RESPONSE BY APPLICANTS

TO

FEDERAL TRADE COMMISSION STAFF SUBMISSION

ON SEPTEMBER 30, 2016

AND SUPPORTING MEMORANDUM

TO THE SOUTHWEST VIRGINIA HEALTH AUTHORITY

AND VIRGINIA DEPARTMENT OF HEALTH REGARDING

COOPERATIVE AGREEMENT APPLICATION

Pursuant to Virginia Code § 15.2-5384.1
and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by:	Mountain States Health Alliance Wellmont Health System
Date:	October 14, 2016

Mountain States Health Alliance and Wellmont Health System ("the Parties") submit this response and supporting memorandum to address the submission dated September 30, 2016, by Federal Trade Commission staff ("staff") to the Southwest Virginia Health Authority and Virginia Department of Health ("staff comments") regarding the Parties' Cooperative Agreement Application ("Application"). As discussed below, staff's comments lack merit and do not overcome the compelling reasons for issuance of a Cooperative Agreement in this matter.[1]

I. INTRODUCTION

Sixteen months ago when it unanimously passed the Cooperative Agreement Law, the Commonwealth of Virginia clearly articulated and affirmatively expressed a policy to improve the welfare of Southwest Virginians by encouraging integration among healthcare providers, even in anticompetitive transactions, if the overall net effect is to facilitate better care for rural patients:

> The policy of the Commonwealth related to each participating locality is to encourage cooperative, collaborative, and integrative arrangements, including mergers and acquisitions among hospitals, health centers, or health providers who might otherwise be competitors. To the extent such cooperative agreements, or the planning and negotiations that precede such cooperative agreements, might be anticompetitive within the meaning and intent of state and federal antitrust laws, the intent of the Commonwealth with respect to each participating locality is to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority, and to invest in the Commissioner the authority to approve cooperative agreements recommended by the Authority and the duty of active supervision to ensure compliance with the provisions of the cooperative agreements that have been approved. Such intent is within the public policy of the Commonwealth to facilitate the provision of quality, cost-efficient medical care *to rural patients*.[2] (emphasis added).

The General Assembly's action to institute this policy solely in Southwest Virginia is a response to the unique and very substantial health needs of this region. The Authority's *Blueprint for Health Improvement and Health-Enabled Prosperity* (updated January 7, 2016)[3] identifies many critical issues for the Southwest Virginia counties served by the Parties.[4] For example, the 2015 America's Health Rankings report[5] finds that Virginia ranks 31st in the nation in smoking; the Virginia counties in the Parties' geographic service area exceed the national average for smoking by a range of 21% to 33%. These counties have obesity rates that exceed Virginia statewide levels, ranging from 29% to 35%. Teenage pregnancy rates in the Virginia

[1] As the 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)
[2] Virginia Code Section 15.2-5384.1.A.
[3] *Goals Update, available at*: https://swvahealthauthority.net.
[4] All references to "Virginia counties" refer to counties in the New Health System's Geographic Service Area.
[5] *Virginia State Data*, America's Health Rankings, United Health Foundation, Annual Report 2015, *available at*: http://www.americashealthrankings.org/VA.

counties exceed the national average of 26.5 births per 1,000 adolescent females,[6] and four of the counties have rates that exceed double the national average (Dickenson, Lee, Smyth, and Wise). Low birthweight is also an issue of concern. Only three of the Virginia counties– Grayson, Russell and Wythe – have low birthweight rates that are better than the state average. Of the eleven Virginia counties, all eleven exceed the state average for mortality rate due to drug poisoning. Dickenson County's rate is the highest in either Tennessee or Virginia. Physical inactivity, obesity, tobacco abuse and substance abuse are major health challenges that disproportionately impact residents of Southwest Virginia, and are associated with other health challenges and conditions. The Parties' Application reported key statistics on the population in all Virginia counties in the service area, and Virginia state-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. (Application Table 15.2 at 71)

Health conditions such as these, combined with external factors as outlined below, have contributed to financial pressures facing rural hospitals and difficulties in sustaining inpatient services, because these damaging health outcomes disproportionately impact the poor and substantially add to the charity care burden of the rural facilities. Historically, Wellmont and Mountain States have supported these hospitals financially, and most rural hospitals of Wellmont and Mountain States operate with negative or very low operating margins. The staff seemingly assume that because this financial support has existed in the past that each of the systems will continue, or even can continue, such support in the future. Without the synergies resulting from the merger, there should be no such assumption. In 2015, Mountain States and Wellmont collectively invested more than $19.5 million to ensure that inpatient services would remain available in smaller communities, and $11 million of that funding was directed to the Parties' Virginia rural hospitals.

Most of the Parties' Virginia rural hospitals currently have an average daily census of thirty patients or less, with licensed bed occupancy at these hospitals ranging from 0.1% to 36.7%.[7] The populations of the Virginia counties in the Geographic Service Area are declining or stagnant, and this trend is expected to continue. The economic strain on the Parties is serious and must be addressed, particularly because the Parties' survival is crucial for the residents in these rural counties to continue 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 supporting redundant costs borne by the market and duplicating services and programming as separate health care systems. The significant ongoing duplication of costs and health care services in the region cannot be sustained with the status quo.

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,[8] and more than 600 could be vulnerable going forward.[9] Wellmont and

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

[7] See Application Tables 5.2 and 5.3, pages 18-19.

[8] *See 78 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at*: https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/ (accessed October 13, 2016). Twelve rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.

Mountain States, along with other providers nationwide, are faced with reduced payment for services, services moving from the inpatient to the outpatient setting, and higher patient out-of-pocket costs due to increased copayments and deductibles which have led to more hospital bad debt. The challenges are intensified in Southwest Virginia, a rural area with extremely low Medicare payment rates, high volumes of Medicaid and uninsured populations, declining population and significant health care challenges, as noted in the Application.

The policy expressed in the Cooperative Agreement Law to facilitate the provision of quality, cost-efficient medical care to Southwest Virginia's rural patients is of such high importance to the Legislature that the law encourages mergers that are "anticompetitive within the meaning and intent of state and federal antitrust laws." In those instances, the Commonwealth's intent is "to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to" Southwest Virginians.[10]

In their comments, staff pay very little attention to the serious health challenges confronting Southwest Virginia's rural patients or the serious challenges facing the rural hospitals that form the underpinnings to the Legislature's new policy approach to resolve those challenges. Staff make clear that they disagree with the Legislature's policy choice to institute a regulatory program that supplants competition with respect to healthcare transactions for Southwest Virginians. Repeatedly, staff's disagreement with the concept of cooperative agreements permeates their commentary about the merits of the Parties' Application. Staff's policy opinions are not relevant. Under longstanding U.S. Supreme Court doctrine, a sovereign state policy is beyond the reach of federal antitrust laws. See *infra* at Section III for a more detailed discussion of this point.

Staff 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 merged health system would operate in a regulated program that places strong constraints on any attempted exercise of market power. 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 the system but also can institute proceedings to terminate the Cooperative Agreement if needed. Staff take inadequate account of these substantial regulatory restrictions and the overwhelming benefits to the region through the Parties' commitments, merger efficiencies, and other measures. Staff's 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.

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[9] See iVantage's 2016 Rural Relevance: Vulnerability to Value Study, which assesses rural and Critical Access Hospital performance; Ellison, A. (2016, February). The rural hospital closure crisis: 15 key findings and trends. Becker's Hospital CFO. Retrieved from http://www.beckershospitalreview.com/finance/the-rural-hospital-closure-crisis-15-key-findings-and-trends.html; Rural Hospital Closures: 2010-Present (2016); and Kaufman BG, Thomas SR, Randolph RK, Perry JR, Thompson KW, Holmes GM, and Pink GH. 2016. The rising rate of rural hospital closures. Journal of Rural Health 32(1):35-43.

[10] Virginia Code Section 15.2-5384,2.A.

In contrast to the staff's assessment, the Parties are aware of the many letters and statements submitted for the record to the Authority by a variety of business, government and community leaders who, upon their own conclusions, support approval of the Cooperative Agreement Application. These individuals represent companies, municipalities, consumers, employees and families directly affected by this decision. That they have taken the time to educate themselves on the proposal, and have engaged with the Authority, speaks volumes about the level of community interest in this endeavor. It also speaks to the transparency and inclusiveness of the process.

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

> "*Although competition is generally thought of as the best way to keep prices down, competition in the health care sector works differently than competition in other sectors, due to additional cost redundancies associated with new facilities and equipment. Health care costs for Strongwell increased by 23% between 2015-2016. Eliminating the duplication of services and materials would help decrease costs, and assist Strongwell by keeping costs affordable and ensuring a greater degree of price certainty*."
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> David Ring, Bristol, VA, Strongwell Corporation, Manager of Government Affairs and Strategic Projects, Comments at public hearing October 3, 2016

> "*Our Chamber of Commerce represents well over 500 businesses and individuals…. We believe integrating [the Parties] into one locally governed health system would provide our community and region great benefits. Our residents already face the challenge of limited health insurance options and this proposed new, integrated system will allow our residents the opportunities to use the physicians and facilities closest to them… Our current relationships with both systems give us comfort knowing local people will be making decisions locally*."
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> Suzanne Lay, Abingdon, VA, Washington County Chamber of Commerce, Executive Vice President, Letter dated September 20, 2016 to the Authority

> "*I believe this merger will provide a better health care system for our community by providing affordable and high quality care that would be more accessible to our residents…. Also, we must keep our jobs in our area and by this merger I believe we would have a stronger workforce because it would encourage better pay and some of the most qualified workers could stay in the area*."
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> Donald Baker, Town of Clintwood, VA, Mayor/Town Manager, Letter dated September 28, 2016 to the Authority

> "*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 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, Comments at a public meeting held on June 7, 2016.

"*[I]n today's world, we should all aspire to drive collaborative community change… It means working collaboratively on community-wide and community-based strategies that can drive real change – not tweaks in the status quo…. I agree with the sentiment that communities are Better when they work Together*."

Travis W. Staton, Abingdon, VA, United Way of Southwest Virginia, Chief Executive Officer, Letter dated September 29, 2016 to the Authority.

"*The challenges of providing quality health care in a rural area are unique and many hospitals and other health care facilities have been forced to close down due [to] the difficulty in maintaining financial viability…. [T]he merger would result in a much stronger health care institution than either Wellmont or Mountain States could ever hope to be on their own. Many economies of scale would occur from the merger that will make the new entity much stronger and more stable financially. In the long run, the merger will result in improved health care for all of the citizens of Southwest Virginia from a health care system that is stronger and better positioned to grow and improve into the future*."

Dr. Scott Hamilton, Big Stone Gap, VA, Mountain Empire Community College, President, Letter dated September 28, 2016 to the Authority.

"*I am a private citizen who lives, in Southwest, VA and purchases health coverage for 50 employees and their dependents….During the past decade our annual insurance premiums have climbed higher each and every year. Unfortunately, we have been required to pass along a large share of these increases to our employees to keep ourselves in business. We live in a rural area where education is often limited leading to high occurrences of obesity, diabetes, smoking, overall poor diet and drug use…. With Commonwealth oversight the combined health systems will integrate patient care, focus on specific needs of the community while keeping jobs in our region and remaining financially viable in the fast-changing health care industry. I urge you to support the merger and support the long term health of our region*."

Eric Miller, Abingdon, VA, Wolf Hills Fabricators, President and Owner, Letter dated September 19, 2016 to the Authority.

"*The region would be improved due to the proposed merger. Calling attention to the proposed commitments to address some of the region's most pressing problems, including obesity, substance abuse, and diabetes, duplication of services get in the way of true effectiveness and delivery of services. The proposed merger would eliminate the duplication of services and would allow the areas that need the greatest attention be addressed*."

Beth Rhinehart, Bristol VA/TN Chamber of Commerce, President and Chief Executive Officer, Comments at public hearing October 3, 2016.

"*I had concerns when the proposed merger was initially announced. My fears were that the absence of competition in healthcare services for our region would not be a good thing.*

Subsequently, I have devoted a fair amount of time to better understanding the kinds of protections that will be placed into any agreement that receives approval by Virginia…. I recognize the challenges that these health care systems face operating rural hospitals in an economically depressed region of our state. Bringing the two systems together to realize significant financial savings is the only viable way to provide businesses and individuals in our area with quality affordable healthcare."

Bruce Hatch, Abingdon, VA, Lawson and Hatch Financial Services, Principal, and immediate past chairman of the Johnston Memorial Hospital Foundation, Letter dated September 26, 2016 to the Authority.

"[*T]his merger would be the best solution for our region in overall healthcare. We see a positive future for our region and feel this comprehensive Health Care System will be an asset to retain and recruit businesses*."

Rick Surratt, Clintwood, VA, Dickenson County Chamber of Commerce, President/CEO, Letter dated September 16, 2016 to the Authority.

"*Keeping [Russell County Medical Center] open and sustainable is one of my top priorities….MSHA and Wellmont have pledged to keep all hospitals functioning as health care facilities for five years. In our current unstable economic environment, a promise like that give me hope. It tells me that the leaders of these two organizations care deeply about our region and want to make investments here that other outside health systems have never and would never make…. This merger will provide quality care at a lower cost, will invest in the health of our people and will give me, as a local elected official, a very attractive incentive to recruit badly needed industry and jobs to Russell County*."

David Eaton, Honaker, VA, Russell County Board of Supervisors, Vice Chairman, letter received by Authority September 2016.

"*We believe the merger of Mountain States and Wellmont would improve the delivery of health insurance in both states. The combining of these two entities would help attract the best and brightest physicians…. It would also enhance needed services such as mental health care, and illegal substance and prescription medication abuse treatment*."

James K. Gilley, Norton, VA, South-West Insurance Agency, Inc., Senior Vice President, letter dated September 26, 2016.

II. STAFF'S POLICY OBJECTIONS ARE NOT RELEVANT

The Virginia Legislature has clearly articulated and affirmatively expressed a policy for Southwest Virginia to supplant competition with regulation for mergers that meet the statutory requirements of the Cooperative Agreement Law, which specifically identifies rural patients as targeted beneficiaries of this policy. Staff clearly believe that the Commonwealth's policy for improving healthcare conditions in the rural communities of Southwest Virginia is in error. They contend that "[c]ompetition is the most reliable and effective mechanism for controlling healthcare 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) Repeatedly throughout their submission, staff interject their policy bias into comments ostensibly directed to the merits of the Parties' Application under the Cooperative Agreement Law.

Staff's disagreement with Virginia's public policy choices has no significance in this proceeding and should be discarded on its face. The Virginia General Assembly's decision to enact the Cooperative Agreement Law is solely within the purview of Virginia. 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. Virginia acted in its sovereign capacity when the Legislature passed the Cooperative Agreement Law and the Governor signed it into law. The staff's opinion that competition is the preferred policy for Southwest Virginia healthcare consumers over the regulatory model encompassed in the Cooperative Agreement Law is legally irrelevant, and seems to attempt to prioritize the staff's policies over that of the Commonwealth's. The Commonwealth's policy objectives, however, are very different from the staff's.[11]

III. STAFF'S TRADITIONAL ANTITRUST LAW ANALYSIS DOES NOT RESPOND TO THE ISSUES IN THE COOPERATIVE AGREEMENT LAW

Turning to the Cooperative Agreement Law, staff contend that the Authority should evaluate the Parties' Application according to the FTC's methods for merger analysis. Staff say this is appropriate because their antitrust approach is "similar to that which the Authority and the Commissioner will take when reviewing cooperative agreement applications." (staff comments at 7) Staff is incorrect. A traditional antitrust analysis does not respond to the different policy goals embedded the Cooperative Agreement Law.

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[11] A 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 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 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:
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> > '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.'"

FTC 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-sclaw-statement.pdf?utm_source=govdelivery (citation omitted).

A. State Policy And Not Antitrust Law Governs Cooperative Agreements

The Virginia Legislature established a significantly different set of analytical factors for the consideration of mergers under the Cooperative Agreement Law from those used by the FTC to scrutinize traditional mergers under the antitrust laws. The Cooperative Agreement Law authorizes *approval* of anticompetitive mergers that meet the Law's evidentiary tests. The antitrust laws *prohibit* anticompetitive mergers. This fundamental distinction is lost in the staff's comments. The result is a submission replete with incorrect and unhelpful analysis that is disconnected from the policy goals and evidentiary requirements applicable to cooperative agreement applications. (See *infra* at Section IV for more detailed discussion of inaccuracies in the staff comments.)

Staff urge the Authority and Commissioner to scrutinize the Parties' merger under the methods of the FTC-Department of Justice Horizontal Merger Guidelines. (See 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 a cooperative agreement application. The Virginia 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 anticompetitive. Rather, under the Cooperative Agreement Law, mergers that might be anticompetitive under the antitrust laws can be authorized pursuant to a policy that supplants "competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority." [12]

The regulatory program replaces any lost market-based competition in order to achieve pro-consumer benefits in other ways. It does this through mechanisms such as rate restrictions to ensure reasonable prices, conduct restrictions to ensure non-exclusionary practices, obtaining commitments from the Parties to pursue high quality performance, and obtaining 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 Southwest Virginia's rural patients. All of the latter commitments offer significant public advantage above and beyond market protections. Active and ongoing supervision of these commitments is implemented, moreover, to ensure the system's compliance with the policy goals articulated by the Legislature in the Cooperative Agreement Law that displaces competition with regulation. Staff's antitrust/Merger Guidelines analysis does not take proper account of this regulatory framework.

B. Efficiencies In A Cooperative Agreement Are Not Governed By Antitrust Analysis

The gap between staff's antitrust-centric analysis and that which the Authority must undertake in this proceeding is perhaps most pronounced with respect to consideration of the cost efficiencies and other community benefits likely to flow from the merger. Under the

[12] Virginia Code Section 15.2-5384.1.A.

Cooperative Agreement Law, even potentially anticompetitive mergers qualify for approval if the totality of cost-savings, synergies, community benefits and other advantages from the merger (collectively herein, "efficiencies") exceed the disadvantages that may result from the loss of competition between the merging Parties. [13] The potential disadvantages can be minimized by mechanisms such as rate caps for pricing, restrictions on anticompetitive conduct, commitments to improve quality measurably, and active supervision along with the power to withdraw approval of the cooperative agreement.

The staff's approach to efficiencies under its Merger Guidelines is focused solely on whether the efficiencies enhance *competition* – not on other policy goals, such as Virginia's policy "to facilitate the provision of quality, cost-efficient care to rural patients." [14] The FTC does not credit an efficiency unless that efficiency is "merger-specific" (likely achievable only through the merger at issue or another 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)

Each of these antitrust-focused efficiency restrictions in the Merger Guidelines operates to further federal antitrust law's principal purpose, which is to *prevent* mergers and conduct that are anticompetitive. Conversely, the purpose of the Cooperative Agreement Law is to create a pathway for *approval* of mergers which might be seen as anticompetitive if they qualify under the statute's balancing test for benefits versus disadvantages, coupled with active supervision to ensure that the balance of net benefits is maintained in keeping with state policy. Efficiencies that would not be credited under the Merger Guidelines because they would not be sufficient to reverse the merger's potential harm in a specifically defined relevant market can be accorded weight under the Cooperative Agreement Law. Virginia Cooperative Agreement Law establishes a regulatory program with substantial checks on the merged entity's ability to charge anticompetitive prices or engage in exclusionary conduct, along with active supervision to ensure compliance. Such is the case with this merger, which sharply limits any risk of potential disadvantages while enabling the provision of numerous benefits of substantially greater weight. It should also be noted that due to the significance of the investment commitments being made by the merged system, there is overwhelming incentive for the system to achieve the synergies outlined in the Application.

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 belied by the facts and should be rejected.

[13] Virginia Code Section 15.2-5384.1.E.1 and F.2.
[14] Virginia Code Section 15.2-5368.B.

C. West Virginia Recently Rejected The Same Staff Arguments

Conspicuously absent from staff's submission is any reference to the recent detailed and carefully reasoned decision of the West Virginia Health Care Authority ("WVHCA") approving a cooperative agreement between two West Virginia hospitals.[15] The WVHCA approved that cooperative agreement pursuant to a recently enacted West Virginia statute very similar to the Virginia statute, including provisions for ongoing oversight and active supervision by state agencies of cooperative agreements and exemption from scrutiny under state and federal antitrust laws. Just like the Virginia Cooperative Agreement Law, the West Virginia statute requires the WVHCA to weigh the advantages and disadvantages of a proposed cooperative agreement by taking into consideration many of the same factors that are set forth in the Virginia statute.

In the proceeding before the WVHCA, staff filed a lengthy opposition to the West Virginia hospitals' application that was very similar to staff's submission in this case. The WVHCA rejected staff's arguments on a variety of grounds. Most notable is the WVHCA's response to staff's attempts to persuade it to analyze the proposed merger using the same traditional antitrust/Merger Guidelines approach that staff espouse here. 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 Authority'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)

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

- 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 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 Authority 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 those for 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 the 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 the 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 the 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.
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> [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 WVHCA's rationale for its rejection of staff's antitrust law arguments concerning the application for a cooperative agreement in that state has equal force in the Southwest Virginia region and proposed Cooperative Agreement here. Accordingly, the staff's comments to the Parties' Cooperative Agreement should also be rejected.

IV. STAFF'S COMMENTS ON THE STATUTORY FACTORS LACK MERIT

In their comments, staff address the individual statutory factors that the Authority must evaluate when assessing the potential benefits and disadvantages resulting from the merger. Staff assess these factors under an 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 the 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 broadly that they recognize the challenges facing many states regarding unmet healthcare needs in rural communities and the regulatory and financial pressures that providers face in delivering healthcare 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 Southwest Virginia that the Parties have detailed in their Application and subsequent submissions to the Authority (briefly mentioned above). Staff do not squarely address the strained economic conditions that have led to the need for an investment of $11 million by the Parties to ensure inpatient services continue to remain available in the Southwest Virginia communities and the high number of rural hospital closures across the country. These are examples of facts that underlie Virginia's cooperative agreement policy and illustrate the rationale for the Parties' Application but the staff does 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."[16] (*Id.* at 2; emphasis added) Obviously, the Legislature has concluded that this is not the case, or at least that a regulatory program can have the potential to outperform competition's effects. The effects of a competition policy in Southwest Virginia include, among other things, a hospital closure within the past two year, and a shortage of specialists such as endocrinologists in a region suffering from a high rate of diabetes. Such specialists are difficult to support in a rural market where scarce hospital resources are significantly divided and where the competitive focus often includes a duplication of costly inpatient services. These conditions are reflected in the overwhelming community support for the merger discussed above.

Staff express concern that a Cooperative Agreement "would undermine" the Authority's goals, but they 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

[16] See Section I. above for comments in support of the merger from area employers.

health, addiction recovery and treatment, expansion of specialty services and the other region goals if the Authority denies the Parties' Application. In fact, since the Authority has no alternative funding source for addressing these priorities, the 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.

A. Staff's Market Share And Concentration Analysis Are Not Informative

Staff argue that benefits from the Cooperative Agreement do not likely outweigh the disadvantages and that the merger "would likely lead to increased prices and reduced quality and availability of healthcare services in Southwest Virginia and Northeast Tennessee." (staff comments at 8) The staff's discussion does not take into account the fact that the merged health system will be subject to a rate cap commitment that will prevent anticompetitive prices. It also does not address the Parties' commitments to improve quality and expand access, among other things. There also is no discussion by staff of the active supervision that Virginia will exercise over the merged entity.

Staff evaluated the Cooperative Agreement Law's statutory factors "in conjunction with [their] standard analysis under the Merger Guidelines" (*Id.*) Staff concluded that Mountain States and Wellmont are competitors and the two largest health systems in their 21-County geographic service area in Virginia and Tennessee. This is not in dispute. The staff discussion of market shares and concentration statistics merely informs the Authority that in the staff's view the merger may be anticompetitive. The staff's discussion does not address whether the benefits from the merger outweigh its disadvantages under the Cooperative Agreement Law.

Staff's market share and concentration analysis also highlight the fact that it was highly foreseeable to the Virginia General Assembly when it enacted the Cooperative Agreement Law that one of the few hospital mergers (or perhaps the only one) that would potentially trigger an application for a cooperative agreement in the region targeted by the law was a Mountain States-Wellmont merger. The Cooperative Agreement Law only applies to the Southwest Virginia region served by the Authority; it does not apply to any other region in the Commonwealth. This suggests that the Legislature passed the law with this very merger in mind as one that has the potential to improve the cost and quality of healthcare services to meet the significant and challenging needs of the rural patients in Southwest Virginia. The staff cannot and should not supplant the judgment of the Legislature with their own policy priorities. The Legislature clearly recognized the potential that such a merger would have for the region.

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

In their comments at subparts 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 19 & 21) Staff, cross-referencing to Section VI.A of their submission, state that the price commitments made by the Parties to the Authority and Commissioner "are unlikely to mitigate this harm." (*Id.* at 20 & 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 state supervisory authorities.

1. Staff Err On The Timing And Effect Of The Rate Commitments

As set forth in the Application, the Parties have agreed to two distinct rate commitments. The first is to reduce any inflator increase for Principal Payers by 50% in the first contract year following the first fiscal year after the formation of the New Health System ("One Year 50% Rate Reduction Commitment"). This would automatically reduce the rate of increase in any existing Principal Payer contract with a fixed inflator or indexed inflator measured by a particular index by 50% of the fixed rate. The second commitment is to 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).

The staff have made two erroneous assumptions concerning the timing of the Parties' rate commitments. Staff mistakenly assume that these commitments are intended to operate only in sequence, with the Rate Cap Commitment taking effect only *after* the One Year 50% Rate Reduction Commitment has expired. This error further leads staff to assume that there will be a one year gap following consummation of the merger before any rate commitment enters into effect. Both of these assumptions are wrong.

The Parties commit to apply the Rate Cap Commitment *immediately upon consummation* of the merger. The meaning of this commitment is clear. First, the Rate Cap Commitment will apply to *existing* Mountain States or Wellmont Principal Payer contracts that are in effect at the time the merger is consummated. Thus, if an existing Principal Payer contract provides for a 4% annual hospital rate inflator and the calculated hospital rate cap at the time the merger is consummated is 3%, then the annual inflator under that contract will be reduced to match the rate cap. Second, the Rate Cap Commitment will apply *with immediate effect* to any future Principal Payer contracts signed after consummation of the merger. Thus, if the New Health System enters into a new contract with a Principal Payer 90 days after consummation of the merger, the Rate Cap Commitment will apply. Contrary to staff's assertions, there is no window following consummation of the merger during which the New Health System could negotiate contracts with Principal Payers that are not subject to any rate commitments.

In addition to the immediate benefit of the Rate Cap Commitment, the Parties have also agreed to a One Year 50% Rate Reduction Commitment. The meaning of this commitment is also clear. In the first fiscal year following the first contract year after the consummation of the merger, the New Health System will reduce existing fixed rate increases in commercial contracts with Principal Payers by 50%.

An example using a contract with multiple year inflators of 4% is illustrative. Assuming for analysis that the merger closes January 31, 2017, the Rate Cap Commitment would be

immediately applied. In an example where the previous year hospital specific CPI is 3.25%, a rate cap of 3% would be applied to this contract, *immediately* lowering the inflator for that year from 4% to 3%. Then, during the first full fiscal year following the first contract year after the close (in this case the period of July 1, 2018, through June 30, 2019), the annual inflator of 4% would be reduced by half to 2% under the One Year 50% Rate Reduction Commitment. This new rate would then be compared against the annually calculated Rate Cap Commitment. If the rate for this period was higher than the calculated Rate Cap Commitment for that period, the rate would be *further* reduced to the Rate Cap; if it was lower it would remain reduced by 50% off the original until the next period. For all periods after that, the Rate Cap Commitment would remain in effect. Clearly, under the Parties' commitments, a savings would be obtained versus the original contract.

Payers have the ability to verify and validate the rate commitments using common models and methods used currently and to provide feedback or express any concerns to the Authority and Commissioner.

2. Staff Wrongly Claim the Rate Commitments Would Not Protect Patients

Staff assert that because the Parties' rate commitments would not apply to any "governmental plans offered by payors where prices are negotiated," many patients in the region would be unprotected against price increases. This assertion is inaccurate. Although the original definition of "Principal Payers" in the Parties' Cooperative Agreement Application inadvertently excluded governmental plans offered by payers where rates were negotiated (e.g. Medicare Advantage plans and Medicaid managed care plans), the Parties have agreed in discussions with the Authority to correct this unintended omission. The revised definition of "Principal Payers" includes commercial payers *and governmental payers with negotiated rates* who provide more than two percent (2%) of the New Health System's total net revenue.

The Parties' rate cap commitments will therefore apply to governmental plans offered by payers to the extent rates are negotiated with those payers. Rate changes that occur as the result of government actions (*e.g.*, market basket adjustments, adjustments tied to area wage indices, or other governmentally imposed rate adjustments) would not be covered by the rate commitments. The limitations on pricing to which the Parties have agreed are intended to protect consumers from pricing increases as a result of the merger. To the extent pricing for insurers providing coverage on behalf of governmental payers is tied contractually to Medicare rates (i.e., a percent of Medicare), the Cooperative Agreement is not intended to interfere with such pricing relationships.

3. Staff's Claim That CPI Is An Inappropriate Benchmark Is Unfounded

Staff assert that use of a CPI as a benchmark in the Parties' rate commitments is inappropriate, arguing that these benchmarks could overstate cost changes in Virginia and Tennessee if during some year, average costs in these states were to grow more slowly than they do elsewhere (e.g., on average for the nation as measured by the CPI). Staff miss the essential points with regard to a CPI-based measure, which are that it is calculated on a consistent basis,

reflects the range of highly relevant health care input costs and is provided by a government agency on a reliable basis. Staff also ignore commercial realities. Health systems and payers in Virginia, Tennessee and across the nation routinely utilize the CPI as a reliable benchmark for contracting and other purposes in the ordinary course of business. The CPI has the advantage that it is derived on a consistent basis each year, and includes relevant categories of inputs and costs. In addition, the proposed formula already reduces the relevant hospital and medical care CPI by .25% to calculate the applicable rate cap.

The Parties' rate commitments are designed to be transparent and based on neutral and reputable benchmarks that are familiar to all stakeholders, and that would be available for the foreseeable future to be used as benchmarks. The Parties remain committed to working with the Authority and the Commissioner to assure that the rate commitments are anchored to an appropriate benchmark.

4. Staff Wrongly Claim The Rate Cap Is Also A Rate Floor

Staff assert that while the rate cap formula "may guarantee insurers a rate no higher than the cap, it also guarantees a rate no lower than the cap" – implying that the cap will become a floor. Staff makes such a guarantee without offering any evidence to support it. Further, this view ignores the realities of commercial negotiations. Data and information on the CPI is readily available to all, as will be the rate cap. Accordingly, 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. Parties will be negotiating from a narrow range. Given recent changes in CPI, the rate cap is likely to be in the 2-4% range in upcoming years, which reflects a very modest rate of change for new contracts. The rate cap is also considerably below the model-predicted (and highly unrealistic) estimate of 130% price increases that FTC staff references[17] and well below any levels that would appear

[17] Staff provide little 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 and which importantly do not account at all for practical realities of negotiations with major payors 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, Competition Economics LLC, *An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance*, 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 Authority to an economic paper that predicts a potential price increase of 130% – 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 Authority 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)

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.

Also ignored by the staff is the relative market and bargaining power of the largest payer in the Southwest Virginia region, Anthem. With commercial market share of greater than 80 percent in the Virginia communities to be served by the New Health System (rising to more than 90 percent if Anthem's merger with Cigna - under challenge by the Department of Justice as anticompetitive - were to be consummated), Anthem's market position is dominant, giving them substantial market power potentially to impose rates and certainly not to fall victim to rates by a health system subject to a limiting rate cap and active supervision.[18]

Ultimately, the proposed rate caps represent a substantial benefit for insurers and patients in Southwest Virginia (and Northeast Tennessee). Despite staff's claims to the contrary, the commitments will begin to impact insurers and patients immediately upon consummation of the merger. The commitments are tied to reasonable indices that create transparency to enable commercial payers and state regulators to verify compliance with the commitments.

Staff's concerns that the Parties could somehow manipulate the metrics and formulas to feign compliance are unfounded. Already today, providers and payers rely on sophisticated modeling methodologies that enable them to model, for an existing patient population and specific services, current payments and projected payments under new rate structures. None of this will change with the merger. Compliance with the rate cap commitments can be easily monitored and the Parties will be held accountable for the commitments.

The Parties have pointed out that a denial of their Application for a Cooperative Agreement, which staff advocate, would present a 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.[19] An out-of-market acquisition has substantially lower potential for cost savings in traditional efficiencies as well as important health and other medical expenses. Consequently, there is a significantly higher risk that rates in Southwest Virginia will be higher if the Cooperative Agreement is denied than if it is granted. Under the Cooperative Agreement, the merged system will be subject to rate caps. Absent a Cooperative Agreement, however, there would be no antitrust impediment to an acquisition of Wellmont or Mountain States by a non-competitor, no reason for a Cooperative Agreement, and therefore no likelihood of 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

[18] "Covering nearly 3 million residents, Anthem is by far Virginia's largest insurer. As of June 2015, it had 22.14 percent of the state's accident and sickness insurance market..." "Va.'s Bureau of Insurance advises against Anthem-Cigna merger" Richmond-Times Dispatch, August 1, 2016, *available* at: http://www.richmond.com/business/local/article_07cf1479-86c8-5c05-aa4c-cad5686787b0.html.

[19] See February 24, 2015 Workshop Transcript: Examining Healthcare Competition Hosted by the Federal Trade Commission and U.S. Department of Justice, Antitrust Division, *available at*: https://www.ftc.gov/system/files/documents/public_events/618591/transcript-day1.pdf.

health care market." (staff comments at 26) The Parties never claimed differently. The point is that an out-of-market merger raises a tangible risk of higher prices and the Cooperative Agreement does not, because the latter is subject to price regulation and the former is not. Moreover, this transaction provides opportunities for substantial community benefits not achievable by out-of-market health systems.

C. Staff's Arguments On Quality And Access Are Not Supported

Staff's arguments that quality will suffer due to the merger are baseless. Staff 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 the 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, 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.[20]

Staff attribute incentives to innovate and expand service lines to competition. (staff comments at 22) However, competition may also lead to unnecessary cost, and duplication of core services, which reduces resources available for innovation or expansion. By reducing unnecessary duplication, the New Health System will be better positioned to invest in expanded services, and it has committed to make a definitive investment of $140 million in those services.

Staff erroneously contend that the merger will result in reduced access and quality in regard to certain physician specialty services. (staff comments at 21) Staff 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. This commitment undermines staff's assertion that the merger is not consistent with the Authority's *Blueprint* goals regarding access to physician specialty services and other needed services. Staff also largely ignore the substantial independent physician population in the area.

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

The Authority should evaluate the 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 Southwest Virginia (and Northeast Tennessee), that take into

[20] For 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, September 30, 2016, available at: http://kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/.

consideration the unique features and challenges of this region, and that will be subject to active supervision by the Commonwealth.

The 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. As the West Virginia Health Care Authority recently asserted in rejecting similar arguments by the staff in the Cabell Huntington cooperative agreement, this Application 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.[21] Staff do not dispute the principal factual justifications for the merger set forth in the Application. These include:

- Southwest Virginia disproportionately suffers from serious health issues, with higher rates of health risks than the Commonwealth overall in such areas as obesity, blood pressure, cholesterol levels and substance abuse. (Application at 10, 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 Virginia for the exact same services. (Application at 72, 82)

- Inpatient utilization is declining and the population in the area overall is declining, resulting in less utilization of inpatient facilities.

- 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 20-21)

- Patients are willing to leave the Parties Geographic Service Area to obtain services elsewhere, particularly for specialty services. (Application at 21; July 13 Authority Responses at 51)

[21] In their comments, staff rely on who it refers to as "our [i.e. staff's] quality expert" and a Dr. Kizer for support (staff comments at 31, 37), but provide no further information about the qualifications and the bases of the opinions of these individuals. There is no evidence these individuals have awareness of the issues in Southwest Virginia, 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, the staff's reliance on these individuals should not be considered.

- 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.

The 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 Authority and the Commonwealth to ensure they are aligned with the Authority's and Commonwealth's goals. Once established and agreed upon, the Commonwealth will actively supervise the merger to ensure these commitments are met. Importantly, there are many quality and health improvement commitments which are not challenged by the 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 Authority and its staff, and feedback from the Community Health Work Groups (discussed below) and academic partners.[22]

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) The 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, the 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 the Commonwealth and Tennessee:

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

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

[22] The plan was prepared in conjunction with the public health resources at East Tennessee State University. See July 13, 2016 Responses to Southwest Virginia Health Authority Questions dated May 27, 2016 ("July 13 Authority Responses"), Exhibit 18.

- **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.[23]

- **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 6-7)

The Application provides comprehensive commitments addressing fundamental health issues and priorities in Southwest Virginia 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 Commonwealth. The Application describes 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 Commonwealth, will achieve a result for this region that negates the 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 Cooperative Agreement Law, along with the Authority's *Blueprint* goals, the Virginia Plan for Well-Being and local business and community goals.

The 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 Southwest Virginia, and ignore the priorities that are well established by Virginia health authorities and the Virginia Legislature, and the substantial new investments required to address the region's health needs and improve access, quality, and cost of care delivery in this region.

1. Staff Ignore Key Facts And Fundamentals About Southwest Virginia

The region faces key health issues, the resolution of which are Virginia's highest priorities in order to improve health, access, cost, quality, and outcomes: *Southwest Virginia and Northeast Tennessee disproportionately suffer from serious health issues.*[24] The cost of this poor health is not sustainable for the well-being of the region's communities.

[23] As discussed below, the 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 1 1/2 hours away from some of the Virginia markets that would be served by the New Health System.

[24] 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

This region is a unique geographic area that requires a unique solution to its significant health care challenges. With the approvals of Virginia and Tennessee, under the Virginia Cooperative Agreement and the Tennessee Certificate of Public Advantage, respectively, 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 10)

The staff's submission only tangentially refers to the specific geography, population, and health issues facing the Southwest Virginia area and ignores the substantial health care challenges of the area, of which the Parties have first-hand knowledge. As shown in Exhibit 1 – Virginia Geographic Service Area Statistics attached hereto, virtually all of the residents of the counties served by the New Health System in Southwest Virginia live in areas classified as rural;[25] and sixteen of the counties in the overall Geographic Service Area (excluding the Independent Cities) are more than 50% rural.[26]

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 Virginia government authorities, and the Application specifically addressed those issues. As noted previously, the Authority's *Blueprint*[27] identifies many critical issues for the Southwest Virginia counties served by the New Health System, including tobacco use, obesity, teenage pregnancy, low birthweight babies and substance abuse issues:[28] The Southwest Virginia statistics on these show serious issues:

(1) The 2015 America's Health Rankings report[29] finds that Virginia ranks 31st in the nation in smoking. Virginia counties in the Geographic Service Area exceed the national average for smoking and range from a low of 21 percent (21%) to a high of 33 percent (33%).
(2) Virginia counties have obesity rates that exceed the Virginia state levels, ranging from 29 percent (29%) to 35 percent (35%).

Health Rankings & Roadmaps, *available at*: http://www.countyhealthrankings.org/. Tennessee county-level data for the region is available at "2015 Drive Your County to the Top Ten," Tennessee Department of Health, Division of Policy, Planning, and Assessment, July 2015; *available at*: https://www.tn.gov/health/topic/specialreports/.

[25] The 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://ahrf.hrsa.gov/. Total Population is from the U.S. Census Bureau's 2010 Census Redistricting Data (Public Law 94-171) Summary File. Rural residency is available from the Census of Population and Housing: Summary File 1 (SF1) Urban/Rural update.

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

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

[28] All references to "Virginia counties" refer to counties in the New Health System's Geographic Service Area.

[29] *Virginia State Data*, America's Health Rankings, United Health Foundation, Annual Report 2015, *available at*: http://www.americashealthrankings.org/VA.

(3) Teenage pregnancy rates in the Virginia counties exceed the national average of 26.5 births per 1,000 adolescent females,[30] and four of those counties have rates that exceed double the national average (Dickenson, Lee, Smyth, and Wise).
(4) Only three of the Virginia counties– Grayson, Russell and Wythe – have low birthweight rates that are better than the state average.
(5) Of the eleven Virginia counties in the Parties' Geographic Service Area, all eleven exceed the state average for mortality rate due to drug poisoning. Dickenson County's rate is the highest in either Virginia or Tennessee. (Application at 68-71)

The Virginia County Health Rankings submitted in the Application, and attached hereto as Exhibit 2, demonstrate that physical inactivity, obesity, tobacco abuse and substance abuse are major health challenges that disproportionately impact residents of Southwest Virginia, and are associated with other health challenges and conditions. Additionally, the County-Level Data in the Application and attached hereto as Exhibit 3, provide key statistics on the population in all Virginia counties in the service area, and Virginia state-wide averages for physical inactivity, obesity, tobacco use, and substance abuse. (Application at 70) The county-level data show that all Virginia Counties in the region exceed the state average in these four categories.

The data on health conditions and issues in Southwest Virginia 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 Commonwealth's and the Authority'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, as well as the Technical Advisory Panel that will work to define the ongoing Quantitative Measures for the Cooperative Agreement.[31] The staff 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 Virginia.

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

a. Overview

The 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.[32] While the 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

[30] *Trends in Teen Pregnancy and Childbearing*, Office of Adolescent Health, U.S. Department of Health & Human Services, *available at::* http://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html and search "Trends in Teen Pregnancy and Childbearing."
[31] 12VAC5-221-120.
[32] Many of the specific commitments made by the Parties are not challenged by the staff.

information and require agreements between the Parties on the services which each will offer and 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 efficiencies, as staff contends (staff comments at 44), any such synergies would benefit the out-of-market acquirer, not the local region. 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 with daily censuses of 35, 13 and 10 is ignored.[33] 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. Continued access to appropriate hospital-based services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement.

As an example of the duplicative services that the New Health System can potentially consolidate 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 Parties' statement that these centers are duplicative and that consolidation would likely result in lower cost, but instead hypothesize about potential patient inconvenience. Staff ignore the fact that the savings generated could instead be invested in more needed services for the region such as pediatric trauma.[34] Further, staff speculation about additional travel time to reach a trauma center 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. As demonstrated in the Application, consolidation of the Level I Trauma Centers can improve outcomes. (Application at 38) The staff's only response is to cite an unnamed "quality expert" who speculates that the trauma centers may have already reached a volume/outcome threshold. (staff comments at 31) The staff 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.

As noted by the Parties in the Application, health care services offered by rural hospitals are at increasing risk of closure, with 78 rural hospitals closing since 2010, including eight in Tennessee and one in Virginia.[35] The Parties collectively invested more than $19.5 million last year alone to to ensure that inpatient services would remain available in smaller communities.

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[33] Based on the 2013 data. See Application Tables 5.2 and 5.3 at 18-19.

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

[35]. *See 78 Rural Hospital Closures: January 2010 – Present*, The Cecil G. Sheps Center for Health Services Research at the University of North Carolina, *available at*: https://www.shepscenter.unc.edu/programs-projects/ruralhealth/rural-hospital-closures/ (accessed October 13, 2016). Twelve rural hospitals have closed since the Application was filed in February, 2016, including two rural hospitals in Tennessee.

(Application at 81) Of that $19.5 million, $11 million was directed to the Parties' Virginia hospitals. 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 $27 million 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 40) 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, especially due to the lack of pediatric specialists in the rural areas of Southwest Virginia. (July 13 Authority 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. It is misleading for the staff to list all hospitals that offer pediatric services when pediatric specialists *do not* exist in these areas. Contrary to what the staff say, the Parties believe that pediatric specialty centers and pediatric emergency rooms with connectivity to local hospitals are clearly needed. Also misleading is the staff's reference to a partnership with a children's hospital in Knoxville (staff comment at 40), 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. The reality is that there are few pediatric specialists available in the rural areas of Southwest Virginia. 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. 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 42; July 13 Authority Responses at 41) 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 Commonwealth in the Certificate of Public Need process, or for services which do not require a Certificate of Public Need.

b. Contrary To Staff's Assertion, Behavioral Health Services Are Needed; The Parties Have Committed To Provide These Services

The staff specifically recognizes 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 32) 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 91-92) 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 92)[36]

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 94)

The staff attacks this commitment, arguing that Mountain States and other organizations are already willing to develop new facilities, but cite a *planned* Mountain State/Frontier Health facility in Gray, *Tennessee*, which is approximately 25 miles from Bristol, Virginia, but as much as 1 1/2 hours away from some of the Virginia markets served by the New Health System.[37] The 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.[38] While the staff apparently recognize the serious need for behavioral health services, its hands-off solution ignores the needs of the region.[39] 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.

c. A Common Clinical IT Platform Yields Higher Quality And Cost Savings

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. The staff's opposition lacks credibility. The staff first argue that each hospital system has well-functioning electronic health records ("EHR") systems that are fully integrated within their respective hospitals, ignoring the fact that the commitment is for a Common Clinical IT Platform ***between*** the hospital systems.

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[36] This 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 94)

[37] 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.

[38] ETSU and MSHA agreed to let elected officials consider alternative locations to the Gray Commons site targeted by the parties.

[39] Staff also cite to Mountain States' opposition to a Certificate of Need Application for a new inpatient psychiatric facility in Kingsport, Tennessee. However, that opposition was based on the fact that Mountain States' current facility averages 50% charity and Medicaid patients, while the for-profit applicant indicated it would do less than 5% charity or Medicaid. Accordingly, the applicant's cherry picking of commercial paying patients would significantly undercut Mountain States' ability to continue to subsidize care for the poor. Mountain States has always recognized the need for additional outpatient behavioral services, which are not addressed in the CON application.

The staff then speculate that such a Common Clinical IT Platform would not benefit patients who choose to use only one hospital system, 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. The staff then suggest that such a Common Clinical IT platform should be done with an entity other than a competitor, 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. The staff's skepticism of the value of a Common Clinical IT Platform is directly contrary to federal policy attempting to increase interoperability.[40]

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. 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 15.a.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 36) 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.

Many of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers. These practices will 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

[40] See "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-roadmap-advance-health-information-sharing-and-transform-care.html.

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 36)

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. (staff comments at 35-36) 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. (July 13 Authority Responses at 22-26)

d. Increased Transparency Of Quality Reporting Is A Substantial Benefit

The Application describes a wide range of comprehensive quality metrics which the new system will publicly and timely report. The staff does 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. The 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 Commonwealth.

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 measures[41] 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 report them 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.

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

- 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.[42] CMS periodically changes the core measures it requires hospitals to report.

- 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 CMS[43] 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 eighty percent (80%) of the discharges from the New Health System facilities:[44] 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

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

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

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

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.

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.

e. 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 41-42) 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 the 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 41) For example, due to financial constraints, Mountain States has cut ten funded residency slots since 2012, and Wellmont has also reduced funding for residency slots. 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% to 50% 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.

The staff does not question the importance of this academic funding and the fact the Parties have been reducing funding for residency slots. Contrary to the staff's assertions, this $85 million funding is incremental and would not be possible in the absence of the savings from the merger. The staff also contends that the Parties already "invest significantly in healthcare education" (staff comments at 38), but do not dispute the importance of this additional funding. While the staff complains that the commitments are not specific enough, they ignore the fact that the Commonwealth will actively supervise compliance with this important commitment.

E. Summary Of Commitments

To assure the Authority 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/certificate of public advantage that were granted in our neighboring states of North Carolina (Mission Health COPA) and recently West Virginia (Cabell Huntington cooperative agreement).[45] 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 Cooperative Agreement Law. Many of the commitments can be categorized into the following areas, which align with the Cooperative Agreement Law'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 current commitments in each of these categories are outlined in Exhibit 4 "Commitments Outlined in the Application" attached hereto. 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.[46]

Now that the Application has been deemed complete and the Authority is reviewing the Application, the Parties have been engaged in productive dialogue with the Authority about the commitments. Based on its extensive knowledge of the health care needs of the region, the Authority 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 and measured by the Authority and the Commissioner on an ongoing basis after the Cooperative

[45] Some 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.
[46] See especially Section 15 of the Application.

Agreement is approved. The Authority 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, or would make certain commitments Virginia-specific. The discussions with the Authority are ongoing as of this date. The Authority'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 her review of the Cooperative Agreement, may have additional input on specific focus of the commitments and how achievement of these commitments should be shown.

The staff's submission criticizes the Parties' commitments as not addressing anticompetitive effects, but, as noted in detail above, the proper analysis of the Parties' commitments under the Cooperative Agreement Law is whether the benefits accruing from the commitments in their totality outweigh any disadvantages from a reduction in competition. We emphatically believe they do and submit that the facts demonstrate this.

1. FTC Staff's Criticisms Of The Commitments Have No Merit

The 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 Virginia'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 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.[47] 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.

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.

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 argues that the Virginia Legislature established a policy that cannot work, and that

[47] A more detailed discussion of why the staff's comments regarding the Parties' rate commitments lack merit is in section IV.B.1 above.

the Authority and Commissioner are unable to do what is needed to make the Cooperative Agreement successful for the region. Both opinions are flatly wrong. The Authority 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 her 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 Virginia Department of Health 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/ COPAs if more commitments are agreed upon by the Parties and the Authority 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 Cooperative Agreement Law and without regard to how the Authority and the Commissioner make their final determinations of compliance. As previously mentioned, the Parties have made significant progress with the Authority toward making stronger and clearer commitments about quality and how achievement can be measured, and they expect this dialogue to continue with the Authority and with the Commissioner and her staff during her 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 Authority and 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 57) Their argument shows a lack of understanding of the region and its health care trends. Patients in Southwest Virginia are capable of and do seek health care at alternative systems. There are inpatient hospitals not affiliated with either Wellmont or Mountain States in Wythe, Tazewell, and Buchanan Counties in Southwest Virginia, for example. In addition, there are other third-party hospitals in Roanoke, Asheville, Boone, Pikeville, Winston-Salem, and Knoxville where patients regularly seek care, as well as academic medical centers in the region and beyond. 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.

Staff criticize the Parties' contractual commitments[48] as not doing enough to solve the problem of lost competition. Again, the Virginia Cooperative Agreement Law contemplates that

[48] These 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.

competition will be lost in exchange for overriding benefits to the region. The contractual commitments are yet another part of the overall benefits to flow to Southwest Virginia that outweigh any disadvantages of lost competition. We note that our commitments go beyond those accepted in the successful Mission Health COPA.

F. Staff Criticisms Of The Plan Of Separation Are Speculation

Staff claim at pages 59-61 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 59; emphasis in original) This is because the antitrust agencies seek to prevent mergers with anticompetitive effects from ever occurring. The Cooperative Agreement Law, in contrast and as discussed above, expressly authorizes approval of a merger with anticompetitive effects in Southwest Virginia 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 Commissioner 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 Cooperative Agreement Law gives the Commissioner the authority to investigate 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 Law.[49]

Staff list a set of purported deficiencies in the Plan of Separation needed to, in their words, "restore pre-merger competition." (staff comments at 59) Their comments lack merit. As a threshold point, staff misstate the regulatory requirement for the Plan of Separation. The Virginia Rules and Regulations Governing Cooperative Agreements[50] ("Cooperative Agreement Regulations") establish that a Plan of Separation is a written proposal submitted with an application to return the parties to a *preconsolidation state*.[51] 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.

[49] Virginia Code Section 15.2-5384.1.G and H.
[50] 12VAC5-221-10 *et seq.*
[51] 12VAC5-221-20.

It is important to note that, at the request of the Tennessee Department of Health, the Parties revised the initial Plan of Separation (submitted as Exhibit 18.1 in the Virginia 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 5.

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

Staff assert at pages 62-65 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 Virginia Legislature and do not address the facts concerning the Parties' Application for a Cooperative Agreement. One of the states that enacted a cooperative agreement law with which staff have concerns is West Virginia, where, as described above, the West Virginia Health Care Authority 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.[52]

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.[53] The 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 North Carolina despite having the highest Medicare and Medicaid Payer mix in North Carolina.[54] 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.[55]

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

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[52] See "Morrisey hails FTC decision to withdraw challenge to Huntington hospital merger," West Virginia Record, July 7, 2016, *available at*: http://wvrecord.com/stories/510955448-morrisey-hails-ftc-decision-to-withdraw-challenge-to-huntington-hospital-merger (accessed October 14, 2016).

[53] See "Legislation Repeals COPA" Mission Health website, *available at*: http://scope.connectwithmhs.org/content/legislation-repeals-copa (accessed October 14, 2016).

[54] See "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).

[55] See " 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).

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 62) 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 62 n.260) Staff chose not to advise the Authority 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."[56]

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 Virginia resolved its public policy in 2015. Its policy is one that promotes the approval of Cooperative Agreements for health care transactions in Southwest Virginia 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 Virginia, particularly in light of the absence of substantial facts that supports their position.

Importantly, while the 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 Authority 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.[57] 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.[58] 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

[56] See RANDALL R. BOVBJERG & ROBERT A. BERENSON, URBAN INSTITUTE, CERTIFICATES OF PUBLIC ADVANTAGE: CAN THEY ADDRESS PROVIDER MARKET POWER? 22 (2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf (accessed October 14, 2016).
[57] *Id.*
[58] See http://www.charlotteobserver.com/news/local/article83142307.html.

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 the 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 of which was terminated in 2007. (staff comments at 63-64) Staff refer to a blog site that purports to report price increases that followed repeal of the COPA statute in Montana. (*Id.* at 64 n.266) 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."[59] 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% lower than . . . Montana peers for inpatient and outpatient care combined, according to the most recent data from the Montana Hospital Association."[60] If this is true, then even after the COPA was repealed and prices increased, the prices remained 16 percent below peer hospitals. The article shared by the 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.

CONCLUSION

The staff's application of traditional merger analysis to the cooperative agreement framework established by the Virginia General Assembly is incorrect. The Cooperative Agreement Law sets forth Virginia's policy to supplant competition with a regulatory program to permit cooperative agreements that are beneficial to citizens served by the Authority 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 Cooperative Agreement Law and demonstrate that the significant benefits to the people of Southwest Virginia will outweigh any anticompetitive effects of the merger. The staff's misplaced analysis along with the unsubstantiated claims and inaccuracies contained in their submission lead to the conclusion that the Authority should disregard and reject the assertions of the staff's submission.

[59] http://missoulanews.bigskypress.com/IndyBlog/archives/2014/03/26/great-falls-hospital-merger-holds-lessons-for-missoula
[60] *Id.*

Exhibit 1

Virginia Geographic Service Area Statistics[1]

County Name	Total Population	Percent Rural	Rural Population
Grand Total	***962,309***	***52.0%***	***500,270***
Buchanan, VA	24,098	100.0%	24,098
Dickenson, VA	15,903	100.0%	15,903
Grayson, VA	15,533	99.9%	15,514
Lee, VA	25,587	99.6%	25,475
Russell, VA	28,897	88.2%	25,483
Scott, VA	23,177	82.1%	19,034
Smyth, VA	32,208	75.3%	24,248
Wythe, VA	29,235	75.3%	22,023
Washington, VA	54,876	71.7%	39,333
Wise, VA	41,452	56.7%	23,491
Tazewell, VA	45,078	51.9%	23,390
Norton City, VA	3,958	2.6%	102
Bristol City, VA	17,835	0.0%	7

[1] Norton and Bristol, VA are Independent Cities. The full listing of statistics for the Geographic Service Area may be found in Table 5.1 of the Application.

Exhibit 2

Virginia Geographic Service Area Health Rankings[1]

Service Area Health Rankings By State, County or City	Overall State or County Health Rank	Percentage of Adults Reporting Fair or Poor Health	Percentage Of Adults That Are Obese	Percentage of Adults Who Are Currently Smokers	Percentage of Children In Poverty	Drug Poisoning Mortality Rate per 100,000 Population
Virginia	21st	14%	28%	18%	16%	9
Buchanan	132/133	29%	29%	30%	33%	37
Dickenson	130/133	31%	29%	32%	28%	53
Grayson	74/133	20%	32%	22%	29%	Not Reported
Lee	116/133	29%	29%	25%	39%	14
Russell	122/133	29%	35%	25%	26%	32
Scott	114/133	23%	34%	28%	27%	14
Smyth	123/133	29%	31%	22%	26%	15
Tazewell	133/133	29%	30%	21%	23%	37
Washington	82/133	19%	32%	24%	21%	13
Wise	129/133	24%	32%	33%	28%	38
Wythe	85/133	27%	30%	24%	22%	18

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

[1] The full listing of county health rankings for the Geographic Service Area may be found in Table 15.1 of the Application.

Exhibit 3

Virginia County-Level Data for Physical Inactivity, Obesity, Tobacco Abuse, and Substance Abuse[1]

	Physical Inactivity Score[2]	Obesity[3]	Tobacco Abuse[4]	Substance Abuse Score[5]
Virginia Average	22%	28%	18%	9
Buchanan	28%	29%	30%	37
Dickenson	32%	29%	32%	53
Grayson	30%	32%	22%	Not reported
Lee	27%	29%	25%	14
Russell	36%	35%	25%	32
Scott	35%	34%	28%	14
Smyth	23%	31%	22%	15
Tazewell	31%	30%	21%	37
Washington	30%	32%	24%	13
Wise	38%	32%	33%	38
Wythe	27%	30%	24%	18

[1] The full listing of county-level data for the Geographic Service Area may be found in Table 15.2 of the Application. Red shading indicates that the county scores are worse than the state average for that particular metric, and show that all Virginia Counties in the region exceed the state average in all four categories.

[2] Physical Inactivity: Percentage of adults aged 20 and over reporting no leisure-time physical activity. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

[3] Adult Obesity: Percentage of adults that report a BMI of 30 or more. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

[4] Adult Smoking: Percentage of adults who are current smokers. Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

[5] Substance Abuse: Drug Poisoning Mortality Rate per 100,000 Population Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps, *available at:* http://www.countyhealthrankings.org/.

Exhibit 4
Commitments Outlined in the Application

COMMITMENTS
Improving Community Health ***Enhancing Health Care Services*** ***Expanding Access and Choice*** ***Improving Health Care Value: Managing Quality, Cost and Service*** ***Investment in Health Education/Research and Commitment to Workforce***
IMPROVING COMMUNITY HEALTH
The New Health System is committed to creating a new integrated delivery system designed to significantly enhance community health through the investment of not less than $75 million over 10 years in population health improvement.
The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the Commonwealth and the New Health System in the Cooperative Agreement. Feedback from the initial community stakeholder input process provided information from which the Parties identified five potential Key Focus Areas: ensuring strong starts for children, helping adults live well in the community, promoting a drug-free community, decreasing avoidable hospital admissions and emergency room use, and improving access to behavioral health services.
The New Health System commits to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System.
ENHANCING HEALTH CARE SERVICES
The New Health System commits to spending at least $140 million over 10 years pursuing specialty services, which otherwise could not be sustainable in the region without the financial support offered by the New Health System. Specifically, the New Health System will create new capacity for residential addiction recovery services, develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents, ensure recruitment and retention of pediatric sub-specialists, and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals.
The New Health System will create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.
The New Health System will ensure recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.
The New Health System will develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes.
The New Health System will commit to the development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference. The Parties expect the

combined system to facilitate this goal by employing physicians primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.

EXPANDING ACCESS AND CHOICE

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

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

The New Health System will maintain open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the New Health System's Board of Directors.

The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health System's Board of Directors.

The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.

The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.

IMPROVING HEALTH CARE VALUE: MANAGING QUALITY, COST AND SERVICE

For all Principal Payers,[1] the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an

[1] For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers. Note that the Parties have agreed in discussions with the Authority to correct the definition of "Principal Payers" to include commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System's total net revenue.

alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer[2] are unable to reach agreement on a negotiated rate, New Health System agrees to mediation as a process to resolve any disputes.

The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers,[2] the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.

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

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

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

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

The New Health System will negotiate in good faith with Principal Payers[2] to include the New Health System in health plans offered in the Geographic Service Area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.

The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.

The New Health System will not engage in "most favored nation" pricing with any health plans.

INVESTMENT IN HEALTH EDUCATION/RESEARCH AND COMMITMENT TO WORKFORCE

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

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

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

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

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

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

Exhibit 5
Revised Plan of Separation

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.