TN Department of Health

April 22, 2016

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

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

Re: Request for Information (#2)

Dear Mr. Levine and Mr. Hove:

Thank you for your willingness to work with us on the three priority issues raised in the March 28, 2016, letter from Commissioner John J. Dreyzehner, MD, MPH, FACOEM. The first two items covered information required for the Cooperative Agreement, the legally binding document between Mountain States Health Alliance and Wellmont Health System. Ultimately, if a Certificate of Public Advantage (COPA) is granted, the Tennessee Department of Health (department) will supervise the Cooperative Agreement between the parties to merge. As such, it is imperative that this agreement specify certain information required by department rule, whether or not the information is documented elsewhere in the Application. The third request was for a more detailed Plan of Separation. Since you are amenable to resolving these items, the department is providing this Request for Information (#2).

In the department's view, the Application and Addendum #1 lack the depth required for the department to evaluate a Cooperative Agreement for a merger of this magnitude. Pursuant to state law, "the department shall issue a certificate of public advantage for a cooperative agreement, if it determines that the applicants have demonstrated by *clear and convincing evidence* that the likely benefits resulting from the agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement."[1] As defined by the Tennessee Supreme Court, "[c]lear and convincing evidence means evidence in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the *evidence*."[2] Where the applicants provide responses to the requirements set forth in the rules, the responses do not provide enough evidence of the claimed benefits presented. Please understand that providing responses to the application requirements without sufficient explanation and documentation does not mean the information is clear, convincing, or complete. Applicants should avoid conclusory responses. As your team compiles the additional information requested

[1] T.C.A. § 68-11-1303(e)(1), emphasis added.
[2] Hodges v. S.C. Toof & Co., 833 S.W.2d 896, 901 n. 3 (Tenn.1992), emphasis added.

below, be mindful that many of these requests are necessary because the responses in the application and addendum failed to substantiate stated benefits and commitments.

In addition to the foregoing, the applicants must show the "likely benefits *resulting from the agreement* outweigh disadvantages attributable to a reduction in competition."[3] That is, benefits considered by the department in its evaluation must result from the proposed Cooperative Agreement.

As you know, it is the responsibility of the parties to provide sufficient information for the department to evaluate the application. As detailed in the March 28, 2016 letter, the department will identify sections of the application as complete or incomplete. Incomplete shall have one of the following meanings and shall be identified as such:

Incomplete (1): The section is deemed incomplete because the section does not meet the letter of the rule; or

Incomplete (2): The section is deemed incomplete because the information provided is insufficient to determine the advantages and disadvantages of the proposed merger.

Below, the department lists incomplete sections, provides general comments, and notes inconsistencies in application materials. Please use this list in preparing additional information necessary for the department to evaluate the application. This list is not exhaustive and further information will be required. In addition, the department encourages the applicants to revisit the application requirements outlined in the rules.

[3] T.C.A. § 68-11-1303(e)(1), emphasis added.

REQUEST FOR INFORMATION (#2)

I. INCOMPLETE (1)

a. **Services Offered by Other Providers**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)8

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

i. Limit services and products provided to those within the geographic service area;[4]

ii. Revise classification of facilities to reflect substitutable services or products;[5]

iii. Provide information on the structure of physician practices to calculate the appropriate market share.[6]

iv. Identify physicians under an exclusive contract or arrangement with either applicant or a subsidiary of either applicant.

b. **Description of the Competitive Environment**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(v)

Recalculate market shares using appropriate geographic market and output measures.[7]

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[4] Pursuant to department rule, identification of services offered by other providers and the corresponding market share calculations should be limited to the geographic service area identified in the application. The application identifies the geographic service area (GSA) as a 21-county area that includes ten (10) Tennessee and eleven (11) Virginia counties. In contrast, Application Section 6, Exhibit 6, and Addendum #1 Section 3 include products from competitors located outside this 21-county GSA.

[5] A facility is the method of delivery for the product but is not necessarily itself the product. For example, gastroenterology, orthopedic, and eye surgery centers are not substitutable (i.e., a patient with eye issues would not consider accessing the former two surgery centers). Consequently, these facilities cannot be listed under the same product or used to calculate a market share.

[6] The market power of a single physician is not equal to the bargaining power of a physician group. Therefore, in Exhibit 6.1-E, the number of physician groups and their size (i.e. number of doctors) by specialty and county is required.

[7] See Incomplete Item I.a.

c. **Cooperative Agreement - EXHIBIT 11.1**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13

i. Provide a copy of the nonbinding April 2, 2015 Term Sheet referenced in the Master Affiliation Agreement and Plan of Integration, page 1 paragraph 6.

ii. Provide the following exhibits referenced in the Master Affiliation Agreement, page 56:

1. Exhibit C-1: Interim Parent Company Articles and Interim Parent Company Bylaws.

2. Exhibit C-3: Amended Parent Company Articles.

3. Exhibit C-4: Amended Parent Company Bylaws.

II. INCOMPLETE (2)

a. **Potential Disadvantages**
Tenn. Comp. R. & Reg. 1200-38-01-.02(2)(a)3(iv)

Identify any potential disadvantages that may result from the Cooperative Agreement.

b. **Geographic Service Area**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)7

Detail whether the New Health System intends to increase its market share in the following counties: Harlan and Letcher in Kentucky; and Ashe, Avery, Madison, Mitchell, Watauga, and Yancey in North Carolina.

c. **Insurance Contracts / Proposed use of any Cost Savings to Reduce Prices Borne by Insurers and Consumers** [8]
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(vii)(III)I, II
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)13(ix)(I)

i. Provide the number of current insurance contracts that represent less than 2% of patient services revenue.

ii. Identify any potential insurers that would represent less than 2% of patient services revenue that do not currently contract with either system.

[8] See Application pp. 46 and 47.

iii. Detail the percent of current insurance contracts that have fixed rate increases as written. Provide the amount and timing of these currently planned fixed rate increases. You may aggregate these rates separately for MSHA and Wellmont if you include the mean and standard deviation of the planned fixed rates.

iv. Provide the negotiated rate increases for the past five years. These increases should be calculated using the same methodology proposed in the commitment to not increase negotiated rates for hospital, physician or non-hospital outpatient services by more than the hospital or medical care Consumer Price Index minus 0.25%.

v. Detail the proposed methodology to cap negotiated rates, including whether contractual out-of-pocket payments will be included.

vi. Detail how the New Health System will handle price setting for uninsured or private pay patients.

d. **Common Clinical IT and Health Information Exchange**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)10

i. Provide your anticipated 10-year timeline with milestones for development and implementation for both the Common Clinical IT platform, connectivity for information exchange and quality measurement reporting. At a minimum, the timeline should include targeted objectives for each year following the formation of the New Health System, including target dates for the following activities:

1. Behavioral health capability. If your chosen Clinical IT system does not currently include a behavioral health module, detail your plans here, including integration or interoperability of electronic behavioral health record systems from third-party vendors.

2. Integration of systems and / or linkage of records (medical, lab, pharmacy, diagnostic, and referral / scheduling).

3. Migration and / or archiving of pre-existing records.

4. Training for new users (System and non-System providers).

5. Patient access to information.

6. Capabilities for collecting, analyzing and reporting quality outcomes (clinical, cost, patient satisfaction, etc.) for providers (System and non-System).

ii. Provide estimates for how and when the $150 million investment in a Common Clinical IT Platform and Health Information Exchange will be allocated, including but not limited to the amount designated for the Common Clinical IT Platform, the amount designated for connectivity with non-System providers, population health management and quality reporting capabilities. If relevant, provide estimated costs to offer EHR solutions for non-System providers, and estimated expenses to support connectivity for non-System providers, along with estimates for any revenue projected to be realized from any services offerings related to these capabilities.

iii. Describe the current commitment and timeframe for participation of both MSHA and Wellmont in OnePartner, the operational regional health information exchange. Also describe the options and plans for future participation (e.g., continued participation or acquisition of OnePartner, participation with a competing HIE provider, or development of a competing service offering).

e. **Total Cost Resulting from Cooperative Agreement**
Tenn. Comp. R. & Regs. 1200-38-01-.02(2)(a)15

Provide the total amount detailed in the reports from MSHA and Wellmont, referenced in the Master Affiliation Agreement Section 10.04(d), setting forth all Expenses incurred by the parties. Include justification for the above amount. Detail all additional merger-related expenses, including capital costs and management costs. Provide documentation of the availability of the necessary funds.

f. **Description of Financial Performance**
Tenn. Comp. R. & Regs. 1200-30-01-.02(2)(a)13(vii)

i. The description and summary of financial performance of Wellmont and MSHA does not adequately detail all components noted by department rule. (See Exhibits 11.4 and 11.5)

ii. Provide additional detail on the activities to be funded by the following proposed community reinvestment: 1) the $75 million investment in population health improvements; 2) the $140 million to expand mental health, addiction recovery, substance abuse prevention programs; and 3) the $85 million to develop and grow academic and research opportunities.[9]

iii. Complete the "Year-by-Year Summary" that requests an estimate of the year-by-year timing of reinvestments and cost savings. (See Attachment 1)

[9] Requests for additional detail regarding the $150 million investment in Common Clinical IT and a Health Information Exchange are detailed in Incomplete Section II.d.

iv. Provide an updated amount of net expenditures on community health improvement, health professions education, and research as detailed on your most recent IRS Form 990 Schedule H.[10]

v. Detail whether a $75 million investment in population health over ten years represents an increase in spending over that of past community health investment, and if so, provide an estimate of the aggregate planned population health investment.

vi. Detail whether an $85 million investment in research and training over ten years represents an increase in spending over that of past research and training investment, and if so, provide an estimate of the aggregate planned research and teaching investment.

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

viii. Provide the audited financial statement on MSHA as of June 30, 2015. (See Exhibits 11.4-F)

ix. On April 06, 2015, Fitch Ratings placed on Rating Watch Evolving the 'BBB+' rating for Health and Educational Facilities Board of Johnson City, TN, revenue bonds issued on behalf of MSHA and parity debt issued on behalf of MSHA listed in April 06, 2015 press release. Provide the current status regarding Fitch's Rating Watch. (See Exhibits 11.4-H)

g. **Efficiencies in Operating Costs and Shared Savings**
Tenn. Comp. R. & Regs. 1200-30-01-.02 (a) 13(ix)

Provide the report prepared by FTI Consulting, Inc. that details the assumptions used in calculating the proposed economies and efficiencies of the proposed merger.

III. GENERAL COMMENTS

a. Detail how an additional layer of governance (i.e., the parent company) benefits the organization.

b. Provide an organizational chart that shows the resulting institution.

[10] As non-profit hospitals, MSHA and Wellmont already provide some level of community benefit. The department notes that in 2012 MSHA and Wellmont had net expenditures of $10.8 million on community health improvement and $18.9 million on health professions education and research.

c. Clarify the amount of current debt and what is proposed in debt repayment and/or incurring additional debt as a result of this proposal.

d. Provide details regarding severance packages, including but not limited to, timing of implementation and dollar amount. Include details of severance packages currently being paid. (See Application p. 61)

e. Provide proposed employment agreements mentioned in the application.

f. Describe the proposed performance parameters that will be used to measure employee performance.

g. The resulting board appears to be comprised of nine (9) members, of which only eight (8) will be voting members. Identify and/or detail how the board would deal with a 4/4 vote.

h. Provide the Physician Needs Assessment from Niswonger Children's Hospital and detail how recruitment strategy will differ post-merger.

IV. INCONSISTENCIES

The applicants should address the inconsistencies noted below.

Exhibit 11.4, pages 3 and 5 (Adobe pgs. 709 and 711/2578)	The Statement of Operations summary for the fiscal year ended June 30, 2014 did not always appear to agree with amounts presented on the financial statement included in the application (Exhibit 11.4, Attachment F). For example, the summary reported net patient revenue decreased by $3.8 million; however, the audited financial statement (Adobe pg. 1538/2578) reflected a decrease of $4.96 million. Additionally, the Balance Sheet summary for the fiscal year ended June 30, 2014 stated that part of the reason for the increase in assets was due to an increase in patient receivables; however, the Consolidated Balance Sheet (page 1536/2578) reflected a decrease in patient accounts receivable of approximately $3 million from the prior year.
Exhibit 11.5 – Attachment C Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures (as listed on page 126) (Adobe pg. 128/2578)	The exhibit was not included in the application. This exhibit was not included in the list of excluded information on page 119; therefore, it appears to have been omitted from the application in error.

Exhibit 11.8, page 2 (Adobe pg. 2500/2578)	The "Timing and Phases of Efficiency Assumptions" section stated that no efficiency savings are projected to be implemented in whole or in part until the FYE 6/17; however, the "Preliminary Efficiencies" Model Income Statement appeared to reflect savings of $41,144 over the "Baseline" model for the FYE 6/16 (i.e., savings of $21,632 in medical supplies and drugs, $5,651 in purchased services, $1,002 in maintenance and utilities, and $12,859 in other).
Exhibit 11.8, page 9 (Adobe pg. 2507/2578)	It appears, for the forecasted columns of the "Baseline" Model Balance Sheet, total net assets should equal the prior year ending net assets balance plus revenues in excess of expenses reported on the operating statement on the previous page. However, the total net assets balances reported on the "Baseline" Model Balance Sheet in the 2016 through 2020 columns did not equal this. The difference appears to be related to the income attributable to non-controlling interests.
Exhibit 11.8, pages 12 and 13 (Adobe pgs. 2510-11/2578)	On the "Preliminary Efficiencies" Model Cash Flows, the cash flows from financing activities included amounts for each year for payments made related to income attributable to non-controlling interest. However, it appears the "Preliminary Efficiencies" Model Balance Sheet on the previous page reflected this amount as part of net assets each year (i.e., the non-controlling interest component of net assets increased each year by the amount of income attributable to non-controlling interest)
Exhibit 11.8 – pages 10 and 13 (Adobe pgs. 2508 and 2511/2578)	The amounts reflected for Payments on LTD and liabilities (net of interest) on the "Baseline" and "Preliminary Efficiencies" Model Statement of Cash Flows were not consistent with amounts disclosed in the debt service schedules presented in the most recent financial statements included in the application. The financial model notes referenced a "Debt Schedule" (page 6) which may provide explanation; however, this schedule was not included with the model. It was expected that the LTD and liabilities payments would agree with debt service amounts presented in the notes to the financial statements (Exhibits 11.4, Attachment F and 11.5, Attachment B) (Adobe pgs. 1559 and 2421/2578).

Sincerely,

Jeff Ockerman | Director

cc: J. Richard Lodge
Richard G. Cowart
John J. Dreyzehner, MD, MPH, FACOEM