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April 7, 2016

The Honorable Natalie Tennant
Secretary of State
State Capitol Complex
Building 1, Suite 157K
Charleston, West Virginia 25305

Re: State Register
Notice of Public Comment Period

Dear Ms. Tennant:

Enclosed herewith please find the following application for public notice in the State Register:

**CABELL HUNTINGTON HOSPITAL, INC.
COOPERATIVE AGREEMENT FILE NO. 16-2/3-001**

Please publish this application **in its entirety** in accordance with the Administrative Procedures Act on April 8, 2016.

In addition, written comments regarding this application may be submitted in care of Cynthia Dellinger, Assistant General Counsel, at the address set for below and must be received no later than April 18, 2016. Copies of the application are available on the West Virginia Health Care Authority's web page at www.hca.wv.gov or copies may be obtained by contacting Janet Huffman at (304) 558-7000 or toll-free at 1-888-558-7002.

Thank you for your assistance in this matter.

Sincerely,

A handwritten signature in blue ink, appearing to read "Janet Huffman", is written over a circular blue stamp. The signature is fluid and cursive.

Janet Huffman
Paralegal

Enclosure

STATE OF WEST VIRGINIA
HEALTH CARE AUTHORITY

RECEIVED



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WEST VIRGINIA
HEALTH CARE AUTHORITY

APPLICATION
FOR
APPROVAL OF COOPERATIVE AGREEMENT

COOPERATIVE AGREEMENT FILE NUMBER: _____
CERTIFICATE OF NEED FILE NUMBER: 14-2-10375-A

SECTION A. IDENTIFICATION OF THE APPLICANT AND PROJECT

Project Name: Acquisition of St. Mary's Medical Center

Applicant Name: Cabell Huntington Hospital, Inc.

Address of Applicant: 1340 Hal Greer Boulevard, Huntington West Virginia 25701

Name and Title of Chief Executive Officer: Kevin Fowler, President and CEO

Contact Person Regarding Application:

Monte Ward, Sr. Vice President, CFO and Chief Acquisition Officer
1340 Hal Greer Boulevard
Huntington, West Virginia 25701
304-526-2052
Monte.Ward@chhi.org

SECTION B. DESCRIPTION OF COOPERATIVE AGREEMENT

This application seeks approval of the Cooperative Agreement considered by the Health Care Authority in Certificate of Need File No. 14-2-10375-A relating to the proposed acquisition of St. Mary's Medical Center by Cabell Huntington Hospital, Inc. to be accomplished through the substitution of Cabell Huntington Hospital, Inc. for Pallottine Health Services, Inc. as the sole member of St. Mary's Medical Center, Inc. A copy of the Cooperative Agreement was filed in the above referenced Certificate of Need matter and is attached hereto as Exhibit B-1.

SECTION C. AUTHORIZATION TO PURSUE APPLICATION

At its regular meeting held on March 22, 2016, the Board of Directors of Cabell Huntington Hospital, Inc. authorized the filing of this application. Attached hereto as Exhibit C-1 is a resolution of the Board of Directors authorizing the application.

SECTION D. DESCRIPTION OF THE PROJECT

This project involves the acquisition of the ownership interests of St. Mary's Medical Center, Inc. ("SMMC") by Cabell Huntington Hospital, Inc. ("CHH") (the "Acquisition"). SMMC is a 393 bed acute care hospital located in Huntington, Cabell County, West Virginia. Pallottine Health Services, Inc. ("PHS") is currently the sole member of SMMC. Following the Acquisition, CHH will replace PHS as the sole member of SMMC, and, in effect, acquire

SMMC, and SMMC's two subsidiaries, St. Mary's Medical Center Foundation, Inc. ("SMMCF") and St. Mary's Medical Management, Inc. ("SMMM"), and substantially all of the assets and liabilities of SMMC, SMMCF, and SMMM. In addition, certain property used in the operation of SMMC, which is currently owned by PHS, will be transferred to SMMC upon consummation of the transaction. CHH will also acquire substantially all the assets and liabilities of Vanguard Financial Services, Inc., SMMC's billing and collection agency.

In addition to inpatient and outpatient services, SMMC operates several ambulatory care facilities, off-campus magnetic resonance imaging ("MRI") services, and emergency room, lab, imaging, and physician services in Ironton, Ohio. SMMC also operates three schools in cooperation with Marshall University, a School of Nursing, School of Medical Imaging, and School of Respiratory Care, located off-campus in its Center for Education.

CHH is a 303 bed acute care hospital also located in Huntington, West Virginia. CHH is a teaching hospital affiliated with Marshall University Schools of Medicine and Nursing. CHH is also a member of an academic medical center which includes the Joan C. Edwards School of Medicine and University Physicians and Surgeons, Inc., d/b/a Marshall Health, the School's Faculty Practice Plan. CHH is a Qualified hospital as defined by W.Va. Code § 16-29B-28(a)(6).

The objective of this project is the creation of a single hospital system in Huntington, West Virginia with two campuses. CHH and SMMC are committed to improving the health of residents of western West Virginia, eastern Kentucky, southern Ohio, and the surrounding area through the delivery of quality, cost-effective health care services. CHH proposes to continue to operate SMMC as a faith-based institution.

SECTION E. BACKGROUND

In 2014, Pallottine Health Services, Inc. ("PHS") determined that because of the dwindling number and advanced age of the Pallottine Sisters, as well as the increased complexity of health care regulation, it could no longer sponsor SMMC and made the decision that the hospital should be sold. A Request for Proposal was submitted to a number of potential purchasers, including CHH. CHH responded to the request and after extensive negotiations, a contract for the purchase of SMMC through the substitution of CHH for PHS as the sole member of SMMC was executed in November of 2014. It is this document which constitutes the Cooperative Agreement for which the Applicant seeks approval.

An application for a Certificate of Need for the project was filed by CHH on April 30, 2015. Steel of West Virginia, Inc. requested affected party status and requested a hearing. A hearing was conducted by the Authority on December 21 and 22. Briefs were submitted by the parties and after deliberation, the Authority issued its decision on March 16, 2016 approving the Certificate of Need application submitted by CHH.

During its 2016 session, the West Virginia Legislature enacted Senate Bill 597 which was signed by the Governor on March 18, 2016. It was made effective upon passage. The Bill vested the

Health Care Authority, in conjunction with the Attorney General, with the authority to consider and approve or reject certain cooperative agreements between a hospital member of an academic medical center and other hospitals or health care providers. This legislation provides for the oversight and supervision of cooperative agreements which are approved by the Health Care Authority and Attorney General. Under the statute, cooperative agreements which are approved by the Authority and the Attorney General are exempt from scrutiny under state and federal antitrust laws.

This application for approval is submitted pursuant to this legislation.

SECTION F. CRITERIA FOR APPROVAL

The recently passed Senate Bill 597 codified as WV Code §16-29B-26, 16-29B-28 and 16-29B-29 sets forth the goals for cooperative agreements as well as the applicable criteria to be considered by the Health Care Authority. The following goals are specified by the statute:

- (A) Improve access to care;
- (B) Advance health status;
- (C) Target regional health issues;
- (D) Promote technological advancement;
- (E) Ensure accountability of the cost of care;
- (F) Enhance academic engagement in regional health;
- (G) Preserve and improve medical education opportunities;
- (H) Strengthen the workforce for health-related careers; and
- (I) Improve health entity collaboration and regional integration, where appropriate.

The statute requires that the application for approval of a cooperative agreement specify the methods for achieving:

- (A) Population health improvement;
- (B) Improved access to health care services;
- (C) Improved quality;
- (D) Cost efficiencies;
- (E) Ensuring affordability of care;
- (F) Enhancing and preserving medical education programs; and
- (G) Supporting the authority's goals and strategic mission, as applicable.

The statute provides that “the Authority shall approve a proposed cooperative agreement and issue a Certificate of Approval if it determines, with the written concurrence of the Attorney General, that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the proposed cooperative agreement.”¹ In evaluating the potential benefits of a proposed cooperative agreement, the

¹W.Va. Code §16-29B-28(f)(3).

Authority is directed by the statute to “consider whether one or more of the following benefits may result from the proposed cooperative agreement:

- (A) Enhancement and preservation of existing academic and clinical educational programs;
- (B) Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse provided to citizens served by the authority;
- (C) Enhancement of population health status consistent with the health goals established by the authority;
- (D) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
- (E) Gains in the cost-efficiency of services provided by the hospitals involved;
- (F) Improvements in the utilization of hospital resources and equipment;
- (G) Avoidance of duplication of hospital resources;
- (H) Participation in the state Medicaid program; and
- (I) Constraints on increases in the total cost of care.”

The statute provides that the Authority’s evaluation of any disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement shall include but not be limited to the following factors:

- (A) The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers;
- (B) The extent of any reduction in competition among physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;
- (C) The extent of any likely adverse impact on patients in the quality, availability and price of health care services; and
- (D) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement.

SECTION G. METHODS FOR ACHIEVING THE OBJECTIVES SET FORTH BELOW

As noted in Section F, the statute sets forth nine separate goals for cooperative agreements. It is the expectation of the Applicant that each of these statutory goals will be achieved by the hospitals as a result of consummation of the agreement. The statute also requires that the

application describe the method by which certain enumerated objectives will be achieved. The manner in which such objectives will be achieved is described below:

(A) Population Health Improvement

As the Authority understands, the population served by CHH and SMMC has long had more significant health challenges than the population in the United States generally. The State of West Virginia, and particularly the area served by CHH and SMMC, has significantly higher rates of many chronic conditions such as obesity, diabetes, heart disease, and cancer.² Behavioral issues prevalent in the community, such as drug use, smoking, and poor nutrition, have made these conditions particularly difficult for health care providers to address in a meaningful way.³ Combining two strong 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.

The creation of a new CHH and SMMC-anchored health care system with the tools to determine how to keep people in the community healthy, instead of just treating those that are sick, is consistent with a national shift in how health care is delivered and paid for.⁴ Public and private payors are increasingly incentivizing improvements in the quality of health rather than paying based on the volume of care provided.⁵ Population Health Management (PHM) provides a framework for designing, implementing, and measuring the impact of a plan to improve a community's overall health by "address[ing] health needs at all points along the continuum of health and well-being through participation of, engagement with, and targeted interventions for

²See, e.g., Robert Wood Johnson Foundation County Health Rankings and Roadmaps, *available at* <http://www.countyhealthrankings.org/app/west-virginia/2015/rankings/cabell/county/outcomes/overall/snapshot>.

³See *id.*; West Virginia Dept. of Health and Human Services, 2013 West Virginia Behavioral Risk Factor Surveillance Report, *available at* <http://www.wvdhhr.org/bph/hsc/pubs/brfss/2013/BRFSS2013.pdf>.

⁴See Centers for Disease Control, Best Practices for Community Health Needs Assessment and Implementation Strategy Development (2011) ("CDC Community Health Report") at 61 ("It is increasingly acknowledged that a sustainable system of financing will require a shift in incentives away from filling hospital beds and conducting procedures and towards keeping populations healthy. In this context, hospitals that invest in building population health capacity in the near term may be optimally positioned to thrive economically in the long term."), *available at* <http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf>.

⁵Notably, the Centers for Medicaid and Medicare Services (CMS) has stated its intention to move care delivery into models that incentivize a focus on quality and outcomes. New delivery and payment models that encourage looking at improving an entire population and incentivizing coordination of care range from patient-centered medical homes (PCMH) and bundled payment care improvement initiatives (BPCI), to Accountable Care Organizations (ACOs) and global population-based payments linked to quality. These models require significant resources, a critical mass of patients for spreading actuarial risk, and an integrated approach that is more achievable at a system level with both SMMC and CHH than by either hospital standing alone.

the population.”⁶ Under the Assurance of Voluntary Compliance (“AVC”) entered into between CHH, SMMC and the West Virginia Attorney General, the parties have committed to developing “Population Health Goals, including Quantitative Benchmarks that may be used to assess whether those goals have been met”⁷ and to being accountable for making progress toward those goals over the next *decade*. Positioning CHH and SMMC to succeed in the face of this post-health care reform paradigm shift, including through the adoption of PHM, is a principal driver for the transaction.⁸

PHM is not only driving health care reform across the country, but is uniquely suited to addressing the entrenched health problems in the community served by CHH and SMMC. The transaction creates a singular opportunity to effectively implement PHM by creating a true continuum of care under united, local leadership and supported by an integrated electronic health record (EHR). The transaction will link the primary care and outpatient specialists of Marshall Health and St. Mary’s Medical Management (SMMM) with the two hospital campuses and more effectively foster partnerships with public providers (Valley Health, FQHC) and private providers with longstanding relationships with the hospitals (Huntington Internal Medicine Group, Scott Orthopedics, Radiology Incorporated). Delivering care using a team of coordinated, aligned providers at all levels of care, and communicating and tracking care through a single EHR, provides the cornerstones for implementing PHM. By being able to gather and analyze data reflecting care delivered by both hospitals and affiliated providers, the new system will be able to identify and implement best practices targeted at patterns and trends across the population. This kind of broad, region-wide perspective and ability to prioritize and address the unique health problems facing the community, under leadership rooted in the community, is critical to improving health in the Tri-State area.

At the same time PHM as implemented by a regional system will be effective at confronting the health challenges that face large segments of the population, gathering information from patients seeking care at both hospital campuses and affiliated outpatient facilities will also allow CHH and SMMC to focus on health disparities of smaller sub-populations (e.g., under-insured Health Exchange participants, WV Medicaid healthcare utilization outliers, I.V. drug users). Post-transaction, an integrated EHR can help identify healthcare quality deficiencies, unnecessary variances in care and utilization outliers in real-time across the population served by the system.

In addition to coordinated care delivery among providers and data-driven strategies, another key tool for implementing PHM is to partner with public health organizations, a process that the transaction would streamline and make more effective. Building on existing relationships, but with pooled resources and singular leadership, a regional system with a unified

⁶See, e.g. “Understanding Population Health,” Population Health Alliance, available at <http://www.populationhealthalliance.org/research/understanding-population-health.html>

⁷AVC Para. 4(c); see also AVC Para. 3(a).

⁸See generally Cooperative Agreement

community outreach function will be able to harness joint efforts with organizations such as Cabell-Wayne County Health Department Regional Health Connect (RHC) and other public, church-based, and non-profit community entities focused on health issues. This kind of community-wide examination of all factors that affect the health of the population, and all resources that can be brought to bear to improve it, is something that a locally invested, regional system would be best positioned to lead.⁹

(B) Improved Access to Health Care Services

Access to health care is affected by a number of distinct factors. Price and quality which are discussed separately below are important elements. Also important is the availability of services in proximity to a patient's residence and workplace. As evidence presented during the CON hearing established, without the combination of their resources, there are services which neither hospital has sufficient capital or volume to provide. And, as testified by Dr. Burdick, "critical mass for tertiary subspecial level work is much more achievable in a system that has a larger population rather than two medium-sized hospitals trying to build tertiary services or recruit tertiary or quaternary national experts to work in a smaller system."¹⁰

CHH and SMMC are both not for profit hospitals which provide care without regard to a patient's ability to pay. The Cooperative Agreement assures that SMMC will remain a not for profit hospital providing services to the medically underserved population.

Working together, the two hospitals can jointly assess community health needs and implement coordinated wellness, prevention and educational outreach programs. The ability of a combined system to attract highly qualified physician specialists and sub-specialists will enhance access to quality care in the community. A combination of financial resources and a critical mass of patients and data, together with the enhanced ability to recruit highly trained specialists to the area, creates the opportunity to expand services. Highly complex orthopedic and cancer surgery may be offered locally. A kidney transplant program becomes a realistic possibility. Finally, the Cooperative Agreement requires that SMMC continue to be operated as a full service acute care hospital. Thus, those patients who wish to receive hospital services at SMMC will continue to have that opportunity.

(C) Improved Quality

The Institute of Medicine has defined quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."¹¹ It contemplates providing patients with appropriate

⁹CDC Community Health Report, at 13 ("Building shared ownership for health among diverse stakeholders in local communities offers the benefit of mobilization and leveraging of resources to achieve measurable improvement in health status and quality of life.").

¹⁰Certificate of Need Tr. I, p. 161.

¹¹Institute of Medicine Committee on Quality of Health Care in America, Crossing the Quality Chasm: A New Health System for the Twenty First Century, Washington, D.C. National Academy Press at p. 32.

services in a technically competent way with good communication, shared decision making and cultural awareness - all without regard to ability to pay. The combination of the resources of CHH and SMMC creates the opportunity to improve health care in numerous and important ways. The combination makes possible the adoption at both facilities of uniform protocols and best practices. As explained by Dr. Yingling in his testimony in the CON proceeding, "in a unified system there will be unification of a lot of protocols and practice protocols that will bring efficiencies and improvement of quality of care."¹²

Secondly, together the two hospitals can establish a modern database and a 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. This fact is particularly important for hospitals located in close proximity to each other where a given patient may seek services at one hospital on one day and at another on a different day. No population health strategy can succeed without robust integrated data analytics for the entire population across the entire continuum of care. While there are some rudimentary efforts to coordinate population health information through state health information exchanges (WVHIN) and emergency room data (EDIE), nothing compares to the power of a single platform electronic medical record system and a consolidated data warehouse. The importance of such an integrated system was described by Dr. Burdick in testimony during the CON hearing. He stated "[a]nd one of the most promising aspects of that whole report to me is for the first time in the Huntington community to have a consolidated, interactive medical record between the two major healthcare campuses, that...you can't put a price on that."¹³

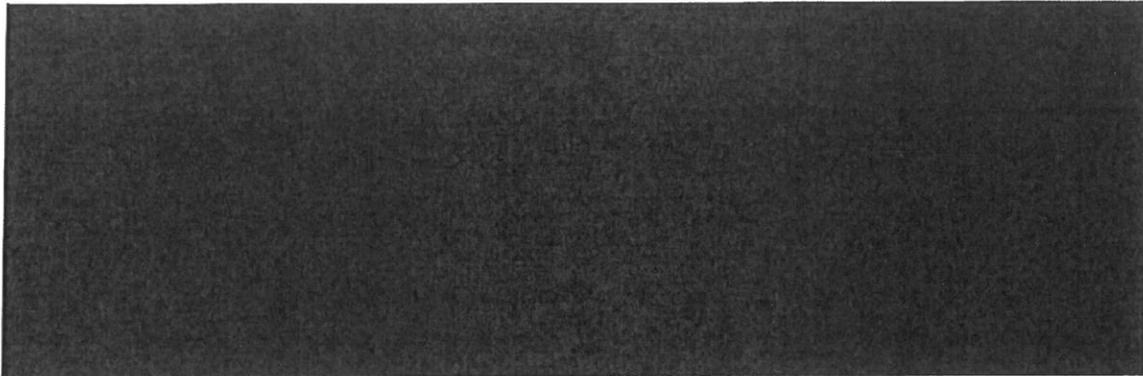
As noted above, the combined system will be better able to adopt and implement wellness, prevention and education programs to tackle in a coordinated way existing community health issues such as problems with substance abuse and illegal drug use. The Cooperative Agreement makes it possible for the combined system to implement new services which neither hospital standing alone has the resources or volume to provide separately. Such services may include highly complex surgery or the creation of a kidney transplant program. [REDACTED]

Numerous articles from members of the academic community and governing specialty organizations support the proposition that high volume is associated with better outcomes across a wide range of procedures and conditions.¹⁴ [REDACTED]

¹²Certificate of Need Tr. I, p. 187.

¹³Certificate of Need Tr. I, p. 156.

¹⁴Institute of Medicine, Interpreting the Volume-Outcome Relationship in the Context of Health Care Quality: Workshop Summary (2000), at pp. 4-5.



(D) Cost Saving Efficiencies

In 2014, a nationally recognized healthcare consulting firm, The Camden Group, performed a comprehensive study of the efficiencies which are likely to result from the cooperative agreement between CHH and SMMC. The results of this study were contained in a report styled Business Plan of Operational Efficiencies (“BPOE”) dated November 12, 2014 which was admitted in evidence in the CON proceeding.



A further analysis of the savings specific to this transaction which will result from the cooperative agreement was performed by Deloitte & Touche, also a nationally recognized consulting firm and efficiencies expert. This study authored by Lisa Ahern determined that the savings which this transaction makes possible, but which could not be achieved if another purchaser acquires SMMC, amounted to approximately [REDACTED]. A summary of the efficiencies is attached hereto as Exhibit G-1.

(E) Ensuring Affordability of Care

As will be discussed more fully in Section J below, there are a number of safeguards in place to

¹⁵ Am J Obstet Gynecol. 2012 Dec; 207(6): 478.e1–478.e7. See also, *American College of Cardiology (SCAI/ACC/AHA Expert Consensus Document: 2014 Update on Percutaneous Coronary Intervention Without On-Site Surgical Backup*.

¹⁶ Resources for Optimal Care of the Injured Patient. Committee on Trauma. American College of Surgeons. 2014.

¹⁷ Certificate of Need Tr. I, p. 29.

¹⁸ See CON Record Exhibit 76, Document 17.

restrain price increases post transaction. These include provisions in the AVC entered into on November 4, 2015 between CHH and SMMC and the West Virginia Attorney General, the Letter Agreement with Highmark Blue Cross and the recently enacted West Virginia Code §16-29B-28. In addition, the efficiencies and cost savings discussed in Section (D) above also reduce costs and reduce the necessity for price increases.

(F) Enhancing and Preserving Medical Education Programs

One of the important results of consummation of the transaction is the assurance it provides of continued support for medical education in the region served by the two hospitals. As explained by Dean Shapiro, the hospitals provide the teaching laboratories in which physicians are trained and learn the practice of medicine.¹⁹ The support provided by the two hospitals to the Marshall University School of Medicine is critical to the continued viability of the medical school. As Dr. Yingling explained in testimony in the CON proceeding, substantially more monetary support to the School of Medicine comes from the hospitals than from the State of West Virginia. Testimony of Dr. Yingling during the CON hearing indicated that state support for the School of Medicine constitutes roughly 10-11% of the School's budget as compared to 30-40% provided by the hospitals.²⁰ Were SMMC to be acquired by another hospital system, the level of support provided by SMMC could be drastically reduced or eliminated. As expressed by Dr. Burdick, "[s]o my greatest fear is that the resident support system through Medicare for St. Mary's Medical Center is optional and an alternate buyer who is not as committed to Marshall Medical School as our community is might have different feelings about supporting graduate medical education."²¹

The testimony of Dr. Shapiro concerning the experience of the Medical College of Ohio when a hospital system decided that it no longer wanted to be involved in medical education and eliminated 100 residency positions within the space of a few months constitutes a vivid example of the importance of hospital support for medical education.²² And, as explained by Dr. Yingling, if SMMC ceased to participate in the cardiology educational programs of the medical school, these programs could be seriously jeopardized.²³

The recruitment of highly qualified physicians, specialists and sub-specialists, combined with the ability to expand services offered locally will enhance the educational opportunities for students, residents and fellows.

¹⁹Certificate of Need Tr. I, p. 170.

²⁰Certificate of Need Tr. I, p. 179-180.

²¹Certificate of Need Tr. I, p. 157.

²²Certificate of Need Tr. I, p. 167.

²³Id. at p. 183.

(G) Supporting the Authority's Goals and Strategic Mission as Applicable

As the Authority found in its Decision awarding the Certificate of Need to CHH, the proposed project "will reduce duplication, increase efficiency, quality and coordination of care and allow for greater recruitment of professionals, promoting more effective management of population health, enhancing existing programs of health science education, all while maintaining and potentially expanding access to essential acute care services to West Virginia residents."²⁴ The Authority explained that this is a core principle and purpose of the Certificate of Need law. Additionally, the Authority found that the Cooperative Agreement "will promote the development of a community-oriented, integrated health care network consistent with the policy recommendations set forth in Chapter 4 and 5 of the 2000-2002 State Health Plan."²⁵

SECTION H. ANALYSIS OF BENEFITS LIKELY TO RESULT FROM THE PROPOSED COOPERATIVE AGREEMENT

The statute directs the Authority, in evaluating the benefits which will result for a Cooperative Agreement to consider nine specific potential benefits. It is the position of the Applicant that eight of the nine identified benefits will accrue to the area as a result of the cooperative agreement's consummation. These will be discussed in order.

(A) Enhancement and preservation of existing academic and clinical educational programs

CHH is a member of an academic medical center which includes the Marshall University Joan C. Edwards School of Medicine ("the School of Medicine") and its faculty practice plan, University Physicians & Surgeons, Inc., d/b/a-Marshall Health ("Marshall Health"). CHH is the primary teaching hospital affiliated with the School of Medicine. It provides a high level of monetary support each year to enable the School of Medicine to meet its financial needs. It also assists the School of Medicine in the recruitment and retention of faculty members. SMMC is also a teaching hospital which provides vital clinical training to student residents and fellows, particularly in the area of cardiology, cardiovascular services and internal medicine. It also provides much needed financial support to the School of Medicine. More importantly, as pointed out by Dean Shapiro, the hospitals serve as the laboratory for training students, residents and fellows in the practice of medicine.²⁶ There are currently 158 residents and 27 fellows participating in clinical training at CHH and SMMC.

The assurance that the clinical training programs offered to the School of Medicine by SMMC will continue following the sale of SMMC constitutes a major benefit of the Cooperative Agreement. Both CHH and SMMC through their history of support for the School of Medicine have demonstrated their understanding of the importance of educating physicians who will practice in this state and their commitment to support this objective. Were SMMC to be acquired by a national or regional chain with no ties to the area, the vital support provided by SMMC may be diminished or eliminated. The testimony of Dean Shapiro, Dr. Burdick and Dr. Yingling

²⁴Certificate of Need Decision, CON File No. 14-2-10375-A, p. 26.

²⁵CON File No. 14-2-10375-A, p. 21.

²⁶Certificate of Need Tr. I, p. 170.

during the CON hearing confirms the risk to medical education if the Cooperative Agreement is not consummated.²⁷

(B) Enhancement of the quality of hospital and hospital-related care, including mental health services and treatment of substance abuse provided to citizens served by the Authority

As explained in Section C, subsection (J) above and Section J subsection (C), *infra*, consummation of the transaction will enhance the quality of hospital care in a number of important ways. The discussions in Section C, subsection (J) above and Section J subsection (C) *infra* are incorporated here by reference. In addition, because SMMC provides the only inpatient behavioral health services, the transaction will make possible the coordination of mental health services at CHH with the inpatient services at SMMC. And, as noted in Section G subsection (A), the combined system will have the aligned incentives and improved ability to successfully implement coordinated programs to deal with substance abuse.

(C) Enhancement of population health status consistent with the health goals established by the Authority

As explained in Section G, subsection (A) above, the ability to deal with population health will be substantially enhanced by the combination of resources and information of the two hospitals. A single hospital system can better analyze community needs and formulate and implement education and other programs to engage them.

(D) Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care

Consistent with its existing practices, it is the intention of CHH that the two hospitals will work collaboratively with small community hospitals in rural areas within the region served by them through the provision of tertiary specialty services not available in their respective areas. The hospitals will continue and expand existing training and educational programs conducted at community hospitals and with community health care providers. Programs provided to community hospitals include training in advanced cardiac life support, pre-hospital trauma life support, a 16-hour emergency trauma nursing course, a pediatric education course for pre-hospital professionals, and a 16-hour advanced life support course for nurses, physicians and paramedics. The hospitals will continue their support for the School of Medicine to further the School's mission of educating primary care physicians who will serve the rural areas of the state. The hospitals will continue to provide rapid transportation capability through the Health Net Aeromedical service.

(E) Gains in the cost-efficiency of services provided by the hospitals involved

As explained in Section G, subsection (D), consummation of the transaction makes possible very

²⁷ See Certificate of Need Tr. I, pp. 156-168, pp. 166-167, pp. 182-184.

substantial cost savings. [REDACTED]

(F) Improvements in the utilization of hospital resources and equipment

The Cooperative Agreement enables the two hospitals to avoid purchasing unnecessarily duplicative equipment. Rather than each hospital acquiring costly equipment to compete with the other, equipment needs will be evaluated on a system-wide basis. The combined purchasing power of the two hospitals will create significant savings in supply and equipment costs. Combined resources of the two hospitals will also enhance the hospital's access to necessary capital.

(G) Avoidance of Duplication of Hospital Resources

CHH intends to implement each of the recommendations contained in the Camden report in order to eliminate unnecessary duplication of hospital services. The Camden report projects that the implementation of the recommendations contained therein will result in [REDACTED]

(H) Hospital participation in state Medicaid Program

Both CHH and SMMC are West Virginia not for profit hospitals which have participated and will continue to participate in the state Medicaid program as well as in Medicaid programs in Ohio and Kentucky.

(I) Constraints on Increases in the total costs of care

Gains in cost efficiency, improvements in resource utilization and the avoidance of the duplication of resources all will contribute to constraining the total costs of care. In addition, as will be discussed more fully below, there are a number of instrumentalities in effect which will ensure that inappropriate increases in the total cost of care will not occur. These instrumentalities include an agreement entered into with the West Virginia Attorney General styled an Assurance of Voluntary Compliance, a letter agreement with Highmark Blue Cross and the recently enacted legislation which requires that rate increases be approved by the Attorney General and provides a mechanism for the return to payors of charges which exceed by more than two percent the Consumer Price Index for hospital inpatient care and the Consumer Price Index for outpatient services. Each of these instrumentalities is discussed fully in subsequent sections of the application.

SECTION J. ANALYSIS OF DISADVANTAGES ATTRIBUTABLE TO ANY REDUCTION IN COMPETITION LIKELY TO RESULT FROM THE PROPOSED COOPERATIVE AGREEMENT

The Act provides that the Authority's evaluation of the possible disadvantages of a cooperative agreement shall include consideration of four separate issues attributable to a reduction in competition. Each of these issues will be discussed separately below but before considering the specific issues set forth in the statute, it is important to understand the role of competition in the analysis.

While competition is highly valued in our free market system, it is not an end in itself. Rather, it is valued because of the benefits it can provide to consumers. In the antitrust case of *Brooke Group Ltd.*, the United States Supreme Court pointed out that "the principal objective of antitrust policy is to maximize consumer welfare by encouraging firms to behave competitively."²⁸ In the recent *ProMedica* case, the Court of Appeals noted that "the goal of antitrust law is to enhance consumer welfare."²⁹ And, in *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979) the Court (Quoting Bork, *The Antitrust Paradox* 66 (1978)), explained that "Congress designed the Sherman Act as a 'consumer welfare prescription'." It is in this context that the potential disadvantages set forth in the statute should be evaluated.

(A) The extent of any likely adverse impact of the proposed cooperative agreement on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals or other health care providers;

To analyze properly the competitive effects of a hospital merger, it is necessary first to define both the relevant product market and the relevant geographic market in which the hospitals compete for patients.

Product Market. It is the position of the Applicant that the relevant product market here consists of the bundle of inpatient hospital services as well as the bundle of outpatient services offered by CHH and SMMC collectively. Both CHH and SMMC are considered full service acute care hospitals and each provides basic hospital services such as general surgery, primary acute care services, imaging services, emergency departments and select tertiary services. Certain important services, however are provided only at one of the two hospitals. Such services are complementary and not substitute services. To the extent that such services are complementary and not substitutes for each other, there currently exists little or no competition between the hospitals with respect thereto and, therefore, the proposed transaction can have no anti-competitive effect with respect to them. For example, cardiology services are provided largely at

²⁸ *Brooke Group Ltd. v. Brown & Williamson Tobacco Corp.*, 509 U.S. 209, 221 (1993).

²⁹ *ProMedica Health Sys., Inc. v. FTC*, 749 F.3d. 559, 571 (2014).

SMMC with no equivalent services at CHH. SMMC offers 33 cardiac DRGs that CHH does not. CHH is not authorized to perform open heart surgery and, therefore, is not permitted to provide elective interventional therapy and may perform only a narrowly defined category of emergency PCI intervention. Analysis of discharge data for the year 2013 for West Virginia, Kentucky and Ohio discloses that only 6% of the discharges at CHH consisted of cardiac patients while the number at SMMC was 24.5%.³⁰ SMMC regularly has triple or quadruple the number of cardiac discharges from CHH. Additionally, the severity of cardiac patients treated by both hospitals is evident by comparing case mix indices; the cardiac CMI at SMMC is approximately 70 percent higher than that at CHH. Basically CHH and SMMC simply do not compete for cardiac services. SMMC is generally recognized as the heart center in the area with its primary competitor being KDMC and not CHH.

Conversely, pediatric care and obstetrical services are performed almost exclusively at CHH. CHH has both a pediatric intensive care unit and a neonatal intensive care unit. SMMC has neither. CHH also has the Hoops Family Children's Hospital, a "children's hospital within a hospital." 2,789 babies were delivered at CHH during fiscal year 2014 compared to only 399 at SMMC. The two hospitals effectively do not compete with respect to pediatric care or high risk obstetrical care.

CHH has the only burn unit in the area while SMMC provides inpatient behavioral health services and CHH does not. Clearly, services with respect to which there is no meaningful competition represent a very important portion of the operations of the two hospitals. Cardiology and circulatory treatment account for nearly a quarter of SMMC total inpatient revenue. Pediatric and obstetrical services at CHH represent nearly one half of its operating revenue.

The fact that major segments of the inpatient services offered by the two hospitals represent complementary services rather than substitute services is highly relevant in judging the impact which the transaction may have in negotiations with health maintenance organizations, preferred provider organizations and other health care payors. The core, non-overlapping services make the hospitals complements and not substitutes when they are included in payors' hospital networks. To the extent that a payor needs Huntington hospital coverage in its network, the payor needs both of the Huntington hospitals to provide the full range of core services and, therefore, the proposed transaction would not increase the hospitals' leverage in negotiating prices with payors.

Geographic Market

It is the position of the Applicant that the relevant geographic market consists of those areas from which the hospital regularly draws at least 80% of its patients. In a leading antitrust case, the United States Supreme Court explained that the relevant geographic market should correspond to

³⁰West Virginia Inpatient Discharge Data, 2012-2013; Kentucky Inpatient Discharge Data, 2013; Ohio Inpatient Discharge Data, 2013.

The 80% primary market delineation used by CHH is consistent with the definitions used by a majority of the hospitals across the country.³³ In the American Bar Association's Health Care Merger and Acquisitions Handbook it states that "a PSA [Primary Service Area] is usually defined as the smallest set of zip codes from which the hospitals in question draw 90% of their patients. It is supposed to approximate where the hospitals compete for and draw patients from on a regular basis."³⁴ A nationally recognized health care consulting firm, HFS Consultants, recommends the use of the concept of the total service area as the relevant geographic market for a hospital and defines the total service area as the area which "provides 85%, plus or minus 3% of total discharges."³⁵ Another consulting firm, Arnett, Foster & Toothman, conducted studies for four West Virginia hospitals, Davis Memorial, Grafton City, Highland Clarksburg and Montgomery General. This firm defined the service area for a hospital "as the geographic area from which a significant number of patients utilizing hospital services reside."³⁶ This definition resulted in the inclusion of contiguous groups of zip codes which together represented 84 percent, 91 percent, and 74 percent of discharges for Davis Memorial, Grafton City and Montgomery General, respectively, and approximately 72% of patients for Highland Clarksburg Hospital.³⁷

Within the CHH and SMMC 80% service area, there are seven hospitals in addition to CHH and SMMC - Kings Daughters Medical Center, Our Lady of Bellefonte, CAMC - Teays Valley, Pleasant Valley Hospital, Holzer Health System, Williamson Memorial Hospital and Lifepoint Systems in Logan, West Virginia. In addition, a number of other hospitals located adjacent to this area aggressively compete with CHH and SMMC for patients residing within the 80% market area. These hospitals include Charleston Area Medical Center, the Thomas Health System and Southern Ohio Medical Center. Thus, there are a minimum of 12 hospitals which compete for patients residing within the 80% service area. Following the merger there will be 11.

Below is a pie chart showing the relative market share of hospitals who compete for patients within the 80% market area.³⁸

³³"Data by Region," The Dartmouth Atlas of Health Care.

³⁴*Health Care Mergers and Acquisitions Handbook*, (American Bar Association, 2003) pp. 31-84 at p. 47.

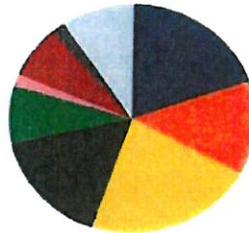
³⁵Gomes, Jim, "What to Consider When Defining a Hospital's Service Area". *HFS Blog*.

³⁶Davis Memorial Hospital - Community Health Needs Assessment, 2013.

³⁷"Davis Memorial Hospital Community Health Needs Assessment, 2013," *Davis Health System 12/13*"; "Community Health Needs Assessment, 2013," *Grafton City Hospital, 12/13*; "Community Health Needs Assessment 2013," *Montgomery General Hospital, 12/13*; "Community Health Needs Assessment 2014," *Highland Clarksburg Hospital*, undated.

³⁸ The color index identifying respective hospitals contained within the pie chart are more easily ascertained when referring to Exhibit J-2.

80% Service Area Shares



- CABELL HUNTINGTON HOSPITAL
- KING'S DAUGHTERS MEDICAL CENTER
- BON SECOURS KENTUCKY HEALTH SYSTEM
- THOMAS HEALTH SYSTEM
- HOLZER HEALTH SYSTEMS
- Other Systems
- SAINT MARY'S MEDICAL CENTER
- CHARLESTON AREA MEDICAL CENTER HEALTH SYSTEM
- COMMUNITY HEALTH SYSTEMS
- HIGHLANDS HEALTH SYSTEM
- LIFEPOINT HOSPITALS

Sources:
[1] CHH Inpatient Discharge Data - Specification 5 Response (5/16/2014-5/15/2015); [2] SMMC Inpatient Discharge Data - Specification 9 Response (5/16/2014-5/15/2015); [3] WV KY OH Inpatient Discharge Data 2013 for other hospitals; [4] Google Maps API

As the chart demonstrates, both Charleston Area Medical Center and King's Daughters Medical Center draw a larger percentage of patients from the relevant geographic market than do either CHH or SMMC. The chart makes it abundantly clear that the majority of patients residing inside the CHH - SMMC service area can conveniently seek services at hospitals other than CHH and SMMC should their prices be increased beyond competitive levels or quality diminished.

Undoubtedly, there are people who live in very close proximity to CHH or SMMC who would be less likely to seek services at another hospital because of a price increase, e.g. persons residing within the city limits of Huntington. Huntington residents, however, account for less than 25% of the admissions to CHH and SMMC. Hospitals cannot discriminate in prices based upon a patient's residence. Thus, even if residents of Huntington were willing to pay increased prices rather than travel to a competing hospital, the loss of patients residing outside of Huntington likely would render any non-competitive price increase unprofitable to the two hospitals. The Applicant submits, therefore, that the Cooperative Agreement can have no adverse impact on the price of hospital services.

In some cases, the departure of a competitor from the market may increase the bargaining power of surviving entities in their dealings with customers and others. Here, however, when the

proposed transaction is viewed in the context of the product market and the relevant geographic market, it is clear that the transaction will have a de minimis impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and services arrangements with the hospitals.

[REDACTED]

In order for an insurer successfully to market a health plan, it is necessary that the plan be able to offer a full array of hospital services. As noted above, neither CHH nor SMMC provides that full range of services. Thus, both hospitals are necessary for payors to be able to successfully market a health plan. They are, in essence, "must have hospitals." Since that will not change post merger, there will be no significant increase in bargaining power.

While commercial payors insure only roughly 30% of the patients of CHH and SMMC, it is only with respect to such payors that bargaining power or market power is relevant. Virtually all of the remaining 70% of patients are covered by government or quasi government payors such as Medicare, Medicaid, PEIA or Military Tri-care. These payors do not negotiate with hospitals but instead establish rates unilaterally.

While it is the position of the Applicant that robust competition between the combined entity and other hospitals will continue following CHH's acquisition of SMMC, in the circumstances present here, such competition is not necessary to provide consumer protection. In this case, there are three separate instrumentalities in place to ensure that consumers will not be harmed by the transaction. The first such instrumentality is the Assurance of Voluntary Compliance entered into between the two hospitals and the West Virginia Attorney General, a copy of which is attached hereto as Exhibit J-4.

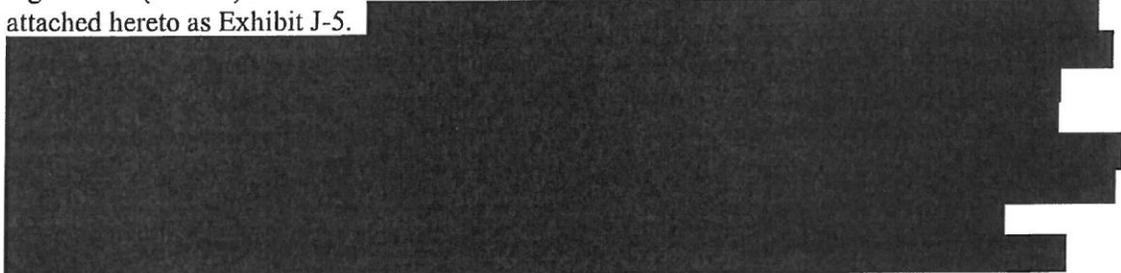
The AVC has several terms designed to assure that the transaction does not result in noncompetitive rate or price increases. Thus, the AVC provides that for a period of ten years, neither CHH nor SMMC will seek an increase in hospital rates beyond those rates which would be established using the benchmarking methodology previously used by the Health Care Authority.

In addition, under the AVC, neither CHH nor SMMC may terminate any existing payor contracts that are set to automatically renew in the absence of termination by either party. All of the current commercial contracts for both CHH and SMMC, other than the Highmark contract, fall into this category and all provide for reimbursement based upon a discount off charges. The payor is still able to terminate the contract, but because the hospitals cannot, the payor is guaranteed the same terms negotiated prior to the proposed merger. The hospitals also agree "for a period of five (5) years following consummation of the transaction not to negotiate for a reduction in the amount of the discount off charges contained in the prior third party payor

[contract]” for any payor that terminates an existing contract.³⁹ After five years, the parties agree for another three years to negotiate terms of payor contracts “in good faith’ and to be bound by arbitration if they cannot agree with payors on prices and terms.

CHH and SMMC also agree under the terms of the AVC that if the combined operating margin of the hospitals exceeds an average of 4 percent during any three-year period, the hospitals’ rates will be reduced by the amount of the excess for the following three years.⁴⁰

The second important instrumentality which provides protection to consumers is the Letter of Agreement (“LOA”) entered into between CHH and Highmark in November of 2014 which is attached hereto as Exhibit J-5.

 Highmark is by far the largest commercial insurer in the State of West Virginia. Its insureds account for approximately 74% of the commercially insured patients at CHH and 72% at SMMC.⁴¹

The third, and most important instrumentality which provides protection to consumers is the recently enacted W.Va. Code §16-29B-28. With respect to prices, the statute prevents a hospital party to a cooperative agreement involving a combination of hospitals from increasing inpatient prices as well as outpatient prices by an amount which exceeds the respective consumer price indices for all urban consumers by more than two percent without justifying such increases to this Authority. The Authority may require the rebate to the payors of any unjustified price increase. Additionally, the Act gives to the West Virginia Attorney General, with respect to hospital parties to an approved cooperative agreement involving a merger of hospitals, the authority to reject any non-competitive price increases as well as contracts with payors with reimbursement rates above competitive levels.

Given the combined effect of the AVC, the Highmark Blue Cross LOA and the recently enacted legislation, the combination of CHH and SMMC simply cannot have an adverse impact on the ability of health maintenance organizations, preferred provider organizations, managed health care organizations or other health care payors to negotiate reasonable payment and service arrangements with CHH and SMMC.

³⁹See Exhibit J-4, p. 8.

⁴⁰See Exhibit J-4, pp. 7-8.

⁴¹CHH Discharge and Visit Data, 2014; SMMC Discharge and Visit Data, 2014.

(B) The extent of any reduction in competition among physicians, allied health professionals, other health care providers or other persons furnishing goods or services to, or in competition with, hospitals that is likely to result directly or indirectly from the proposed cooperative agreement;

Applicant is aware of nothing in the Cooperative Agreement that will result in a reduction in competition among physicians, allied health professionals, other health care providers or those furnishing goods or services in competition with the hospitals. On the contrary, if the agreement is consummated, provisions of the AVC will promote competition between such persons or entities and the hospitals. Thus, the AVC increases competition by protecting physicians and other health care providers seeking to participate in competing facilities by releasing them from obligations not to compete with the hospitals upon termination of their employment. It also protects non-physician employees seeking to participate in a competing facility by releasing them from their obligation not to compete.

The AVC includes several additional provisions that would tend to increase competition by making it easier for other providers to offer new services. In particular, the hospitals agree that they will not oppose “the award of a certificate of need by the West Virginia Health Care Authority to any health care provider seeking to provide inpatient services similar to or competitive with services provided by either or both hospitals in the geographic area identified by CHH and SMMC as being the 90% Market Service Area unless the applicant for the certificate of need is a hospital which does not accept inpatient Medicaid patients and uninsured patients.”⁴²

A similar provision applies to outpatient services. For a period of ten years, neither of the hospitals “will oppose the award of a certificate of need by the West Virginia Health Care Authority to any Healthcare Provider seeking to provide outpatient services similar to or competitive with services provided by either or both hospitals in the geographic area identified by CHH and SMMC as being their 90% Market Service area.”⁴³

Other pro-competitive provisions of the AVC include the hospitals’ commitment not to bargain for or insist upon clauses that could potentially hinder the entry or expansion of competing facilities. Thus, the AVC provides that the hospitals will not bargain for or insist on “most favored nations” clauses or anti-tiering or anti-steering clauses in contracts with third party payors.⁴⁴

⁴²See Exhibit J-4, p. 6.

⁴³Id.

⁴⁴Id. at p. 9.

(C) The extent of any likely adverse impact on patients in the quality, availability and price of health care services;

As discussed in Section G, subsection (C), it is the position of the Applicant that the transaction will enhance the quality of care in numerous and important ways. The discussion in Section G, subsection © is incorporated by reference here. A vocal opponent of the transaction has argued that the loss of competition from SMMC will diminish the quality of care provided by the two hospitals. This contention belies an understanding of the factors which motivate hospital quality. They involve far more than competition from an across town hospital. An important driver of health care quality is the philosophy and culture of a hospital's governing board and management. The boards of CHH and SMMC are composed of local community and consumer representatives and in the case of SMMC, Catholic sisters. As noted by Dr. Yingling in his testimony in the CON proceeding, the Board meetings at each institution begin with a review of quality. Dr. Yingling further explained "there's a presentation of what the quality outcomes are for that hospital. That's...you would refer to that as a dashboard. A dashboard of some sort is provided to the individuals sitting at that board meeting to define exactly where quality is in that hospital. Those are reviewed at every meeting. Those are, in my view....culture is not a business model. Culture is a practice culture. And I think both hospitals have made it clear that the practice culture of their hospital is first and foremost about quality. I think that's from the leadership, from the board to the CEO, to the senior management, to the staff, to the patients who receive that benefit."⁴⁵ The Boards of CHH and SMMC and their management are totally committed to quality improvement.

As explained above, robust competition with CHH and SMMC for inpatient hospital services will continue from at least eleven other hospitals following consummation of the transaction. Each of these competitors offers outpatient services competitive with CHH and SMMC. Equally important to local competition, however, are the penalties and incentives implemented by governmental and commercial payors. Quality performance by CHH and SMMC is not judged by comparisons to the performance of each other but by how each compares to national, regional and statewide quality performance levels.⁴⁶ Quality penalties which may be imposed by CMS through a reduction in payments made to CHH can amount to as much as \$4,500,000 per year. A 5% meaningful use incentive could add an additional \$2,500,000 to the reimbursement at risk. \$3,000,000 in payments from Highmark Blue Cross is dependent on achieving quality scores set by Highmark each year. Thus, for CHH up to \$10,000,000 annually can be dependent on meeting quality goals. Comparable amounts can be at risk at SMMC. In addition, there are several independent entities such as Healthgrades, Leap Frog and CareChex that publish quality scores of hospitals throughout the country. These reports are available to consumers and provide powerful incentives for quality improvement.

Assurance of enhanced quality and improved access is also provided by the AVC. In this

⁴⁵Certificate of Need Tr. I, p. 184-185.

⁴⁶See Certificate of Need Tr. I, p. 151-152 and p. 184-191.

document CHH and SMMC agree that within six months following the closing of the transaction they will develop population health goals including centers of excellence with quantitative benchmarks and a proposed timeline to be provided to the Attorney General.⁴⁷ The hospitals agree that they will implement community wellness programs reaching out to medically underserved areas, the details of which will be communicated to the Attorney General.⁴⁸ The hospitals commit in the AVC to establish a fully integrated and interactive medical records system at both hospitals so that patient encounters at both hospitals will be readily available in real time to treating physicians at both hospitals.⁴⁹ The hospitals agree to provide to the Attorney General 90 days written notice of any proposed addition or deletion of a service line and commit to continue to accept Medicaid patients residing in Ohio and Kentucky at payment rates established by such states for in-state providers.⁵⁰ The AVC further requires the two hospitals to apprise the Attorney General in detail of the steps they propose in order to achieve projected efficiencies and quality enhancements from the transaction.⁵¹

Finally, the recently enacted code W.Va. Code §16-29B-28 requires an annual report to the Authority submitted by the parties to the cooperative agreement setting forth, among other things, a corrective action plan in those instances in which the average performance score of the hospitals in any calendar year is below the 50th percentile for all United States hospitals with respect to certain quality metrics selected by the Authority. The report must also provide for a significant rebate to commercial health plans if, in any two consecutive year period, the average performance score is below the 50th percentile.

(D) The availability of arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement

The Applicant is aware of no alternative arrangements which would achieve the same level of benefits which the Cooperative Agreement provides. As explained above, this transaction will have at most a minimal impact upon competition in the relevant geographic market. It creates the opportunity for savings [REDACTED] which are specific to this transaction and could not be achieved by another purchaser of 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

⁴⁷See Exhibit J-4, p. 9-10.

⁴⁸Id. at p. 10.

⁴⁹Id.

⁵⁰Id.

⁵¹Id. at p. 10-11.

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. [REDACTED]

[REDACTED] 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.

It is important to remember that SMMC will be sold. The benefits listed above as well as many other benefits from the transaction could be lost to the community if SMMC is sold to another purchaser.

SECTION K. CONCLUSION

W.Va. Code §16-29B-28 clearly mandates that the decision to approve or reject a cooperative agreement should not be governed solely by a transaction's impact on competition but should be based on a comparison of the likely benefits which the agreement provides to the likely disadvantages from a reduction in competition. While it is the position of the Applicant that the Cooperative Agreement will have only a minimal impact on competition, it is abundantly clear that because of the AVC, the LOA and West Virginia Code Sections 16-29B-28(g)(1)(D) and 16-29B-28(i)(1)(B), the Cooperative Agreement will not negatively impact consumers in any way - there are no likely disadvantages. In contrast, as the Application demonstrates, the benefits of the Cooperative Agreement are numerous. Consummation of the Cooperative Agreement will not only constrain the cost of health care, it will permit improvements to health care which are not merely important but transformative.

COUNTY OF CABELL

STATE OF WEST VIRGINIA, to wit:

Upon first being duly sworn, I hereby state that, to the best of my information, knowledge, and belief, the information provided in this application is true and correct.



(Signature)

President and CEO
(Title)

Sworn to, stated, and subscribed before me on this 25th day of March 2016



NOTARY PUBLIC