RESPONSE BY APPLICANTS

TO SUBMISSION OF

FEDERAL TRADE COMMISSION STAFF

TO THE TENNESSEE DEPARTMENT OF HEALTH

REGARDING

CERTIFICATE OF PUBLIC ADVANTAGE APPLICATION

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

Submitted by: Mountain States Health Alliance
Wellmont Health System

Date: January 11, 2017
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Introduction

FTC staff have submitted supplemental comments to the Application by Mountain States Health Alliance and Wellmont Health System for a Certificate of Public Advantage,1 in which staff purport to “address some of the parties’ most critical errors and misrepresentations.” Staff never identify a single error or misrepresentation, but, as described below, do provide inaccurate comments, to which the Department should accord no weight in its consideration of the Application.

I. Staff Misconstrue Application of the “Clear and Convincing Evidence” Standard

While staff correctly cite the black letter law on how Tennessee courts have applied the “clear and convincing” standard, their narrow application of that standard to the Parties’ Application fails to follow the clear directive under the Hospital Cooperation Act to weigh benefits and disadvantages as a whole in determining whether the certificate of public advantage should be issued.

The Hospital Cooperation Act specifies that the Department shall issue a certificate of public advantage if it determines the applicants “have demonstrated by clear and convincing evidence that the likely benefits resulting from the [cooperative] agreement outweigh any disadvantages attributable to a reduction in competition that may result from the agreement.” Tenn. Code Ann. § 68-11-1303(e)(1). As long as the likely advantages as a whole outweigh the disadvantages by any amount, then the public would benefit from the proposed agreement and the Act requires that the certificate be issued.

The Act provides a non-exclusive list of potential benefits for the Department to consider in evaluating the cooperative agreement: enhancement of care, preservation of facilities, gains in cost-efficiency, utilization improvements, avoidance of duplication, demonstration of population health improvement, access and utilization of services by underserved populations, and “any other benefits that may be identified.” Tenn. Code Ann. § 68-11-1303(e)(2)(A)-(F). Similarly, the Act provides a non-exclusive list of disadvantages to be evaluated. Tenn. Code Ann. § 68-11-1303(e)(3)(A)-(D). The Act does not require the applicants to establish that each of the potential benefits on the list will result from the cooperative agreement. Some potential benefits may be more likely to occur than others, and some potential benefits may carry more weight than others. Similarly, some disadvantages may be mitigated or nullified and carry less weight than others.

Rather, the Act requires the Department to determine whether benefits that are likely to occur, whatever they are and taken as a totality, outweigh the disadvantages from a reduction in competition, whatever they are and taken as a whole, based on clear and convincing evidence. The clear and convincing standard does not require a large gap between likely benefits and disadvantages. It simply requires that any positive gap, of whatever size, between benefits and disadvantages be demonstrated by clear and convincing evidence.

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Staff assert that the Parties have failed to present clear and convincing evidence to support several elements of their Application: the alternative arrangements statutory factor, the elimination of unnecessary duplication, proposed investment commitments, preservation of rural hospitals, application of rate caps to value-based and risk-based contracts, the number of payers subject to the rate cap commitment, and the plan of separation. Of course it is the Department’s right and responsibility, not the staff’s, to determine whether the parties have carried their burden of proof. As we show below, staff’s assertions lack merit, and in fact each of these elements is supported by clear and convincing evidence. But the focus on individual elements of the Application should not obscure the Act’s clear directive: the success of the Application does not depend on any particular element; rather the clear and convincing standard applies to the weighing of benefits and disadvantages as a whole.

II. Response to Staff Supplemental Submission Section II:

Staff submitted their first set of comments to the Application on November 21, 2016. The Parties responded on December 19, 2016, in three primary ways. First, the Parties quoted many staff statements that reveal an unavering preference for competition over the State policy expressed through the Hospital Cooperation Act. The Parties cited U.S. Supreme Court doctrine to show that staff’s policy preference is irrelevant to this proceeding.

Second, the Parties identified the flaws in staff’s approach to analysis of the merger using the FTC’s Merger Guidelines, which provide the framework for mergers subject to antitrust law’s requirement that a merger not substantially lessen competition. The Parties directly quoted Merger Guidelines text to show that staff’s claims of “similarity” between that framework and the Hospital Cooperation Act are overstated. Under the Merger Guidelines, a merger benefit is recognized only if it enhances competition. This principle is not applicable to an analysis of cooperative agreements under the Hospital Cooperation Act, because the Act expressly contemplates the replacement of competition with State regulation. A merger’s benefits are evaluated under the Hospital Cooperation Act for how they advance health and economic policy other than competition.

Third, and comprising the largest portion of their response, the Parties specifically and factually addressed staff’s individual criticisms of the merger, as staff catalogued them under each statutory factor in the Hospital Cooperation Act.

In their supplemental submission, staff charge that the Parties’ response to staff’s comments was an attempt to shift the burden of proof to staff – a third party that submitted comments on its own volition. (supp. comments at 1) This is a frivolous charge on its face. Staff apparently base it on the number of times the Parties pointed out that staff’s claims either lack a factual predicate or reflect traditional antitrust law analysis that does not square with how evidence is evaluated and accorded weight under the Hospital Cooperation Act. Staff argue that

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2 Federal Trade Commission Staff Submission to the Tennessee Department of Health Regarding the Certificate of Public Advantage Application of Mountain States Health Alliance and Wellmont Health System (November 21, 2016) (hereinafter “staff 11/21 comments”).

their submission “included detailed references to sources, data, and analyses” supporting their conclusions. (staff supp. comments at 2) This avalanche of studies and references, however, catalogues mergers that were done outside of a regulatory framework like a COPA and were not subject to active state supervision.

The Parties, on the other hand, provided clear and convincing evidence that other COPAs led to lower costs, lower pricing and nationally recognized higher quality. Staff did not rebut this evidence. At no time did the Parties’ attempt to shift a burden of proof to staff or any other third party that submitted comments. In response to staff, the Parties identified specious claims that lack credibility or facts specific to the merger at issue. It is not burden-shifting under the Hospital Cooperation Act to hold staff or any other third party to a validation of their arguments with facts.

If staff are claiming that the Parties have not buttressed the record with facts showing clearly and convincingly that the merger’s benefits outweigh its potential disadvantages resulting from the reduction in competition between Mountain States and Wellmont, then staff have not carefully considered the record. Space does not allow a full recitation of the record that, the Parties respectfully submit, supports issuance of the COPA, but the Parties have documented that synergies totaling at least $95 million by the end of the fifth year of operations after the merger are available from the merger by eliminating unnecessary duplication and integrating the two health systems – synergies unachievable without the merger. The bulk of synergies will be utilized to provide public benefits also not otherwise available without the merger. These benefits include:

- $85 million of investment into research and academic expansion. Prior to announcement of the merger, medical residencies were being reduced and the number of physicians were declining in rural areas. The State has a compelling interest in seeing these trends reversed.
- $75 million of investment in population health – funds that would not be available but for the merger. The State has a compelling interest in these initiatives, particularly in light of the poor general health of the area’s population.
- $140 million of expenditures for expansion of addiction treatment, pediatric services, mental health and other specialties, in an area of the State facing demonstrable, serious challenges with the opioid epidemic, with access to pediatric specialty care, and with access to community-based, non-institutional mental health services. These initiatives also serve a compelling State interest.
- And development of a common Information Technology platform that is consistent with national policy goals and the priorities of multiple presidential administrations. The State has a clear compelling interest in these services.

As the Parties have demonstrated, State policy, as expressed in the Act, does not presume that preserving competition in healthcare is the goal that preempts all others. The Act requires the Department to weigh likely benefits against "any disadvantages attributable to a reduction in competition that may result from the agreement." This is not a requirement to measure likely benefits against a theoretical construct of what a competitive market might look like. It is
instead a command to consider the negative effects, if any, from a reduction in competition in the region as it exists today.

This means that the Department must look at all of the facts in the region today that are relevant to overall State policy goals, and weigh whether reducing competition as it exists will adversely affect that state of facts going forward. In other words, will the cooperative agreement result in prices increasing at a higher rate because of the merger? Will public health statistics such as obesity, substance use, and infant mortality be worse than they are today? Will the duplication in facilities and services be increased over what they are today?

In the Application the Parties have presented voluminous, and unrefuted, information on the poor state of health of the people in Northeast Tennessee, and its significant implications for quality of life along with medical and productivity costs. The Parties have demonstrated the duplication in facilities and services in the region, and the implications for sustainability and costs. This state of affairs came to be under the current competitive environment in the region. According to staff, this is the state of affairs that the Department should preserve. In contrast, the policy of the State, as expressed in the Act, is to look objectively at the facts as they exist and to ask whether reducing competition is likely to make them worse, or in fact, offer an opportunity not otherwise available to improve conditions. The record amply supports a finding by the Department that the reduction in competition in the region, as it exists today, will not result in any disadvantages and will provide substantial benefits to the region pursuant to the enforceable commitments.

Turning to specific statutory factors in the Hospital Cooperation Act that require the Department’s evidentiary consideration, staff mistakenly charge that the Parties “failed to provide any analysis of available alternative arrangements.” (supp. comments at 2) This is not correct. The Parties addressed this factor in their response to staff’s first set of comments. The charge that the Parties have “failed” to analyze alternative arrangements or show they would be inferior to the merger in providing overriding benefits for Tennesseans is inaccurate.

Wellmont received eight proposals and, as the evidence before the Department shows, undertook a very deliberate process of evaluating the alternatives. Wellmont and Mountain States both provided information to the Department that potential suitors of each system have claimed they could “improve” pricing and in some cases articulated an intention to “centralize” corporate operations in their home cities outside of the Parties’ respective service areas. These statements helped both parties reach the conclusions that pricing would increase and more jobs would be lost in the region with centralization of corporate functions outside the region. The Parties have not asked the Department to take these claims at “face value,” as staff speculate. (supp. comments at 3) Instead, the Parties supplemented the record with information about the alternatives and answered the Department’s questions about discussions each had with potential suitors.

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4 Exhibit A attached hereto lists the important facts presented by the Parties in their Application which are not contested by staff.
5 Parties 12/19 Submission at III-6 through III-9.
Staff do not dispute the accuracy of the Parties’ statement that staff “have provided literally no evidence” of any alternative arrangement that would actually generate similar benefits as those proposed by the merging Parties. (supp. comments at 2) Staff provide no examples of in-market hospital affiliations short of a merger or out-of-market mergers that offer the scope and scale of community benefits outlined in the Application. The Parties point this out not to “shift the burden,” but to show the absence of factual support for staff’s claim on this issue.

All of the alternatives simply replaced the existing owner of Wellmont. In other words, those other options would preserve the status quo, and importantly without any enforceable commitments on community benefits and on pricing cuts and rate caps. There is nothing about any of those options that would lead a reasonable person to conclude that any state policy goals will be advanced. None of those options would “... achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement.” No out-of-market merger by either Party could match the proposed merger’s opportunity for synergies through elimination of unnecessary duplication, and none would involve the regulatory protections – including holding the acquirer to promises for community investment – that come with an actively supervised cooperative agreement. As for more limited collaborations between the Parties, the Parties have explained why these would be inadequate substitutes for the merger.6

Next, staff challenge the merger’s synergy opportunities, arguing that, with reference to Tennessee’s and Virginia’s certificate-of-need processes, “the State had already made a determination that their communities needed each of the services Mountain States and Wellmont provide” and therefore may not approve the elimination of any duplicative resources. (supp. comments at 3) Staff contend that “[t]he CON process creates a presumption that [the Parties’] services are not unnecessarily duplicative.” (supp. comments at 3) (emphasis in original)

As a threshold matter, if staff truly believe that findings of need made in the distant past by CON authorities mean that “each of the services” of both Parties continue to be needed, then one wonders why staff predict any adverse price effects from the merger. If all the services of both Parties’ are “must-have” for commercial health insurance networks, then the Parties presumably already have the leverage to charge what the market will bear, because each Party knows payers cannot drop them from their networks and still have a marketable health plan.

The Parties have bolstered the record with data showing substantial population declines and other changes in demand conditions in the service area that have led to unnecessary duplication. To take just one example, Tennessee originally granted a Certificate of Need for a 48-bed hospital in Unicoi County; that hospital’s average census today is five. In December 2016, Mountain States sought a CON to build a replacement hospital. It was granted for 10 beds. It is unreasonable and speculative for staff to argue that historical findings of need by CON authorities for subsets of the Parties’ services are barriers to capturing the efficiency potential of the merger through elimination of unnecessary duplication and more cost-effective and efficient delivery of care to patients.

6 Parties 12/19 Submission at III-7 through III-8.
When it amended the Hospital Cooperation Act in 2015, the Legislature knew that Tennessee has a Certificate of Need process. Nonetheless, the statute requires the evaluation as a potential benefit from a merger the “avoidance of duplication of hospital resources.”

Likewise, the Department’s regulations require applicants to “describe how proposed Cooperative Agreement plans are . . . efficient with respect to . . . eliminating duplicative resources.” Staff’s speculation about a so-called “presumption” that none of the Parties’ services are unnecessarily duplicative is wholly unfounded.

III. Response to Staff Supplemental Submission Section III:

Staff complain that the Parties somehow acted in a “misleading” fashion by allegedly not recognizing that “[t]he structure of staff’s comment tracks the factors laid out in the Hospital Cooperation Act.” This is a perplexing and unfounded statement. As noted in section II above, the largest portion of the Parties’ response was a specific and factual rejoinder to staff’s individual criticisms of the merger, as staff catalogued them under each statutory factor in the Hospital Cooperation Act.

Holding to the theme of their prior submission, staff claim that the Merger Guidelines framework is “remarkably similar” to the “State policy laid out in the Tennessee Hospital Cooperation Act.” This claim is irreconcilable with the facts. The Hospital Cooperation Act advances “the policy of this State, in certain instances, to displace competition among hospitals.” The Merger Guidelines advance a completely different, federal, policy: to “reflect the congressional intent that merger enforcement should interdict competitive problems in their incipiency.” Moreover, the Hospital Cooperation Act operates “to promote cooperation and coordination among hospitals.” Also completely different, “[t]he Sherman Act serves to promote robust competition.” The dissimilarities between Tennessee’s regulatory policy and federal competition policy could not be starker, yet staff argue as though they do not exist. Courts and federal agencies applying the antitrust laws assess only whether a merger is anticompetitive. Under the Hospital Cooperation Act, however, the State assesses whether a merger, even if it reduces competition, would, upon clear and convincing evidence and if subjected to regulation and active supervision, likely yield health and economic benefits that outweigh any disadvantages resulting from the loss of competition between merger parties.

Staff contend that “[a]t their core, both the Hospital Cooperation Act and the Merger Guidelines seek to weigh the harms from a merger against the potential benefits, an exercise that FTC staff has significant experience with.” (supp. comments at 3) (emphasis added) It is true that under both the Hospital Cooperation Act and Clayton Antitrust Act (from which the Merger Guidelines are derived), the factfinder weighs the evidence to assess whether the merger advances or conflicts with the public policy articulated through the statute. But in fundamental ways, the two policies sharply diverge. Tennessee policy promotes qualified hospital mergers

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8 Tenn. Rule 1200-38-01-.02 (2)(a)(12)(iii).
even if they reduce competition. Federal antitrust policy stops anticompetitive mergers in their tracks. Tennessee policy evaluates a hospital merger’s benefits for value beyond their effects on competition. Federal antitrust policy accords no weight to any benefit that is not substantiated for how it will “enhance the merged firm’s ability and incentive to compete.”

These policy differences are profound. Staff rightly claim “significant experience” enforcing the antitrust laws for the advancement of federal competition policy. But this experience does not extend to the terrain of State healthcare policy, and particularly to a policy that displaces competition and mandates the weighing of evidence be in furtherance of public goals other than the protection and promotion of competition.

Staff could have advanced their learning in this respect by following their own Merger Guidelines:

The Agencies look for historical events, or “natural experiments,” that are informative regarding the competitive effects of the merger. For example, the Agencies may examine the impact of recent mergers, entry, expansion, or exit in the relevant market. Effects of analogous events in similar markets may also be informative.

The Parties provided the Department with literature and data regarding other hospital mergers that were subject to a cooperative agreement regulatory structure – i.e., the very type of “natural experiments” described above in the Merger Guidelines. Staff, however, admit to never conducting an empirical analysis into the market effects of a merger subject to the regulatory restrictions of a cooperative agreement or COPA. The same evidently is true for the authors of the economic literature to which staff refer liberally in their prior submission, since the cited literature makes no reference to any regulated transactions operating with antitrust immunity. Staff admit to having “difficulty in assessing whether the public policy goals of the Mission Health COPA have actually been met.” This admission underscores the inaccuracy in staff’s claim of having “significant experience” weighing evidence for the purpose of implementing a State policy that displaces competition.

IV. Response to Staff Supplemental Submission

Staff’s heading for this section of their submission asserts that the Parties “ask TDH to ignore” central elements of the Hospital Cooperation Act (supp. comments at 4) This is hyperbole and untrue. Staff contend the Parties are deficient in not providing “a full analysis of the competitive harm” from the merger, because otherwise “it is not possible to conduct the balancing test required by the statute.” (supp. comments at 4) This also is untrue. As a threshold matter, the Parties supplied volumes of market information to the Department, as the regulations require, enabling the Department to assess the merger’s competitive implications absent effective

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12 Merger Guidelines at 30.
13 Merger Guidelines at 3.
14 Parties 12/19 Submission at III-4 n.6.
15 Staff 11/21 comments at 67-68 & n. 291.
16 See supp. comments at 4 (“The Legislature intended to displace competition only when applicants proved by clear and convincing evidence that the benefits outweigh the harm; the Applicants ask TDH to ignore this”).
regulation and active supervision. The Parties submitted, among other things, “a description of the competitive environment in the parties’ geographic service area,” identification of all the services and products to be affected by the Cooperative Agreement and their locations, an estimate of market shares, maps of service locations, and a statement about how competition will be reduced by the merger.17

True to their steadfast competition focus, the staff have submitted a “discussion of the market structure, diversion statistics, and predicted price increases” concerning the merger, and clarify that the “tools FTC staff used to determine the competitive impact of the merger are well established and standard in economics and merger law.” (supp. comments at 4) Contrary to staff’s charge, the Parties never suggested that the Department should “ignore” this information. The Parties did point out the flaw in staff’s approach. By divorcing their structural analysis and prediction of gigantic price increases18 from the reality that the merger, if approved, will be subject to regulation, ironclad commitments including a rate cap, and active supervision, staff have “merely inform[ed] the Department that in staff’s view the merger may be anticompetitive.”19 Further, “[s]taff’s discussion in this section does not address whether the benefits from the merger outweigh its disadvantages under the Hospital Cooperation Act.”20 That was true at the time the Parties said it, and remains true.

In subsection A of this section, staff grossly mischaracterize the Parties’ investment commitments, by stating that the commitments “are entirely contingent on achieving the cost savings they project” and that they are a “conditional promise.” (supp. comments at 4-5) (emphasis in original) This is patently untrue. The commitments are neither contingent nor conditional. They are ironclad if the merger is approved. The only exception is for a change due to events outside the control of the merged entity, to which the Department must agree. What the Parties have said is that the merger synergies are funding the commitments, and the synergies are available only through the merger. This creates enormous incentive for the Parties to achieve the synergies as expeditiously as possible.

Staff assert that a “significant body of literature” contains findings that “efficiency predictions made in advance of mergers often prove to be inaccurate and are not achieved.” (supp. comments at 4-5) Staff do not reveal how “often” this outcome is said to occur, or explain any basis for believing the merger at issue is likely to have the same outcome. This is not a merger like those in the literature that occurred outside a COPA context and faced no active supervision to ensure performance, and that faced no risk that an inability to achieve the synergies and fund the investment commitments could cause financial distress or a State order to unwind the merger.

Next, staff criticize certain specific commitments.

17 Tenn. Rule 1200-38-01-.02 (13)
18 Staff relies on an economic consultant’s report that pre-dates the Parties’ Application (and the rate cap formula described therein) that estimates a price increase from the merger to be “as high as 130%.” (staff 11/21 comments at 12-13). The Parties discussed the major flaws in this report – not the least of which being its prediction of a price increase under the COPA of 130% – in their response to staff’s prior submission. See Parties 12/19 Submission at III-20 n.45.
19 Parties 12/19 Submission at III-14.
20 Parties 12/19 Submission at III-14.
A. **Rural Hospital Commitments**

Staff charge that the merger would not protect the Parties’ rural hospitals and that the Parties have provided “little evidence” that rural facilities face closure absent the COPA. (supp. comments at 6) Staff ignore the fact that Wellmont closed Lee Regional in 2013 and Jenkins Community Hospital in 2009\(^1\). Staff also ignore the Parties’ commitment to keep rural facilities open and providing health care services for at least the next five years. Absent the COPA, no such guarantee is available or likely.

Staff comments about the Parties’ financial condition is erroneous and misleading. Staff ignore the more meaningful metric of actual operating results\(^2\), what Mountain States calls “operating income” and what Wellmont calls “income from operations”. In fiscal year 2015 Mountain States had operating income of $37.103 million. Wellmont had $6.694 million in income from operations in fiscal year 2015. This means that Mountain States and Wellmont had operating margins of 3.55% and 0.82%, respectively, compared to the Standard and Poor’s median of 0.8% for systems rated BBB+.

While staff correctly state the combined debt and combined total assets of Mountain States and Wellmont, they again miss the point that these numbers need to be compared to financially stronger organizations. For example, the combined long term debt to capitalization ratio of the Parties, using their fiscal year 2015 financial statements, would be 0.57, compared to the Standard and Poor’s median of .37 for systems rated BBB+. To achieve the S&P median ratio the combined Parties would need to reduce their debt by $450 million.

Staff also fail to mention that in fiscal year 2016, the data for which are publicly available, Mountain States’ “net revenue”\(^3\) declined to $22 million, a decrease of 60%. The combined “net revenue” of both organizations decreased by more than $25 million. This trend underscores other negative economic trends in the region that the Parties have identified for the Department.

Mountain States and Wellmont are disproportionately affected by their assets in Virginia and some in Tennessee that serve communities with stagnant or even declining populations. At the same time, inpatient use rates are declining – from an average in the region of 126 inpatients per 1,000 population to an expected range of 90-100 inpatients per 1,000 – a range more closely resembling markets that have previously adapted to payer risk models and other incentives to reduce lower acuity utilization of inpatient services. These are actual use rates. For instance, Nashville’s use rates are 105 per 1,000. This combination of factors means inpatient admissions are expected to continue declining by up to 13,000-30,000 in the next 5 to 7 years. This year alone, Mountain States is expected to see a decline of more than 2,000 admissions due in part to reduced readmissions, reduced admission rates through the Emergency Department and the

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\(^{1}\) Wellmont sold the assets of Jenkins Community Hospital to Appalachian Regional Healthcare, which closed the facility immediately after the sale.

\(^{2}\) This measure excludes investment income and other non-operating accounting gains and losses from such things as the change in the market value of financial derivatives.

\(^{3}\) “Excess of revenue, gains and support over expenses and losses” (Mountain States) or “revenue, gains and support in excess of expenses and losses” (Wellmont). These items would more appropriately referred to as “net income.”
increased conversion to risk relationships between payers and the large primary care physician groups within the next several years.

A fundamental rationale for the merger is that alternative acquirers of either or both Parties will be unable to generate a rational approach to dealing with the overcapacity and cost pressures that will result from these trends, particularly as they occur in these specific communities and conditions. With population declining or stagnant and use rates declining, each system individually will face extraordinary difficulties sustaining their operating cash flow. The solution, absent the COPA, is to join larger systems with the leverage to increase per-unit pricing. Without the ability to reduce costs rationally across the region, the only mechanism at the disposal of these alternative purchasers would be to increase per unit pricing.

It is not accurate for staff to suggest that the rural hospitals contribute to the overall profitability of each system. (supp. comments at 7) Were this true, Lee Regional would likely still be open. In fact, when Lee Regional closed, Wellmont retained referral relationships from Lee County. In Russell County, Wellmont has no hospital but does have urgent care and some doctors. Wellmont obtains referrals from Russell County without having a hospital there. It is not accurate to suggest that a health system needs a hospital in a community in order to generate referrals from that community.

Staff disparage the Parties’ commitments to the rural communities without justification. (supp. comments at 7). Their submission neglects to mention the commitment to conduct routine physician needs assessments in the communities the Parties’ serve and to spend up to $140 million expanding access through additional services, such as community based mental health, addiction recovery, expansion of pediatrics and investment into physician recruitment to serve the needs. Access to efficient and effective healthcare is critical for addressing the fundamental health needs and poor health status of this region. The commitment is not ambiguous and not available without the synergies that can be obtained from the merger. Staff also mischaracterize the Parties’ rural commitments as contingent on a rural community’s showing of “demonstrated need”; they base this claim on an isolated phrase in the Parties’ previous submission. (supp. comments at 7) To avoid any doubt, the Parties will not require after five years a “showing” by any community “to persuade the New Health System” to maintain access to healthcare services. The New Health System will provide healthcare services where and when they are needed within the defined market area under the supervision of the Department pursuant to the COPA.

B. Rate Cap Commitments

Staff’s criticisms of the Parties’ rate commitments ignore a fundamental premise of the Act. A cooperative agreement to authorize a merger that lessens competition must include a mechanism to govern rate-setting for the protection of consumers. Staff complain that the Parties’ rate proposals do not guarantee to replicate “what pricing would have been with ongoing competition between Mountain States and Wellmont.” The “but for” price is of course impossible to know. Were it the standard, the Hospital Cooperation Act could not be implemented. This may be staff’s ultimate goal for their comments, but proposing a rate mechanism that is impossible to apply is unhelpful and does not warrant the Department’s consideration.
The Parties’ pricing commitment, on the other hand, is very well-suited for its statutory purpose. The rate cap is based on a long-standing, widely accepted federal government statistic that is fully transparent to all parties. All negotiated contracts with principal payers will be easily analyzed on that basis and readily monitored by state officials. All the principal payers are very aware of this commitment and will be holding the New Health System accountable to comply with it.

Staff’s supposed “concern” that the rate caps will not apply to value- and risk-based contracts is misplaced. (supp. comments at 9) As a threshold matter, “risk-based” contracting models exist on a spectrum of terms and conditions. The characterization “risk-based” can apply in many ways, depending on the contract. Some contracts have provisions for only upside risk to the provider (i.e., the potential for shared savings). Other contracts encompass upside and downside risk (i.e., the potential for the provider to have to pay money back for failure to achieve savings). For any current or foreseeable risk-based contract of which the Parties are aware, fee-for-service rates will apply to the services that are provided, i.e. to the particular episode of care from provider to patient. The rate commitments made by the Parties would readily apply to such contracts, and will form a firm basis for transition to other future models of risk-based contracts.

The Parties understand risk-based models to mean a financial and clinical arrangement between a payer and provider where a substantial portion of the financial risk related to the medical spending for the care of the patients over time has been assumed by the provider. This definition understands “risk-based” models to encompass both upside and downside risk. The Parties are committed to discuss risk-based models with willing payers that entail upside and downside risk, and to proceed in good faith in any such discussions.

There is no one-size-fits-all risk-based model appropriate for all payers and providers. The Parties’ risk-contracting commitment recognizes this reality. It commits the Parties to pursuing true risk-based contracting models, while recognizing that different payers will approach this concept according to their own interests and goals. The Parties recognize they cannot force a specific, pre-defined risk-based model on any payer. If no meeting of the minds occurs in the discussion of a risk-based contract between the New Health System and a payer, then the parties have agreed to a binding mediation solution.

C. Principal Payer Commitments

The Parties’ definition of “Principal Payers,” to which the rate commitments apply, is “those commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System’s total revenue.” Staff make much of the fact that this definition does not cover approximately 200 payers that have claims from one or both of the Parties, and contend that the New Health System will impose “significant prices increases” on this group of insurers. (supp. comments at 8) Staff fail to point out, however, that the net revenue associated with all of the payers that comprise non-Principal Payers category constitutes less than 3% of NHS’s net revenue.

The NHS cannot extend the pricing commitments to the non-Principal Payers for the following reasons:
1. The vast majority of the payers in this category do not have a contract with NHS. These are payers that are based in other states or other countries that have no reason to contract with NHS due to their very small amount of annual volume.

2. The administrative burden on NHS and the payer to administer the payer commitments would be excessive relative to the amount of business that the payer has with NHS.

3. Other controls and processes are in place that will provide assurances that any annual pricing adjustments will be fair and consistent with current and past practices. These include: (a) requirement that gross charge increases be applied consistently across all payers; (b) oversight by NHS board and finance committee of changes to NHS's charge structure; and (c) the ability of any payer to express its concerns about any NHS pricing change to the Department.

   Staff speculate that payers may not bring pricing concerns to the Department, but that is all it is – speculation. The NHS will have no incentive to charge unfair rates to two hundred payers – particularly when they together account for less than 3% of NHS’s net revenue – on the hope that not one of them reports this conduct to the state in its active supervision role. All it would take is one meritorious complaint for the door to open into further State scrutiny into NHS’s contracting practices. For all of these reasons, therefore, staff’s criticism of the definition of Principal Payers has no merit.

D. Plan of Separation

   Staff criticize the Parties’ response to the alleged “deficiencies” identified in staff’s prior submission to the Plan of Separation by evading the merits of that response. Staff’s gloss on the plan of separation requirements as being a mandate to articulate the steps to “restore pre-merger competition” is hardly a distinction without a difference from the actual regulation, which calls for a plan to return to a “pre-consolidation state.” The regulation plainly pertains to the mechanical process of separating the New Health System’s assets and functions into two independent organizations as existed pre-consolidation. It does not require the Parties to forecast how they would recreate the demand for healthcare services and other indicia that determine the competitive process that exists on the day of closing.

   Companies, including health systems, divest assets in the ordinary course of business without encountering the list of problems the staff identify. The New Health System would be prepared to do the same thing, and the Plan of Separation presents a reasonable framework to accomplish this. It would occur, moreover, under a regime of active supervision that begins on the day of closing. The State will have knowledge of all integration activities and be prepared to monitor an orderly separation if that time ever comes.

E. Quality Improvement

   To provide the Department with a more streamlined response to staff’s supplemental comments, the Parties have limited this submission to discussion of the comments in staff’s front nine page memorandum and not to the chart that follows it. The Parties make one exception here. Page eight of the chart addresses the Parties’ quality improvement commitment, which states: “In order to enhance quality, improve cost-efficiency and reduce unnecessary duplication
of hospital services for all Principal Payers, 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.” (supp. comments, appended chart at 8)

Staff’s comment number 4, on the same page, states the following about this commitment: “The commitment states that it is intended to reduce unnecessary utilization, but this is not a meaningful benefit unless the parties are suggesting that they engage in unnecessary medical care today.”

This is a false premise and fundamental misinterpretation of the Parties’ commitment and the importance of their efforts through the transaction to improve quality, increase preventative care, and address population and patient health needs in the most effective location and means. These are the steps that will move the region far more rapidly to reduce hospital utilization that can be avoided by improved health or by sustained access to care in the best locations. Moreover, staff ignore the unnecessary duplication of services that will be reduced by the merger, both in terms of location of services and provision of services by providers (e.g., physicians).

V. No Defense of “Independent Assessment” of Dr. Kizer

Staff offer little or no defense of the “independent assessment” of their consultant, Dr. Kizer. As demonstrated by the parties in their December 19 Response, Dr. Kizer’s criticisms were totally lacking in support and foundation. In fact, as the Parties demonstrated, Dr. Kizer has been a strong advocate for many of the programs which the Parties have committed to undertake, including emphasis on information technology and performance reporting to improve quality (Parties 12/19 Submission), merging hospitals to dramatically increase quality of care and reduce operating costs (Parties 12/19 Submission), emphasis on programs that focus on population health and modifiable health behaviors such as physical inactivity, poor nutrition, tobacco use and excessive alcohol consumption (Parties 12/19 Submission), the importance of integrated health care delivery systems (Parties 12/19 Submission), and the many benefits of a common electronic health records system (Parties 12/19 Submission). Staff offer no explanation why the programs that Dr. Kizer strongly supports should be denied to this region which suffers disproportionately from economic and health care challenges. Like staff, Dr. Kizer offers no solutions to the significant issues in this region, including solutions that will provide anywhere near the level of enforceable commitments that Parties have specifically identified in great detail.
EXHIBIT A
FACTS NOT CONTESTED BY STAFF

**Poor Population Health.** Staff do not dispute that the region suffers disproportionately from numerous significant health care challenges—obesity, diabetes, low birthweights, tobacco and substance abuse, high rates of opioid addiction and death from addiction, high blood pressure, high cholesterol levels, and physical inactivity. Parties 12/19 Submission at Sec. I, 2-3; Sec. III at 13, 25-26.

**Reduction in Residencies.** Staff do not dispute that due to financial pressures facing the Parties, each system was reducing the number of funded residency programs in the area, which reduces pipeline of future physicians for the region. Parties 12/19 Submission at Sec. I, 2.

**Expanded Services: Community Health Initiatives.** Staff do not dispute the need for additional important services such as outpatient mental health, residential addiction recovery and expansion of pediatric services, which the Parties are committed to providing. Response at Sec. I, 2. Nor do staff dispute the need for the following initiatives which the Parties have committed to fund with an investment of not less than $75 million: ensure strong starts for children, help adults live well in the community, promote a drug free community and decrease avoidable hospital admissions and ER use. Parties 12/19 Submission at Sec. III, 26-27.

**Low Education: High Poverty.** Staff do not dispute that 10 counties in the GSA served by the New Health System in Northeast Tennessee are largely rural with disproportionately low educational attainment levels and high levels of poverty. Parties 12/19 Submission at Sec. I, 3.

**Parties Facing Financial Pressure.** Staff do not dispute that the Parties are facing significant financial pressures, especially for rural hospitals, including disproportionate levels of uncompensated care and Medicaid, fixed cost structures required to keep the rural hospitals open, declining or stagnant populations, which is projected to continue, declining inpatient use rates, and the second lowest Area Wage Index in the United States (making Medicare and Medicaid reimbursement, which represent 70 percent of the payer mix, among the lowest in the nation), and a small and shrinking base of commercial patients with downward pressure on reimbursement. Parties 12/19 Submission at Sec. I, 3; Sec. II, 1; Sec. III, 26-26, 29.

**Low Census and Occupancy.** Staff do not dispute that most of the Parties’ rural Tennessee hospitals currently have an average daily census of twenty patients or less, with licensed bed occupancy ranging from 0.1 percent to 30.9 percent. Parties 12/19 Submission at Sec. I, 4.

**Rural Hospitals Closing.** Staff do not dispute that 78 rural hospitals have closed since 2010, including eight in Tennessee and one in Virginia, and more that 600 could be vulnerable going forward. Response at Sec. I, 4. In fact, Tennessee has seen the second highest number of closures since 2010. Parties 12/19 Submission at Sec. III at 13.
**Overwhelming Community Support.** Staff do not dispute the overwhelming community support for the merger from employers, government officials and residents. Parties 12/19 Submission at Sec. I, 5-9.

**Absence of Available Alternatives.** Staff do not dispute that they are unable to provide evidence of the availability of any alternative arrangement that would provide the same level of benefits and enforceable commitments that this merger provides. Parties 12/19 Submission at III, 7-8.

**Benefits of the Mission Health COPA.** Staff do not dispute that the Mission Health COPA resulted in substantial benefits, including pricing well within the mainstream of hospital pricing, costs well within the median of a COPA peer group, recognition as one of the highest value hospital systems in the nation and recognition as one of the top hospitals in the country. Parties 12/19 Submission at Sec. III, 9, 16, 23, 46-47.

**Factors Ensuring High Quality.** Staff do not dispute that several factors will keep quality at high levels, including the importance of national quality measures, payment incentives and penalties, reimbursement tied to quality measures, including reimbursement from government payers, and competition from out of area systems. Parties 12/19 Submission at Sec. III, 24, 32, 44.

**Benefits of the Common IT Platform.** Staff do not dispute the many benefits from the Common Clinical IT Platform. Parties 12/19 Submission at Sec. III, 35-36.

**Transparency of Quality Reporting.** Staff do not dispute the benefits of greater transparency in quality reporting. Parties 12/19 Submission at Sec. III, 36-38.

**Additional Funding for Training and Research.** Staff do not dispute the importance of additional funding for academic and research opportunities, including training of health care professionals, which the Parties have committed to fund with $85 million in incremental funds over ten years. Parties 12/19 Submission at Sec. III, 39.