Medical Center is not available, it is clear that, on a case-mix adjusted, volume adjusted basis, gross revenue per adjusted admission increased dramatically after the acquisition. Generally, gross revenue per adjusted admission relates to gross charges, while net revenue per adjusted admission relates to collections on a per-unit basis. Adjusted for case mix, there appears to be no other explanation for such dramatic increases in volume adjusted revenue other than *pricing increases*. The Parties are not aware of publicly available data to suggest substantial improvements in quality, cost, or patient satisfaction. The Parties believe that this type of “out-of-market” acquisition is not what is best for the region and this data underscores why the Parties believe there is greater value in the proposed merger than turning the Parties’ hospital assets over to an outside system, as Amerigroup would have the Parties do.

Amerigroup also argues that the Parties could achieve some of the proposed efficiencies and benefits without merging (Amerigroup comments at 18) but offers no examples of

¹⁹A news release from this entity states that the population of western Prince William County is projected to grow more than 20 percent over a two-year period. Prince William Health System, *Prince William Health System Completes Merger with Novant Health to Expand Quality Health Care in Northern Virginia*, PR NEWswire (July 1, 2009), available at <http://www.prnewswire.com/news-releases/prince-william-health-system-completes-merger-with-novant-health-to-expand-quality-health-care-in-northern-virginia-62090857.html>.

²⁰Amerigroup also cites to Novant “steering” members to a UVA hospital, but it is unclear whether members were being steered to an out-of-market hospital. (Amerigroup comments at 17) Here, the Parties intend to provide needed services locally, including specialty services.

²¹See *Novant Health UVA Health System Prince William Medical Center Profile*, AMERICAN HOSPITAL DIRECTORY, available at: https://www.ahd.com/free_profile.php?hcfa_id=98bd57eed13c350c01e783b9186db671&ek=6f27bcb739d76b93b4326cdfc35ad934.

collaborations that would not be challenged under the antitrust laws and/or involve a very complicated and costly antitrust compliance infrastructure. Such alternative collaborations would very likely require, among other things, sharing of confidential and competitively sensitive cost and price information between competitors along with agreements regarding the services each system will offer and not offer, the direction of referrals, which facilities to keep open, close, downsize or repurpose and the number, type and the compensation of specialists and subspecialists. The cost-savings potential is much smaller without full integration, leaving the Parties with fewer and probably insufficient resources with which to fund the ongoing capital and operating needs of the hospitals, much less the proposed new spending by the Parties for the public benefits.

In fact, many of the Parties' rural hospitals were previously owned by not-for-profit or for-profit systems. For a variety of reasons, each of these hospitals chose to become part of either Mountain States or Wellmont. These reasons included, among others, downward pricing pressure, reduced utilization of services, and lack of growth leading the boards or corporations to conclude the hospitals could not thrive in the market. In some cases, the hospitals were part of large multi-state or regional hospital systems. And in other cases, the hospitals went through multiple owners before being acquired by either Mountain States or Wellmont. The conditions leading to these divestitures and partnerships, in fact, have worsened. Without the commitments contained in the Application by the New Health System to keep these hospitals open, the reality exists that many of the hospitals in Northeast Tennessee and Southwest Virginia would struggle to survive. Tellingly, Tennessee has had the second-highest number of hospital closures in the nation since 2010 at eight.²²

Finally, Amerigroup asserts that Covenant Health System "continues to express interest" in partnering but provides no support. (Amerigroup comments at 4) Amerigroup is not aware of the proposals of the various health systems to acquire Wellmont or Mountain States and is not aware of the potential financial and other implications of such proposals. Amerigroup's comment about Covenant is uninformed and irrelevant.

C. Response To Amerigroup Claim That Commitments Offered By The Parties Are Not A Replacement For Competition And Will Not Adequately Protect Patients Against Competitive Harm

Amerigroup claims that the commitments will not assure that the Cooperative Agreement will result in the claimed benefits. (Amerigroup comments at 5) This assertion is false.

As discussed above, the legislative intent of the Hospital Cooperation Act is to create a pathway for approval of hospital mergers that might be seen as anticompetitive, if they qualify under the statute's balancing test for benefits versus disadvantages. To ensure that the balance of net benefits is maintained in keeping with state policy, the Act, including the regulations accompanying the Act, provides that the COPA shall be governed by terms of certification that

²²Ayla Ellison, *A state-by-state breakdown of 80 rural hospital closures*, BECKER'S HOSPITAL REVIEW (Dec. 13, 2016), available at <http://www.beckershospitalreview.com/finance/a-state-by-state-breakdown-of-80-rural-hospital-closures.html>.

include “conditions of reporting and operations determined by the Department to demonstrate Public Advantage.”²³

Instead of evaluating the commitments on whether they mirror the results of competition, the Department must evaluate whether the benefits of the Cooperative Agreement outweigh the potential disadvantages in consideration of Tennessee’s stated goal to “further improvements in the quality of health care for Tennessee citizens, moderate increases in cost, improve access to needed services in rural areas of Tennessee and enhance the likelihood that smaller hospitals in Tennessee will remain open in service to their communities.”²⁴

The Parties have made commitments in the Application to address the benefits listed in the COPA Regulations by which the State will measure the success of the Cooperative Agreement.²⁵ The Parties’ substantial, comprehensive commitments address fundamental health issues and priorities in Northeast Tennessee that compel the need for highly integrated and organized solutions led by the New Health System in close collaboration with community leaders and under the direct, active supervision of the State.²⁶ The commitments made by the Parties create mechanisms such as rate restrictions to ensure reasonable prices, conduct restrictions to ensure non-exclusionary practices, commitments from the Parties to pursue high quality performance, and significant other commitments to invest money from merger-generated cost savings into programs that will improve population health, expand access to care, and create community benefits tailored specifically to the needs of Northeast Tennessee’s rural patients. Active and ongoing supervision of these commitments will be performed by the State, as set forth in the Hospital Cooperation Act, to ensure the New Health System’s compliance with the policy goals articulated by the Tennessee General Assembly.²⁷

The Parties do not dispute that they should be held to commitments that are both meaningful and enforceable. The commitments are the mechanisms by which the Parties will mitigate the disadvantages, if any, from elimination of the areas of competition, and improve quality of health care and access to health care in this rural region. In fact, the Parties proposed specific accountability mechanisms in their Application to enforce each commitment.²⁸

To ensure that the commitments are enforceable, the Parties have also proposed that the New Health System be held to an overall standard each year under the Overall Achievement Scoring mechanism. The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the State to objectively track the progress of the Cooperative Agreement over time to ensure the merger results in public advantage. If the New Health System fails to achieve an agreed upon passing score in any year, the State may invoke its

²³Tennessee’s regulations implementing the Hospital Cooperation Act, Tenn. Comp. R. & Regs. § 1200-38-01-.03 [hereinafter “COPA Regulations”]. The Parties have made numerous commitments in the Application to ensure the Cooperative Agreement results in and demonstrates public advantage.

²⁴Hospital Cooperation Act of 1993, Tennessee Laws Pub. Ch. 331 (1993).

²⁵Tenn. Comp. R. & Regs. § 1200-38-01-.03(2)(a).

²⁶See Application Table 11.12 at 110-114 for a summary of the Parties’ 30 commitments.

²⁷Tenn. Code Ann. § 28-11-1303; Tenn. Comp. R. & Regs. § 1200-38-01-.06.

²⁸See Application Table 11.12 at 110-114 for a summary of the Parties’ 30 commitments, including accountability mechanisms.

authority to seek modifications to the Cooperative Agreement or to begin regulatory action up to and including to revocation of the Cooperative Agreement.²⁹

1. Overall Achievement Scoring

The "Overall Achievement Scoring" system proposed in the Application was intended to be a proposal for the two states to consider. Ultimately, the states will determine the active supervision mechanism that is required to ensure the continuing public advantage of the Cooperative Agreement as required by the Hospital Cooperation Act and Regulations.

The Parties have been engaged in productive dialogue with the Department regarding specific measures, weighting of measures, scoring of measures, and the overall scoring system. (See *Response to FTC Staff Submission* at 43-44) The discussions with the Department are ongoing as of this date. The Department's review of the Parties' proposed Cooperative Agreement has been, and continues to be, thorough and focused on the health care needs of the region it serves. The Parties anticipate that the Department may have additional input as the review process continues on the specific focus of the commitments and how achievement of these commitments should be substantiated.

2. Rate Commitments³⁰

Amerigroup criticizes the Parties' rate commitments on the grounds that "[s]ubstituting price regulation for market-based competition among providers is rarely done because it is almost impossible to do." (Amerigroup comments at 24) This is wrong on two grounds. First, this criticism is aimed at the State's policy to supplant competition with a regulatory program for qualified health care transactions in Tennessee. Amerigroup's policy objection is not relevant to the Department in its consideration of the Parties' Application.

Second, Amerigroup's criticism is wrong because the Parties' rate commitments are not "regulation" in the sense that Tennessee would be tasked with affirmatively setting rates. The Parties have agreed to two distinct rate commitments. In the first, for all Principal Payers, the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System" ("Rate Reduction Commitment"). In the second commitment, the Parties will not increase negotiated rates by more than a fixed index rate for both existing and prospective Principal Payer contracts. For negotiated hospital rates, this cap is the hospital Consumer Price Index (CPI) minus 0.25%. For physician and outpatient service rates negotiated by the New Health System, the cap is medical care CPI minus 0.25% (collectively, the "Rate Cap Commitment").³¹

Amerigroup makes much of the fact that "there are only a few examples of hospital mergers being granted an exemption from antitrust scrutiny under the state action

²⁹Tenn. Comp. R. & Regs. §§ 1200-38-01-.06, 1200-38-01-.07.

³⁰Many of Amerigroup's comments regarding rate commitments overlap with comments by staff. Accordingly, the Parties incorporate by reference herein the Parties' *Response to Staff Submission* Section III, which relates to the rate commitments.

³¹These commitments reflect revisions that Parties have recommended be incorporated into the Tennessee COPA. See *Response to Staff Submission* at 17-21.

doctrine.” (Amerigroup comments at 24) This argument is meaningless. One of those examples occurred this year in West Virginia. It is an example of the dynamic responses recently taken by many states to worsening health and economic conditions, including those in Tennessee, Virginia (Cooperative Agreement law passed in 2015) and New York (Certificate of Public Advantage law passed in 2011). Amerigroup does not identify a single application for a Cooperative Agreement or Certificate of Public Advantage for a hospital merger rejected by any state. Not surprisingly, Amerigroup also does not come forward with any argument or evidence that the twenty-year Mission Health Certificate of Public Advantage in North Carolina led to supra-competitive prices or sub-competitive quality. Indeed, the facts show otherwise.³²

Without supplying evidence, Amerigroup says the approach North Carolina led to “distortions in the market.” (Amerigroup comments at 25) Amerigroup's contention that even an effective rate cap may be evaded by shifting services from one category to another, or by dramatically changing utilization patterns at facilities, thereby permitting higher than anticipated revenues, is inapplicable to the pricing caps proposed by the Parties. Amerigroup apparently is unaware that the economists engaged to evaluate specific forms of regulation in North Carolina expressly supported the implementation of price caps for inpatient and outpatient services that are very similar to those in the Parties' commitments. Those economists explained ways in which simpler rate cap regulation applied to specific services address alleged “distortions.” (See Response to Staff Submission at section III.B.1).

Moreover, the Parties' proposed rate caps will apply to both inpatient and outpatient services, thereby eliminating the alleged risk of evasion or incentive to evade. Caps apply to physician services as well. Further, any attempted major changes away from current customary and usual contract terms that would permit such alleged substantial changes in utilization would be immediately detectable by payers and readily reported to the Department as part of the active supervision function.

Further, as Amerigroup should know, payer contracts contain many terms and conditions that greatly minimize if not eliminate the “gaming” that Amerigroup alleges. This is particularly the case for a health system subject to binding commitments and active state supervision. Any attempt to evade the rate commitments or re-write them without justification related to incumbent contract provisions that protect the payer would be easily identified by both the payer and the state supervising officials. Where, for example, contracts involve terms for inpatient care at fixed rates per DRG regardless of length of stay or services utilized (i.e., a fixed price for a particular diagnosis) and a similar system for outpatient care, the provider is at risk for managing length of stay. Amerigroup suggests in its comments that the New Health System may over-utilize services or extend hospital stays without clinical justification (Amerigroup comments at 26); however, existing provisions limit economic incentives for such actions.

³²See *Response to Staff Submission* at 46-48. See Randall R. Bovbjerg and Robert A. Berenson, *Certificates of Public Advantage, Can they Address Provider Market Power?*, URBAN INSTITUTE, at VI (February 2015), available at <http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf>. which states in part:

“Both Medicare and private payer per-person costs have been found to be low in Asheville, while quality is good, according to independent findings using different data. Indeed, well-recognized policy experts have held up Asheville as one of the best communities for providing high value hospital care.”

Moreover, with regard to the other means that Amerigroup suggests, there are, for example, “circuit breaker” provisions that effectively prevent rate increases above a certain level.

Amerigroup contends the rate cap will operate as a price floor rather than a cap. (Amerigroup comments at 26) This is not correct. It ignores the commercial realities of contract negotiations when both payer and the New Health System will be informed with data and information about their current contract as well as the Consumer Price Index (“CPI”) and rate cap. It also ignores that the rate cap, being tied to the hospital CPI (for hospital rates) and the Medical CPI (for physician rates), ties the rate increases to industry-level increases driven by widely accepted inputs for costs as determined by the United States Bureau of Labor Statistics. This ensures rate increases reflect actual industry experience in cost increases, which protects against increases in excess of what would otherwise have resulted from increased market concentration without such regulation.

The rate cap is also considerably below any levels that would appear likely to raise concerns about price increases. To support its claim that the proposed rate cap will act as a floor, Amerigroup relies on a single contracting example from outside Tennessee, where Amerigroup says Anthem obtained rates below the proposed cap. (Amerigroup comments at 25-26) This assertion is misleading on several grounds. First, it is backward-looking and misses the point of the proposed rate cap. The cap’s purpose is not to maintain past pricing levels, but rather to prevent future prices from increasing at rates of change that are substantially above would have been achieved with competition. The proposed rate cap constrains price increases to be lower than the hospital CPI and the Medical CPI, demonstrating that pricing increases will be at a rate below the industry norms. Further, Amerigroup ignores the commitment which will reduce rate inflators by 50 percent in the second full year after completion of the merger. This reduction resets the rate of increase for rates even prior to implementing the annual cap in rate increases. Thus, it is accurate to say that pricing will be generally lower with the merger than it would have been without the merger.

Second, Amerigroup conspicuously ignores Anthem’s significant market and bargaining power. Anthem has a dominant share of more than 80 percent in the commercial market embracing the Virginia communities to be served by the New Health System (which will rise to exceed 90 percent if Anthem’s proposed merger with Cigna, under antitrust challenge by the Department of Justice, is consummated). This gives Anthem substantial market power to impose favorable rates and certainly not to fall victim to rates by a health system subject to a limiting cap and active supervision. For other commercial payers that lack Anthem’s dominant position, the proposed rate cap represents a significant achievement that will provide immediate benefit to their enrollees. Moreover, even for Anthem, the proposed rate cap provides increased predictability of cost changes to Anthem for a portion of its covered population across the years, thereby providing greater ability to establish premiums and relevant targets.

Moreover, the cap will be a cap – even if it is a floor, the floor is also the ceiling, and rate increases will be constrained to reflect measures of overall cost changes based on neutral benchmarks that in recent history have been small percentage changes. Amerigroup and the New Health System have aligned incentives to achieve improved quality and value, and thereby reduce costs – and to seek contractual terms that will achieve improved outcomes as well as cost reduction. Where the Parties are constrained to keep rate increases across the scope of their

health care activities consistent with CPI rates that are anticipated to change at only a low rate, the Parties have every incentive to align quality and cost of care with payer's incentives to manage these for their enrollees.

Amerigroup criticizes the exclusion of non-“Principal Payers” from the rate cap commitment, contending that it should apply to all commercial payers, regardless of how much they contribute to the New Health System's net revenue. (Amerigroup comments at 25) Although Amerigroup trumpets the “substantial” number of payers implicated by this threshold, the raw number vastly overstates the local significance of the payers in question. Collectively, the roughly 200 payers that individually provide less than 2 percent of net revenue together account for less than 3 percent of the New Health System's total net revenue. From a business perspective, application of the proposed rate cap to such de minimis payers could risk net losses to New Health System.³³ Further, it is in the interest of the New Health System to ensure multiple payers compete in the market, and the New Health System will be likely to encourage entry by payers with a stable history and high quality. The New Health System should not, however, be compelled to assume the business risk of advantageous pricing to new entrants or existing payers which have a poor history of operation, poor patient satisfaction, poor provider relationships or a poor network of providers from which consumers can choose.

Amerigroup also complains that the proposed rate cap commitments exclude certain government insurance programs, contending that commitments offered in Virginia with respect to Medicaid managed care, TRICARE and Medicare Advantage plans differ from commitments offered in Tennessee. (Amerigroup comments at 25) The Parties have, as noted, amended the rate cap commitment in Virginia to extend to negotiated government plan contracts including managed Medicaid, TRICARE and Medicare Advantage plans, and the Parties have offered this same revised commitment to the Department for consideration.

Amerigroup's comments on risk-based contracting models are misleading and inaccurate on several counts. First, Amerigroup flatly dismisses, with no reasonable justification, the Parties' commitment to discuss risk-based models with its Principal Payers. Second, Amerigroup weakly attempts to refute the Parties' specific statements about a distinct form of risk contracting with vague generalities about “risk-based arrangements” Amerigroup has allegedly entered into in unidentified “nearby” regions. Third, Amerigroup draws inappropriate and inaccurate conclusions about Mountain States' capacity to engage in risk based models from the example of the AnewCare Accountable Care Organization.

“Risk-based” contracting models exist on a spectrum. The Parties understand risk-based models to mean a financial and clinical arrangement between a payer and provider(s) where a substantial portion of the financial risk related to the medical spending for the care of the patients over time has been assumed by the provider(s). This definition understands “risk-based” models to encompass both upside and downside risk.

The Parties' commitment to discuss such risk-based models with willing payers is a meaningful and substantial commitment. It demonstrates the Parties' willingness to consider and

³³Even very small changes in the risk profile of payers with very small numbers of enrollees could cause relative costs to change very substantially.

enter into true risk arrangements that entail not only upside risk (i.e., the potential for shared savings) but downside risk as well. Amerigroup offers no definition of “risk-based” models and, as a result, its criticisms of the Parties’ commitment are vague, inaccurate, and, ultimately, meaningless.

Amerigroup first attacks the Parties’ assertion that “no payer has historically expressed an interest in a global spending cap for hospital services in the region.” Amerigroup then insinuates that its own supposed interest in exploring “risk-based models” somehow disproves the Parties’ statement. The Parties stand by their assertion, and in fact state emphatically that Amerigroup has not provided any evidence of such global spending cap contracts it has entered. In the Parties’ experience payers operating in the region have approached these kinds of risk-based models (i.e., global spending caps) with caution. Amerigroup’s vague statement about its own contracts not only fails to contradict the Parties’ statement, it highlights the point that “risk-based models” encompass a broad spectrum of contracting possibilities.

Amerigroup wrongly claims that Mountain States’ experience with the Accountable Care Organization AnewCare shows that Mountain States can already engage in risk-based models without need of a merger. Here, again, Amerigroup’s failure to define “risk-based” models distorts the facts and results in misleading claims. Mountain States has indeed developed the AnewCare Accountable Care Organization. It has also worked in good faith with willing payers to explore risk-based models as a standalone system. Mountain States has even concluded contracts with a few payers that include some risk-based elements. But these examples fail to support Amerigroup’s claim about Mountain States’ ability to act alone; in fact, they show the reverse. The proper lesson to take from the AnewCare example is that, acting alone Mountain States is incapable of assuming significant downside risk, and will not do so without a meaningful critical mass of lives in the market. In fact, Mountain States has already attempted to pursue such a risk-based model with downside risk through its offering of a Medicare Advantage Plan, Crestpoint Health. Crestpoint Health was closed in 2016 due in large part to its inability to generate enough critical mass of lives. Wellmont, as a competitor to Mountain States, did not contract as a provider, thus limiting the ability of Crestpoint to achieve the lives necessary for assumption of full risk.

There is no one-size-fits-all risk-based model appropriate for all payers and providers. The Parties’ risk-contracting commitment recognizes this reality. It commits the Parties to pursuing true risk-based contracting models, while recognizing that different payers will approach this concept according to their own interests and goals. The Parties recognize they cannot force a specific, pre- defined risk-based model on any payer.

Amerigroup also criticizes a proposed commitment concerning “most favored nation” (“MFN”) pricing and exclusivity. The Parties are committed to this provision. The Parties also recognize that compliance with the sizeable commitments relies upon achieving synergies in the market. Further, the Parties have pointed to ongoing competition that will exist in the market for outpatient services. In the event Certificate of Need (“CON”) regulation is repealed, and new market entry occurs, it is possible that with the increase in competition, some of the conduct commitments may no longer be beneficial to the State. While Amerigroup is incorrect in asserting that these MFN and exclusive contracting conduct commitments are conditioned on the continued existence of CON regulation in Tennessee, the Parties do believe that such a material

event affecting the operations of the New Health System could be adverse to the expenditure commitments and thus, be of interest to the State.

3. Service Commitments

Amerigroup claims that the service commitments are incomplete and lack any details regarding specific plans, timelines or the costs to achieve them. (Amerigroup comments at 6) The Parties address both of Amerigroup's claims individually below.

Amerigroup Claim about Commitment #1: Amerigroup claims the commitment that "[a]ll hospitals in operation at the effective date of the merger will remain in operation as clinical and healthcare institutions for at least five [(5)] years" is too vague to be meaningful. (Amerigroup comments at 28)

Response: As noted above, the Parties have presented Revised Commitments to the Southwest Virginia Health Authority and have offered the same Revised Commitments to the Department for consideration. In the Revised Commitments, the Parties agreed to define "essential services" for purposes of this commitment as:

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community and based on physician availability;
- Helicopter or high acuity transport to tertiary care centers;
- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;
- Primary care services;
- Access to a behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commonwealth and the Authority.³⁴

The Parties believe this proposed definition of "essential services" provides clarity for the minimum levels of service availabilities that the Parties are committing to post-combination for this five-year period.

Amerigroup Claim about Commitment #2: Amerigroup claims the Parties' commitment to adopt a Common Clinical IT Platform as soon as reasonably practical is too vague. Amerigroup further claims that Wellmont's participation in the OnePartner HIE makes the Parties' commitment to participate meaningfully in an HIE open to community providers a benefit that is not merger-specific. (Amerigroup comments at 29)

³⁴*Proposed Revised Commitments.*

Response: The Parties direct Amerigroup to the detailed timetable for implementation of the new Common Clinical IT Platform in their July 13 Department Responses.³⁵ Amerigroup also fails to note that neither Wellmont nor Mountain States is a full participant in OnePartner and even if they were, that would not replicate the functionality of a single, integrated electronic health record system.

Amerigroup fails to recognize the difference between a Common Clinical IT Platform and an HIE. As noted in the July 13 Department Responses, the Common Clinical IT Platform is designed to facilitate the sharing of electronic health information across the New Health System, while the HIE will allow the New Health System to share electronic health information with participating providers across the region and nation - regardless of their affiliation with the New Health System.³⁶

Providers across the Geographic Service Area use a variety of EHR systems that may not be able to share data with the New Health System. The HIE is a way of sharing electronic health information among doctors' offices, hospitals, labs, radiology centers, outpatient centers, and other health organizations. While the OnePartner HIE system is useful in reaching out to independent physicians, the current system is limited in the data that it can transmit.³⁷ There is significantly more functionality for a provider utilizing a Common Clinical IT Platform, including order entry, pharmaceutical management and clinical patient management, among many other functions, which are not the core purpose of an HIE.³⁸

The investment in a Common Clinical IT Platform is essential to creating a "One Patient, One Record" approach that allows all clinicians practicing within the New Health System to effectively evaluate a patient's clinical profile and to make decisions that support high quality care without duplication of clinical resources. Better communication of patient data and best practices via a thriving regional HIE will also improve patient care and lower cost of care.

4. Quality Reporting Commitments

Amerigroup attacks the quality reporting commitments as too vague, apparently conceding that such commitments would have value if more clearly defined.³⁹ (Amerigroup comments at 29-30) In the July 13 Department Responses, the Parties set out additional detail related to the potential benefits and disadvantages that form the basis for the quality reporting commitments.⁴⁰

³⁵July 13 Department Responses, Exhibit 17.

³⁶July 13 Department Responses, Exhibit 10, 19.

³⁷See July 13 Department Responses, Exhibit 10 for a detailed description of the Parties' plans for the EHR system, a description of the plan to convert to a single records system, and the expected features, the benefits of the Common Clinical IT Platform, and the expected benefits of the Common Clinical IT Platform to the Regional Health Information Exchange.

³⁸July 13 Department Responses, Exhibit 10.

³⁹In this regard, Amerigroup recognizes that the exchange of health information across a common IT platform "is a benefit." (Amerigroup comments at 29)

⁴⁰July 13 Department Responses, Exhibit 10.

5. Physician Commitments

With respect to physician commitments, Amerigroup lists a number of commitments made by the Parties which it does not challenge. (Amerigroup comments at 30-31)⁴¹ Amerigroup then argues that there are inappropriate concentration levels in certain physician specialty areas, but lists only five of the twenty-three specialty areas identified by the Parties. (Amerigroup comments at 31)⁴² Notably, Amerigroup does not mention that it is referencing only a very few categories out of the twenty-three physician specialties serving the area that happen to have shares where 60% or a lower percentage of physicians are independent. Nor does it mention that these categories account for only a small proportion of the total physicians in the area. In fact, a very large number of physicians in the area are independent, and there are several specialties in which there is no overlap between the Parties (in terms of employed physicians) and the majority are in categories where independents' shares are high (and the Parties' share is commensurately low).

Of the five specialty areas selected by Amerigroup, two are hospitalists and urgent care physicians who, because of the nature of their practice, would not be competing for ongoing patient relationships as their interaction with patients is based on facility use. Even in these categories, there are a large number of independent physicians in the area – 146 hospitalists and 38 urgent care physicians. By referencing only the share numbers, Amerigroup suggests that there are limited alternatives, which these numbers show otherwise. Similarly, for the other three categories, which include more highly specialized physicians, these also have a number of independent physicians (50 cardiovascular, 39 pulmonology, and 19 hematology/oncology physicians in addition to those employed or affiliated with the Parties). In sum, of the remaining eighteen categories of specialists, they are made up mostly of independent specialists and half of the categories show no overlap between Mountain States and Wellmont.

Amerigroup also speculates, without foundation, that despite the Parties' commitment not to materially increase the percentage of physicians employed or affiliated with the New Health System, this may still happen, especially with respect to high-level specialties. (Amerigroup comments at 32) Amerigroup ignores the specific statement by the Parties that the physician employment model will only be used to facilitate bringing **needed** specialties to rural or underserved areas or when private physician groups do not want to expand or do not exist.⁴³ Amerigroup's objection is misguided in a region currently deprived of needed specialties. The Parties also expressly state in their submissions that their objective is to support the independent practice of medicine.⁴⁴ Amerigroup also acknowledges that the use of caps on physician

⁴¹These commitments described by Amerigroup include maintaining open medical staffs, not engaging in exclusive contracting for physician services (other than hospital-based physicians), not requiring exclusivity by physicians practicing at the new system's hospitals, and not inhibiting independent physicians from participating in health plans and health networks of choice.

⁴²See *Responses to Questions Submitted May 27, 2016 by Southwest Virginia Health Authority in Connection with Application for Letter Authorizing Cooperative Agreement*, at Replacement Exhibit 14.1 (Section E) (July 13, 2016) [hereinafter "*July 13 Authority Responses*"], available at <https://swvahealthauthority.files.wordpress.com/2016/07/msha-responses-to-questions-bates.pdf>.

⁴³*July 13 Authority Responses* at 46.

⁴⁴*July 13 Authority Responses* at 46.

numbers is not always effective.⁴⁵ This is an important notation because of the national trend of physicians to seek employment with health systems or large physician groups. While it is not the desire of the New Health System to grow their numbers of employed physicians, the New Health System must be able to attract and retain high quality physicians in specialties that require employment.

6. Plan Of Separation

Amerigroup's brief complaint about the Plan of Separation fails to recognize that the Department will have active and ongoing supervision over the New Health System over the lifetime of the Cooperative Agreement. The Department will therefore have knowledge about integration actions and be in a position to evaluate the benefits of that integration as it monitors the New Health System's compliance with the terms of the Cooperative Agreement. It is true that markets evolve over time for many reasons, but it will always be possible to divide assets of the merged system to re-create competitive dynamics, should the merger fail to produce continuing public benefits that outweigh anticompetitive effects. Such a determination would be based on a plan submitted to the Commissioner at that time, which would be based on the current reality of the market and the merged system.

⁴⁵See Amerigroup comments at 32.

V. RESPONSE BY APPLICANTS
TO SUBMISSION OF
PROFESSORS AND ACADEMIC ECONOMISTS

This section responds to comments by several professor and academic economists urging the Department to reject the Application, and to instead “encourage” the Parties to seek alternative yet unspecified arrangements. Like the other critics, the Academics fail to acknowledge the critical health care needs of the region, challenges to the long-term financial sustainability and stability of health care delivery and the express policy of the State of Tennessee to approve cooperative agreements in order to improve health care, moderate cost increases, improve access in rural areas and enhance the likelihood that smaller hospitals will remain open. In fact, the Academics appear not to have reviewed in any detail the extensive Application and subsequent submissions filed by the Parties that address these objectives, nor do they acknowledge the extensive community support for the merger.¹

Importantly, the Academics’ comments provide no guidance relevant in the context of the State of Tennessee’s important public policy objectives expressed in the Hospital Cooperation Act, which governs the Application. Under the COPA process, and through ongoing active supervision by the State, rate regulation and contractual commitments can directly mitigate any potential market power effects, and specific enforceable commitments can assure substantial benefits to the region.² Moreover, the COPA context is uniquely relevant for mergers where continued competition by two independent competitors does not provide benefits that are as sustainable or as substantial as a merger reviewed and approved by the State with specific commitments that the State actively supervises.³ The Academics’ analysis totally fails to address the State’s public policy objectives to supplant competition with regulation for mergers and should therefore not be accorded any weight. Significantly, nowhere do the Academics challenge the need for the specific commitments by the Parties, which the savings from the merger will fund, that will directly benefit health care in the region.

The Academics’ comments assume, without any factual inquiry into this specific merger, that the elimination of “head-to-head” competition between the Parties would result in substantial harm to consumers and communities, and most importantly, that forcing the continuation of such “head-to-head” competition by blocking this merger would result in significantly more efficient, effective and high-value delivery of care and consumer and community benefits than the care that the New Health System will provide as a result of this merger under the COPA. The Academics’ comments provide no basis other than general academic studies to assert that continued competition would yield greater consumer and pro-competitive benefits in this particular case. The Academics’ comments do not appreciate the

¹The Academics do not state their experience and qualifications to comment on state-supervised and approved mergers involving health care entities and the public policy benefits of such state-approved and supervised mergers. Moreover, conspicuously absent from the Academics’ comments is any reference to or evaluation of net benefits of COPA arrangements, including the literature that recognizes the benefits of the Mission Health COPA.

²A COPA is further distinguished from settlements and consent decrees, such as those referred to by the Academics’ comments by, among other factors, the role of a regulator such as the Department, which actively supervises the merger and has substantial knowledge about the health care needs of the region, in contrast to a court.

³Market conditions such as declining admissions, financial pressures due to reduced or low reimbursements for Medicaid or Medicare patients and significant excess capacity can result in higher operating costs per patient or poor financial performance of individual facilities or of systems. They can also create less-than-optimal scale services. Competition may make reduction or elimination of excess capacity difficult, while mergers and consolidation may permit it. For a discussion of the economics of excess capacity, *see, e.g.,* Kathleen Carey, *Stochastic Demand for Hospitals and Optimizing “Excess” Bed Capacity*, 14 J. REG. ECON. 165 (1998); Esther Gal-Or, *Excessive Investment in Hospital Capacities*, 3 J. ECON. & MGMT. STRATEGY 53 (1994).

impact that significant projected declines in reimbursements and in inpatient admissions due to expected population and patient trends and shifts to other care locations will have on hospital operations and costs. They also do not comment on the urgent need to reduce health care costs in this region by, along with other efforts, reducing avoidable admissions and emergency department utilization.

The Academics' comments fail to account for critical drivers of medical costs and expenditures in this region, which include significant underlying health needs and suboptimal management of health care delivery and risk. They do not address the imperatives to align incentives and care delivery and to make substantial investments in specific programs to improve health care, like the investments that efficiencies from the proposed merger will fund. These investments and merger-specific changes in health care delivery are necessary to support a financially sustainable, high-quality care delivery system in the region. Simply put, the Academics' comments appear to assume that the current system of service duplication and limited investment in the substantial health care needs of the region is preferable to reduction of duplication, investment of the \$450 million in resulting efficiencies, and price caps to regulate pricing. They do not address the financial ramifications or instability caused by two large health systems operating side-by-side with duplicative services, heavy debt obligations and numerous rural facilities with low utilization.

The Academics' comments state that hospital mergers of direct competitors are likely to result in anticompetitively higher prices and that there is limited evidence supporting any likely cost efficiencies or benefits from such mergers. They also assert that integrated delivery systems and most forms of coordination involving hospitals, including ACOs, are unlikely to yield benefits. The Academics conclude that price and other commitments in regulatory arrangements or consent decrees are complex and unenforceable.⁴

These opinions are predicated largely on general academic literature or reference to unrelated litigated or settled cases. The assertions are neither fact-based nor informed by detailed examination of this proposed merger, the local communities and conditions in which these health systems operate or the challenges facing the Parties and their communities if the merger does not proceed. The Academics' comments seem to assert that competition between two organizations always yields better outcomes for consumers and communities than a merger—regardless of specific marketplace conditions, hospital financial and cost conditions or underlying

⁴The Academics' comments reject the idea that a shift from fragmented and independent care delivery to an integrated delivery system, such as an ACO, is likely to result in reduced costs or achieve benefits. "The recent performance of Accountable Care Organizations ('ACOs'), alliances formed to bear risk for medical spending of Medicare enrollees, provides another data point with regard to the ability of provider organizations to reduce health care spending and maintain and improve quality. The Centers for Medicare and Medicaid Services ('CMS') reported in 2014 that slightly less than half of ACOs participating in the Medicare Shared Savings Program achieved savings relative to the CMS benchmark – about what one would expect from a random sample of health care delivery organizations. More recently, a study in the *New England Journal of Medicine* found that savings generated under ACO models were small at best, and that savings were consistently greater in independent primary care groups than in vertically-integrated hospital-provider groups." (Academic comments at 5) (internal citations omitted). However, ACOs do not approach the same level of substantial integration as this proposed merger, and this merger is not vertical, so the comparison is inapposite. This quote from the Academics' comments also illustrates the reliance on "average" (Academic comments at 1) or irrelevant comparisons and overlooks that even within their cited studies there are specific examples of significant benefit, especially between independent groups. The Academics' comments appear to discount or reject any "mixed" or inconsistent results as informative of the prospect of benefits from a specific combination.

demographics and health conditions. They discount substantially benefits of health system–driven realignment involving elimination of duplicative services, merger-specific efficiencies, reinvestment of efficiency savings to promote health care in the region and price caps that limit rate increases.⁵

The Parties respond to the Academics’ comments as follows:

A. Competitive Effects and Pricing: The Academics’ comments state the proposed merger should be rejected based on selected survey papers that review academic studies evaluating hospital merger price effects.⁶ While the cited survey papers, such as Town and Vogt (2006) and Gaynor and Town (2012), emphasize findings suggesting significant price effects from hospital consolidation, these same academic survey papers also include academic studies that find no significant price increases from hospital mergers or increased concentration and statistically significant decreases in prices in post-merger retrospective studies.⁷ The Academics’ comments

⁵This viewpoint stands in contrast to health care and economic literature on the benefits of integrated delivery systems and the reality of extensive ongoing realignment and transformative change in health care. The Affordable Care Act has accelerated such change, but the change is independent of the law and is driven by efforts to align incentives and control around closely integrated and coordinated care by health systems trying to address dramatically changed demand conditions with facilities and assets designed for past demands. While there are many models of integrated health delivery, an especially important model involves merger and alignment of hospitals and their integration with other providers. For a review of integrated delivery systems, see Anthony Shih, *et. al*, COMMISSION ON A HIGH PERFORMANCE HEALTH SYSTEM, THE COMMONWEALTH FUND, *Organizing the U.S. Health Care Delivery System for High Performance* 4-8 (August 2008). The Commonwealth Fund also commissioned studies of 15 different integrated systems, and the results highlight the diversity of organizational arrangements accomplishing re-alignment of health care and the importance of health-system led initiatives. Douglas McCarthy & Kimberly Mueller, *Organizing the U.S. Health Care Delivery System for High Performance* (July 2009). For a review of more health-system led initiatives in integrated care delivery with population health, see David B. Nash, *Improving Population Health by Working with Communities*, 9:5 AM. HEALTH & DRUG BENEFITS 257 (2016); David B. Nash, *Population health: where's the beef?* 18:1 POPULATION HEALTH MGMT. 1-3 (2015); and David B. Nash, *The population health mandate: A broader approach to care delivery*, 23:1 BOARD-ROOM PRESS 3-8 (2012).

⁶The Academics’ comments assert: “An extensive body of economic literature finds that hospital mergers among close competitors lead to higher prices, on average, while evidence of cost savings and quality improvements is scant.” (Academic comments at 1) (emphasis added) (internal citations omitted). In support of the statement that this effect occurs “on average”, the Academics’ comments cite two survey papers that review and summarize results of studies on horizontal effects. *Id.* (citing Martin Gaynor & Robert J. Town, ROBERT WOOD JOHNSON FOUND.: THE SYNTHESIS PROJECT, *The Impact of Hospital Consolidation—Update* (2012), available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; William B. Vogt & Robert J. Town, ROBERT WOOD JOHNSON FOUND.: THE SYNTHESIS PROJECT, *How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?*, Policy Brief no. 9, at 11 (2006), available at <http://www.rwjf.org/en/research-publications/find-rwjf-research/2006/02/how-has-hospital-consolidation-affected-the-price-and-quality-of.html>). The Academics also reference Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*, 52(3) J. LAW & ECON. 523-550 (August 2009) (which is included in the 2012 review); and M. G. Vita & S. Sacher, *The Competitive Effects of Not-for-Profit Hospital Mergers: A Case Study*. The Academics’ comments do not reference many of the caveats associated with the referenced studies, including those by the authors. The Dafny article, for example, cautions against “extrapolating the results” of the empirical evaluation to hospital mergers in general. Moreover, the Academics’ comments do not note that the Gaynor-Town and Vogt-Town articles include examples of merger studies that show no systematic statistical relationship between concentration and price and a retrospective study that shows statistically significant price decreases.

⁷The two survey papers cover a range of empirical studies of hospital mergers or price-concentration studies and generally find mixed results and no systematic relationship between price and consolidation. For example, with regard to merger retrospectives, the results do not support a consistent finding of higher prices from all mergers (even accepting the methodologies by which estimated price effects are derived, which have been criticized). Some retrospectives show statistically significant price decreases, including a study of a merger in a highly concentrated market investigated by the FTC, which closed its investigation. See STATEMENT OF THE FEDERAL TRADE COMMISSION, F.T.C. File No. 011 0225, *Victory Memorial Hospital/Provena St. Therese Medical Center* (2004), available at http://www.ftc.gov/sites/default/files/documents/closing_letters/vista-health-acquisition-provena-st.therese-medical-center/040630ftcstatement0110225.pdf. For two retrospective studies, including one with significant price decreases, see Deborah Haas-Wilson & Christopher Garmon, *Hospital Mergers and Competitive Effects: Two Retrospective Analyses*, 18:1 INT’L J. ECON. & BUS. 17-32 (2011). Studies of price concentration examined in these survey papers also do not

do not reference the findings of these latter papers, even though they appear in the same survey papers that the Academics rely on. The Department should have a more complete and balanced view of the cited academic literature in order to put the Academics' comments in perspective. It should also be noted that the conclusions drawn in the cited academic literature are mixed, and only about "average" or general findings, not about a specific merger or this specific merger, analysis of which would require a detailed, fact-intensive and individual inquiry.

- B. Merger Benefits Including Efficiencies:** The Academics' comments also state that there is little, if any, empirical evidence of cost-savings or benefits from hospital mergers and use this purported lack of evidence to support rejection of the proposed merger.⁸ Any alleged difficulty in academic research regarding clear findings about efficiencies or quality does not mean that individual hospital mergers—including the proposed merger—will not provide significant consumer and community benefits. The Academics' comments do, in fact, note that a major empirical study demonstrated "substantial" cost savings from horizontal hospital mergers (Academic comments at 4), but they fail to state that the cited study examined mergers of the same type as the proposed merger: in-market mergers with planned consolidation of clinical services and other cost-saving approaches.⁹

The Academics' comments also fail to reference more recent articles identifying benefits from hospital mergers,¹⁰ which include an article co-authored by the Academics' comments' lead author, Leemore Dafny, discussing the attributes of "good" mergers and listing several examples of "cognizable" efficiencies as benefits from mergers.¹¹ These include several efficiencies similar to those that the Parties have identified as likely to result from the proposed merger and documented for the Department.¹² The Dafny-Lee article on "good" mergers also describes the importance of health care leaders' actions in shaping change and efficiencies:

A "good" merger or affiliation is one that increases the value of health care by reducing costs, improving outcomes, or both, thereby enabling providers to generate and respond to competition. Although regulators can sometimes stop a "bad" merger, they cannot create a good one. Which type of merger predominates as consolidation proceeds will depend on the

show systematic increases in prices. See, e.g., Asako S. Moriya, et. al, *Hospital Prices and Market Structure in the Hospital and Insurance Industries*, 5:4 HEALTH ECON., POLICY & LAW 459-479 (2010) (one of the reviewed studies which does not find a statistically significant relationship). For a summary of related studies, see also Margaret E. Guerin-Calvert, *Competitive Effects Analyses of Hospital Mergers: Are We Keeping Pace with Dynamic Healthcare Markets?*, ANTITRUST BULLETIN (2014).

⁸David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22:6 J. HEALTH ECON. 983-97 (2003).

⁹*Id.*

¹⁰See, e.g., Toby Singer, et. al, *The Pro-Competitive Benefits of Hospital Mergers*, HOSPITALS AND HEALTH NETWORKS DAILY (Sept. 25, 2012), available at <http://www.hhnmag.com/articles/5212-the-pro-competitive-benefits-of-hospital-mergers>.

¹¹The authors note "clear specification of cognizable efficiencies with explicit accountability for achievement is a key input to a "good merger." Leemore S. Dafny & Thomas H. Lee, *The Good Merger*, 372 NEW ENG. J. MED., 2077-79 (May 28, 2015), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1502338>.

¹²*Id.*

actions of the leaders of our health care institutions. The decisions they make will have enormous influence on the ability of our health care system to deliver on its promises. (Footnotes omitted)¹³

The article's finding indicate that the health system's leadership, coupled with identification of community health care needs and undertaking and implementing detailed planning, are fundamental steps for community and consumer benefits. The leadership at Wellmont and Mountain States has taken these steps, and the commitments in the Application provide for accountability and measurement by the Department.

C. Inconsistency of the Academics' Comments with Merger Enforcement: The Academics' comments are conceptual and general, not tied to evaluation of any individual merger evaluation. The most compelling evidence that the Academics' comments' selective and literature-based concerns overstate the risks of anticompetitive price increases from horizontal mergers is their inconsistency with the enforcement landscape. The vast majority of hospital mergers reviewed by the federal antitrust agencies are approved, including many involving hospitals in concentrated markets.¹⁴ In fact, only a small portion of hospital mergers that receive intensive antitrust scrutiny are challenged.¹⁵ A recent empirical review of FTC second request transactions, which include those receiving intensive scrutiny, demonstrated that the majority of hospital mergers with second requests were approved, and many appear to have involved efficiency benefits.¹⁶

D. Rate Caps, Commitments, and Regulation: Rate caps and related contractual commitments substantially mitigate concerns about anticompetitive pricing in this proposed merger. The Academics' comments challenge whether the proposed rate cap methodology can emulate the effect of competition and keep rates of price growth reasonable. They claim that rate regulation and caps are susceptible to regulatory evasion and not adaptable to changes in health care payment models or to entities (e.g., payers) that are newly contracting with the Parties. They assert further that the

¹³The authors go on to articulate the importance of accountability and public commitments: "Higher-value health care will not result from good intentions alone; translating this ideal into reality takes vision, planning, and resolve. . . . Making these goals explicit not only helps stakeholders and regulators to assess the merits of a proposed deal, but it also creates public commitments that can facilitate the execution of those plans after the merger occurs." *Id.*

¹⁴Table 4, Darren Tucker, *A Survey of Evidence Leading to Second Requests at the FTC*, 78 ANTITRUST L.J. 591 (2013).

¹⁵According to a former Chairman of the FTC, less than 2 percent of all reviewed mergers were challenged, and many transactions subject to intensive scrutiny were not challenged. See Jon Leibowitz, Chairman, Fed. Trade Comm'n, Remarks at the Antitrust in Healthcare Conference, *Are Titanic Health Care Costs Sinking Us? What the FTC is Doing to Keep Patients Afloat* (May 3, 2012), available at <http://www.ftc.gov/speeches/leibowitz/120503antitrusthealthcare.pdf> ("Let me pause here lest you get the impression that we never see a hospital merger we like. These are rough numbers, but according to public sources, 2007 to 2011 witnessed approximately 333 hospital mergers nationwide. About one third of those, approximately 111, were reported to the FTC under Hart-Scott-Rodino. Of those, approximately one tenth triggered Second Requests. We challenged only four in court – less than two percent of all hospital mergers over the last five years.")

¹⁶See Table 4, Darren Tucker, *A Survey of Evidence Leading to Second Requests at the FTC*, 78 ANTITRUST L.J. 591 (2013); see also Margaret E. Guerin-Calvert & Jen Maki, CTR. HEALTHCARE ECON. & POLICY, "Hospital Realignment: Mergers Offer Significant Patient and Community Benefits" (2014), available at <http://www.fticonsulting.com/~media/Files/us-files/insights/reports/hospital-realignment-mergers-offer-significant-patient-and-community-benefits.pdf>.

Parties' commitments are complex and not enforceable.¹⁷ These comments are addressed elsewhere in the Parties responses in more detail. The Academics' views on the workability and value of the form of rate caps and the commitments appear to be general or based on selected consent decrees. They are inconsistent with economists' reports on preferred forms of rate caps in other COPA contexts that address the types of regulatory evasion and complexity raised by the Academics' comments.¹⁸ They do not appear to be based on any systematic review of the specific commitments that the Parties have made. The Academics' comments also ignore the important benefits to employers and payers of low and predictable rates of price growth.

For these reasons, the Department should not give any weight to the Academics' comments in its consideration of the proposed merger and its expected benefits. The Academics do not dispute that the region suffers from significant health care needs that are not currently being adequately addressed and that require more effective use of resources. The merger offers cost savings, efficiencies and investments in needed facilities, including specific enforceable commitments totaling \$450 million over ten years, to respond to these needs in accordance with the State of Tennessee's express objectives as stated in the Hospital Cooperation Act. The Academics offer no specific alternatives that would provide similar benefits to an area with these significant health care needs.¹⁹

¹⁷For example, the Academics' comments note: "We are also concerned about the enforceability of the Applicants' commitments. These concerns have both conceptual and practical bases. As an example of the former, consider the Applicants' promises to fund community investments through cost reductions. Assessing whether post-merger cost reductions are in fact being used for this purpose requires well-accepted, relevant, and comprehensive measures of cost. However, such measures do not exist." (Academic comments at 6). This is incorrect. It is not necessary for the Department to have cost measures in order to verify that the Parties have honored commitments to expend certain dollar amounts of commitments on specific programs. There are clear commitments and accountability measures, and no need to link each expenditure and commitment back to comprehensive cost measures. Questions and concerns regarding the Partners consent decree, including the court's opinion in that case about enforceability of commitments, are inapt. That matter involved a consent decree and not a COPA and did not involve application of a state public policy objective to displace competition with mergers that provide substantial benefits to a region with significant needs. The proposed rate caps were much more complex in that case, as were the commitments. In this case, the funding commitments are readily observable and enforceable, as is the rate cap.

¹⁸Cory S. Capps, "Revisiting the Certificate of Public Advantage Agreement Between the State of North Carolina and Mission Health System, A Review of the Analysis of Dr. Greg Vistnes, with Additional Recommendations for Lessening Opportunities for Regulatory Evasion by Mission Health," at Section III (May 2011); Greg Vistnes, "An Economic Analysis of the Certificate of Public Advantage (COPA) Agreement Between the State of North Carolina and Mission Health," 18-19 (February 10, 2011).

¹⁹The Academics also raise concerns about the difficulty in measuring performance and the ability of the Department to monitor performance. (Academic comments at 2) In this regard, the Academics ignore the various submissions by the Parties on performance measurement and the actual oversight and supervision that the Department will conduct.

VI. RESPONSE BY APPLICANTS

TO SUBMISSION OF

KENNETH KIZER, M.D., MPH, AND

A. Introduction.

Dr. Kizer's "Independent Assessment" of the proposed merger consists merely of unsupported opinions and citations with little relevance to the proposed merger, representing another attempt by staff to generate opposition from individuals who are neither qualified as experts to comment on local health economic conditions or have chosen to ignore the critical health care needs of the area. Dr. Kizer simply recites staff's unfounded opinions without any facts in support, cites broad studies pulled from public sources such as the internet that have no application to the specific circumstances of the proposed merger, and speculates about the merger, but offers little independent assessment. Unlike other experts who have opined in favor of the merger,¹ Dr. Kizer has never even spoken with the Parties about the Application. Dr. Kizer admits he has conducted only a limited review of information relevant to the Parties' proposal, focusing mostly on the one-sided staff "draft" submission to the Department and staff's submission in Virginia. Dr. Kizer's comments make only limited reference to the detailed submissions made by the Parties, which specifically describe the programs the Parties will initiate if the merger is approved, including \$450 million in increased spending to benefit the region.

Like staff and other critics, Dr. Kizer does not comment on the potential harm an out-of-market acquisition would pose to the region in the way of higher pricing, elimination of services or hospitals, or loss of local governance. He does not comment on the impact that population stagnation combined with reduced inpatient utilization will have, particularly given the region has the second lowest Area Wage Index in the nation (and thus, among the lowest Medicare and Medicaid Reimbursement rates). And he does not comment on how the combination of these factors with an out-of-market entity absorbing at least \$1.4 billion in debt will affect the acquiring entity's pricing models. With decreased projected utilization, substantial cost of duplication and downward pressure on Medicare and Medicaid rates, remarkably, Dr. Kizer does not comment on the need of an acquiring system to create incremental new revenue to deal with these market realities. Ignoring these facts does not make them go away.

Instead of dealing with these financial and utilization facts, Dr. Kizer focuses on alternatives which involve loose affiliations. He references these loose affiliations but does not substantiate any savings he suggests they might generate. In fact, no independent study provides evidence these affiliations have generated even a fraction of the synergies equivalent to the \$450 million that the merger will generate and reinvest in the community or the \$110 million in annual savings. Had Dr. Kizer reviewed more of the extensive information that the Applicants provided to the State, he would have at least been able to measure the independently validated savings the proposed merger will generate against the imagined savings he suggests *might* occur under a loose affiliation.

¹The Southwest Virginia Health Authority engaged experts with knowledge of national health care trends and who also had familiarity with Southwest Virginia and Northeast Tennessee. Dr. E. Richard Brownlee, the Dale S. Coenen Professor Emeritus of Business Administration at the University of Virginia Darden School of Business, stated that he had entered the assignment as a consultant for the Authority with a perspective that generally favors market dynamics over regulation. But, he added that, four decades-plus experience as a business school professor helped him understand that, as he put it, "there were not many pure markets where competition could occur as described in the textbooks". After meeting with the Parties, reviewing the evidence, and participating in discussions related to the commitments, Dr. Brownlee strongly favored the proposed Cooperative Agreement in Virginia.

Not only do Dr. Kizer's comments ignore the well-developed record, but they also grossly distort the record with respect to cultural integration between the systems. Again, had Dr. Kizer reviewed more of the evidence in the record, he would have known the Applicants engaged expert consultants on the issue of cultural integration. As more fully described below, the systems are very compatible culturally, evidence of which has been provided to the State.

Nowhere is Dr. Kizer's distortion more troubling than in the manner in which he misrepresents the editorial of Dr. Dale Sargent, the Medical Director of Hospitalist Programs for Wellmont.² Dr. Kizer cites the editorial to demonstrate cultural incompatibility, selectively quoting only the following very brief excerpt: "Our cultures are incompatible. We could never bury the hatchet." Tellingly, Dr. Kizer omits the remainder of Dr. Sargent's editorial which states:

The board had one other option, the local option, Mountain States Health Alliance. "Anyone but MSHA!" many said at the start of the process. "MSHA and WHS have been battling one another since the two health systems formed. Our cultures are incompatible. We could never bury the hatchet. What about their debt? Besides, the regulatory hurdles will be too daunting."

Great leaders know how to tune out static and find opportunity. Mountain States proposed, not an acquisition, but the dissolution of both systems with the formation of a new organization that will incorporate the strengths of both. After suspending their skepticism, the Wellmont and Mountain States boards worked through a detailed analysis and came to the conclusion that not only is forming a new organization viable, but it is the obvious choice for the future of health care in our region.³

Dr. Sargent then lists the significant benefits to the region from the merger, which Dr. Kizer largely ignores or dismisses:

1. Wellmont and Mountain States spend tens of millions of dollars yearly in duplication of (nonclinical) support services. A combined system will realize huge savings in these areas.
2. The operational savings will be used to support badly needed but unprofitable services such as mental health and drug abuse treatment and access to rural hospitals.
3. A combined system will invest in its existing workforce with improved wages and benefits and expanded training opportunities.
4. A combined system will leverage the clinical and information technology expertise of both to develop care processes that incorporate best practices.
5. A combined system will invest in new high-end services that require significant capital and the recruitment of top talent.

²Dale Sargent, *It's Up To Us: We Alone Can Seize Opportunities For Region's Health Care*, BRISTOL HERALD COURIER, Nov. 8, 2015, available at https://swvahealthauthority.files.wordpress.com/2016/09/41-bristol-herald-courier-it_s-up-to-us-we-alone-can-seize-opportunities-for-region_s-health-care.pdf. Staff also engage in the same gross distortion of Dr. Sargent's editorial, which calls into question their credibility as well.

³*Id.*

6. A combined system, in partnership with East Tennessee State University and several regional osteopathic medical schools, can support expanded medical education.
7. A combined system will use the energy and innovation formerly spent fostering competition to engage with its communities and measurably improve community health.

Dr. Sargent concisely and accurately summarizes the critical importance of this merger to the community, including the fact that no one else will provide these much-needed benefits to the area:

The merger is a once-in-a-generation opportunity for our region to assure that our health care is financially sustainable, clinically excellent, up-to-date and innovative, as well as provides access and needed services for all. If our region doesn't fight for and seize this opportunity, no one else will do it for us.

Dr. Sargent's perspective is entitled to substantially more weight than the unsupported opinions of Dr. Kizer. Dr. Sargent has practiced medicine in this area for 31 years, and continues to do so now, and has served as Chief of Staff for Bristol Regional Medical Center and Chief Medical Officer of Wellmont Health System. He also attended high school and college in this area. As a practicing physician, he sees firsthand the pressing health care needs of this area, including the recent death of a 31-year-old mother of four due to drug abuse and the lack of inpatient psychiatric care and mental health facilities in the area, a shortage that is especially acute in rural communities.⁴ He has conducted and published research on initiatives to achieve efficiencies and improvements in care at hospitals in the GSA.⁵ Additionally, Dr. Sargent is serving on the Integration Council and Clinical Council Functional Team using his extensive and firsthand knowledge to try to improve the health care needs of the region, which Dr. Kizer, staff and other critics largely ignore.

While Dr. Kizer references in passing the significant health care challenges facing the region (rural and other underserved communities with "higher than average rates of substance abuse, teen pregnancy, low birth weight babies, chronic illness, illiteracy, and unemployment, among other problems"⁶ (Kizer comments at 7)), he does not propose any viable solutions to these problems. Instead, he attacks the comprehensive and detailed solutions the Parties offer.

⁴Dr. Sargent's curriculum vitae is attached as Exhibit VI.A. See also Press Release, Wellmont Newsroom, Dr. Dale Sargent returns to bedside as hospitalist at Lonesome Pine (Feb. 22, 2011) ("One of the region's most respected physicians, who most recently served as Wellmont Health System's chief medical officer, has returned to the bedside as a hospitalist at Lonesome Pine Hospital.").

⁵Dale Sargent et. al, *Reducing health care delivery costs using clinical paths: A case study on improving hospital profitability*, 21:3 J. HEALTH CARE FIN. 18-54 (1995).

⁶These problems have been well-documented in the Parties' submissions, including, in addition to the above, high rates of obesity and a large percentage of children living in poverty. Other issues of concern are the lack of primary physicians in certain areas, as evidenced by the large percentage of hospital patients who do not have a primary care physician when admitted and do not have one to oversee their care when discharged. Other areas which the Parties intend to address are enforceable standards of care developed by a physician led Clinical Council based on best practices for issues such as treatment of sepsis, opioid over-prescribing, blood utilization, and antibiotic overuse. Finally, a Common Clinical IT platform will minimize fragmentation and duplication of care by providing a complete record of the patient's history, including recent MRIs, CT scans, X-rays, and lab results. (Application for COPA, State of Tennessee, at 36-37).

His criticisms are based on only the most general studies or observations about hospital mergers, many of which are dated.⁷ Dr. Kizer's opinions are based on generalities without close investigation of the specific facts and conditions of this merger, the communities and their needs, or what the realistic alternatives would provide compared to the accountability and commitments that will be part of the COPA. In particular, Dr. Kizer ignores the financial challenges hospitals face in a region with a large percentage of Medicare, Medicaid, underinsured and uninsured patients.

Dr. Kizer challenges both the likelihood and magnitude of the benefits to be gained by creating a fully integrated delivery system that aligns all services across the New Health System, asserting that it will only provide for "a greater mass of much the same range of services." (Kizer comments at 9) He has not assessed (1) the specific services offered by either Party, (2) the plans to combine, realign, and add new services or (3) any of the specific sources of savings. Indeed, Dr. Kizer provides no evidence supporting his claim that the New Health System will provide "a greater mass of much of the same range of services." He ignores the Parties' commitment to provide new addiction treatment services, expanded pediatric specialties, and expanded community based mental health services. He also ignores the fact that integrated health systems are better suited for assumption of risk-based arrangements and the mounting evidence that integrated health systems are better positioned to deliver on the promise of value-based care.

Dr. Kizer also rejects the benefit of the Parties consolidating their trauma units on a single campus, supported by continued emergency and related care in the other facility that currently offers trauma services. As discussed below, the Parties' analysis of potential gains from a consolidated unit is very conservative and consistent with industry standards. Dr. Kizer dismisses these benefits by reference to an academic debate over findings with regard to volumes. (Kizer comments at 19) He fails, however, to address any of the substantial literature that documents efficiency gains from in-market consolidation and realignment of facilities or clinical services.⁸

Dr. Kizer questions the financial viability and benefits of the merger, noting: "Another recently published study that specifically assessed rural hospital mergers found that mergers 'may not improve bottom-line profitability.'" (Kizer comments at 22) However, this same study states that mergers and acquisitions are, **for rural hospitals, "a viable option for maintaining the hospital and the access to care it provides."**⁹ His assessment does not specifically assess the financial implications of the proposed merger. He blindly relies on broad studies, selectively provides information from the studies, and ignores the actual facts and evidence that have been provided to the State.

Contrary to Dr. Kizer's assertions (Kizer comments at 8), the Parties have specifically quantified the savings to be achieved and have set out specific details on how they will be achieved. (Application at 82-84) This information is based on detailed analyses undertaken by

⁷This literature is not relevant given results from more current studies and findings on the modern health care market. LR Burns & MV Pauly, *Integrated Delivery Networks: A Detour On The Road To Integrated Patient Care?*, 21:4 HEALTH AFF. 128-141 (2002).

⁸See, e.g., David Dranove & Richard Lindrooth, *Hospital Consolidation and Costs: Another Look at the Evidence*, 22:6 J. HEALTH ECON. 983-997 (2003).

⁹MJ Noles et. al, *Rural Hospital Mergers and Acquisitions: Which hospitals are being acquired and how are they performing afterward*, 60:6 J. HEALTHCARE MGMT. 395-407 (2015) (emphasis added).

an independent, nationally recognized health care consulting firm which has been provided to the State as evidence. Also, contrary to Dr. Kizer's comments (Kizer comments at 8), the Parties have provided specific details about exactly how funds will be utilized. The Parties have provided details about the need for, among other things, additional outpatient mental health access, residential addiction treatment, expanded access for pediatric services, and investments into expanded research and academic training. (Application at 49-56) In each of these areas, the Parties have articulated the need to engage with the State and with local entities to develop specific objectives to be funded, and the Parties will invest in alignment with the State's objectives.¹⁰

In reviewing Dr. Kizer's commentary about a common EHR, it is difficult to conclude exactly what his opinion is. In his previous role with the Veterans Administration, he advocated for spending more than \$1 billion taxpayer dollars for an EHR, making significant claims about the benefits. Now, he seems to question the benefits, even suggesting a common EHR is costly and may deliver limited benefit. Dr. Kizer then questions the Parties' abilities to implement a common EHR, which he is not qualified to do given that he has no firsthand knowledge of the Parties' expertise in creating or deploying IT systems. Had he merely made a single inquiry, he would have found that Wellmont has been recognized as having among the most successful deployments of the Epic Health Information System.

Dr. Kizer's suggestion that MSHA and Wellmont are seeking to merge "based on the belief that increased size will better position the New Health System to deal with the new health care payment models" (Kizer comments at 7) is false and misleading. The Parties have been very public with the reasoning for the proposed merger. As the Parties have shared with the Department, current inpatient hospital use rates in the region are approximately 126/1,000. There has been overall negative population growth in the service area over the last five years, and the projected growth over the next five years is flat to one percent. The projected inpatient hospital use rates in the region suggest that use rates will decline to between 90/1,000 and 110/1,000. Based on these demographics, the region is expected to see a decline in admissions ranging from 19,000 to 41,000 in the next five to seven years. The combination of the region's declining population and use rates and the poor economy, along with the fact that the region has the second lowest Medicare Wage Index in the United States, create an impetus to rationally consolidate the inpatient capacity in the region.

Dr. Kizer's overly broad statement that the combined health system will be the "overwhelmingly dominant" health care provider in the region relies exclusively on false and speculative statements in staff's papers. This statement fails to reflect that the combined new health system will have significantly smaller market share than its competitors in several outpatient services and (with the exception of a small handful) have less than a majority of the market share for most physician specialties. (Application at 26-27)

Finally and tellingly as discussed below, Dr. Kizer is very critical of programs the Parties have proposed, even though Dr. Kizer has himself proposed and strongly advocated for these

¹⁰Dr. Kizer states the Parties will have to achieve merger related savings of at least \$45 million per year to meet the \$450 million spending commitments. (Kizer comments at 8) He is correct, and in fact, the merger related savings are approximately \$110 million annually. This has been affirmed by an independent consultant and provided to the State.

same programs. He provides no explanation why this region should be deprived of the benefits of programs that he has specifically endorsed.

B. References To Non-merger Collaborations Are Inapposite.

Dr. Kizer cites to a number of non-merger collaborations in an attempt to argue that a merger is not needed. (Kizer comments at 9) However, the characteristics of those alliances are very different than the proposed merger. For example, none of those alliances appears to involve direct competitors. This is relevant because Dr. Kizer does not state that the FTC or another antitrust agency would permit the Parties to coordinate on contracting for specialists, sharing of competitively sensitive information, allocation of capacity and services or any of the financial and clinical integration that would be necessary for non-merger collaboration. Because the Parties' facilities are in the same geographic region, unlike the alliances Dr. Kizer references, the cited examples are not applicable. Additionally, none of the examples Dr. Kizer cites took place in a region sharing the same challenges as this region such as declining populations, depressed economies, high percentage of Medicare, Medicaid and uninsured and underinsured patients and significant health care challenges. For instance, reimbursement is significantly higher in each of those regions than in applicant's region, as the Area Wage Indexes are higher. Further, none of the collaborations that Dr. Kizer mentions is generating \$110 million in annual synergies or committing \$450 million to improve health care in economically depressed areas with significant health care challenges.

Dr. Kizer provides only a brief and high-level description of these alliances. He relies heavily on a handful of articles and websites, and his opinions are not based on in-depth research or personal experience with in-market mergers. Many of his examples and comments are based on a single, non-academic article, "3 Ways Hospitals Can Collaborate Without Merging."¹¹

The types of alliances in Dr. Kizer's examples would not allow the Parties to sufficiently address the financial, medical, and community needs of the region. Dr. Kizer asserts a non-merger alliance is a viable alternative to the proposed merger for achieving most if not all of the claimed benefits, including improved population health; realignment of the health care delivery system; coordination and integration of care; and improved efficiency, quality and outcomes. However, even cursory examination of Dr. Kizer's specific examples demonstrates that they are far different from the proposed merger and do not offer these benefits. They largely include arrangements that enable smaller hospitals to achieve greater purchasing power when negotiating with suppliers through approaches like formation of new GPO-related organizations. Moreover, they are often formed by hospitals that are not direct competitors and do not involve the kind of clinical, financial and operational integration contemplated by this merger. In fact, as discussed

¹¹Dr. Kizer's discussion of Granite Health, BJC Collaborative, and Trivergent relies mainly on one article. (Kizer comments at 11-3) (*citing* Lola Butcher, *3 Ways Hospitals Can Collaborate Without Merging*, HOSPITALS & HEALTH NETWORKS (July 19, 2016), *available at* <http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/>. For Advanced Health Collaborative, he relies on a single source. (Kizer comments at 13-4) (*citing* Press Release, Advanced Health Collaborative, Five Maryland-Based Health Systems Come Together to Form "Advanced Health Collaborative," (February 24, 2015) *available at* <http://www.ahcmaryland.org/press-release/>. For Stratus Healthcare, he relies on one article, from which he directly extracts language without quotes, that is not cited in his paper. (Kizer comments at 14) (*citing* AMERICAN HOSPITAL ASSOCIATION, *Stratus Healthcare Integrated Network: Keeping Health Care Local across Georgia*, *available at* <http://www.aha.org/content/15/Stratus%20Case%20Example.pdf>.

below, one of the articles cited by Dr. Kizer specifically states that the Parties to an affiliation had to abandon consideration of consolidation of facilities and strategies due to antitrust concerns.

It is very clear that out-of-market acquisitions of the systems would not generate the synergies resulting from elimination of duplicative services within the market. To the contrary, Wellmont and Mountain States would be driven to reduce local jobs and would continue offering duplicative services, with no incentive for either system to reduce unnecessary utilization. Dr. Kizer does not mention that when out-of-market acquisitions occur, the synergies from such acquisitions benefit the acquiring out-of-market entity, and not the local market.¹²

1. The Parties' Relationships With Vanderbilt Are Not Applicable And Provide A Different Set Of Benefits, Unrelated To The Goals Of The Proposed Merger.

A local clinically integrated network between the New Health System and the local physicians, with robust sharing of data, provides a much more meaningful platform than a Vanderbilt affiliation for taking full risk, identifying opportunities in partnership with payers to reduce cost drivers and measuring improvement in the health of the local population. Certainly, the Parties will seek to collaborate with Vanderbilt where possible, but Vanderbilt is located four and one-half hours away, and there would be little synergy that would generate the size and magnitude of what the local merger will generate. Vanderbilt and the Parties do not share the same patient population, other than referrals for quaternary services not provided locally. The referral relationships and possible clinical collaborations with Vanderbilt are very different than the concept of creating \$110 million in synergies through the merger to invest in sustaining local hospitals, and no arrangement with Vanderbilt would result in \$450 million of investment in the community.¹³

Dr. Kizer's claims also lack merit because he has no firsthand knowledge of the Parties' relationships with Vanderbilt.¹⁴ His commentary, which relies exclusively on press releases and news articles, is unwarranted and uninformed. Mountain States' involvement with Vanderbilt does not provide any synergies locally, and the local physicians are not part of the relationship.

2. References To Other Collaborations Are Similarly Inapplicable.

Dr. Kizer references a number of other collaborations, but does not cite any actual synergies from these alliances—certainly nothing equivalent to the \$110 million annually that

¹²Note that Wellmont came to a carefully considered conclusion about the potential for an out of market acquisition as an alternative. Upon reviewing the proposals, Wellmont understood that out of market candidates were surprised by the unique health care challenges of the region and by how efficiently Wellmont was already being managed.

¹³The Vanderbilt Health Network, at the moment, is merely a statewide contracting network, which is something Mountain States has chosen not to participate in as anything more than a messenger model. The Vanderbilt Health Network is also a means by which participating hospitals would acquire health coverage for their employees – again something Mountain States has not found beneficial at this time. While the vision of the Vanderbilt Health Network is to provide information and data, because there is little cross utilization, there is also little utility for those services locally.

¹⁴Additionally, Dr. Kizer states that Wellmont has achieved cost savings through a purchasing collaboration with Vanderbilt. As Dr. Kizer has not spoken with Wellmont about the Application, he has no basis for this opinion, nor is he qualified to represent the purchasing savings Wellmont may or may not have achieved. His opinion on this is pure speculation.

the proposed merger will generate. The other collaborations that Dr. Kizer cites also did not result in any specific benefits similar to the detailed commitments that the Parties have made, including expanded pediatric access and investment in drug treatment and mental health facilities. These partnerships appear to be limited to joint purchasing, sharing of some data, evaluating utilization improvements (such as analyzing utilization data on MRI for lower back pain), developing tools for asthma, addressing common issues like government relations and some other opportunities that do not raise antitrust concerns.

Dr. Kizer says Granite Health is now “offering more coordinated care with improved patient outcomes at a lower cost,” but he provides no evidence of improved outcomes or this lower cost, or the magnitude of cost savings. (Kizer comments at 12) Moreover, Granite Health’s collaboration is much less integrated than what the Parties intend to accomplish through this merger: the hospitals are noted to have “distinct” geographic markets and do not consider themselves competitors.¹⁵ The participants themselves acknowledge the inherent risk in an informal partnership, stating: “At its core, the GHN partnership is a handshake relationship among five individuals, so any partner could walk away from the relationship. That’s sort of an ongoing risk that we have.”¹⁶

Many aspects of Granite Health’s collaborative efforts are distinguishable from the proposed merger, or any health care delivery system merger. The services involved tend to be purchasing rather than care delivery, and the facilities do not have a joint EHR system.¹⁷ The partnership is designed to increase purchasing power, contracting for reference lab services (saving \$5 million over 5 years) and combining purchasing on a data analytics software provider.¹⁸ The Granite Health facilities also share an employee benefits provider.¹⁹ While this collaboration may provide for cost-savings, the benefits are categorically different than the critical, population health–focused benefits of the proposed merger.

The BJC Collaborative example is also irrelevant because those hospitals are not located in the same geographic areas and collaborate on issues that do not raise antitrust issues such as emergency preparedness, government relations and data analytics. Dr. Kizer says that “instead of taking on risk contracts, the collaborative has worked to develop the foundational skills and

¹⁵Granite Healthcare Network has a goal to drive down costs while increasing quality of care, N.H. BUS. REV. (June 3, 2011), available at <http://www.nhbr.com/June-3-2011/Granite-Healthcare-Network-has-a-goal-to-drive-down-costs-while-increasing-quality-of-care/>.

¹⁶Lola Butcher, HEALTHCARE FIN. MGMT. ASSOC., *Making Decisions Across Health System Lines: The Granite Approach*, (March 1, 2013), available at http://www.hfma.org/Leadership/Archives/2013/Spring_2013/Making_Decisions_Across_Health_System_Lines__The_Granite_Approach/.

¹⁷“3 Ways Hospitals Can Collaborate Without Merging,” HOSPITALS & HEALTH NETWORKS (July 19, 2016), available at <http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/>.

¹⁸M. Stempniak, *Five Hospitals Innovate Through Collaboration*, HOSPITALS & HEALTH NETWORKS (May 16, 2012), available at <http://www.hhnmag.com/articles/5440-five-hospitals-innovate-through-collaboration>.

¹⁹The articles make it clear that the organizational form of GHN is quite different from a fully integrated health care delivery system. For example: “When a GHN initiative requires it, a limited liability corporation (LLC) with its own formal governance is established for that purpose. For example, the medical malpractice insurance company is its own LLC. GHN operations are managed by Rowe and a growing staff that includes data analysts, a medical director responsible for population health management initiatives, and a director of government affairs and communications. Overhead expenses are prorated based on the relative size of the five partners.” Lola Butcher, HEALTHCARE FIN. MGMT. ASSOC., *Making Decisions Across Health System Lines: The Granite Approach* (March 1, 2013), available at http://www.hfma.org/Leadership/Archives/2013/Spring_2013/Making_Decisions_Across_Health_System_Lines__The_Granite_Approach/.

capabilities needed to manage the total cost of care for a patient population in eight operational areas, including revenue cycle management, emergency preparedness, telehealth, and government relations.” (Kizer comments at 12-13) These are skills that do not involve integration, alignment of risk or the ability to take increasing financial risk for the population.

The Parties believe the proposed merger makes moving toward risk-based relationships with payers possible, which is a compelling benefit for the State of Tennessee. Dr. Kizer’s statement indicates he believes a non-merger collaboration cannot engage in risk-based arrangements, which supports the Parties’ assertion that a merger will more likely and more rapidly achieve needed progress in the realm of risk-based contracting. With a single balance sheet and aligned financials across the entire system, the Parties will be in a better position to take risk.

The Modern Healthcare article that Dr. Kizer cites also reveals key differences between the BJC Collaborative and the proposed merger. The article notes that the systems are “in adjacent regions but are not competitors,” and “instead of sharing capital [they] plan to take advantage of their joint purchasing power.”²⁰ The systems are “not planning to form their own GPO, but aim to extract savings by aligning their purchases, such as setting standards for products or coordinating times for buys.”²¹ Additionally, the BJC Collaborative participants do not plan to form accountable care organizations or negotiate joint contracts with payers. The president of the BJC Collaborative specifically notes: “We’re really focused on the expense side of the organization, and to be more specific, we’re focused on the non-labor expense side.”²² Any clinical integration this collaborative plans to achieve is very limited.²³

Dr. Kizer states that the Trivergent collaboration in Maryland had a goal of saving \$40 million over three years, but he does not indicate whether the collaboration achieved its goal or whether savings were sought from arrangements for joint purchasing versus integration of health care delivery systems. Dr. Kizer references “significant” savings for Trivergent in the purchase of antibiotics, but he does not provide any detail regarding the savings. However, the article acknowledges that the hospitals’ independence does create some inefficiencies: for example, when the hospitals combined for a pharmacy initiative, each hospital needed its own approvals, committee meetings, and formulary changes.²⁴ Antitrust concerns also limited what initiatives the hospitals were willing to undertake:

²⁰Beth Kutscher, *Bang without the buck?*, MODERN HEALTHCARE (October 27, 2012), available at <http://www.modernhealthcare.com/article/20121027/magazine/310279960>.

²¹*Id.*

²²*Id.*

²³*3 Ways Hospitals Can Collaborate Without Merging*, HOSPITALS & HEALTH NETWORKS (July 19, 2016), available at <http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/>.

²⁴For example, Trivergent formed a central pharmacy and therapeutics committee made up of physicians, pharmacists and other clinicians from each hospital. The committee has screened nearly 4,000 drugs to date to start creating a common drug formulary for all three hospitals. ‘But each hospital is still independent, so that means each medical staff has to approve any changes to its drug formulary,’ Grahe says. ‘So the corporate director for pharmacy travels to the three hospitals, goes to their medical executive committees and presents the proposed changes to the formularies.’ *3 Ways Hospitals Can Collaborate Without Merging*, *Hospitals & Health Networks*, (July 19, 2016), available at <http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/>.

The members of Trivergent Health Alliance created a work team to focus on urgent care facilities and strategy, but it was disbanded. **The antitrust attorney felt that urgent care did not lend itself to the kind of collaboration we were looking at and thought we could run afoul of some of the antitrust laws.**²⁵

Dr. Kizer also references a state planning grant Trivergent received to plan for population health management, but he ignores the fact that the Parties will spend at least \$85 million to recruit faculty and invest in research, much of which the Parties expect to be seed money for seeking matching grants. (Application at 68-69) The \$75 million committed by the Parties for population health can also be used to attract matching grants. Dr. Kizer does not challenge the New Health System's potential for attracting such significant outside investment.

In 2015, Trivergent joined with four independent health systems to form Advanced Health Collaborative to "share ideas and explore opportunities," but Dr. Kizer does not identify a single dollar in synergies or a single resulting improvement in quality from this collaborative.²⁶ (Kizer comments at 13) The collaborative's clinical initiatives were poorly defined from the outset and not mandated as part of the members' agreement: "AHC initiatives could involve collaborations on population health and care coordination programs, and could include cost savings through shared population health and care coordination resources or services."²⁷

The Stratus Healthcare example involves 13 health systems from central and south Georgia, and unlike the Parties to the proposed merger, the members of Stratus Healthcare do not appear to have the same patient population or the same geography. The Stratus Healthcare collaboration started as a "non-equity partnership," suggesting that the alliance did not involve financial commitments or engagement.²⁸ Expansions into clinical integration and population health efforts have been limited largely to information sharing and collaborating on population data analysis.²⁹

Notably, Dr. Kizer does not reference the successful Certificates of Public Advantage where the data demonstrates lower costs and higher value for the combined health systems. Mission Health, operating under a COPA in Asheville, has been held up as one of the best health systems for high value care in the nation and is consistently among the top 15 health systems nationwide, with facilities among the top 100 hospitals in the nation, according to Truven Analytics. Further, according to the State of North Carolina, Mission Health has lower pricing and costs than its peers throughout North Carolina.

²⁵3 *Ways Hospitals Can Collaborate Without Merging*, HOSPITALS & HEALTH NETWORKS (July 19, 2016), (emphasis added), available at <http://www.granitehealth.org/news/2016/07/19/hospitals-health-networks-3-ways-hospitals-can-collaborate-without-merging/>.

²⁶Both this Collaborative and the Trivergent collaborations are in Maryland which operates the nation's only all-payer hospital rate regulation system.

²⁷News Release, Advanced Health Collaborative, Five Maryland-Based Health Systems Come Together to Form "Advanced Health Collaborative" (February 24, 2015), available at <http://www.ahcmmaryland.org/press-release/>.

²⁸AMERICAN HOSPITAL ASSOCIATION, *Stratus Healthcare Integrated Network: Keeping Health Care Local across Georgia*, available at <http://www.aha.org/content/15/Stratus%20Case%20Example.pdf>.

²⁹*Id.*

C. The Claimed Benefits Resulting From The Merger Are Substantiated.

In connection with the proposed merger, the Parties have substantiated \$110 million of annual savings and committed to an average of almost \$50 million per year to benefit the community.³⁰ By Dr. Kizer's own recognition, the Parties are spending up to \$150 million on a common IT platform; spending \$140 million on expanded access to needed services, such as a residential addiction treatment facility, outpatient mental health services, and pediatric access expansion; investing \$75 million in improving population health; and committing \$85 million to health professional training and research and academics. (Kizer comments at 8) The Parties have committed to collaborate with the State to establish priorities they will be measured against. Foundations or other entities that are not fully aligned and incentivized to provide the most high-value health care cannot achieve these financial benefits. The Parties have also committed to increase their charity care beyond what either Party currently provides and take other specific steps to benefit needy patients. (Response to Questions Submitted April 22, 2016)

While the Parties acknowledge Dr. Kizer's service as CEO of the Veteran's Affairs ("VA") health care systems and the difficulties he purports to have faced in consolidating and reallocating services, the Parties respectfully question whether Dr. Kizer's experience is applicable to the proposed merger. The Parties cannot speak to the difficulties Dr. Kizer describes in his responsibility for handling consolidation and reallocation processes, although the Parties do note that Dr. Kizer also states that he successfully merged 52 individual hospitals into 25 medical centers at the VA, which undercuts his claims about the difficulties of consolidation or the lack of need for consolidation. (Kizer comments at 25)

The Parties' leadership is highly trained and experienced and has already made difficult decisions related to consolidation and reallocation.³¹ Even a cursory inquiry would have revealed to Dr. Kizer that both Parties have experience of this nature, independently closing service lines and, in one case, a hospital. Dr. Kizer has no firsthand knowledge of steps the Parties have already taken independently, and he is not qualified to challenge this merger based on his incomparable experience at the VA, which is not a local health care system with shared geography and a shared culture.

The proposed Alignment Policy provides that the Parties will conduct a comprehensive review before any consolidation, including consolidation of the two Level I trauma centers. While the Parties have not made any decision with respect to the trauma centers, reconfiguring trauma in the region to more effectively balance needs with resources would make sense. There are only six Level I trauma centers in Tennessee, and two of them, Johnson City Medical Center and Holston Valley, are in the Geographic Service Area 15 miles apart. Of the State's six trauma centers, these two have the lowest volume: even combined, the volumes of the two centers would only rank third in the State. In each of the other four regions where Level I trauma centers exist,

³⁰Like the FTC, Dr. Kizer states that he only considered benefits that could be achieved solely by the merger and not by other means. (Kizer comments at 10) As discussed above, this is not the appropriate standard under Tennessee law.

³¹Mountain States Health Alliance closed the Obstetrics Unit at Sycamore Shoals Hospital, and consolidated the services with the new Franklin Woods Community Hospital in Johnson City. Wellmont closed Lee Regional Medical Center. Mountain States closed surgical services at Unicoi County Memorial Hospital and consolidated services with hospitals in Johnson City, TN.

there is also a pediatric trauma center. In this region, there are two Level I trauma centers, a Level II trauma center, and no pediatric trauma center.

There is significant evidence that higher-volume trauma centers lead to better outcomes. (Application at 45, n. 40) Based on long-standing consensus in peer-reviewed literature, the State's well-informed policy is to reduce duplication of trauma services and ensure appropriate geographic distribution to best serve the population. Dr. Kizer questions the correlation between volume and outcomes, referring to studies supporting that concept as "older literature." However, studies as recent as 2013 appear to validate that higher volumes equate to better quality.³² There is not enough data to challenge this longstanding thesis about trauma, and, until the data proves otherwise, the Parties will continue to agree with the State of Tennessee higher volumes will lead to better outcomes. (Application at 40, n.36)

Dr. Kizer recognizes that the Parties plan to reallocate and expand pediatric and behavioral health services, but he criticizes the Parties for not providing specific plans for operationalizing these goals. Dr. Kizer's comments ignore the fact that antitrust laws prevent the Parties from agreeing to specific plans prior to approval of the Application. The Parties are committed to pediatric specialty centers and emergency rooms in Bristol and Kingsport and to recruitment of pediatric specialties based on need, as well as creating new capacity for residential addiction treatment and expanding mental health access in partnership with local resources. (Application at 5, 56 & 87)

D. The Merger Will Result In Improved Quality.

Dr. Kizer states that the merger is unlikely to improve quality, but he fails to offer evidence to support his conclusory statement. Even after the merger, the parties will face significant competition for inpatient and outpatient services and outmigration to other health systems in Asheville and Knoxville, to smaller community hospitals in Southwest Virginia, and to Roanoke, Virginia and systems where large academic medical centers have substantial resources. (Application at 22) Because patients are mobile and have access to information, and because there are significant high-quality competitors within driving distance, the New Health System will continue to compete based on quality. The Parties have established top-decile performance as the objective so that the New Health System can remain competitive. To this end, the Parties have committed to invest resources and clinical expertise to align care with the goal of reducing variation and improving quality. The Parties have also committed to unprecedented transparency in quality measures, which, along with the investments the Parties have committed to, is an enforceable commitment that the Parties cannot make absent the merger.

Combining transparency with reimbursement incentives tied to quality is proven to improve hospital performance, as supported by several studies. For example, a New England Journal of Medicine study found that financial incentives "are capable of catalyzing quality-improvement efforts among hospitals already engaged in public reporting."³³ The study goes on

³²JJ Tepas et. al, *High-volume trauma centers have better outcomes treating traumatic brain injury*, 74:1 J. TRAUMA & ACUTE CARE SURGERY 143-7 (Jan. 2013).

³³Peter Lindenauer et. al, *Public Reporting and Pay for Performance in Hospital Quality Improvement*, 356 N. ENG. J. MED. 486, 494 (2007), available at <http://www.nejm.org/doi/full/10.1056/NEJMsa064964#t=article>.

to note that “participants across the entire spectrum (of hospitals) responded similarly, perhaps equally motivated by the desire to avoid financial penalties.”³⁴ The merger will allow the Parties to collectively align their quality goals with the quality goals that nearly all payers are establishing. The New Health System will have the ability to move the needle on quality of care for the region using data available through a common EHR, strategies deployed by a physician-led Clinical Council directly linked to the New Health System’s Quality Committee, and deployment of quality initiatives applicable to the entire combined patient population. Specifically, the New Health System will devote significant resources to eliminating clinical variation (through the use of the EHR’s common data and order sets) and promoting regional standardization in physician-developed care plans in partnership with the New Health System’s clinically integrated network. Dr. Kizer should have considered these commitments, which the Parties included in the Application and in subsequent filings with the Department.

Dr. Kizer says: “The parties suggest that quality of care will improve because a higher volume of services will be provided.” (Kizer comments at 17) This is not accurate and is a misrepresentation of the Parties’ public comments. The Parties’ argument that higher volume in trauma centers will result in higher quality, while true, should not be conflated to mean the entire system will produce higher quality as a result of higher volumes. Quality, generally, will improve as a result of critical mass in combination with a Common Clinical IT Platform, a physician-led Clinical Council to reduce variation and local governance focused on outcomes and enhanced reporting of quality and performance metrics. All of these mechanisms will be on full display for payers who are incentivizing (or penalizing) the New Health System based on quality measures.³⁵ (Application at 37-42)

Dr. Kizer himself has advocated for the same quality-of-care principles that the Parties intend to implement with the merger-generated savings:

In conclusion, the reengineering of the Veterans Health Administration appears to have resulted in dramatic improvements in the quality of care provided to veterans. Many of the principles adopted by the VA in its quality-improvement projects, including an emphasis on the use of information technology, performance measurement and reporting, realigned payment policies, and integration of services to achieve high-quality, effective, and timely care, have recently been recommended for the health care system as a whole by the Institute of Medicine. Our findings suggest that initiatives based on these principles may substantially improve the quality of care.³⁶

As noted above, Dr. Kizer acknowledges that re-engineering the VA system, which resulted in dramatically improving quality of care, reducing per capita expenditures by more than

³⁴*Id.* at 494.

³⁵It has been difficult for either system, alone, to enter into full risk based arrangements that blend quality with price. Mountain States attempted this with its own insurance plan, but Wellmont, as a competitor, never participated as a provider in the plan. As a result, Mountain States closed the insurance plan. The intent of the insurance plan was to gain enough critical mass to use incentive based payment to drive quality. The plan simply did not work because it could not generate the number of lives necessary.

³⁶Ashisha Jha et. al, *Effect of the Transformation of the Veteran Affairs HealthCare System on the Quality of Care*, 348 N. ENG. J. MED. 2218-27 (2003).

25 percent and reducing operating costs by almost a billion dollars per year, included *merging* some 52 individual hospitals into 25 two- or three-campus medical centers. (Kizer comments at 25) Thus, Dr. Kizer’s own experience substantiates that mergers can generate significant savings and dramatically improve quality of care.

Importantly, Dr. Kizer does not dispute that the Parties’ commitments to the Common Clinical IT Platform and increased transparency on quality measures will improve quality. In fact, Dr. Kizer has advocated that the VA should implement measures like this to restore trust in VA health care. Specifically, Dr. Kizer has stated that focusing and reporting on certain important quality metrics is a “good start that will improve with use and would help to hold the VA accountable for results.”³⁷ Dr. Kizer advocates for “performance-reporting initiatives” and “making performance data broadly available” because “[t]ransparency may expose vulnerabilities, but it is easier to improve when weaknesses are publicly acknowledged.”³⁸ Likewise, Dr. Kizer stresses the importance of a “new access strategy that draws on modern information and advanced communications technologies to facilitate caregiver-patient connectivity and that uses personalized care plans to address patients’ individual access needs and preferences.”³⁹ These are exactly the quality improvement measures the New Health System plans to undertake.

One of the major projects of Dr. Kizer’s organization, the Institute for Population Health Improvement, is collecting and disseminating patient safety and quality improvement data from California hospitals “with the endpoint of improving patient safety and quality outcome measures for California hospitals and patients.”⁴⁰ The project is part of a Medi-Cal Quality Improvement Program that is employing population health initiatives throughout the state to improve California’s Medicaid program.⁴¹ The program’s annual report emphasizes focus on the health needs of the population, not just the underlying socioeconomic determinants of health. For example, the program works to implement tobacco cessation⁴² and acknowledges that creating an obesity program is important for health promotion and disease prevention.⁴³ The report stresses the importance of health care systems in improving population health:

³⁷Kenneth Kizer & Ashisha Jha, *Restoring Trust in VA Health Care*, 371 N. ENG. J. MED. 295, 297 (2014), available at <http://www.nejm.org/doi/full/10.1056/NEJMp1406852#t=article>.

³⁸*Id.* at 297.

³⁹Kenneth Kizer and Ashisha Jha, *Restoring Trust in VA Health Care*, 371 N. ENG. J. MED. 295-97 (July 24, 2014).

⁴⁰Moreover, one of the major projects of Dr. Kizer’s organization, the Institute for Population Health Improvement, is to collect and disseminate patient safety and quality improvement data from California hospitals “with the endpoint of improving patient safety and quality outcome measures for California hospitals and patients.” INST. FOR POPULATION HEALTH IMPROVEMENT, UC DAVIS HEALTH SYSTEM, *IPHI partners with the Hospital Quality Institute to support quality improvement and patient safety activities*, available at <http://www.ucdmc.ucdavis.edu/iphi/Programs/HQI/index.html>.

⁴¹UC DAVIS HEALTH SYSTEM, *MEDI-CAL QUALITY IMPROVEMENT PROGRAM*, Oct. 1, 2013 - Sept. 30, 2014, <https://www.ucdmc.ucdavis.edu/iphi/Programs/MediCal/index.html>.

⁴²Desiree Backman, & Kenneth Kizer, INST. FOR POPULATION HEALTH IMPROVEMENT, UC DAVIS HEALTH SYSTEM, *Medi-Cal Quality Improvement Program: Third Annual Report to the California Department of Health Care Services*, at 32 (December 2014), available at https://www.ucdmc.ucdavis.edu/iphi/Programs/MediCal/resources/2014-Annual-Report_Medi-Cal-QuIP.pdf.

⁴³“As part of DHCS’ commitment to deliver high-quality care, an assessment was conducted in 2012 to inventory all Departmental quality improvement (QI) efforts in the areas of clinical care, health promotion and disease prevention, and administration. Although a wide variety of QI activities was reported in the areas of clinical care and administration, little activity

There is a need to create a stronger bridge between health care and public health to transform our disease management, sick care system, into a true health care system that addresses population health. This is especially critical given that merely four modifiable health behaviors—lack of physical activity, poor nutrition, tobacco use, and excessive alcohol consumption—are responsible for much of the illness, suffering, and early death related to chronic disease.⁴⁴

The Parties plan the same focus on population health in this region that Dr. Kizer is undertaking in California.

In his role at the VA, Dr. Kizer made integrated care delivery and the creation of clinical networks a priority in the system's overhaul. For example, changes included the creation of twenty-two Veterans Integrated Service Networks ("VISNs"), each with an integrated delivery system⁴⁵ combining several hospitals and other medical facilities.⁴⁶ These VISNs, which Dr. Kizer promotes in his writings as a way to "reduce care fragmentation,"⁴⁷ exemplify the type of clinical, administrative and technological integration proposed in the potential merger. The Parties have proposed to do exactly what Dr. Kizer has strongly advocated for. Unfortunately, in his eagerness to support staff's opposition to the merger, Dr. Kizer ignores the specific policies he has endorsed that would benefit the residents of the region. He provides no adequate explanation as to why the region should be deprived of the benefits of better health care that are achievable through this merger.

The proposed transaction represents far more than a traditional merger of two independent organizations into a single, commonly controlled and operated health system. The Parties intend to affirmatively transform two traditional delivery systems into a single, fully integrated health care delivery system ("IDS") of hospitals, outpatient facilities, physicians and other providers in the New Health System, working collaboratively with the region's independent physicians. The New Health System IDS will be aligned to meet the needs of the

was noted in the area of health promotion and disease prevention. Most notably, there was an absence of QI activities in the areas of healthful eating, physical activity, and obesity prevention despite the high rates of overweight and obesity among children (29.6 percent), adolescents (35.2 percent), and adults (65.7 percent) enrolled in the Department's largest program, Medi-Cal. The results of the assessment provided a call to action to develop, implement, evaluate, and sustain a comprehensive obesity prevention program that links the many facets of the health care delivery system to NEOP's existing community-based efforts. At this time, unfortunately, there are no programmatic funds available for such a program." *Id.* at 215 (internal citations omitted).

⁴⁴*Id.* at 33.

⁴⁵Kenneth Kizer & R. Adams Dudley, *Extreme makeover: Transformation of the Veterans Health Care System*, 30 ANN. REV. PUBLIC HEALTH 313-39 (Apr. 2009) ("The selection of 22 VISNs was based on a judgment about the best distribution of care delivery assets matched with geographic catchment areas that had ~250,000 veteran users. The catchment areas of the VISNs were determined primarily according to prevailing patient referral patterns, the ability of each VISN to provide a continuum of primary to tertiary care with VA assets, and state or county jurisdictional boundaries. A typical VISN encompassed 7–10 VA hospitals, 25–30 ambulatory care clinics, 5–7 nursing homes, 1–2 domiciliaries, and 10–15 counseling centers.").

⁴⁶As described by Dr. Kizer, "the VISN has become the Veterans health care system's basic budgetary and management unit. It provides a structural imperative for pooling and aligning resources to meet local needs, coordinating services, reducing service duplication and administrative redundancies, improving the consistency and predictability of receiving high-quality care, and, overall, optimizing health care value. The VISN is designed to promote both vertical and 'virtual' integration." Kenneth Kizer et. al, *Reinventing VA health care: systematizing quality improvement and quality innovation*, 38:6 (Supp. 1) MEDICAL CARE 1-11(2000).

⁴⁷Kenneth Kizer & R. Adams Dudley, *Extreme makeover: Transformation of the Veterans Health Care System*, 30 ANN. REV. PUBLIC HEALTH 313-39 (Apr. 2009).

full population of the Geographic Service Area in the most effective and appropriate location of care, with the requisite investments and financial commitments by the New Health System. Achieving IDS goals of enhanced value involves coordination across the health care delivery system on best location of care, care closer to home and approaches that rely on enhanced IT investments and platforms and their integration, strong physician leadership and clinical alignment around health, outcomes, access and quality. The New Health System will be accountable, both clinically and fiscally, for the clinical outcomes and health status of the population it serves, and its commitments and plans involve systems both to manage and improve these initiatives. The New Health System's IDS will be fully aligned, complementary to and supportive of community health initiatives that will be funded in large part by the New Health System.

The New Health System IDS will replace the largely fragmented health care delivery system in the Geographic Service Area. The IDS will operate based on proven approaches to care systems and embedded protocols, through clinically aligned networks and a common EHR system that enable independent physicians and other providers to actively participate in and benefit from the New Health System's investments and infrastructure. The New Health System will improve the efficiency and effectiveness of care and operations by combining facilities and resources. The Parties' efforts to combine will focus on clinical consolidation, realignment and re-purposing resources that maintain or enhance services at reduced costs with improved quality. The new IDS provides the platform through which the New Health System will work with payers to align incentives and initiatives. Independent physicians and providers will also have access to the system and its benefits. Newly developed leadership, clinical council, investments, infrastructure and quality initiatives will further facilitate enhanced partnerships with payers on risk-based and value-based initiatives to serve common interests of improved outcomes and savings.

The New Health System's specific plans for its IDS share the attributes of successful IDSs, including some operating in largely rural communities with similar significant health challenges and diverse populations. One such IDS is Geisinger Health System.⁴⁸ Extensive studies of IDSs, including studies commissioned by the Commonwealth Fund, indicate there is no one-size-fits-all model for "ideal" integrated health delivery.⁴⁹ Yet, based on these and other studies, successful IDSs share several key characteristics:

⁴⁸Geisinger Health System is often referenced as an example of a successful IDN operating in a largely rural environment. See, for example, Douglas McCarthy and Kimberly Mueller; Organizing the U.S. Health Care Delivery System for High Performance; July 2009, which includes a comprehensive review of Geisinger Health System's IDN. Geisinger shares some of the same geography and health challenges as Ballad Health. It is described as: "A nonprofit, physician-led integrated health system serving an area with 2.6 million people in 43 counties of rural northeastern and central Pennsylvania through three acute/tertiary/quaternary hospitals and an alcohol/chemical dependency treatment center; a multispecialty group practice employing more than 740 physicians; 50 practice sites including 40 community practice clinics; the 220,000-member Geisinger Health Plan, which offers group, individual, and Medicare coverage and contracts with more than 18,000 independent providers including 90 hospitals; the Geisinger Center for Health Research; and medical education programs. Annual patient volume exceeds 40,000 inpatient discharges and 1.5 million outpatient visits." For further discussion on the Geisinger Health System IDN and its programs and environment, also D. McCarthy, K. Mueller, and J. Wrenn, Geisinger Health System: Achieving the Potential of System Integration Through Innovation, Leadership, Measurement, and Incentives, The Commonwealth Fund, June 2009.

⁴⁹The Commonwealth Fund commissioned studies of 15 integrated systems, results show diversity of organizational arrangements accomplishing re-alignment of health care, and the importance of health system led initiatives. Several involve very

- They provide patient-centered care and involve significant financial and clinical accountability by the lead organization.
- They frequently involve common ownership and control of hospitals and other facilities.
- They involve clinical integration and re-alignment.
- They are supported by EHR, other IT platforms and shared data and systems that support the IDS, independent physicians and patients.
- They have clinical support, particularly in terms of strong physician leadership and communication.
- They use evidenced-based population health medicine.
- They involve initiatives to motivate and change patient behavior.

A particularly important feature is the fiscal and clinical accountability of the IDS to the population it serves and the clinical resources it manages. Ownership, rather than contract between otherwise independent entities, may be the most effective way to achieve this accountability.⁵⁰ The New Health System's IDS shares these attributes. Moreover, the New Health System's specific plans and the commitments made to the State reinforce each of these important IDS attributes and hold the Parties accountable to the State, the community and especially to the residents of the area.

close integration and control by health systems, some with health plans and others without. The Commonwealth Fund study divided IDNs into 4 models, the first of which involved fully integrated health systems with health plans (e.g., Kaiser), and the second involved fully integrated health systems without plans. See Anthony Shih et. al, COMM'N ON A HIGH PERFORMANCE HEALTH SYSTEM, THE COMMONWEALTH FUND, *Organizing the U.S. Health Care Delivery System for High Performance*, 4-8 (August 2008) ("THE COMMONWEALTH FUND").

⁵⁰Specifically, the Commonwealth Fund Commission on a High Performance Health System identified six attributes: (1) Clinically relevant patient data are available to all providers at the point of care through electronic health record systems (2) Patient care is coordinated among multiple provider and transition of care is actively managed, (3) Providers have accountability to each other, review each other's work, and collaborate to reliably deliver high quality, high value care, (4) Patient access to appropriate care and information is easy, with multiple points of entry to the system, (5) Clear accountability exists for the total care of the patient, and (6) the System is continuously innovating and learning to improve quality, value and patients' experience. THE COMMONWEALTH FUND at 9-15. Ballad Health's planned IDN includes each of these 6 attributes, which are also strongly reinforced by commitments to the State or to the community. Other authors have studied IDNs with similar findings. Alain Enthoven's attributes of a successful IDN include: shared value and goals with physician leadership and accountability, patient-centered and population health focus that provides multiple points of access to care, inclusion of patients in health care decision-making, and resources directed at improving health care in the population or community served, coordination of care and sharing of information across providers, financial incentives aligned with delivering high quality, affordable care among providers, deploying evidence-based best practices to minimize quality shortfalls and variations in care, accessible and shared electronic medical records among providers to enable tracking each patient through the provision of care, performance review, and status of health problems across provider panels, ability to "right-size" capacity, and continuous innovation and learning to improve value. Alain C. Enthoven, , *Integrated Delivery Systems: The Cure for Fragmentation*, AM. J. MANAGED CARE 284, 285 (2009). The National Public Health and Hospital Institute (NPHHI) recognizes these same attributes of success. See NPHHI, Literature Review, Integrated Health Care." See also WA. ST. HOSP. ASS'N, GOVERNING BD. MAN., Chapter 11 at 3 (2006); Federico Lega, *Organizational Design for Health Integrated Delivery Systems: Theory and Practice*, SCIENCE DIRECT, HEALTH POLICY, 258-79 (2007) ("provides or aims to provide a coordinated continuum of services to a defined population and are willing to be held clinically and fiscally accountable for the outcomes and the health status of the population served."); Keith D. Moore& Dean C. Coddington, *Multiple Paths to Integrated Health Care*, HEALTHCARE FIN. MGMT., (December 2009) ("...uses corporate structure, strategic alliances, governance, management approaches, culture, financial practices, clinical information systems, and other tools to facilitate and insure delivery of this type of care.").

E. The Merger Will Improve Population Health.

Dr. Kizer ignores the fact that without the synergies from the merger, the systems would not have the financial wherewithal to spend incrementally on community and population health beyond current efforts. Nor does he consider that realignment of care into an integrated delivery system supported by a common IT platform and a physician-led Clinical Council is a key element in achieving critical population health goals. Keeping sustainable and financially sound care delivery systems in place is critical to population health, as is the ability to partner with payers across a larger population to meaningfully share in risk.

As revenue pressure increases and costs continue to rise, the resources that Wellmont and Mountain States can devote to population health programs and community health improvement will diminish. For example, prior to the announcement of the proposed merger, both systems had already independently begun efforts to reduce the number of residency slots they were funding. As projected volumes decline, the more than \$19 million in rural hospital operating losses that the health systems are already absorbing are likely to worsen. The systems will have to make choices—like the decision to eliminate residencies—about what services to eliminate or close. Absent savings from the merger and a commitment to fund these initiatives as outlined in the Application, there is no certainty about future funding.

To develop the proposed population health programs, which are one of the merger's most important features, the Parties carefully examined state and nationally reported health data for the region, reviewed the Tennessee State Health Plan, the Virginia Department of Health Plan for Well-Being, the Southwest Virginia Health Authority Blueprint. The Parties also contracted with ETSU School of Public Health to conduct multiple community-based listening sessions on local health priorities using the World Café model and organized subject matter experts into four Community Work Groups to identify key health priorities and promising solutions for health in the region. These four Work Groups held numerous town hall meetings throughout the region focused on four issues: Mental Health and Addiction; Healthy Children and Families; Population Health and Healthy Communities; and Research and Academics. Representatives of the Parties attended the meetings, which also included business and community leaders from throughout the region and master's and doctoral level students from ETSU. (Application at 50-51) The Application includes the charters and membership lists of each Work Group and their extensive schedule of public meetings. (Application Exs. 8.2A, 8.2B, 8.3) The Parties jointly funded this effort, which was specifically in connection with proposed merger and would not have been undertaken otherwise.

Dr. Kizer did not review the Tennessee and Southwest Virginia responses delivered post-Applications, which provide significant additional detail on the areas of focus, potential solutions and measurement of population health improvement, clinical integration and other initiatives. He also fails to recognize the role of the Index Advisory Group, which will provide comment and suggestions on key areas of population health investment and measurement. The Advisory Group recently presented the Parties with a draft of the Index, which was substantially similar to the material initially provided to the Department.

The areas of focus for the region will be determined in consultation with the State before the COPA is approved, so the initial work between the New Health System and ETSU on the

Community Health Improvement Plan (“CHIP”) will be to match local needs, capacity and interest with promising strategies in order to create detailed implementation plans using merger-generated savings. The New Health System and ETSU will collaborate closely with the State throughout the process. The achievement of each commitment will be subject to active supervision and will be reviewed regularly. Changes to the CHIP will be made with the State’s input as needs change, or programs fail or succeed. The CHIP and its anticipated programs (to reduce tobacco use, obesity rates, physical inactivity, drug poisoning deaths and neonatal abstinence syndrome) are described in detail in the Parties’ post-Application submissions. (Addendum No. 1 to the Application, submitted March 16, 2016 at 7-8; July 13, 2016 Submission at 13 and Exs. 21 & 22)

The New Health System and ETSU will develop the CHIP in the context of a larger Accountable Care Community effort, which will involve decision makers from government (public health, schools, law enforcement, housing), business, faith-communities and others working on the broad regional issues of economic development, education and health. (Application at 50-51) The New Health System has committed to funding and helping to lead this effort, and executives of the New Health System have prior successful involvement and leadership experience with similar collaborative efforts elsewhere.

Contrary to Dr. Kizer’s assertion, this commitment goes well beyond the minimal requirements of the typical Community Health Needs Assessment (“CHNA”), including the IRS’s newly issued requirements. First, the scale is substantially different. Should the COPA be granted, the Parties have committed to a net increase of \$75 million in aggregate over that of past community health investment for the ten year period following the creation of the New Health System. Second, the IRS continues to require hospital-by-hospital CHNAs. In rural areas, where a small local hospital losing money has little ability to influence community health, regional resources and planning are required. Third, the IRS admittedly has few resources to monitor compliance with the production of a high-quality CHNA, much less monitor the actual implementation. Partly for this reason, 23 states have more stringent requirements that non-profit hospitals demonstrate a community benefit. Virginia is among the states requiring such a demonstration, specifically as a condition for a certificate of public need approval.⁵¹ The proposed CHIP goes far beyond CHNA standards and demonstrates the Parties’ willingness to work with Tennessee and Virginia to exceed federal standards.

The community members participating in the Community Work Group town hall meetings recognized the role of social determinants in regional health, even without the prior benefit of Dr. Kizer’s perspective. Issues such as lack of education, employment and transportation are all crucial for health improvement and were cited frequently by community members.⁵² In spite of his definition of population health, Dr. Kizer takes a very narrow view of population health in a number of instances. For example, he cites only the \$75 million investment as a “population health” investment. He seems unaware of the access challenges that rural Appalachia faces and that expanded access to mental health, addiction and pediatric

⁵¹For a summary of community benefits laws by state, see THE HILLTOP INST., COMMUNITY BENEFIT STATE LAW PROFILES (through May 2016), available at http://www.hilltopinstitute.org/hcbp_cbl.cfm.

⁵²Summaries of the town hall meetings are available here, <http://becomingbettertogether.org/get-involved/apply-to-join-a-workgroup/>.

services is critical in the region to improve the overall health of the population. Individuals with behavioral issues are far less likely to be screened and treated for chronic conditions such as diabetes and hypertension, and conversely, individuals with chronic diseases are much more likely to suffer from depression. The Parties propose to invest an additional \$140 million in providing these and other critical services over the next decade. Expanding these services in the community and better integrating behavioral health in primary care are key to improving overall health.

Dr. Kizer also fails to recognize the potential for long-term population health improvements through investment in maternal health and pediatric services, which can drive improved social determinants such as education and income. Numerous studies indicate that investment in maternal and child health services has a significant future return on improved health, which in turn leads to improved education and employment attainment. In furtherance of its commitment to population health, the New Health System has committed to improving community health through investment of not less than \$75 million over ten years in science and evidence-based population health improvement. The funding may be committed to the following initiatives, as well as others as determined 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-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.
- ***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.

Dr. Kizer also fails to recognize the role that the \$85 million in increased funding for research and academics will play in improving population health. For example, this region of Appalachia is heavily impacted by the epidemic of addiction. Recruitment of research faculty funded by the investment will net returns for the region by helping the area's academic institutions compete for National Institutes of Health grants and other sources of funding for

research in this underinvested area. With the passage of the 21st Century Cures Act, \$1 billion of new investment is available in this area of research alone. The timing could not be better for the New Health System and its academic partners. To compete for these funds and others, the New Health System needs to invest in the faculty, but that investment will not be available without the synergies resulting from the merger.

With respect to recruitment and retention of physicians in this rural region, the location and design of medical school and residency programs are critical to the choice of specialty and post-residency practice sites for physicians.⁵³ It is also likely that health systems will increasingly be asked to contribute more to training their own physicians.⁵⁴ The New Health System must maintain and expand residency positions and support the local education of medical students, nurses and allied health providers to maintain local access to care for individuals often challenged by lack of transportation, child care and job flexibility. As stated previously, both health systems were in the process of eliminating dozens of residency slots prior to filing the Application. The State has a compelling interest in preventing the ongoing reductions in these slots.

The Parties agree with Dr. Kizer that the New Health System “cannot by itself fix the social and environmental problems that negatively impact health” (Kizer comments at 21), and have maintained in the Application and in meetings with the Department that they should not be held solely responsible for moving the needle on complex multifactorial health problems such as obesity. The New Health System has agreed to invest hundreds of millions of dollars and use its considerable management expertise and position in the community to ensure that the short-term and intermediate goals for each program are achieved through contracting or direct provision of services and that efforts are implemented efficiently and according to best practice.

The region has endured struggling and failed attempts in this vein, such as HEAL Appalachia which has suffered due to a lack of funding. However, the region has demonstrated it can work together across the continuum of care and across industry sectors, and leadership exists with significant experience inside and outside the health systems.⁵⁵ Sustainable investment for collaborative infrastructure is the missing piece in the region. The Parties have committed to this investment, and to the corresponding programming, but these commitments are not possible without the synergies the merger will bring and continued local governance of the health systems. Dr. Kizer makes much of his own self-described background but fails to acknowledge the significant experience and expertise of the leadership of Mountain States and Wellmont.

Finally, Dr. Kizer fails to acknowledge what is potentially the largest direct social-determinant benefit of the proposed merger: the retention of employment and income in the

⁵³ROBERT PHILLIPS ET. AL, ROBERT GRAHAM CENTER, SPECIALTY AND GEOGRAPHIC DISTRIBUTION OF PHYSICIAN WORKFORCE: WHAT INFLUENCES MEDICAL STUDENT & RESIDENT CHOICES (2009).

⁵⁴See, e.g., INST. OF MED., GRADUATE MEDICAL EDUCATION THAT MEETS THE NATION’S HEALTH NEEDS: RECOMMENDATIONS, GOALS, AND NEXT STEPS (July 2014), *available at* <https://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2014/GME/GME-REC.pdf>.

⁵⁵See Overview Response Exhibit A to the November 22, 2016 Request for Information which provides a representative list of all the experience Mountain States and Wellmont executives have with multi-stakeholder collaborative efforts.

region. The Parties have indicated that an expected 1,000 jobs would be eliminated if both systems were absorbed by larger, out-of-market systems – many more than with the proposed merger of the Parties. Most back-office and corporate functions would be eliminated locally to capitalize on synergy for the acquiring system – a system that would be absorbing almost \$1 billion of debt in the case of Mountain States or almost \$500 million of debt in the case of Wellmont. Dr. Kizer’s contention that the need for these jobs will continue to exist with two competing system in the market, even following an out-of-market acquisition, is incorrect: evidence shows that out-of-market acquisitions of health systems result in closure of corporate offices and functions locally.⁵⁶

While the proposed merger will result in synergies between the two systems as duplicative administrative functions are consolidated, the essential fact remains: the functions will remain in the community, minimizing the negative job impact. The New Health System will redirect resources resulting from these synergies to fund the commitments that themselves will create new jobs. Right-sizing corporate functions by eliminating wasteful duplication and redirecting these scarce resources to create high-wage jobs related to needed clinical and population health improvement is a compelling benefit of this proposed merger.

F. The Alleged Potential Impediments To Implementing The Merger Are Without Foundation.

In alleging several potential impediments to implementing the merger, Dr. Kizer ignores the extensive work the Parties have done in preparation. Further, his references to allegedly unsuccessful mergers (of which he does not purport to have firsthand knowledge) do not address the level of the planning that was undertaken. Dr. Kizer has no firsthand knowledge of the work that has been done relative to the proposed merger and is therefore unqualified to render an opinion.

1. The Parties Have Undertaken Substantial Merger Implementation Planning.

The Parties have created seventeen Functional Teams that have been working diligently on merger planning for more than six months, with oversight from antitrust counsel. These teams include: Clinical Council, External Affairs, Finance, Human Resources, Information Technology, Strategy, Post-acute Operations, Quality, Research and Academics, Managed Care, and Supply Chain. Each team has developed a plan for pre-merger priorities, “first 30 day” priorities and long-term priorities. The work these teams are performing is being reported to an Integration Council composed of senior executives from each system.⁵⁷ The Integration Council then reports to the Joint Board Task Force, which is composed of board members and the CEOs of each system.⁵⁸ The Joint Board Task Force will be the governing body of the New Health System upon closing.

⁵⁶See Laura Layden, *HMA informs state of possibly up to 400 layoffs*, NAPLES DAILY NEWS, Jan. 28, 2014, available at <http://archive.naplesnews.com/business/hma-informs-state-of-possibly-up-to-400-layoffs-ep-313072986-330749621.html>.

⁵⁷Application at Exhibit 10.2 (Press Release, Wellmont Health System & Mountain States Health Alliance, Wellmont Health System Mountain States Health Alliance Name Members of Integration Council, Apr. 2, 2015).

⁵⁸Application at Exhibit 10.2 (Press Release, Wellmont Health System & Mountain States Health Alliance, Wellmont Health System Mountain State Health Alliance Name Members of Joint Board Task Force, May 4, 2015).

The Parties have undertaken significant planning internally and are following a robust governance and project management structure to ensure accountability. The Joint Board Task Force has also adopted best practice governance policies, which were validated by outside experts in not-for-profit health system governance. The Joint Board Task Force has received training, and each system's board has separately engaged in training to prepare for the future. The Joint Board Task Force has appointed a Governance Committee, which has populated the committees of the New Health System board based on competencies and the experience of each committee member. (Application at Ex. 10.1)

2. Dr. Kizer Fails To Identify Any Significant Cultural Differences.

Dr. Kizer contends that cultural differences could impede the merger, but he fails to identify what those cultural differences are and merely states that it is "logical and reasonable to expect that there will be some degree of difficulty" (Kizer comments at 24) He does not identify the "degree of difficulty," and his basis for concern about cultural differences appears to be drawn from his gross distortion of Dr. Sargent's editorial, discussed above.

In fact, the Parties engaged leading consultants to conduct a governance audit and a culture audit of each organization. The culture audit revealed that there is very little difference between the cultures of the systems. Further, the Joint Board Task Force has been functional for more than one year, and the culture of the Joint Board Task Force has been exceptionally positive and strongly focused on achieving the results and promise of the merger. Dr. Kizer also ignores the extensive discussion in the Application describing the specific steps the Parties will take to align culture, including the composition of the New Health System's board, the equal representation of the systems on board committees, the physician composition of the new Clinical Council and the adoption of a Common Clinical IT Platform. (Application at 78)

Without providing evidence specific to the Parties, Dr. Kizer asserts that the merger will fail due to the inability of the system cultures to integrate: "It is well established in health care, as well as in other enterprises, that difficulty in integrating and unifying disparate organizational cultures is a primary reason why mergers do not achieve their anticipated benefits and often fail." (Kizer comments at 22-23) However, the source that Dr. Kizer cites to support his argument offers a much more nuanced approach to merging cultures, providing specific recommendations to assure culture integration and noting success stories in which culture integration has been an important component of successful mergers.⁵⁹ Further, Dr. Kizer makes no mention of the culture assessments that independent, nationally recognized firms performed on the Applicants, which concluded that the cultures between the Applicants were compatible.

Dr. Kizer cites his experience as the CEO of the VA system to illustrate the difficulty in changing a culture. However, according to Dr. Kizer, the problems he encountered there were fundamental problems such as lack of accountability and the need to dramatically improve poor patient care (Kizer comments at 25). Dr. Kizer does not allege those problems exist for the Parties, and the comparison is inapplicable.⁶⁰

⁵⁹LARRY SCANLAN, HOSPITAL MERGERS - WHY THEY WORK, WHY THEY DON'T (2010).

⁶⁰Unfortunately, Dr. Kizer apparently failed to fix those fundamental problems. Within the last month, a series on WJHL, a local CBS affiliate, highlighted abuse of veterans and the lack of accountability in the system. See, e.g. Nate Morabito, *American*

3. The Parties Have Adequate Plans For Closing Or Realigning Facilities And Services.

Dr. Kizer does not take issue with the need to realign duplicative services or the cost savings that will result from such realignment. Instead, he states it is unclear how the New Health System would address the challenges in closing or consolidating facilities and services. Again, Dr. Kizer ignores the comprehensive Alignment Policy adopted by the New Health System and described in the Application, which provides for a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service and requires an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. (Application at 76-77 and Ex. 11.13) For two years after formation of the New Health System, a super majority vote of the Board will be required to consolidate a service in a way that results in discontinuation of that service in a community. (*Id.*)

4. Dr. Kizer's Alleged Problems With Consolidation Of EHR Systems Are Baseless.

Dr. Kizer falsely asserts that the Parties do not articulate why moving to a Common Clinical IT Platform is necessary. In fact, the Parties provided detailed answers to questions that the Department posed about this issue. (Response to Questions Submitted April 22, 2016, Ex. 2-Description of the Parties' Plan for Electronic Health Records Systems & Ex. 4-Timeline for Implementation of the Common Clinical IT Platform) The interoperability the Parties will achieve is consistent with current national policy, based on the widely accepted principal that decreasing clinical variation, commonality of data and ease of use by providers is critical to the improvement of quality and reduction in overall cost.

Dr. Kizer mentions that Mountain States and Wellmont each have their own EHRs and questions why the Parties cannot simply continue using their existing systems. Cerner has acquired Mountain States' Soarian system, and the system will be phased out. Mountain States will eventually need to acquire a new system, or evolve to Cerner. If Mountain States evolves to Cerner, each hospital system will have hardwired different systems for the next generation, permanently making it more complex for splitter physicians and making elimination of variation very difficult. Even if Mountain States were to acquire EPIC, which Wellmont currently uses, different EPIC systems do not necessarily communicate. If the Parties want a seamless IT system that benefits physicians and patients and lends itself to opportunities for research and standardization of care, Wellmont and Mountain States should be on the same platform. Dr. Kizer himself identifies the many benefits of a system-wide EHR based on his experience at the VA. (Kizer comments at 25)

Legion rep "horrified" by VA discipline, WSJL, Nov. 30, 2016. National stories about the VA system have exposed disgraceful treatment of its patients, up to and including reporting on deaths of patients who could not access care. *See, e.g.,* Curt Devine, *307,000 veterans may have died awaiting Veterans Affairs health care, report says*, CNN, Sept. 30, 2015. In this region, the Parties have had difficulty in getting veterans access in local hospitals due to VA policies *See* Josh Smith, *Two years after reforms, some Tri-Cities veterans still having to wait for medical care*, WJHL (Jul. 7, 2016), available at <http://wjhl.com/2016/07/07/two-years-after-reforms-some-tri-cities-veterans-still-having-to-wait-for-medical-care/>. The culture of VA cannot be compared to the culture at Wellmont and Mountain States, and is not relevant to the Application.

Dr. Kizer expresses doubt about whether the Parties could successfully deploy such a system. However, he notes that Wellmont launched its EPIC system in 2014 (Kizer comments at 26) and he does not assert that Wellmont experienced any problems in that conversion. Given that Wellmont recently executed a successful deployment, the Parties have the expertise and resources locally to handle the rollout of a system-wide Common Clinical IT Platform.⁶¹

After questioning why the Parties need a Common Clinical IT Platform, Dr. Kizer says that “there could be potential benefits to having a single EHR in the new health system.” (Kizer comments at 27) He then qualifies this statement by saying the potential benefits must be viewed with an eye toward the substantial financial and operational impacts of changing EHR systems. However, Wellmont has successfully completed a conversion, and now has the requisite experience to work with Mountain State’s legacy system should the EPIC platform be selected.

Dr. Kizer’s commentary on EHR is contradictory. He vacillates between saying there could be potential benefits and suggesting significant pitfalls (Kizer comments at 27-28), even at times questioning how a proposed Common Clinical IT Platform will materially benefit patient outcomes. He does not explain why, if he felt the benefits to patient outcomes were not material, he supported spending what appears to be more than \$1 billion of taxpayer dollars on a system for the VA. In his own comments, Dr. Kizer references his work at the VA by highlighting the largest deployment of an EHR anywhere to date, “dramatically improving quality of and access to care, reducing operating costs” (Kizer comments at 25)

Dr. Kizer’s reference to OnePartner demonstrates his lack of understanding of the difference between a hospital operating system, which helps manage patient flow, revenue, physician orders, pharmaceutical management and all the concomitant systems that ensure full capture of patient data, analytics, standardization of care, patient safety mechanisms, and discharge planning and deployment versus a regional Health Information Exchange (“HIE”), which simply permits the sharing of certain bits of data about patients. The two are entirely different. OnePartner is not designed to do physician order entry or to manage patients through the entire process of care. The Parties’ detailed plans for implementation of a Common Clinical IT Platform and the significant differences between an HIE and the Common Clinical IT Platform are described in detail in the Parties’ July 1, 2016 Submission.⁶² Dr. Kizer ignores the detailed plans and the significant differences between the Common Clinical IT Platform and an HIE described in this submission.

While the OnePartner HIE system is useful in reaching out to independent physicians, the system is limited in the data it can transmit. There is a significant difference between a regional

⁶¹Dr. Kizer uses his experience at the VA to suggest deployment could be a challenge. Given Dr. Kizer’s apparent experience, his skepticism is justified. A recent GAO report demonstrated that after at least 18 years (which covers the span of time Dr. Kizer was at the VA), and billions of dollars spent, the VA and Department of Defense still have not figured out a way to share patient files across the agencies. Benjamin Krause, *Electronic Health Records Quagmire, VA, DOD Still Can’t Share*, DISABLEDVETERANS.ORG, July 15, 2016, available at <http://www.disabledveterans.org/2016/07/15/electronic-health-record-quagmire-va-dod-share/>. In fact, a recent Commission on Care has advised Congress that the “VA should abandon its homegrown electronic health record system in favor of a commercial solution.” Aisha Chowdhry, *Commission on Care, lawmakers want commercial HER for VA*, FCW, Sept. 8, 2015, available at <https://fcw.com/articles/2016/09/08/va-commission-hearing.aspx>. In contrast to the VA, the Parties here have experience with successful conversions.

⁶²See Responses to Questions Submitted April 22, 2016, Exhibit 17 - 19.

health information exchange supported by a Common Clinical IT Platform and the current OnePartner system or any other HIE. The proposed Common Clinical IT Platform will be able to collect significantly more detailed patient information, including order entry, nurse notes and medication reconciliation, and will have additional analytical capabilities for population health management. (See Exs. 2 & 3.1 to Parties July 1, 2016 Submission)

Finally, Dr. Kizer's position seems to contradict national policy encouraging seamless IT technology and interoperability,⁶³ though he has not acknowledged any disagreement with this national policy. As pointed out, Wellmont has had a successful "big bang" conversion, and the Parties can benefit from Wellmont's experiences and related best practices.⁶⁴

5. Dr. Kizer's Commentary On Increased Academic Research And Funding Is Insensitive To The Needs Of The Region And Demeans ETSU.

Dr. Kizer does not question the importance and benefits of the Parties' commitment of at least \$85 million over ten years to develop and grow academic research opportunities, support post-graduate health care training and strengthen the pipeline and preparation of nurses and allied health professionals. Instead, he argues that the Parties have not provided sufficient detail about how the funds will be spent. However, the Parties have provided such detail in the Application (Application at 68-69), including creation of new specialty fellowship training opportunities, building an expanded research infrastructure, adding new medical and related faculty and attracting research funding (especially for translational research to address regional health improvement objectives). Further, the Parties have made clear that this commitment is in addition to what the Parties are already spending. As the Application points out, state and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private companies such as pharmaceutical companies want to know their research dollars are being appropriated to the highest-quality and resourced labs and scientists. (Application at 69) As evidence of their commitment to Academic Research and Funding in the region, the Parties convened the Research and Academics Community Work Group as one of four Community Work Groups organized in March, which had representation from the major academic institution in the region and which has for the first time begun to outline the structure and operation of a Collaborative Research Institute.⁶⁵

The Parties believe the \$85 million of investment provides the necessary seed money to create a growing research enterprise in the region. The objective is to hire faculty and develop a center that can attract research grants that can benefit the area. There is a tremendous opportunity to expand research in this region, given the vast health care disparities that exist here, and the historic underinvestment. As a combined system, there will be more than 100,000 discharges on a Common Clinical IT Platform, a physician-led Clinical Council and an academic partnership

⁶³See Press Release, U.S. Dep't of Health & Human Servs., HHS Publishes a Roadmap to Advance Health Information Sharing and Transform Care, Oct. 6, 2015, *available at* <http://www.hhs.gov/about/news/2015/10/06/hhs-publishes-roadmap-advance-health-information-sharing-and-transform-care.html>.

⁶⁴See Response #6 to November 22, 2016 Request for Information at V.B.2.

⁶⁵See Application Exhibit 8.2 Attachment A (Charters of Work Groups) & Attachment B (Members of Work Groups).

with ETSU. This will be an attractive research investment for National Institutes of Health and other sources of funding.

Dr. Kizer's self-aggrandizing comments about his own research dollars within the University of California System are simply not relevant here, nor are they called for. ETSU is not the University of California, and Dr. Kizer's remarks are quite insensitive toward the efforts to invest in research in this region. This lack of concern for the difference between California and East Tennessee reaches beyond Dr. Kizer's lack of preparation or expertise to comment on the proposed merger. Unfortunately, it evidences a condescending attitude toward this region and the Parties' efforts to improve health care here by implementing programs similar to what Dr. Kizer strongly advocates.

Apparently, Dr. Kizer believes common EHRs are good for other parts of the nation, like the VA, but not for the people in this region. He believes population health efforts should involve organized care delivery systems elsewhere, but not in this region. He makes no mention of the fact that the Area Wage Index in this region is the second lowest in the United States, while it is among the highest where he resides, meaning the difference in reimbursement for his hospitals and the Parties' hospitals is substantial. He does not recognize the economic difficulty imposed on this region due to loss of jobs and an environment where alcoholism, drug abuse and mental illness have thrived. Instead, he suggests the Parties' local efforts to address these issues through the merger are ill-contrived, without providing any evidence to support his assertions and without even having reviewed much of the supporting information to the Application. He denigrates an \$85 million investment in recruitment of faculty and retention of residencies as insignificant relative to his university in California, a comparison that is irrelevant. No new dollars will be provided in the region for investment in new research faculty without the merger, and \$85 million will be invested with the merger. This is a stark difference.

Importantly, Dr. Kizer, like the other critics, proposes no solutions to the significant health care problems in this region. As Dr. Sargent, who has practiced here for 31 years, stated in the article from which Dr. Kizer and staff misquoted:

The merger is a once-in-a-generation opportunity for the region to assure that our health care is financially sustainable, clinically excellent, up-to-date and innovative, as well as provides access and needed services for all. If our region doesn't fight for and seize this opportunity, no one will do it for us...

...There isn't an external benefactor out there that is going to ride in on a white stallion and solve our problems. If we're going to survive and thrive, it's up to us.⁶⁶

⁶⁶Dale Sargent, *It's Up To Us: We Alone Can Seize Opportunities For Region's Health Care*, BRISTOL HERALD COURIER, Nov. 8, 2015, available at https://swvahealthauthority.files.wordpress.com/2016/09/41-bristol-herald-courier-it_s-up-to-us-we-alone-can-seize-opportunities-for-region_s-health-care.pdf.

VII. RESPONSE BY APPLICANTS
TO SUBMISSION OF
HOLSTON MEDICAL GROUP

A. Introduction

The Parties agree with the premise of HMG's comments to the Department that, "if properly regulated, the new health system could benefit the geographic service area." (HMG comments at 1) As detailed in the Application, the Parties will submit to appropriate regulation by the State of Tennessee as provided for in the Hospital Cooperation Act of 1993. Despite its acknowledgement of the New Health System's "potential for significant community benefits," (HMG comments at 1) HMG, which is a direct and significant competitor of the Parties, has expressed concern with respect to regulatory oversight, quality and cost, hospital reimbursement, size of the combined system's physician (employed and affiliated) workforce and the health information exchange. None of HMG's concerns reflects a reason to deny the COPA, and the benefits of the merger outweigh any disadvantages attributable to any reduction in competition likely to result from the merger.

B. The Hospital Cooperation Act Provides For Adequate Regulatory Oversight By The State

HMG's unsupported assertion that implementation of a Cooperative Agreement will result in indirect state regulation of the entire health care delivery system and related non-health care service providers in the Geographic Service Area overstates the impact of a merger between Wellmont and Mountain States, and HMG provides no evidence to support this claim. (HMG comments at 2) While the New Health System will play an important role in creating access to and providing high-quality care for patients throughout the Geographic Service Area, other large physician groups and other service providers, including HMG, will continue to operate outside the purview of the State's regulation of the New Health System and compete with the New Health System, for example, with respect to outpatient care services. The Parties do not influence HMG's referral patterns or HMG physician utilization of HMG-owned diagnostic, lab or other outpatient services from which HMG profits.

The New Health System will also continue to compete with HMG and its peer outpatient service providers for favorable contracts with payers to provide services to residents of the Geographic Service Area. In the Application, the Parties committed that the New Health System will not block HMG or any other provider¹ from contracting with a payer by agreeing to be the exclusive network provider to that payer. (Application at 28) HMG and other outpatient providers are not subject to any such restriction, meaning that not only is the New Health System not operating as a monopoly with respect to these services, but it may have placed itself at a competitive disadvantage. Furthermore, primary care physician groups typically play a more prominent role in risk-based contracting than hospitals do, and HMG is particularly well positioned with payers given its large group of employed primary care physicians in the area and its influential role within the Qualuable Accountable Care Organization ("ACO"). Primary care physicians tend to have substantial control over patient utilization, potentially more than hospitals. It is these groups, not large health systems, like the New Health System, that tend to drive the terms of risk-based arrangements.

¹The term "provider" is used in this document to refer to both physicians and physician group facilities providing outpatient services (such as imaging or surgical procedures).

As an example of the high degree of influence HMG has over patient utilization, the Parties point to the implementation of “Extensivist” clinics by HMG and other physician groups. Such clinics are being deployed as an alternative to hospitalization, but are not currently regulated and will not be regulated under the COPA. The care site is lower cost and financially advantageous to physicians in a risk-based environment. Physicians are incentivized through their contractual arrangements with payers to reduce the use of inpatient hospitalization, or even outpatient “observation” status. Hospitals have limited influence over this model and continue to contend with the cost of duplicative inpatient and hospital capacity that is exacerbated as physicians are responding to payers' financial incentives to decrease hospitalizations. HMG has enormous market power to influence hospital utilization and to shift the location of care, and it does so. This substantial power and ability to shift patients to outpatient care will not change with the proposed merger.

Based on the significant influence that large physician groups like HMG will continue to have with patients and with payers in the event of a merger between Wellmont and Mountain States, the Parties dispute HMG’s characterization of the New Health System as a “monolithic, region-wide, monopolistic structure.” (HMG comments at 2) While the New Health System will operate the majority of inpatient beds in the Geographic Service Area, approximately 25 percent of the area residents will continue to seek inpatient services outside the New Health System, and there is and will continue to be a robust and competitive market for outpatient services. Moreover, with regard to physicians, according to the chart included in HMG’s comments, the majority of physicians in the Geographic Service Area (75%) are independent physicians and will remain so after the merger. (HMG comments at 3) HMG’s control of a large segment of the patient population along with commitments that constrain the New Health System’s competitive behavior toward physician groups will ensure that the New Health System will act competitively.

HMG correctly notes that the New Health System’s share of total physicians is low, yet asserts that there are substantial disadvantages for independent physicians because they are organized into several groups rather than a few groups that are as large as the employed New Health System’s physicians. However, no basis is provided for asserting that physician groups of 50-100 physicians in the Geographic Service Area are unable to provide outstanding care and participate actively in the delivery of care in outpatient facilities and physician offices, as well in inpatient services. In fact, many of the investments and commitments made by the New Health System are ones that benefit these physicians indirectly and their patients.

Based on unfounded concerns of a “monopolistic” New Health System, HMG recommends a “robust regulatory authority” that is “locally based, collaboratively structured, with authority to orchestrate dialogue within the [Geographic Service Area] and make enforceable decisions,” but it is not clear what kind of regulatory body HMG is proposing. (HMG comments at 2) The Parties submit that the law does not provide for delegation of the State’s regulatory authority to any other entity. However, the Parties do wish to emphasize their intent to develop a collaborative relationship with the organized and independent physician community, especially with respect to the ongoing transition to value-based purchasing that all are undertaking and also with respect to establishment of an Accountable Care Community. The Parties desire to identify health improvement priorities for the region and align incentives with physician groups so that all providers can be a part of successfully “moving the needle.” In this

regard, the New Health System will be governed by a local board, composed of a variety of business leaders from both large and small companies representing purchasers of health care in the region, independent physicians and the President of East Tennessee State University.

C. The Merger Will Not Decrease Quality, Increase Cost Or Limit Access To Value-Based Care

The Parties disagree with HMG's statement, relying wholly on the assertions by staff that the Parties contend are false, that the merger will reduce quality of care and raise costs and have the effect of preventing patients and providers, including independent physicians, from participating in innovative, value-based health care delivery models. (HMG comments at 2-3)

HMG does not present any analysis related to its concerns about price increases as a result of the merger, instead summarily citing staff's concerns and providing no detail in support. The Parties agreed in the Application to reduce existing commercial contracted rate increases by 50 percent in the first contract year following the first full year after the formation of the New Health System and to cap increases to negotiated reimbursement rates in subsequent years. (Application at 46-47) HMG's comments do not address why it believes the proposed price controls are inadequate.

Additionally, HMG does not compare the likely pricing effects of the merger with the impact that one or both of the Parties undergoing an out-of-market merger would have on pricing. One recent study found that net reimbursement rates at hospitals on average "increase by about 17 percent after joining an out-of-market hospital system with some specifications suggesting even larger effects."² While this study did not assess pricing effects of in-market mergers, its findings indicate that if Wellmont or Mountain States were to merge with a health system in another market, that merger could result in significant price increases. FTC officials have commented publicly, "We also hear growing concern that provider consolidation in non-overlapping product or geographic markets may lead to higher prices."³

When considering the pricing effects of the Parties' merger, it is a mistake to use the status quo as a baseline for comparison, as HMG seems to, because if the Parties do not merge, one or both will likely be acquired by an out-of-market system. Acquisition by an out-of-area system is less likely to achieve the substantial efficiencies from the in-market combination of Wellmont and Mountain States, and as a result will not provide the synergies that fund investments and activities, including electronic medical records, technology and other programs that will benefit the community as well as independent physicians who will have the benefit of access to and use of these tools for their own and their patients' benefit. There may be upward pressure on costs and hence pricing from continued duplication and likely reduced inpatient

²Matthew S. Lewis & Kevin E. Pflum, *Hospital Systems and Bargaining Power: Evidence from Out-of-Market Acquisitions*, RAND J. ECON. (forthcoming August 13, 2016), available at <http://www.johnsoncitypress.com/.media/5/2016/12/09/66a04d6f-d97f-4aef-837e-e8712ca2806e.pdf>.

³Chairwoman Edith Ramirez, Retrospectives at the FTC: Promoting an Antitrust Agenda, ABA Retrospective Analysis of Agency Determinations in Merger Transactions Symposium (June 28, 2013), transcript available at: https://www.ftc.gov/sites/default/files/documents/public_statements/retrospectives-ftc-promoting-antitrust-agenda/130628aba-antitrust.pdf.

utilization across the two health systems absent this merger. The likely impact on pricing from an out-of-market merger is the relevant comparison to the pricing effect of the proposed merger.

With respect to quality, two compelling drivers reinforce the Parties' mission-driven commitment to providing high-quality care: transparency and reimbursement impact. In the Application, the Parties committed that the New Health System will publicly report its performance on a broad array of quality measures. (Application at 110, Table 11.12) Between the New Health System's unique reporting under the Application and existing quality reporting by the Centers for Medicare and Medicaid Services ("CMS"), patients will easily be able to tell how well the New Health System is performing against its own commitments and against other health systems in the region. This broad and deep transparency will create a layer of accountability to ensure that quality does not slip. Additionally, reimbursement incentives and penalties tied to a host of quality measures, from care process to readmissions, now play a major role in driving quality for all providers, including hospitals. The federal government's commitment to alternative payment models, and the increasing implementation of these models by commercial payers, serves as evidence that reimbursement incentives drive quality.

HMG provides no compelling evidence or logic to support the claim that hospitals with a high share or that obtain increased share from a merger have relatively lower quality. There are numerous examples of hospitals and health systems that receive high rankings by, e.g., U.S. News and World Report as a Top 100 hospital, by other well-regarded organizations that award quality and by CMS on various quality measures. Sole community providers can be high-quality hospitals. Relatively low share is not a predictor of higher quality. In fact, the Parties have provided evidence to support that Mission Health's recognition as one of the highest-value health systems in the nation, multiple-year recognition as one of the top 100 hospitals in America by Truven Health Analytics and recognition as one of the top 15 health systems in the nation by Truven Health Analytics, implies that after 20 years operating as a merged system under a COPA, quality was, in fact, not impaired. HMG's argument here amounts to nothing more than second-guessing of Tennessee's sovereign policy to supplant competition with regulation for qualified health care mergers and should be ignored.

The Parties have demonstrated their commitment to providing high-quality care in the Geographic Service Area by committing to spend \$75 million on population health and invest \$140 million in expanded community-based mental health and addiction recovery services, pediatric specialties and other ways for patients to access care. (Application at 4-5) The Parties understand that access to services beyond traditional medical care has a direct impact on overall quality and patient outcomes, and through the Parties' commitments tied to the merger, the merger will directly improve quality by increasing patient access across the continuum of care and across the region.

The Parties also disagree with the implication that the merger will limit patients' and providers' opportunities to participate in innovative value-based payment models. Because physicians, and in particular primary care physicians, play an integral role in the care patients seek and referrals for that care, alternative payment models are largely structured around physicians rather than hospitals. The emphasis on physicians in the transition to value-based payment means that large physician groups, including HMG, will have ample opportunity to participate in, and involve their patients in, innovative reimbursement models regardless of

whether the merger between the Parties occurs. As an example, because risk-based contracts and Medicare's Shared Savings Programs are based on patient attribution to physicians, the success or failure of an ACO (including physician-owned Qualuable and Mountain States-owned Anewcare) depends upon which organized group physicians choose to join.

D. Hospital-Specific Reimbursement Rates Are Irrelevant To Consideration Of The Merger

HMG presents the flawed proposal that “the delta between the hospital-based reimbursement model and the independent reimbursement models should serve as one of the benchmarks for success of the merger.” (HMG comments at 3) This suggestion is baseless, and, in any case, it is infeasible because the Parties do not control hospital reimbursement policy set by CMS or commercial payers. HMG appears to seek policy changes that are completely independent of the merger, and also fails to note that the Parties' overall reimbursement rates will be regulated to increase at reasonable rates. Furthermore, HMG fails to consider the policy reasons for higher hospital reimbursement rates, including the obligation unique to hospitals to provide care for Medicaid beneficiaries and the uninsured. HMG is not required to see patients who are on Medicaid or uninsured, while hospitals are. For these reasons, the Parties contend that HMG's comments with respect to hospital reimbursement are without merit.

E. The Merger Will Not Advantage New Health System Physicians Or Harm Professionalism

HMG incorrectly asserts that New Health System's 737 employed physicians would constitute a single giant medical group with “cost efficiencies, internal referral patterns, marketing power and other benefits that the remainder of the physician community could never match.” (HMG comments at 4) This view dramatically oversimplifies the relationships among hospital-employed physicians, who function cohesively within their specialties but not as a unified multi-specialty group. Furthermore, HMG ignores the differences between “hospital-based” physicians (such as emergency room physicians), primary care physicians in less rural communities, specialists in higher acuity specialties and primary care physicians and specialists in rural communities. It is misleading to “lump” physicians in all of these categories into one number in order to suggest there is market power that does not, in fact, exist. Even so, the vast majority of physicians are independent and the size of individual groups is not a meaningful indicator of market power.⁴ In the health care marketplace, primary care physicians are uniquely positioned to influence patient flow and service utilization. The majority of primary care physicians in the Geographic Service Area today are independent, and the majority of primary care physicians will be independent after the merger.⁵ The same is true of physicians in nearly all specialties, with only limited exceptions, and even in these specialties there are competing physicians.⁶

⁴We note as well that any alleged exercise of market power in terms of increased rates is constrained by the rate cap commitments on physicians.

⁵See Responses to Questions Submitted April 22, 2016, at Updated Exhibit 6.1E (July 25, 2016), available at http://tn.gov/assets/entities/health/attachments/WHS-MSHA_April_22,_2016_Response_2.pdf.

⁶*Id.*

The Parties do not believe that the size of the New Health System creates an inappropriate advantage for its employed physicians, but have nevertheless stated in the Application that they expect the New Health System to employ 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.”⁷ The Parties have committed to prioritize recruitment into existing independent medical practices, as opposed to using employment models, with the exception being underserved areas where employment is the only reasonable way to ensure the needs of the community are met. Limiting its own physician recruitment and assisting independent physician groups with recruitment places the New Health System at a disadvantage with respect to the development of value-based payment arrangements with payers. Even if the New Health System’s size created a competitive advantage for its physicians (which, as previously stated, the Parties strenuously contend that it does not), the New Health System’s willingness to interact with the independent physician community in a way that disadvantages its own physician practice negates any such advantage.

HMG’s unsupported assertion that the Parties’ merger “will inflict irreparable damage to independent professionalism in exchange for corporate efficiencies” is also misguided. (HMG comments at 4) First, while the Parties respect the corporate practice of medicine doctrine and its role in Tennessee’s health care delivery system, the State has determined that hospital employment of physicians is beneficial enough for Tennessee’s residents to merit a statutory exception.⁸ HMG’s belief that “there are too many exceptions to [the corporate practice of medicine doctrine’s] strictures” is irrelevant and unsupported. (HMG comments at 4)

Second, HMG’s conception of “independent professionalism” is subjective, and the Parties believe physicians currently employed by Wellmont and Mountain States would take issue with the assertion that because they are employed by a hospital owned by non-physicians, they are somehow compromised in their professionalism. HMG offers no support for its statement that hospital employment of physicians, which the State of Tennessee has determined merits an exception to the otherwise-observed corporate practice of medicine doctrine, “undermines the physician-patient relationship by imposing non-physician corporate governance over the responsibilities of highly trained professionals.” (HMG comments at 4) Additionally, HMG does not examine the ways in which the Parties’ independent medical staffs assure that physicians’ judgment in professional matters operates free from corporate interference.

Finally, HMG ignores the fact that virtually all of the physicians who would be employed by the New Health System are already employed by Wellmont or Mountain States. HMG fails to articulate why employment by the New Health System would be any different or more harmful than these physicians’ current employment arrangements with regional health systems. There is no basis in HMG’s comments for concluding that changing the upstream corporate parent of these physicians’ current corporate employers would result in “irreparable damage to independent professionalism.”

⁷Application at 44.

⁸Tenn. Code Ann. § 63-6-204(f)(1).

F. The Merger Would Allow The Parties To More Fully Engage In HIE Through A Common Clinical IT Platform

The Parties are dedicated to sharing data and advancing patient care, patient experience and lower cost through population health management methods and interoperability best practices. This objective will be a guiding principle for the New Health System and will be realized by deploying a system-wide Common Clinical IT Platform with fully integrated population health management tools, analytics and interoperability relationships once the merger is complete.

The health information exchange OnePartner is a for-profit entity owned by HMG and its physician owners, which casts doubt on HMG's motives for asserting that "robust and complete participation by the New Health System in OnePartner [is] a lynch-pin in supporting the continued existence and success of independent physicians and other outpatient service providers." (HMG comments at 4) The Parties agree that the free exchange of health information is critical to providing high-quality health care across the Geographic Service Area, which is why the Parties committed in the Application that the New Health System will "participate meaningfully in a health information exchange open to community providers" and 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."⁹ Wellmont and Mountain States both currently participate in OnePartner, and the Parties intend to continue providing their electronic medical records ("EMR") data to OnePartner after the merger, meaning HMG and other independent physicians will have the same access to the New Health System patients' data that they have to Wellmont and Mountain States patients' data today. The Parties respectfully submit to the State, however, that they should not be required to participate in any particular health information exchange—particularly when the party requesting such participation stands to benefit financially. While the State has no compelling interest in forcing the Parties to engage with a private, for-profit company, the Parties have committed to meaningful participation with the HIE, including utilization of the data, so long as the HIE is cost-effective and so long as other, more advanced mechanisms for sharing of data don't become more practical.

HMG has recommended that the COPA Index include measures tracking a variety of activities related to the exchange of health information, but the Parties assert that their current commitments in the Application are sufficient to ensure that the region and its patients have the benefit of a health system that effectively utilizes technology to ensure the highest quality care in a variety of settings. HMG states that implementation of value-based care models "requires seamless coordination of care across all providers," (HMG comments at 4) which the New Health System's Common Clinical IT Platform (the establishment of which is an additional commitment in the Application (Application at 55)) will make possible. All New Health System patient information will be on the same EMR system, and a link to access the data in the New Health System EMR, including data brought into the New Health System EMR from other regional providers' EMRs, will be available in all independent physician offices. This is another example of how the commitments made by the Parties will benefit employed as well as

⁹Application at 55.

independent physicians, with a common goal and incentive to improve health and outcomes in the Geographic Service Area.

HMG also warns that the New Health System's new IT platform must support bi-directional data exchange, or it "will promote barriers to data sharing and provider workflow," (HMG comments at 4) but the Common Clinical IT Platform will allow bi-directional data exchange with the EMR. OnePartner's bi-directional functionality, however, is currently limited to sharing information with other HMG information systems and does not have the capability of transferring data into other providers' EMR systems. The comments from HMG also suggest that the New Health System should be required to share "[t]he actual value of dollars spent by the Applicants for health information exchange that benefit both employed and independent providers of medical services." (HMG comments at 5) Notably, OnePartner is the only vendor with whom the Parties share information that charges any fee. The New Health System's information exchange features will be embedded into the features of its Common Clinical IT Platform, enabling the New Health System to exchange health information with other providers at no additional cost, except the cost of OnePartner's service.

G. Conclusion

While the Parties appreciate and share HMG's concern for maintaining and enhancing high-quality, low-cost care for the region, HMG's role as a competitor of both Wellmont and Mountain States calls into question the motives for its comments. Following the merger, there will still be more independent primary care physicians and more independent physicians in many specialties than those employed by the New Health System, and HMG and other independent providers will continue to offer a robust suite of outpatient services. Based on the analysis above, the Parties submit that HMG's comments, which support that organization's own competitive interests, do not present any reason to deny the Parties the COPA and decline its benefits, which even HMG acknowledges could be "significant," to a region badly in need of a collaborative approach to investing in population health.

VIII. CONCLUSION

The COPA provides a unique opportunity for Tennessee to implement a public policy directed toward improving the cost, quality, and accessibility of health care services in Northeast Tennessee to levels that have not been attained and are likely unattainable under the competitive market status quo. By the mechanism of a COPA, for Wellmont and Mountain States would be authorized to merge in order to become an integrated and efficient single entity, subject to active state supervision. This structure allows the State to replace competition with regulatory oversight of the New Health System's compliance with the mutually agreed enforceable commitments that benefit the community. Ongoing, active supervision by the State ensures that the benefits of the merger continue to outweigh any potential disadvantages and that the State's policies underlying the issuance of the COPA are fulfilled.

The comments opposing the merger fail to consider the specific and significant health care challenges that this region faces and that have prompted the Parties to submit their Application for a Cooperative Agreement. The comments also do not explain how the competitive market status quo from which these challenges emerged is a better approach for solving them. Commenters opposing the merger seek to apply a hypothetical construct of federal antitrust policy that is decidedly different from and inapposite to the sovereign Tennessee policy expressed through the Hospital Cooperation Act. They argue that an antitrust approach is preferable (and could work anywhere) - whether in urban or rural areas, regardless of health and economic conditions, and without the enforceable commitments that are available only in a cooperative agreement. The comments further disregard the substantial new investments required to address the region's health needs and improve access, quality, and cost of care delivery. The commenters fail to offer any realistic alternatives that would offer the same level of commitments as the proposed merger. Finally, the comments fail to recognize that Tennessee has specifically implemented its express public policy whereby mergers that may reduce competition can be regulated to limit sharply any risk of potential disadvantages, while enabling the beneficial attributes of substantially greater importance to flow to the community.

For the many reasons stated herein, the Department should reject the arguments submitted by the staff, Amerigroup, the Academics, Dr. Kizer, and HMG.

IX. EXHIBITS

LIST OF EXHIBITS

Exhibit Number	Description
Exhibit III.A	Comments on Twitter by Professor Gaynor
Exhibit III.B	Revised Plan of Separation between the Parties
Exhibit VI.A	Curriculum Vitae of Dr. Dale Sargent

EXHIBIT III.A

Comments on Twitter by Professor Gaynor



((((Martin Gaynor))) Retweeted



Karson Mahler @KarsonMahler · Jul 6

Ok WV, but don't complain to HHS when your premiums go up. The ACA doesn't mandate dumb competition policy. @SavageLucia @FTC @MartinSGaynor



1



3



((((Martin Gaynor))) @MartinSGaynor · Jul 6

Just one or two...

Altarum_CSHS @Altarum_CSHS

Hope you left a few problems unsolved for our July 12 meeting eiseverywhere.com/ehome/index.ph... Baicker, Chandra, etc., etc. twitter.com/MartinSGaynor/...



2



((((Martin Gaynor))) @MartinSGaynor · Jul 6

Ugh. WV legislators, governor should be ashamed of themselves (if they had any shame).

Dan Gorenstein @dmgorenstein

So this means 11th hour move by hospitals, with assist from state lawmakers and Governor, all went according to plan twitter.com/lschencker/sta...



2





(((Martin Gaynor))) @MartinSGaynor · Jul 6

Monopoly wins, patients lose. WV state government fails its citizens.

[#merger](#) [#healthcare](#) [#antitrust](#) [#ABASAL](#)

modernhealthcare.com/article/201607...?

Modern
Healthcare

BREAKING: FTC drops challenge of West Virginia ...

The Federal Trade Commission is dropping its challenge of a West Virginia hospital merger in light of the passage of a state law meant to protect the deal fr...

modernhealthcare.com



6



2



EXHIBIT III.B

Revised Plan of Separation
between Wellmont Health System and Mountain States Health Alliance

Revised Plan of Separation
between
Wellmont Health System
and
Mountain States Health Alliance

Pursuant to Grant of Certificate of Public Advantage
By the Tennessee Commissioner of Health

This Revised Plan of Separation (“the Revised Plan”) is prepared as part of the application for Certificate of Public Advantage (“COPA”) submitted jointly by Wellmont Health System and Mountain States Health Alliance (collectively “the Parties”) to the Tennessee Department of Health (“the Department”). The Revised Plan is intended to set out the process by which the Parties would effect an orderly separation of the new, integrated health system to be created under the COPA (the “New Health System”) in the event that the Department determines that it is necessary to terminate the COPA previously granted to the Parties, as set forth in T.C.A. section 68-11-1303(g).

1. Overview. The purpose of this outline is to comply with Tenn. Comp. Rules & Regulations 1200-38-01-.02(2)(a)(17). The Revised Plan will be described in two scenarios: the "Short-Term Period" (0 to 18 months) and the "Long-Term Period" (after 18 months).
2. Short-Term Period Plan of Separation. (0 to 18 months post-closing)
 - A. Overview. Re-establish a competitive dynamic by returning assets and operations to the control of the contributing party.
 - B. Assets Held Separate. Mountain States and Wellmont will not, during the Short-Term Period, transfer to the other, or to the New Health System, any Material Operating Assets held by either Mountain States or Wellmont prior to the affiliation. For purposes of this commitment, “Material Operating Assets” shall mean those assets that exceed 10% of the New Health System's total assets or roughly \$300 million. Assets used in providing support services to Mountain States and Wellmont may be transferred as appropriate to effect the integration and achieve cost savings and performance improvement.
 - C. The Process. Upon written notice from the Department that the COPA has been terminated, the following would occur:
 - (1) Preservation of Business. The New Health System will take all actions necessary to maintain the independent viability and competitiveness of Mountain States and Wellmont pending separation.
 - (2) Governance. The New Health System's Board of Directors will oversee the plan of separation to insure that the plan is successfully implemented, minimizing to the extent possible disputes between the separating entities and

disruptions in operations. Upon implementation of the plan of separation, the New Health System will be removed as member of Mountain States and Wellmont. Mountain States and Wellmont will return as the parent corporations of the pre-combination entities:

- a) Mountain States. Mountain States directors will resign from the Wellmont Board and the New Health System Board. Mountain States directors will appoint additional directors to the Mountain States Board.
- b) Wellmont. Wellmont directors will resign from the Mountain States Board and the New Health System Board. Wellmont directors will appoint additional directors to the Wellmont Board.

(3) Management.

- a) The Executive Chair/President of the New Health System will be named the Chief Executive Officer of Mountain States.
- b) The Chief Executive Officer of the New Health System will be named the Chief Executive Officer of Wellmont.
- c) Mountain States and Wellmont will appoint other executive officers of the respective corporations pursuant to established corporate procedures.
- d) Clinical Managers will be assigned to the Mountain States/Wellmont Clinical Site that is the Manager's principal place of service.

(4) Financial. Mountain States and Wellmont will become separate financial enterprises.

- a) Debt. Any debt issued by the New Health System will be allocated to Mountain States and Wellmont based upon the proportion of pre-merger debt that each brought to the merger, except that if the proceeds of any debt issued by the New Health System have been used to benefit a facility or facilities (e.g, debt proceeds used to expand physical plant), such debt will be allocated to the entity which receives that facility in the separation.
- b) Reserves. The cash and marketable securities of the New Health System will be separated between Mountain States and Wellmont in proportion to the original contribution at closing.

(5) Employees. The New Health System employees will be assigned to their principal place of business. Clinical employees will be assigned to the

Mountain States/Wellmont site that is the employee's principal place of service.

- (6) Employee Benefits. To the extent employee benefit plans have been combined, a plan of separation addressing employee benefits will be submitted. Each of Mountain States and Wellmont will be free to change or modify plans under separation. Mountain States and Wellmont will provide all legacy employees with credit for their New Health System service.
- (7) Clinical Services. During the Short-Term Period, the New Health System expects the consolidation of any significant clinical services to be limited. To the extent clinical services are combined, a plan of separation addressing clinical services, including a transition services agreement, will be submitted to the Tennessee Department of Health for information prior to such combination.
- (8) Information Technology. During the Short-Term Period, the New Health System will develop a combined approach to information technology. While planning and implementation are expected to begin, it is not anticipated that the Common Clinical IT Platform will be fully implemented in the Short-Term Period. Mountain States/Wellmont will each establish separate information technology services as part of the plan of separation. Transition services agreements will be utilized to assure no interruption in operations for Mountain States or Wellmont post-separation.
- (9) Payers. During the Short-Term Period, the New Health System expects to negotiate payer agreements consistent with the terms and provisions of the COPA. In the event of any separation of the New Health System during the Short-Term Period, both Mountain States and Wellmont will honor the provisions of the New Health System payer agreements for the balance of any base term (without renewals). If any payer wishes to modify or replace its New Health System payer agreement, Mountain States and Wellmont will negotiate in good faith to reach a mutually acceptable modified or new agreement. All future payer agreements will be negotiated separately by Mountain States and Wellmont.
- (10) Physicians. During the Short-Term Period, the New Health System expects to plan, but not execute, a combination of its physician enterprises. To the extent any physician services are combined, a plan of separation addressing physician services, including actions to return physician and other clinic employees to the Mountain States or Wellmont entity that was his or her employer at the closing, will be submitted to the Tennessee Department of Health for information prior to action. Hospital-based physician contracts, such as radiology, pathology, anesthesia, hospitalists,

and emergency medicine shall be assigned to the site of service. Mountain States and Wellmont shall honor the physician contracts for the remainder of the base terms (without renewals).

- (11) Dissolution. Once Mountain States and Wellmont no longer require support services from the New Health System, the Board of Directors of the New Health System will follow the procedures for voluntary dissolution of the New Health System as provided by Tennessee law.

3. Long-Term Period Plan of Separation. (after 18 months post-closing)

A. Overview. The Long-Term Period plan of separation would be implemented if the Department terminates the COPA after determining that the benefits of the merger no longer outweigh the disadvantages by clear and convincing evidence. Due to the difficulty of predicting the health care environment in the long term, the Long-Term Period plan of separation of necessity is a description of a process for deciding how to separate the assets and operations of the New Health System.

B. The Process:

- (1) Upon receipt of written notice from the Department that the COPA has been terminated, the New Health System will retain a qualified consultant (“the Consultant”).
- (2) The Consultant will assist the New Health System in complying with the written notice that the COPA has been terminated by analyzing competitive conditions in the markets subject to the Department’s written notice and identifying the specific steps necessary to return the subject markets to a competitive state.
- (3) The New Health System will submit a plan of separation to the Department (the “Proposed Plan”). The Proposed Plan will address each of the substantive elements required of a Short-Term Period plan of separation and will be accompanied by a written report from the Consultant concerning the suitability of the Proposed Plan in addressing the competitive deficiencies that resulted in the termination of the COPA.
- (4) The Proposed Plan shall be submitted within 180 days of receipt of written notice from the Department that the COPA has been terminated. The Proposed Plan shall include a timetable for action which shall be approved by the Department.

C. Upon the Department’s approval of the Proposed Plan (or of any plan that contains revisions thereto) (the “Final Plan”), the New Health System will implement the Final Plan within the timetable prescribed in the Final Plan.

D. The Final Plan will provide that the Department may require that an independent third-party health care expert serve as a monitor (“the Monitor”) to oversee the

process of implementing the Final Plan. The New Health System will pay the fees and expenses of the Monitor.

4. Non-Exclusive Plan. To the extent the Parties or the New Health System reasonably determines (based upon the current facts and circumstances) that a competitive dynamic may be restored in another, more efficient or effective means, the Parties or the New Health System may submit a new plan of separation different from the pre-submitted plan. In such event, the amended plan of separation must receive the Department's approval prior to its implementation.
5. Annual Update. Department regulations provide that the plan of separation be updated annually. The annual update will address each of the following elements as appropriate and possible in light of the then existing facts and circumstances: (a) Governance, (b) Management, (c) Financial Separation, (d) Employees, (e) Employee Benefits, (f) Clinical Services, (g) Information Technology, (h) Payers, and (i) Physicians.

EXHIBIT VI.A

Curriculum Vitae of Dr. Dale Sargent

CIRRICULUM VITAE

Jeffrey Dale Sargent, M.D.

Birth: May 22, 1954, Bluefield, West Virginia
Citizen: U.S.A.
Social Security Number: *** ** *****
Wife: Joneen Maxwell Sargent
Children: Millie and Max

EDUCATION

Grad. 1972	Richlands High School, Richlands, Virginia Honors: Beta Club
1972-1975	King College, Bristol, Tennessee BS 1986 Honors: O.L. White Science Scholarship 2 nd in class - Freshman Year 1 st in class - Sophomore Year 1 st in class - Junior Year
1975 -1979	Medical College of Virginia, Richmond, Virginia Degree: Doctor of Medicine, May 1979 Honors: 2 nd in class - Freshman Year Neuroscience's Award Alpha Omega Alpha
1979 - 1982	Residency, Internal Medicine, North Carolina Memorial Hospital, Chapel Hill, North Carolina
1982 - 1984	Fellowship, Pulmonary Medicine, University of North Carolina School of Medicine, Chapel Hill, North Carolina
1984 - 1997	Private Practice of Pulmonary and Critical Care Medicine, Bristol Regional Medical Center, Bristol, Tennessee
1994	Chief of Staff, Bristol Regional Medical Center
1993 - 1997	Medical Director of Quality Improvement and Utilization Management Bristol Regional Medical Center
1997 - 2004	Executive Vice President of Medical Affairs, Wellmont Health System, Kingsport, Tennessee
2004-2005	Chief Medical Officer, Wellmont Health System, Kingsport, Tennessee

2005- 2007	Hospitalist, Kingsport Consultants, Holston Valley Medical Center, Kingsport, Tennessee
2007- 2009	Pulmonary and Critical Care Medicine, Pulmonary Associates of Kingsport, Kingsport, Tennessee
2009-2011	Chief Medical Officer, Wellmont Health System, Kingsport, Tennessee
2011-2014	Hospitalist, Lonesome Pine Hospital, Big Stone Gap Virginia; Mountian View Regional Medical Center, Norton, Va.
2011-2014	Instructor for Inpatient Medicine Service, Osteopathic Family Medicine Residency, Norton ,Va
2014 -2015	Hospitalist and co-medical director, WMA Hospitalist program, Bristol Regional Medical Center, Bristol, Tn.
2015 – Present	Hospitalist and system medical director of hospitalist programs for Wellmont Health System, Kingsport, Tn.

CERTIFICATION

American Board of Internal Medicine - September 1982- present
 American Board of Internal Medicine (Pulmonary Diseases) - November 1984-present
 American Board of Internal Medicine (Critical Care) - 1987 -2007
 Certified B Reader, 1986, Recertified 1990 and 1994

RESEARCH

Involvement of the Lung in Patients with Polymyositis
 Migration of Neutrophils Across Tracheal Epithelium

SOCIETIES

American College of Physicians - Associate
 American College of Chest Physicians - Fellow

PUBLICATIONS

Sargent, Fairman, Sessions - “Pulmonary Vasculitis Complicating Ulcerative Colitis”, Southern Medical Journal, Vol. 78, No. 5, p. 624, 1985

Sargent, Mease, Howard - “Viral Pneumonitis in a Compromised Host: Is An Aggressive Diagnostic Approach Indicated?” North Carolina Medical Journal, 1985

Sargent, Nowiski, Zimmerman - "An Experience with Clinical Case Management and Clinical Pathways", Quorum Health Resources Financial Services Newsletter, April 1995

Clare, Sargent, Moxley, Forthman - "Reducing Health Care Delivery Costs Using Clinical Paths: A Case Study on Improving Hospital Profitability", J. Health Care Finance 1995: 21(3) 48-58

Sargent – "Good-bye, my friend", American Journal of Hospice & Palliative Care, Volume 20, Number 4, p. 311, July/August 2003

LICENSING

Tennessee: MD *****
Virginia: