COMMONWEALTH *of* VIRGINIA

Department of Health
P O BOX 2448
RICHMOND, VA 23218

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TTY 7-1-1 OR
1-800-828-1120

October 30, 2017

VIA EMAIL AND FIRST CLASS U.S. MAIL

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

Mr. Bart Hove, President and CEO
Wellmont Health Systems
1905 American Way
Kingsport, Tennessee 37660

RE: APPLICATION FOR COOPERATIVE AGREEMENT

Dear Mr. Levine and Mr. Hove:

On February 16, 2016, Mountain States Health Alliance and Wellmont Health System (collectively "the Applicants") submitted an application for approval of a cooperative agreement ("Application") to the Southwest Virginia Health Authority ("Authority") in accordance with Virginia Code § 15.2-5384.1(C). The Authority initially recommended approval of the application on November 22, 2016. The Authority's approval was conditioned on the revised commitments made by the Applicants to achieve the improvements in population health, access to health care services, quality, and cost efficiencies identified by them in support of their Application.

To assist me in reviewing the Application, I assembled the following team of state experts from the Department of Health (VDH) and the Department of Medical Assistance Services (DMAS):

Heather Anderson, MPH
VDH, Director, State Office of Rural Health
Erik O. Bodin, MSHA
VDH, Director, Office of Licensure and Certification
Peter Boswell, MHA
VDH, Director, Division of Certificate of Public Need
Richard Corrigan
VDH, Deputy Commissioner for Administration and Chief Financial Officer
Doug Harris, JD
VDH, Office of the State Health Commissioner Adjudication and HIPAA Officer
Joseph Hilbert, MPA
VDH, Office of the State Health Commissioner Director of Governmental and Regulatory Affairs
M. Norman Oliver, MD, MA
VDH, Deputy Commissioner for Population Health
John Stanwix, JD
DMAS, Division of Appeals, Formal Appeals Supervisor

I also retained two independent consultants with health care expertise to assist in my review of the Application: Dr. Peter Knox, President of Knox Consulting; and Dr. Richard F. Tomkins, President of First Chesapeake Group.

On December 22, 2016, I requested supplemental information necessary to the assessment of whether to approve the Application. The Applicants completed their response on April 19, 2017. On January 9, 2017, I made a second request for supplemental information. The Applicants completed their initial response to the second request on April 14, 2017. On April 20, 2017, I notified the Applicants that their initial response to the second request was incomplete. The Applicants completed their response to the second data request on May 10, 2017.

Meetings were held with the Applicants in Richmond on May 17, 2017 and August 8, 2017. The Applicants submitted revised commitments on September 22, 2017. An additional meeting was held with the Applicants in Abingdon on October 4, 2017. The Applicants subsequently submitted revised commitments dated October 9, 2017 to the Southwest Virginia Health Authority and provided a copy to me at that time. The Southwest Virginia Health Authority reviewed the revised commitments at its meeting on October 12, 2017, and provided me with its feedback on October 16, 2017.

In accordance with Virginia Code § 15.2-5384.1, I have reviewed the Application and all information contained in the administrative record, including the recommendation of the

Southwest Virginia Health Authority and its feedback on the October 9, 2017 revised commitments and the information submitted by the Applicants in response to my requests for supplemental information. I have also reviewed public comment contained in the administrative record, including comments from the Federal Trade Commission, Anthem Health Plans of Virginia, the Virginia Association of Health Insurance Plans, and individuals residing in southwest Virginia. In addition, I have reviewed the Staff Analysis Report and Recommendation prepared by the team of state experts referenced above.

Based upon my review of the administrative record and all of the factors contained in Virginia Code § 15.2-5384.1(E), I adopt the findings, conclusions, and recommended decision, including the recommended Conditions, contained in the Staff Analysis Report and Recommendation, which is attached and incorporated herein as Attachment 1.

Based on my review of the Application and the administrative record, and my adoption and incorporation of the Staff Analysis Report and Recommendation, I find by a preponderance of the evidence that if the Applicants meet and comply with the Conditions set forth in Attachment 2, 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.

The reasons for my decision include the following:

1. Southwest Virginia experiences significant challenges with respect to delivery of health care services and population health status.

2. The strong competition between the Applicants has failed to provide meaningful, visible benefits to the people of southwest Virginia in terms of access to care and improvements in health status. People in the region continue to struggle with access to primary and specialty care and with pervasive challenges to population health improvement.

3. At a time when the continued operation of many rural health care facilities is at risk, the Applicants have made commitments to keep all Virginia hospitals open as clinical and health care institutions for at least five years. This is a significant commitment to preserving access to care and a benefit to the people of southwest Virginia that will result from the cooperative agreement.

4. The Applicants have made commitments to create new capacity for residential addiction recovery services, develop new community-based mental health resources, and develop pediatric specialty centers and emergency rooms. In addition, the Applicants have committed to developing a Rural Health Services Plan that will

address access to primary care services with a plan for same day access, and essential services. These commitments should enhance access to critical or currently limited health care services in the region and are likely to provide a benefit for the people of southwest Virginia.

5. The Applicants' commitments to maintain three tertiary hospitals in Tennessee, implement a charity care policy covering individuals with incomes up to 400% of the federal poverty level, and develop a comprehensive physician/physician extender needs assessment and recruitment plan represent other significant commitments to improving and preserving access to care and constitute benefits that will result from the cooperative agreement.

6. The Applicants express a desire to collaborate and coordinate with key stakeholders throughout southwest Virginia on population health initiatives that will make a difference in the lives of people in the region. The Applicants' commitments to establish an Accountable Care Community and spend $75 million over the next ten years on population health improvement efforts are likely to help produce the benefit of improved population health status in the region.

7. The Applicants have expressed the intent to adopt new business models that emphasize risk-based and value-based contracting, which is necessary for population health improvement. Speeding this evolution through the cooperative agreement will result in a benefit to the people of southwest Virginia.

8. The Applicants have committed to the development of a common clinical information technology platform, meaningful participation in a regional health information exchange, and establishment of annual priorities related to quality improvement. These commitments are likely to result in the benefits of improving the quality of services and reducing inappropriate utilization of services.

9. Although reduction in competition resulting from the cooperative agreement could lead to a higher cost of care, the Applicants have offered commitments to mitigate such a disadvantage. The Applicants have committed to significant limitations, beyond what was initially proposed, on the ability to increase the prices it charges to payers. In addition, the Applicants commit to continue to negotiate in good faith with payers.

10. With respect to the State Medicaid program, the Applicants have committed to partner with DMAS to develop and implement value-based payment programs, contract with all Medicaid Managed Care Organizations, and participate in the Addiction and Recovery Treatment Services Program. These commitments are likely to result in benefits to the people of the region.

11. As competitors, the Applicants have largely failed to collaborate or cooperate on a sufficient scale to bring about the types of benefits that the people of southwest Virginia need in order to overcome substantial health care and health status problems.

12. The commitments made by the Applicants create a more favorable balance of benefits over disadvantages from the cooperative agreement than would occur from alternative arrangements.

13. The Conditions being imposed will further ensure that the intended benefits of the cooperative agreement are achieved and that any disadvantages resulting from the cooperative agreement are mitigated. These Conditions will help ensure that the Applicants achieve the improvements in population health, access to health care services, quality, and cost efficiencies identified in their Application.

14. The benefits likely to result from the cooperative agreement outweigh the disadvantages likely to result from a reduction in competition from the cooperative agreement.

ORDER AND LETTER AUTHORIZING A COOPERATIVE AGREEMENT

Based upon the foregoing findings and conclusions, it is hereby ORDERED that the Application for a Cooperative Agreement is APPROVED WITH CONDITIONS as set forth in Attachment 2.

Pursuant to Virginia Code § 15.2-5384.1(G), the cooperative agreement is entrusted to the State Health Commissioner for active and continuing supervision to ensure compliance with Virginia Code § 15.2-5384.1, 12 VAC 5-221, and this Order, including the conditions imposed in Attachment 2.

Pursuant to 12 VAC 5-221-100, I will establish quantitative measures that will be used to evaluate the proposed and continuing benefits of the cooperative agreement by January 31, 2018. A Technical Advisory Panel will be appointed forthwith in accordance with 12 VAC 5-221-120 to provide initial recommendations to me as to the quality, cost, and access measures and benchmarks to be considered to objectively track the benefits and disadvantages of the cooperative agreement. The Technical Advisory Panel shall identify evidence-based cost, quality, and access measures in areas including, but not limited to, population health, patient safety, health outcomes, patient satisfaction, access to care, and any other areas, and make

recommendations to me regarding how to best report performance on quality metrics. Pursuant to 12 VAC 5-221-100(C)(3), I have exclusive authority to add, modify, accept, or reject recommendations of the Technical Advisory Panel when creating or interpreting the quantitative measures.

The Applicants shall submit an annual report meeting the requirements of Virginia Code § 15.2-5384.1 and 12 VAC 5-221-110. The first annual report shall be submitted by one year from the date of the closure of the merger.

The Applicants shall comply with Virginia Code § 15.2-5384.1 and 12 VAC 5-221, including providing any information requested that is necessary to active and continuing supervision to ensure compliance with the cooperative agreement and access to facilities by staff of the Department of Health to conduct on-site inspections.

If the State Health Commissioner finds reason to believe that compliance with the cooperative agreement no longer meets the requirements of Virginia Code § 15.2-5384.1, 12 VAC 5-221, or this Order, a proceeding shall be initiated to determine compliance. During such a proceeding, reasonable modification to the cooperative agreement may be made with the consent of the Applicants.

This ORDER shall remain in effect until such time as it is revoked in accordance with Virginia Code § 15.2-5384.1(H) and 12 VAC 5-221-130, modified pursuant to Virginia Code § 15.2-5384.1(H) and 12 VAC 5-221-130(B), or terminated by the Applicants pursuant to Virginia Code § 15.2-5384.1(I) and 12 VAC 5-221-140.

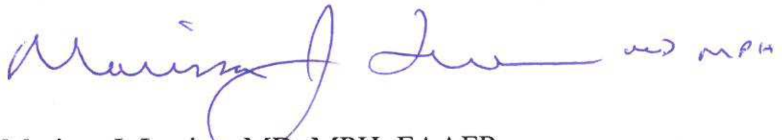
This Order and Letter Authorizing a Cooperative Agreement constitute a case decision under the Virginia Administrative Process Act, Virginia Code § 2.2-4000 *et seq.* In accordance with Rule 2A:2 of the Rules of the Supreme Court of Virginia, any aggrieved party may appeal this case decision by filing, within thirty (30) days after service of the case decision, a signed notice of appeal to:

Erik O. Bodin
Director of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

When the case decision is served by mail, three (3) days are added to the thirty-day period. In accordance with Virginia Code §§ 2.2-4023 and 15.2-5384.1(I), the signed original of this Order

and Letter Authorizing a Cooperative Agreement shall remain in the custody of the Department of Health, as a public record.

It is so ORDERED this 30th day of October, 2017.



Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Attachment 1, Staff Analysis Report and Recommendation
Attachment 2, Conditions

cc: The Honorable Terence R. McAuliffe
Governor of the Commonwealth of Virginia
The Honorable Mark Herring
Attorney General of Virginia
The Honorable William H. Hazel
Secretary of Health and Human Resources
The Honorable Terry Kilgore
Delegate, Virginia General Assembly and
Chair, Southwest Virginia Health Authority
Sue Cantrell, BPharm, MD
Director, LENOWISCO Health District
Karen Shelton, MD
Director, Mount Rogers Health District

VIRGINIA DEPARTMENT OF HEALTH

Application for a
Letter Authorizing Cooperative Agreement
Submitted by
Mountain States Health Alliance
and
Wellmont Health System

Staff Analysis Report and Recommendation

October 27, 2017

In 2015, the General Assembly enacted Virginia Code § 15.2-5384.1 to permit cooperative agreements that are beneficial to citizens served by the Southwest Virginia Health Authority ("Authority").[1] The localities participating in the Authority include all counties or cities in the LENOWISCO or Cumberland Plateau Planning District Commissions and the counties of Smyth and Washington and the City of Bristol.[2] A cooperative agreement is defined as "an agreement among two or more hospitals for the sharing, allocation, consolidation by merger or other combination of assets, or referral of patients, personnel, instructional programs, support services, and facilities or medical, diagnostic, or laboratory facilities or procedures or other services traditionally offered by hospitals."[3]

Under Virginia Code § 15.2-5384.1, parties located within the participating localities of the Authority that wish to enter into a cooperative agreement may submit an application for approval of a proposed cooperative agreement to the Authority.[4] If the Authority determines that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition, it provides a recommendation of approval to the State Health Commissioner ("Commissioner").[5] Upon receipt of the Authority's recommendation of approval, the Commissioner must assess whether to approve the proposed cooperative agreement based on a consideration of the factors contained in Virginia Code § 15.2-5384.1(E) and 12VAC5-221-80(G). If the Commissioner finds by a preponderance of the evidence that the benefits likely to result from the proposed cooperative agreement outweigh the disadvantages likely to result from a reduction in competition, she will approve the application for cooperative agreement.[6] The Commissioner may reasonably condition approval of the proposed cooperative agreement upon the parties' commitments to achieving the improvements in population health, access to health care services, quality, and cost efficiencies identified by the parties in support of their application.[7] If approved, the cooperative agreement is entrusted to the Commissioner for active and continuing supervision to ensure compliance with the provisions of the cooperative agreement.[8]

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[1] Va. Code § 15.2-5384.1(A).
[2] Va. Code § 15.2-5369.
[3] *Id*.
[4] Va. Code § 15.2-5384.1(C).
[5] Va. Code § 15.2-5384.1(E)(1).
[6] Va. Code § 15.2-5384.1(F)(2) and 12VAC5-221-80(H).
[7] Va. Code § 15.2-5384.1(F)(2) and 12VAC5-221-90(C).
[8] Va. Code § 15.2-5384.1(G).

Application

On September 16, 2015, Mountain States Health Alliance ("Mountain States") and Wellmont Health System ("Wellmont") filed a letter of intent notifying the Authority of their plan to submit an application for approval of a cooperative agreement. On February 16, 2016, Mountain States and Wellmont (together, the "Applicants") filed an application for approval of a cooperative agreement ("Application") with the Authority.[9]

The Applicants

Mountain States Health Alliance

Mountain States operates 13 hospitals and numerous outpatient care sites across a 29-county, four-state region. Mountain States is headquartered in Johnson City, Tennessee and is a tax-exempt organization. Mountain States operates the following general acute care hospitals located in southwest Virginia:

- Johnston Memorial Hospital in Abingdon
- Smyth County Community Hospital in Marion
- Norton Community Hospital in Norton
- Russell County Medical Center in Lebanon
- Dickenson Community Hospital in Clintwood.

Wellmont Health System

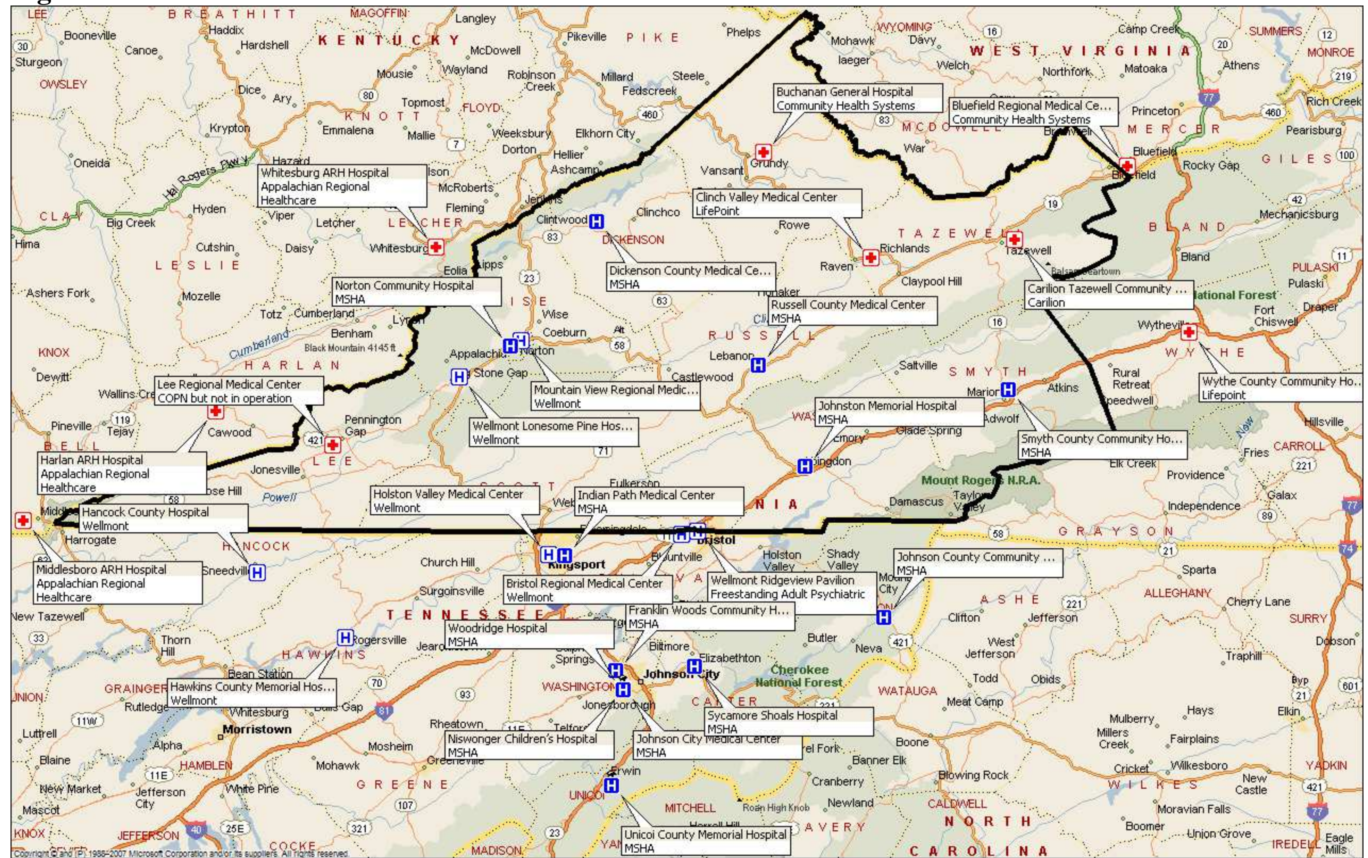
Wellmont operates six hospitals and numerous outpatient care sites, serving communities in northeast Tennessee and southwest Virginia. Wellmont is headquartered in Kingsport, Tennessee and is also a tax-exempt organization. Wellmont operates the following general acute care hospitals located in southwest Virginia:

- Mountain View Regional Medical Center in Norton
- Wellmont Lonesome Pine Hospital in Big Stone Gap.

The area served by the Authority is shown in Figure 1 by the dark line. Blue background "H" signs are Mountain States acute care hospitals; the white background "H" signs are the Wellmont acute care hospitals. The red cross signs are other acute care hospitals within or near the participating localities of the Authority.

[9] The Applicants also filed an application for a certificate of public advantage with the Tennessee Department of Health.

Figure 1.



New Health System

If the Application is approved, Mountain States and Wellmont would merge and operate as a single health system. The New Health System's facilities would include physician services, outpatient services and facilities, and the acute care hospitals in Virginia and Tennessee shown in Table 1.

Table 1. Acute Care Hospitals and Beds

	Virginia Hospitals	Location	2013 Licensed Beds	2013 Staffed Beds Application	2014 Staffed Beds VHI	2015 Staffed Beds VHI
Mountain States	Dickenson Community Hospital	Clintwood	25	2	2	2
	Johnston Memorial Hospital	Abingdon	116	112	116	128
	Norton Community Hospital	Norton	129	50	69	69
	Russell County Medical Center	Lebanon	78	49	50	49
	Smyth County Community Hospital	Marion	44	44	44	44
	Mountain States Total Beds		392	257	293	292

	Virginia Hospitals	Location	2013 Licensed Beds	2013 Staffed Beds Application	2014 Staffed Beds VHI	2015 Staffed Beds VHI
Wellmont	Mountain View Regional Medical Center	Norton	74	18	18	18
	Wellmont Lonesome Pine Hospital	Big Stone Gap	60	21	31	31
	Wellmont Total Beds		134	39	49	49
	Virginia Total Beds		526	296	342	341

	Tennessee Hospitals	Location	2013 Licensed Beds	2013 Staffed Beds Application
Mountain States	Franklin Woods Community Hospital	Johnson City	80	77
	Indian Path Medical Center	Kingsport	239	168
	Johnson City Medical Center	Johnson City	501	497
	Johnson County Community Hospital	Mountain City	2	2
	Niswonger Children's Hospital	Johnson City	69	69
	Sycamore Shoals Hospital	Elizabethton	121	121
	Unicoi County Memorial Hospital	Erwin	48	48
	Woodbridge Hospital	Johnson City	84	84
	Mountain States Total Beds		1,144	1,066
Wellmont	Bristol Regional Medical Center	Bristol	312	261
	Hancock County Hospital	Sneedville	10	10
	Hawkins County Memorial Hospital	Rogersville	50	46
	Holston Valley Medical Center	Kingsport	505	339
	Wellmont Total Beds		877	656
	Tennessee Total Beds		2,021	1,722
	New Health System Total Beds		2,547	2,018

Sources: Application and Virginia Health Information (VHI)

Recommendation of the Authority

In creating the Authority, the General Assembly recognized that "rural communities such as those served by the Authority confront unique challenges in the effort to improve health care outcomes and access to quality health care."[10] In establishing the members of the Authority, the General Assembly included experts regarding the region served by the Authority and the healthcare challenges the region

[10] Va. Code § 15.2-5368(B).

faces.[11] Using its expertise of the region and the region's challenges, the Authority is required to establish regional health goals directed at improving access to care, advancing health status, targeting regional health issues, promoting technological advancement, ensuring accountability of the cost of care, enhancing academic engagement in regional health, strengthening the workforce for health-related careers, and improving health entity collaboration and regional integration where appropriate.[12] In January 2016, the Authority adopted revised health goals for the region. The goals specifically targeted the areas of healthy starts for children, healthy minds, healthy behaviors, healthy communities and an effective system of health care (Attachment A).[13]

In conducting its review of the Application, the Authority did so in consideration of the Commonwealth's policy to facilitate improvements in patient health care outcomes, access to quality health care, and population health in rural communities and by weighing the factors set forth in Virginia Code § 15.2-5384.1(E), including whether population health status would be enhanced consistent with its regional health goals. The Authority utilized five different working groups (Health Care Quality, Population Health, Health Care Access, Health Care Cost, and Competition) to perform its review of the Application. In addition, the Authority hired three part-time employees with expertise in the clinical, legal, and business aspects of health care to further assist with the review.[14] The Authority received and reviewed public comment concerning the Application, and held a public hearing in conjunction with the Commissioner.[15]

In evaluating the potential benefits of the proposed cooperative agreement, the Authority considered whether each of the following benefits would result:

a. 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, resulting in improved patient satisfaction;
b. Enhancement of population health status consistent with the regional health goals established by the Authority;
c. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care;
d. Gains in the cost-efficiency of services provided by the hospitals involved;
e. Improvements in the utilization of hospital resources and equipment;
f. Avoidance of duplication of hospital resources;
g. Participation in the state Medicaid program; and
h. Total cost of care.

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[11] Va. Code § 15.2-5370.
[12] Va. Code § 15.2-5368(B).
[13] Southwest Virginia Health Authority, "Blueprint for Health Improvement & Health-Enabled Prosperity," January 7, 2016. ("Attachment A").
[14] A Review of the Commonwealth of Virginia Application for a Letter Authorizing a Cooperative Agreement Filed by Mountain States Health Alliance and Wellmont Health System, December 22, 2016 (the "Authority Report") at 33-43.
[15] *Id.* at 50-66.

Based on its review and consideration, the Authority found that the benefits described in a-g above would likely exist under the cooperative agreement, and the benefit described in h (total cost of care) may exist under the cooperative agreement.[16] The Authority also found that other potential benefits are likely to occur as a result of the cooperative agreement, including maintenance of corporate offices and jobs in the region.[17]

The Authority's evaluation of any disadvantages attributable to any reduction in competition likely to result from the proposed cooperative agreement included 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 payers 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.

Based on its review and consideration, the Authority found that

- the disadvantage described in "a" might exist;
- the disadvantage described in "b" had the potential to exist but had been mitigated by the Applicants' commitments;
- with respect to the disadvantage described in "c", there was likely to be more benefit from the cooperative agreement than disadvantages in these areas; and
- with respect to the disadvantage described in "d", other arrangements would not achieve the same benefit of guaranteeing rural hospital services and population health improvement that the cooperative agreement does.[18]

On November 22, 2016, having found that the benefits likely to result from the proposed cooperative agreement are likely to outweigh the disadvantages likely to result from a reduction in competition, the Authority recommended the Commissioner issue a letter approving the proposed cooperative agreement. A written report detailing the Authority's review was submitted to the Commissioner on December 22, 2016.[19]

[16] *Id.* at 159-163.
[17] *Id*. at 163.
[18] *Id*. at 163-166.
[19] Authority Report.

Revised Commitments

After receiving the recommendation and the report of the Authority and supplemental information from the Applicants, the Commissioner held meetings with the Applicants on May 17, 2017 and August 8, 2017.[20] The Applicants submitted revised commitments to the Commissioner on September 22, 2017[21], shortly after the Tennessee Department of Health approved the application for a Certificate of Public Advantage (COPA) in Tennessee. An additional meeting was held with the Applicants on October 4, 2017.[22] In response to discussions during the meeting, as well as prior discussions had with Authority staff, the Applicants submitted revised commitments to the Authority and provided a copy to the Commissioner on October 9, 2017 (Attachment B).[23] The Authority considered the Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health (the Tennessee Terms of Certification) and the revised commitments on September 27, 2017 and October 12, 2017, and provided feedback to the Commissioner by letter dated October 16, 2017.[24] That feedback contained recommendations related to submission of five-year financial projections by the New Health System, limitations on rate increases, representation of Virginia residents on the Board of the New Health System, population health improvement, potential lay-offs of hospital employees, academic research, the New Health System's cost of compliance with provisions in the Tennessee Terms of Certification, and transparency.[25]

Staff Analysis

In making her determination, the Commissioner is required to consider the factors contained in Virginia Code § 15.2-5384.1(E) and 12VAC5-221-80(G).[26] Each of those factors are set forth below followed by an analysis based upon the agency record that contains information submitted by the Applicants, including the Application and responses to supplemental requests for information, the recommendation of the Authority and its additional recommendations dated October 16, 2017, comments received from the public, comments received from the Federal Trade Commission (FTC) staff, the reports of the Applicants' independent consultants, and written consultation received from the Attorney General, as well as the written reports received from the Virginia Department of Health's (VDH) two independent experts, Dr. Richard F. Tompkins, President of First Chesapeake Group, a private healthcare consultant organization, and Dr. Peter Knox, President of Knox Consulting, also a private healthcare consultant organization.

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[20] Summary of Meeting between VDH staff and Representatives of Wellmont Health System and Mountain States Health Alliance, May 17, 2017 and August 8, 2017: www.vdh.virginia.gov/content/uploads/sites/96/2017/08/May-17-meeting-summary-final.pdf and www.vdh.virginia.gov/content/uploads/sites/96/2017/08/August-8-summary-final.pdf.
[21] Revised NHS Virginia Commitments – September 22, 2017.
[22] Summary of Meeting between VDH staff and Representatives of Wellmont Health System and Mountain States Health Alliance, October 4, 2017: www.vdh.virginia.gov/content/uploads/sites/96/2017/10/October-4-Summary-Final.pdf.
[23] Revised NHS Virginia Commitments – October 9, 2017.
[24] Letter from Terry G. Kilgore, Chairman, Southwest Virginia Health Authority to Marissa J. Levine, October 16, 2017.
[25] *Id*.
[26] Some statements and conclusions, appearing below and in direct relation to one statutory consideration, may carry significance and relevance in addressing other statutory considerations.

1. 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, resulting in improved patient satisfaction

The Applicants have offered a commitment to "establish annual priorities related to quality improvement" and to publicly report quality measures in an easily-understood manner (commitment 8).[27] The Applicants have not included in their quality-related commitments specifics concerning the role of the Commissioner in the selection and approval of quality metrics, any expectation that the established goals or priorities will actually be met, or whether quality measure reporting will be conducted at the facility and locality level. The Terms of Certification issued by Tennessee contain detailed requirements for data collection and reporting to the public.[28] The Applicants' commitments with respect to quality also do not address Joint Commission accreditation or Medicare participation. The Terms of Certification issued by Tennessee require each hospital that is subject to Joint Commission accreditation to at all times be fully accredited by the Joint Commission, and to at all times maintain compliance with conditions of participation with Medicare.[29] These are gaps that lessen the likelihood of a benefit for the enhancement of the quality of hospital and hospital-related care.

The Applicants have also committed, subject to the agreement of Payers, to establish payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers as follows:

1. All risk-based model components of existing Wellmont and Mountain States contracts would continue from the date of closing into the future upon their terms.
2. One new risk-based model contract would commence no later than January 1, 2020.
3. A second new risk-based model contract would commence no later than January 1, 2021.
4. The New Health System would initiate risk-based model contracts for any remaining Large Network Payers that do not already have at least one risk-based model component in their contracts by no later than January 1, 2022.

Large Network Payers are defined as "a Payer which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges ('Gross Revenue') for the New Health System."[30]

By January of 2022, all of the Large Network Payers are expected to have a risk-based model/population health/partnership relationship with the New Health System that includes aligned incentives. The risk-based components in each contract will be based on the unique priorities and timelines agreed upon by each Large Network Payer and the New Health System. The Applicants have defined "risk-based model" to mean contracts which contain elements of reimbursement tied to incentives for quality, value-based care, shared savings or alignment of financial incentives between Payers, the New Health System, employers and patients (commitment 7).[31] This commitment is intended to enhance

[27] Revised NHS Virginia Commitments – October 9, 2017 at 6.
[28] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 25.
[29] *Id.* at 23.
[30] Revised NHS Virginia Commitments – October 9, 2017 at 4.
[31] *Id.* at 6.

quality, improve cost efficiency, reduce unnecessary utilization of hospital services, and more fully align the New Health System, Payers, the business community, patients and the public.[32] However, this commitment does not include a specific target under which a substantial portion of the New Health System's total revenue from payer contracts would derive from risk-based models by a date certain. The establishment of such a target would provide greater assurance of enhanced quality, improved cost-efficiency, and reduced unnecessary utilization. This is a gap that lessens the likelihood of a benefit from this commitment.

In addition, the Applicants are committing to a series of investments that could directly improve the quality of hospital-based care, including:

- Up to $150 million to enhance hospital quality, improve cost-efficiency, improve the utilization of hospital-related services, and enhance opportunities in research by adopting a common clinical IT platform as soon as reasonably practical after the formation of the New Health System. The New Health System will make access to the IT platform available on reasonable terms to all physicians in the service area (commitment 20).[33]
- Up to $8 million over 10 years for meaningful participation in a regional health information exchange or cooperative arrangement whereby privacy protected health information may be shared with community-based providers for the purpose of providing seamless patient care. In addition, the New Health System will participate in the Commonwealth's ConnectVirginia health information exchange, Connect Virginia's Emergency Department Care Coordination Program, the VDH's Immunization Registry, and the Commonwealth's Prescription Monitoring Program (commitment 5).[34]

These commitments should further the ability to access a more coordinated system of health care within the region, which would promote a higher level of quality of care. It should be noted, however, that commitment 5 does not define what is meant by "meaningful participation" in a regional health information exchange. The Tennessee Terms of Certification mandate that the New Health System develop and submit to the Tennessee Department of Health for its approval a Health Information Exchange plan that shall require the New Health System to coordinate with Independent Physicians and other health care providers in the service area and other relevant third parties to determine the optimal technology solution for expanding the scope and effectiveness of providing access to patient electronic health information to the Independent Physicians and other health care providers. The Tennessee Terms also require that any imposition of fees or costs to Independent Physicians shall be a minimal amount not exceeding what is reasonable based on comparisons with other communities offering such services.[35] The Applicants' commitment 5 does not include these additional types of provisions related to the health information exchange, which creates a gap that lessens the likelihood of a benefit for enhancement of the quality of hospital and hospital-related care.

The Applicants commit to offering competitive compensation and benefits, and combining career development programs to ensure maximum opportunity for career enhancement and training

[32] *Id.*
[33] *Id*. at 13.
[34] *Id*. at 5.
[35] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 18-19.

(commitments 15 and 17).[36] The Applicants further commit that they will maintain an open medical staff (commitment 23).[37] The Applicants have also committed to create a system-wide, physician-led Clinical Council. This body shall be responsible for establishing a common standard of care, credentialing standards, quality performance standards and best practice requirements for the New Health System (commitment 38).[38] Of note, the Applicants have not committed that the Clinical Council's membership shall be representative of the distribution of physicians across the service area. This creates the potential that certain types of physicians, such as independent physicians from the Virginia service area, may be under-represented, or not represented at all, on the Clinical Council. This is a gap that lessens the likelihood of a benefit for enhancement of the quality of hospital and hospital-related care. Overall, however, these commitments would benefit quality of health care in southwest Virginia.

The Applicants have committed to spend $140 million over 10 years to enhance access to health care services, which would include creation of new capacity for residential addiction recovery services; development of community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents; promotion of recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment; and development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals (commitments 26 and 27).[39] Commitment 26 also includes development of a Rural Health Services Plan by the Applicants. Commitment 27 includes development of a Behavioral Health Services Plan and a Children's Health Services Plan. The Applicants have also committed to the development of a comprehensive physician/physician extender needs assessment and recruitment plan (commitment 26). The New Health System will employ physicians and physician extenders primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding.[40] According to the Applicants, the cost of recruitment related to implementation of the recruitment plan will be part of the $140 million referenced in commitment 27.[41]

The Applicants' commitment 26 does not specifically define the term "underserved area." This is another gap that decreases the likelihood of a benefit from this commitment. As utilized by VDH, underserved area means a Health Professional Shortage Area (HPSA) as designated by the Health Resources and Services Administration and tracked by the VDH's Office of Primary Care. Virginia has identified "persistent primary care health professions shortage areas" which identify areas within Virginia that were designated as HPSAs decades ago and represent areas of persistent need in Virginia. Many of these areas fall within the Virginia service area of the New Health System.[42]

In addition, the Applicants have committed to invest $85 million over a 10-year period to develop and implement a plan for post graduate training of physicians, nurse practitioners, physician assistants,

[36] Revised NHS Virginia Commitments – October 9, 2017 at 10-11.
[37] *Id*. at 15.
[38] *Id*. at 22.
[39] *Id.* at 16-18.
[40] *Id*. at 16.
[41] *Id*. at 16-17.
[42] Virginia Primary Care Needs Assessment at 18: www.vdh.virginia.gov/content/uploads/sites/76/2016/05/Primary-Care-Needs-Assessment-OHE.pdf.

and other allied health professionals and a plan for investment in the research enterprise (commitments 18 and 19).[43] If the Applicants meet these commitments, VDH staff believes that the quality of health care in southwest Virginia would be substantially improved.

The Applicants have developed regional annual incremental spending amounts as stated in Exhibit B of the Applicants' Revised New Health System Virginia Commitments dated October 9, 2017 (Attachment C), that further detail how the pledged monetary commitments, such as those made in commitments 18, 19, 26, and 27, will be spent over a 10-year period. Neither the commitments nor Exhibit B to the commitments describes the amount that will be spent in Virginia as opposed to Tennessee or provides any indication how allocations to each state will be made. This is a gap that lessens the likelihood of a benefit to Virginia from the monetary commitments. It will be essential for the New Health System to develop appropriate plans for submission to the Commissioner explaining and justifying the proposed allocation of these funds between Virginia and Tennessee to assure that the health and behavioral health care needs of the residents of Virginia, including children, are being appropriately benefited.

VDH staff acknowledges that Dr. Kenneth Kizer, Director of the Institute for Population Health Improvement, stated in his report that quality of health care services is not normally improved by "mergers or consolidation of services."[44] VDH staff believes, however, that the uniqueness of the challenges faced by the residents in southwest Virginia and the conditions that would be included in an approval by the Commissioner may be effective in ensuring that quality of care is maintained and improved.

VDH staff acknowledges that the FTC advises against the proposed merger due to the tendency of monopolies to result in higher prices and diminished choice for consumers. Such principles may not hold sway, however, in a region as unique as southwest Virginia. A consolidation of health care resources could bring benefits in quality if the Applicants meet their commitments and the recommended conditions. Further, improved quality should result in reduced costs and savings to the Applicants that could be reinvested into population health improvements.

During its consideration of the Application, the Authority formed a Quality Working Group to focus on the quality aspects of the proposed merger. The Authority's Quality Working Group concluded that, with the commitments that have been made by the Applicants, quality would exist.[45]

After review of the record, VDH staff finds sufficient reason to agree with the Authority and to find that if the Application is approved and the Applicants meet their commitments and the conditions recommended below, quality of care, including the quality of mental health services and treatment of substance abuse, is likely to be enhanced, thereby improving patient satisfaction. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 5, 7, 8, 15, 17, 18, 19, 20, 23, 26, 27, and 38.

[43] Revised NHS Virginia Commitments – October 9, 2017 at 11-13.
[44] Independent Assessment of the Proposed Merger Between Mountain States Health Alliance and Wellmont Health System, Kenneth Kizer, MD, MPH, November 21, 2016 (the "Kizer Assessment") at 17.
[45] Authority Report at 159.

In addition, to provide greater assurance that the commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may consider imposing conditions requiring the Applicants to:

- With respect to commitment 5:
  - Develop and submit to the Commissioner for approval a plan describing how the New Health System will participate meaningfully in a health information exchange or a cooperative arrangement whereby privacy protected personal health information may be shared with community-based providers for the purpose of providing seamless patient care; and
  - Ensure than any imposition of fees or costs for access to the health information exchange or cooperative arrangement by Independent Physicians or other health care providers shall comply with federal anti-kickback statutes and rules, and shall be a minimal amount that shall not exceed what is reasonable based on comparisons with other communities offering such services.
- With respect to commitment 7, ensure that a substantial percentage of the New Health system's total health plan contract revenue is derived from risk-based models by a date certain.
- With respect to commitment 8:
  - Establish annual priorities related to quality improvement applicable to all facilities within the first six months of the closing date of the merger;
  - Seek input from, and approval of, the Commissioner in the selection of quality measures;
  - Meet the published annual quality goals/priorities and show improvement at the individual facility and system level over time;
  - Provide quality measure reporting by locality and individual facility level, as well as in aggregate for the system;
  - Maintain Joint Commission accreditation at each hospital subject to such accreditation and compliance with conditions of participation with Medicare;
  - Promptly notify the Commissioner of any deficiencies or other noncompliance cited by the Joint Commission or Medicare; and
  - Submit a plan of correction correcting any deficiencies or noncompliance cited by the Joint Commission or Medicare within the time provided by a Centers for Medicare and Medicaid Services (CMS)-approved Medicare accreditation program, and notify the Commissioner upon completion.
- With respect to commitment 18, develop and submit a plan, subject to the review and approval of the Commissioner, for post-graduate training of physicians, nurse practitioners, physician assistants, and other allied health professionals, which shall include a methodology for allocation of funds between Virginia and Tennessee.
- With respect to commitment 19, develop and submit a plan, subject to the review and approval of the Commissioner, for investment in the research enterprise which shall include a methodology for allocation of funds between Virginia and Tennessee.
- With respect to commitment 26:
  - Develop and submit plans, subject to the review and approval of the Commissioner, for rural health services and children's health services which shall include a methodology for allocation of funds between Virginia and Tennessee; and
  - Define the term "underserved area" as HPSA.

- With respect to commitment 27, develop and submit a plan, subject to the review and approval of the Commissioner, for behavioral health services which shall include a methodology for allocation of funds between Virginia and Tennessee.
- With respect to commitment 38, ensure that the membership of the Clinical Council is representative of the distribution of physicians across the geographic service area.

2. Enhancement of population health status consistent with the regional health goals established by the authority

Population health has been defined by the Institute of Population Health Improvement at the University of California-Davis to mean "the overall health status or health outcomes of a specified group of people resulting from the many determinants of health, including healthcare, public health interventions and social and environmental factors."[46]

As previously noted, the Authority adopted revised regional health goals in 2016 (Attachment A). A total of 38 goals were developed across five aims. The goals address educational attainment, employment, maternal and child health, mental health and substance abuse, nutrition, physical activity, oral health, chronic disease, and population health improvement planning at the community level. The Authority also developed 23 preliminary strategies for achievement of the goals.[47]

According to the 2017 County Health Rankings issued by the Robert Wood Johnson Foundation, and as summarized in the Terms of Certification issued by Tennessee, the Virginia counties that are part of the New Health System's service area have health indicators and outcomes that are generally much worse than the overall state average.[48] For example:

- Smoking is more common in 50% of the Virginia service area counties than in the state as a whole.
- 100% of the counties in the Virginia service area have a higher percentage of adults who are obese than the state as a whole.
- Fewer adults in 100% of the counties in the Virginia service area report any physical activity compared to the state as a whole.
- 100% of the counties in the Virginia service area exceed the state rate for neonatal abstinence syndrome births, with two counties having rates more than three times the state rate, and four counties with rates more than two times the state rate.
- The rate of preventable hospital stays for all of the Virginia counties in the service area exceeds the state rate. Two Virginia counties have rates of preventable hospital stays that are three times the state rate, and another three counties have rates that are double the state rate.
- Eleven Virginia counties in the service area have population to primary care physician ratios that are substantially greater than the statewide ratio, with one county having a ratio three

[46] *See* Kizer Assessment at 20, where a definition of "population health" devised by the Institute for Population Health Improvement, associated with the University of California-Davis, is discussed.
[47] Attachment A.
[48] Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, County Health Rankings 2017: Virginia, as cited in The Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 10-13.

times greater and another five counties with ratios of at least two times greater than the statewide ratio.
- Several Virginia counties in the service area have population to mental health provider ratios that are four to five times greater than the statewide ratio, with one county having a ratio that is 22 times greater.
- Seven of the Virginia counties in the service area have child poverty rates that are almost 15 percentage points greater than the state rate.
- The per capita annual income in Virginia is $56,732. The per capita annual income for the eleven Virginia counties in the service area ranges from a low of $27,137 to a high of $37,388, with most of the counties having an average annual income $12,000 to $25,000 less than the statewide average.
- The median household income in Virginia is $66,300. The median household income for the eleven Virginia counties in the service area ranges from a low of $32,135 to a high of $45,864, with most of the counties having a median household income $20,000 to $35,000 less than the statewide average.

The report submitted to the Commissioner by the Authority stated that the "health of the region and the health of the population are directly linked in a troubling spiral downward."[49] The unique challenges faced by the region were reaffirmed in a recent report, *Creating a Culture of Health in Appalachia – Disparities and Bright Spots*, issued by the Appalachian Regional Commission. Among the report's findings, it found that performance in the Appalachian region is worse than the performance in the United States as a whole in 7 of the 10 leading causes of death.[50] The report also found that the "years of potential life lost, which is a measure of premature mortality, is 25% higher in the Appalachian region than in the nation as a whole.[51]

The Applicants intend to transform their currently separate health systems into an integrated health care delivery system capable of meaningfully improving population health outcomes. The Applicants state in their Application that funding for population health improvement "would be impossible" but for the efficiencies and savings accruing from the proposed merger.[52] The Advisory Board, a consulting group retained by the Applicants, advises that "the merged entity's scale is critical to pursue population health management in a financially sustainable manner." [53] The Advisory Board states that "[c]ontinuing to operate as rival organizations precludes the systems from being able to pursue a population health management strategy that best serves the region."[54]

The population health working group formed by the Authority concluded that the Applicants would have an enhanced ability to provide specialty care in mental health and substance abuse, prevent chronic diseases related to obesity and diabetes, and promote cessation of tobacco use. The College of Public Health at East Tennessee State University (ETSU) issued a report that assessed the efforts and

[49] Authority Report at 9.
[50] Appalachian Regional Commission, "Creating a Culture of Health in Appalachia – Disparities and Bright Spots," August 2017 at 5: www.arc.gov/assets/research_reports/Health_Disparities_in_Appalachia_August_2017.pdf.
[51] *Id.* at 6.
[52] Application at 44.
[53] Advisory Board, "Independent Assessment of The New Health System's Likelihood of Successfully Navigating the Narrow Corridor in a Merged Integrated Delivery System," April 7, 2017 at 6 (the "Advisory Board Report").
[54] *Id.* at 6- 7.

activities of the four working groups. According to the ETSU report, the most important next step "will be to create a region-wide collaborative approach to identifying a small number of key, high-impact actions that are vital to improving the health of the region."[55]

The Applicants have committed to invest not less than $75 million over 10 years in population health improvement (commitment 28).[56] According to this commitment, the distribution of funding across the total population of the New Health System's service area shall consider the relative population of the counties and communities within the service area, the relative per-capita cost of interventions within each community and the relative value of the intervention towards improving overall population health. From the $75 million, the Applicants have committed to spending an amount necessary to support the creation of, and to take the lead to formally establish, at least one accountable care community (ACC) organization. Within 90 days of closing of the merger, the Applicants commit to recruit and convene the ACC's initial leadership team to help develop the population health plan (commitment 28).[57] The Applicants also commit to establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing a population health plan and improving the overall health of the service area population.[58] Further, the Applicants commit to focus on a limited number of interventions that will have a disproportionate impact on breaking the cycle of poor health and reducing the future burden of disease. Such interventions will be consistent with the Authority's Blueprint for Health Improvement and Health-Enabled Prosperity, and Virginia's Plan for Well-Being.[59]

The Applicants have committed to spending at least $140 million over 10 years in part to expand community-based mental health services, and residential and outpatient addiction recovery programs, as well as to further support children's health services (commitment 27).[60] In addition, the Applicants have committed to spend at least $85 million over 10 years to develop academic research opportunities, support post-graduate health care training, and strengthen the pipeline and preparation of health professionals in the region, which should lead to the ability to enhance population health (commitments 18, 19 and 26).[61] With respect to post-graduate health care training, specific focus on establishment of community-based, rural, primary care or preventive medicine residencies, as well as community-based psychiatric residency rotations, would increase the likelihood of a benefit to population health status in southwest Virginia. Development of incentives for clinical employees to pursue terminal clinical degrees would also increase the likelihood of a benefit to population health status in southwest Virginia.

Further, the Applicants have committed to develop a Rural Health Services Plan (commitment 26) which shall address the New Health System's approach to:

- Primary Care Services, with a plan for same day access, which may include telemedicine and other technology based access
- Services to support maternal and prenatal health

[55] College of Public Health-East Tennessee State University, "Key Priorities for Improving Health in Northwest Tennessee and Southwest Virginia: A Comprehensive Report" at iv.
[56] Revised NHS Virginia Commitments – October 9, 2017 at 18.
[57] *Id*.
[58] *Id*. at 19.
[59] *Id*.
[60] *Id*. at 17-18.
[61] *Id*. at 11-13, 16-17.

- Pediatrics and regional pediatric specialty access
- Specialty care and regional specialty care access
- Access to essential services (as defined in commitment 21)
- Improved access to preventive and restorative dental and corrective vision services
- Emergency service access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia Emergency Medical Services Council.[62]

The Applicants state that the Rural Health Services Plan will account for needed workforce development strategies in consultation with the Southwest Area Health Education Center and regional educational institutions. Further, the Applicants commit that the plan will also support the development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops.[63] VDH staff believes that it will also be important for the Rural Health Services Plan to address collaboration with local businesses, industry, and local school divisions in order to achieve the type of community development necessary to attract and retain health care providers in southwest Virginia.

The Applicants assert that the population health strategies proposed in the Application would directly benefit the Medicaid population served, as well as residents, in general. However, the Applicants have not yet provided specifics concerning the extent to which these planned expenditures would occur in the Virginia portion of the service area. This is a gap that lessens the likelihood of a benefit for the enhancement of population health status.

Enhancing health care services, as evidenced in part by prompt access to primary care and specialty care services, is a critical component of improving population health status in southwest Virginia. The Rural Health Services Plan will include the New Health System's approach to primary care services, including a plan for same day access.[64] The Applicants have also included primary care services as an "essential service" in commitment 21.[65] In contrast, the Applicants have not committed to address access within a specified number of days to specialty care services, which is a gap that lessens the likelihood of a benefit to population health.

According to the Applicants' commitment number 30, "best practice governance of the New Health System is critical to the success of the efforts outlined in the Cooperative Agreement."[66] The commitment states further that "It is recognized that the governance of the New Health System should reflect the region, including both Virginia and Tennessee."[67] The Applicants have committed that, at closing, three members of the 11-member Board will be Virginia residents. However, "after the second anniversary of the closing of the merger, not less than two members of the Board shall be Virginia residents."[68] This creates the possibility that the number of Virginia residents on the Board will decrease over time.

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[62] *Id*. at 16.
[63] *Id*. at 16-17.
[64] *Id*. at 16.
[65] *Id*. at 14.
[66] *Id.* at 20.
[67] *Id.*
[68] *Id*.

Concerning Board governance, the Applicants also committed that:

- The New Health System will ensure membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce; and
- The New Health System will ensure than not less than 30 percent of the composition of the Community Benefit/Population Health committee will reside in Virginia.

Adequate numerical representation of Virginia residents on the New Health System Board of Directors is essential to ensure that population health improvement goals and strategies sufficient to address Virginia's needs will be developed and implemented. The Authority recommended in its October 16, 2017 feedback to require three members of the Board to be Virginia residents.[69]

Given the fact that median household income and per capita income in southwest Virginia are far below the state average, the New Health System's approach to population health improvement needs to be very mindful of income and employment as social determinants of health. The Tennessee Terms of Certification require that between the approval date of the COPA and the Issue Date (e.g., the closing date of the merger), the New Health System shall not have terminated, and during the 24-month period commencing with the Issue Date, the New Health System shall not terminate, any employee of any hospital, whether or not such employee is classified as clinical personnel, nor require any such employee to enter into an early retirement package or otherwise resign in lieu of termination, except in either case for cause. In addition, as stated in the Tennessee Terms of Certification, during the same 24-month period, the New Health System shall not require any such employee of a Rural Hospital to transfer his or her principal place of employment to a location more than 30 miles from the location of such employee's principal place of employment as a condition to his or her continued employment. Thereafter (A) if the New Health System decides to terminate an employee without cause it shall provide prior notice to the Tennessee Department of Health and (B) if the New Health System desires to commence a reduction of 50 or more employees, whether in a single act or a series of related acts, in any 90-day period, it shall provide the Tennessee Department of Health with at least 60-days advance notice prior to implementing the reduction action. The notice shall include a severance policy addressing how employees will be compensated if they are not retained in connection with such action. The Applicants have not committed to this type of advance notice requirement in Virginia with respect to employee terminations. This is a gap that lessens the likelihood of a benefit for population health improvement.

Although the Applicants have committed to keep all hospitals in operation at the effective date of the merger operational as clinical and health care institutions for at least five years, the New Health System reserves the right to adjust the scope of services or to repurpose hospital facilities so long as certain "essential services" are provided (commitment 21).[70] The Tennessee Terms of Certification allow such repurposing upon petition to and approval of the Tennessee Department of Health. However, hospitals located in the City of Norton and Wise County, in the Virginia portion of the service area, are exempted from the petition and notice requirement, so long as the New Health System retains at least one hospital in Wise/Norton.[71] Furthermore, the Tennessee Terms of Certification also provide an exception to the employee termination terms discussed above that allows the New Health System to terminate any

[69] Letter from Terry G. Kilgore, Chairman, Southwest Virginia Health Authority, to Marissa J. Levine, October 16, 2017.
[70] Revised NHS Virginia Commitments – October 9, 2017 at 14.
[71] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 27-28.

non-clinical employee—even if not for cause—of any of these three Virginia hospitals that may be repurposed upon 60-days' notice to the Tennessee Department of Health.[72] Because income and employment are social determinants of population health, termination of any employee, even with notice, will have an adverse impact on population health. Terminating employees within the first two years before population health initiatives and career development programs are fully implemented will only worsen the adverse impact.

The definition of "essential services" in commitment 21 includes provision of "rotating clinic or telemedicine access to specialty care consultants as needed in the community" but also includes the caveat "and based on physician availability."[73] This caveat is not found in the Tennessee Terms of Certification.[74] This is a gap that lessens the likelihood of a benefit to population health.

The Applicants have attempted to address the needs of current Wellmont and Mountain States employees who may be adversely affected in order to achieve the savings and efficiencies that are expected to result from the merger. The Applicants have committed to invest up to $70 million over 10 years to address differences in salary/pay rates and benefit structures between Wellmont and Mountain States (commitment 15).[75] This is different from what the Applicants agreed to in the Tennessee Terms of Certification, in which they agreed to create and begin the implementation of, an Equalization Plan to spend a minimum of $70,000,000 over 10 years to eliminate differences in salary/pay rates and employee benefit structures among the employees of the New Health System.[76] In addition, the Applicants have committed to combining the best of Wellmont's and Mountain States' career development programs in order to ensure maximum career enhancement and training. (commitment 17).[77] The Applicants have also committed to provide the Commissioner, within two months of the closing of the merger, with a severance policy addressing how employees will be compensated if they are not retained by the New Health System. Under this commitment, however, the severance policy will not affect termination of employees if the termination was related to the "routine operation of the facility" (commitment 16).[78] This exception is very broad and causes concern. This is a gap that lessens the likelihood of a benefit for population health improvement. The applicants have also committed to honor prior service credit for eligibility and vesting under the employee benefit plans (commitment 14). However, the Applicants have not specified that full credit shall be provided.

After review of the record, VDH staff believes that if the Applicants meet their commitments, population health status in the Virginia service area could be enhanced consistent with the Authority's regional health goals as a result of the cooperative agreement. VDH staff additionally notes that benefits to population health would likely not occur without the merger as stated by the Applicants and the Advisory Board.

If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 14, 15, 16, 17, 18, 19, 21, 26, 27, 28, and 30.

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[72] *Id.* at 28.
[73] Revised NHS Virginia Commitments – October 9, 2017 at 14.
[74] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health, Exhibit E at 1.
[75] Revised NHS Virginia Commitments – October 9, 2017 at 10.
[76] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 22.
[77] Revised NHS Virginia Commitments – October 9, 2017 at 11.
[78] *Id.*

In addition, to provide greater assurance that these commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may consider imposing conditions requiring the Applicants to:

- With respect to commitment 14, to fully honor prior service credit for eligibility and vesting under employee benefit plans.
- With respect to commitment 15, to create and begin implementation of a plan to spend a minimum of $70,000,000 over 10 years to eliminate differences in salary/pay rates and employee benefit structures among the employees of the New Health System.
- With respect to commitment 16:
    - Not terminate an employee of any hospital in Virginia, except for cause, for a period of time from the approval of the cooperative agreement until 24 months from the closing of the merger;
    - Not require the employee of any rural hospital in Virginia to transfer his or her principal place of employment to a location 30 or more miles distant as a condition to his or her continued employment; and
    - Subsequent to 24 months from the closing of the merger, provide the Commissioner with prior notice of employee terminations made for reasons other than cause.
- With respect to commitment 18, ensure that the plan for post-graduate training also addresses:
    - Establishment of a new community based rural training track primary care residency or preventive medicine residency in Virginia;
    - Incentives for clinical employees to pursue terminal clinical degrees through loan forgiveness, clinic rotation sites, clinical hours and preceptorship; and
    - Collaboration with existing psychiatry residency programs to establish community psychiatry rotations in southwest Virginia.
    - With respect to commitment 21, provide rotating clinic or telemedicine access to specialty care consultation as needed in the community, regardless of physician availability.
- With respect to commitment 26, ensure that the Rural Health Services Plan also addresses:
    - Access to specialty care within five days; and
    - Collaboration with local businesses, school districts, and industry on community development necessary to attract and retain providers in southwest Virginia.
- With respect to commitment 30, appoint three residents of the Commonwealth of Virginia to the 11-member Board of the New Health System as of the closing date of the merger, and maintain three residents on the Board for the life of the cooperative agreement.

3. Preservation of hospital facilities in geographical proximity to the communities traditionally served by those facilities to ensure access to care

As noted in the discussion of consideration number 2, the Applicants have committed not to close any hospital that is operational on the effective date of the cooperative agreement for five years following the date of the merger and have committed to keep certain basic ”essential services” available (commitment 21).[79] However, the Applicants have only committed to provide these essential services in the county where the hospital is currently located, as opposed to also providing the essential services in

[79] *Id*. at 14.

contiguous cities and counties. This is a gap that lessens the likelihood of ensuring access to care in communities traditionally served by those hospital facilities. In addition, also as discussed as consideration number 2, the Applicants commitment to provide rotating clinic or telemedicine access to specialty care consultation as needed in the community contains the caveat "based on physician availability."[80] This caveat is not found in the list of essential services contained in the Tennessee Terms of Certification.[81] This is a gap that lessens the likelihood of a benefit ensuring access to care in communities traditionally served by those hospital facilities. The Applicants have also committed to keep the three Tennessee tertiary hospitals in the region open and operational (commitment 22).[82]

In considering what constitutes reasonable access to care it is helpful to look to the State Medical Facilities Plan, 12VAC5-230, which has as its guiding principles to seek the geographical distribution of medical facilities and to promote the availability and accessibility of proven technologies, and to promote the development and maintenance of services and access to those services by every person who needs them without respect to their ability to pay.[83] Under the State Medical Facilities Plan, inpatient hospital beds and obstetrical services should be within 30 minutes driving time one way under normal conditions for 95% of the population in a health planning district;[84] and acute inpatient psychiatric services should be within 60 minutes driving time one way under normal conditions for 95% of the population in a health planning district.[85] The area encompassed by the proposed cooperative agreement is composed of, in whole or in part, Planning Districts 1, 2, and 3.

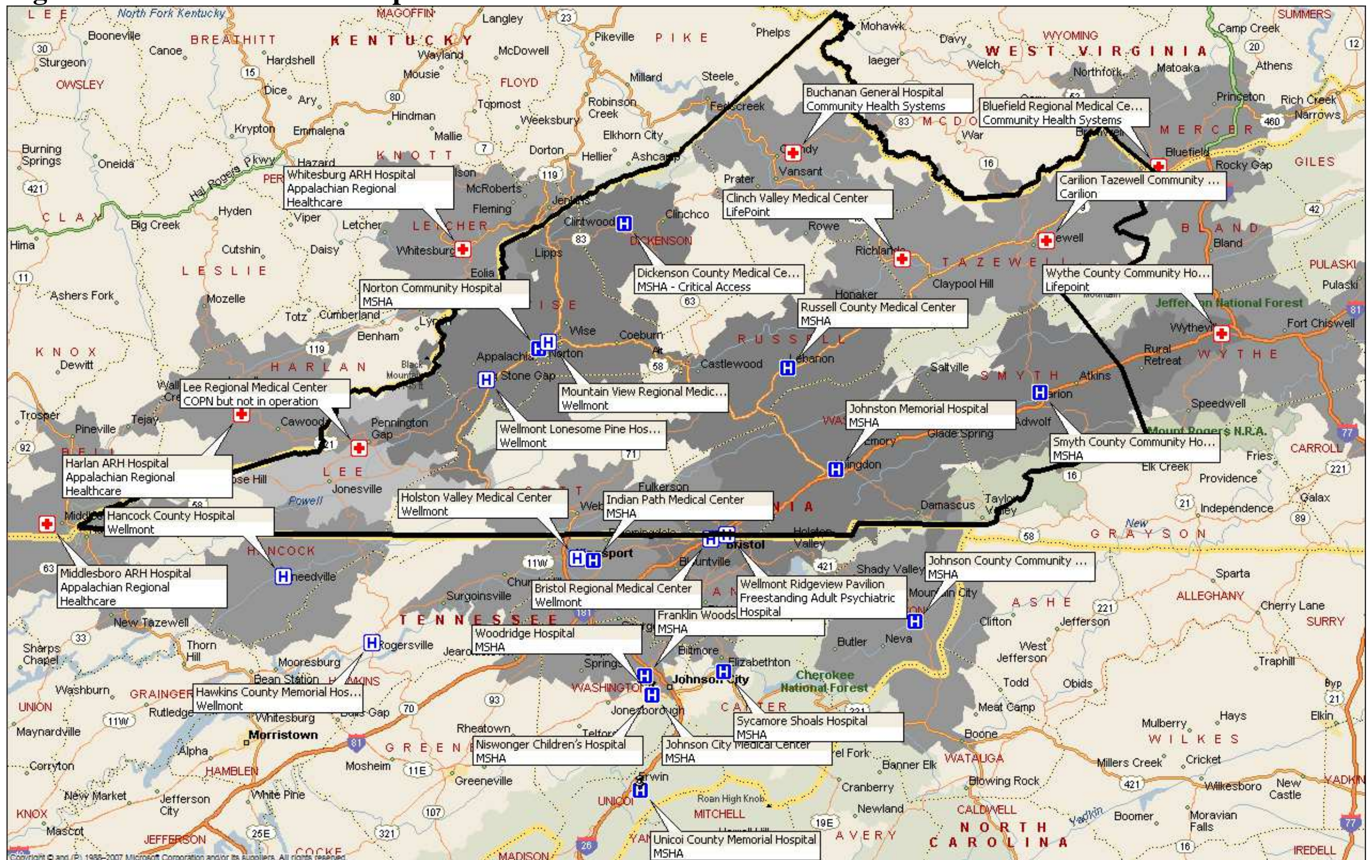
General Hospital Services

Figures 2, 3, and 4 show the area served by the Authority and the same facilities as are depicted in Figure 1. The shading in Figure 2 illustrates the area that is within a 30-minute drive of an existing general inpatient hospital facility. The areas with the darkest shading are within a 30-minute drive of an Applicant facility in Virginia. The areas with the medium shading are within a 30-minute drive of an Applicant facility in Tennessee or a non-applicant facility. The lightest shading is the area within a 30-minute drive of Lee Regional Medical Center.

The largest area without reasonable access to general inpatient hospital services is centered at the junction of Dickenson, Buchanan, and Russell Counties. A large portion of Scott County also does not have reasonable access to general inpatient services. Given the rural nature of these areas, it is likely that 95% of the population is within 30 minutes driving time one way under normal conditions of an acute care hospital, assuming that Lee Regional Medical Center will open.

[80] *Id.*
[81] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health, Exhibit E at 1.
[82] Revised NHS Virginia Commitments – October 9, 2017 at 15.
[83] *See* 12VAC5-230-30.
[84] *See* 12VAC5-230-520 and 12VAC5-230-900.
[85] *See* 12VAC5-230-840.

Figure 2. Access to General Inpatient Services

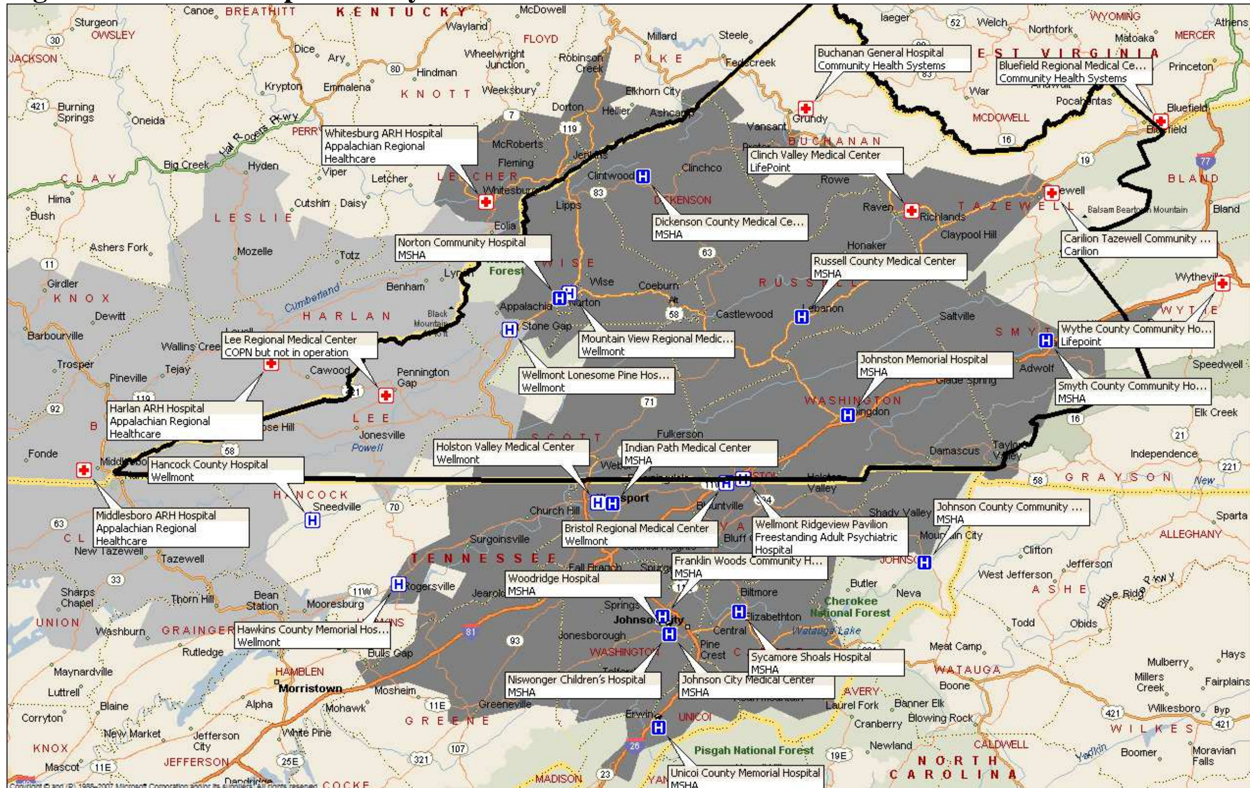


With the commitment to maintain "essential services" and to maintain operation of hospitals as clinical and health care institutions for at least five years, including the three tertiary hospitals in Tennessee, access to general inpatient hospital services will be maintained for the short term, resulting in a short-term benefit for the time period of the commitment.

Inpatient Psychiatric Services

Adult psychiatric services are available at the Wellmont Ridgeview Pavilion, a 28-bed, secure adult inpatient psychiatric facility in Bristol, Virginia near Bristol Regional Medical Center (in Tennessee). Its location is marked in Figure 3 by the white square near Bristol Regional Medical Center. Inpatient psychiatric services are also provided in a 20-bed adult unit at Russell County Medical Center and a 10-bed unit at Dickenson Community Hospital. The area with the dark shading in Figure 3 includes the population of the area served by the Authority within a 60-minute drive under normal conditions of one of these Applicant facilities. There are also two non-applicant inpatient psychiatric facilities in Kentucky available to some residents of southwest Virginia. The 60-minute drive area is marked with the lighter shading.

Figure 3. Access to Inpatient Psychiatric Services



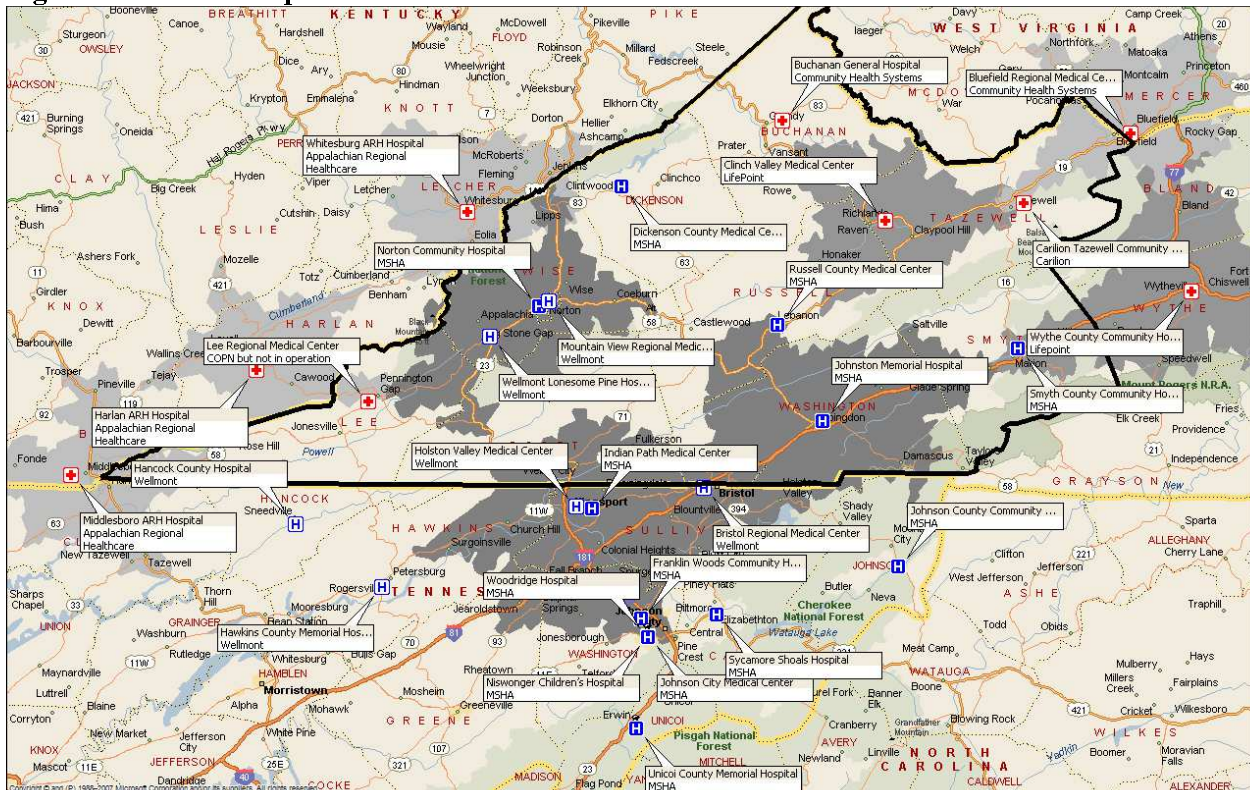
The largest area without reasonable access to inpatient psychiatric services is in the north and eastern parts of Buchanan, Tazewell, and Smyth counties. Access to inpatient psychiatric services for the residents of Lee County is provided by non-applicant facilities in Kentucky.

Inpatient Obstetric Services

There are three Applicant hospitals in Virginia that provide inpatient obstetric services: Norton Community, Wellmont Lonesome Pine, and Johnston Memorial. Residents of the area can also access inpatient obstetric services within 30 minutes driving time at two non-applicant facilities: Clinch Valley Medical Center and Wythe County Community Hospital. There are also three non-applicant facilities that provide inpatient obstetric services in Kentucky and one in West Virginia that are available to some residents of southwest Virginia within 30 minutes driving time.

These facilities and shading, to illustrate the areas within a 30-minute driving time of the facilities, are shown in Figure 4. The areas with the darkest shading are within a 30-minute drive of an Applicant facility providing obstetric services. There are minimal areas within the medium shading that are within a 30-minute drive of a non-applicant facility in Virginia. The areas with the lightest shading are within a 30-minute drive of non-applicant facilities in Kentucky and West Virginia.

Figure 4. Access to Inpatient Obstetric Services



Access to inpatient obstetric services in the area served by the Authority is significantly lower than is considered reasonable. The Applicants have committed to keep hospitals in operation as of the effective date of the merger operating for at least five years as clinical and health care institutions. In the event any acute care hospital is repurposed, the Applicants have committed to provide “essential services” in the county where the repurposed hospital is located.

The Applicants have committed, should it prove necessary to close a facility, to adhere to the relevant considerations and process described in the New Health System Alignment Policy, which was attached to the Application as Exhibit 12.1 (commitment 33).[86] As stated in the policy, “Alignment of clinical facilities and/or services, where appropriate, may occur after an evaluation of the potential merits and adverse effects related to access, quality and service for patients . . . . Prior to implementing an alignment, it must be determined that the benefits of the alignment outweigh the adverse effects.”[87] According to the policy, any discontinuation or closure recommended by New Health System management would require approval of the New Health System Board.

As previously noted in discussion of consideration 2, the Tennessee Terms of Certification require the New Health System to petition the Tennessee Department of Health, and receive its approval, prior to the repurposing of any hospital. The Tennessee Terms of Certification also include a significant

[86] Revised NHS Virginia Commitments – October 9, 2017 at 21.
[87] New Health System Alignment Policy at 1.

exception which would allow the New Health System to unilaterally repurpose, without prior permission, up to two of the three hospitals in Norton and Wise without having to wait the otherwise committed minimum of five years.[88] The Applicants' commitments to the Commissioner do not include any provision whereby the New Health System would be required to provide advance notification to the Commissioner or receive the Commissioner's approval prior to adjusting scope of services or service lines, or repurposing a hospital. This is a gap that lessens the likelihood of a benefit for ensuring access to care.

VDH staff concludes that if the Application is approved and the Applicants meet their commitments, access to facilities and services will be maintained, at least for the short-term.

If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 21, 22, and 33.

In addition, to provide greater assurance that these commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may consider imposing conditions requiring the Applicants to:

- With respect to commitment 21:
  - Prior to adjusting the scope of services or service lines, or repurposing any hospital, provide the Commissioner with nine months of advance notice and with a plan for approval demonstrating how "essential services" will continue to be provided in the city or county in which the hospital is located and in any contiguous city or county.
  - Provide rotating clinic or telemedicine access to specialty care consultation as needed in the community, regardless of physician availability.

4. Gains in the cost-efficiency of services provided by the hospitals involved

The New Health System would be the overwhelmingly dominant health system in the region. Together, the Applicants comprise over 70% of the hospitals and other healthcare delivery assets across southwest Virginia and northeast Tennessee. Although job losses and increased travel time to some services could result from the merger if certain hospitals are repurposed as clinical and healthcare facilities, the Applicants estimate that efficiencies gained by the merger would eventually generate approximately $121 million in savings over a 10-year period—$70 million in non-labor savings, $25 million in "labor efficiencies" and $26 million in "clinical efficiencies."[89]

The Applicants have made commitments to recruit health care providers and enhance access to care (commitments 26 and 27), strengthen post graduate medical education and research (commitments 18 and 19), and improve population health status (commitment 28).[90] The Applicants' commitment 7 provides, subject to the agreement of Payers, for the establishment of payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers.[91] Commitment 20 includes adoption of a common clinical information technology platform "as soon as

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[88] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 27.
[89] Application at 44-47.
[90] Revised NHS Virginia Commitments – October 9, 2017 at 11-19.
[91] *Id.* at 6.

reasonably practical" after formation of the new health system.[92] With this commitment, patient records would be accessible at all facilities, reducing duplication of having multiple unlinked records and eliminating staff time to collect and reenter patient histories and information. In addition to improved cost efficiency, this should result in improved hospital quality, better patient care, and enhanced research potential. Finally, the Applicants' commitment 5 promises meaningful participation with community providers in a new or existing regional health information exchange.[93] As noted earlier in the discussion of consideration 1, VDH staff have identified certain gaps with respect to commitment 5. Nevertheless, this proposed commitment would promote the region's ability to access a more coordinated system of health care within the region, resulting in greater cost efficiency.

The Applicants have assured that hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years following the date of the merger (commitment 21).[94] Even without closing a facility for five years, efficiencies will still likely be realized during the initial five years following the merger by not duplicating services within facilities sharing service areas. For example, Norton Community Hospital owned by Mountain States and Mountain View Hospital owned by Wellmont are within a 3.5-minute drive of each other in the City of Norton. Wellmont Lonesome Pine Hospital, in neighboring Wise County, is within a 17-minute drive of the two hospitals in Norton. Multiple services are duplicated among these facilities. If the cooperative agreement is approved, the Applicants will be able to streamline duplicative services in this geographic area thereby generating cost and system efficiencies.

As previously described, the Authority concluded that the Applicants have shown that if the cooperative agreement is approved and their commitments are met, cost efficiencies are likely to result in many areas.[95] The Applicants have committed to use the savings that result from these cost efficiencies to reinvest in the community in ways that will result in further benefits.

VDH staff concludes that if the Application is approved and the Applicants meet their commitments, there are likely to be gains in the cost-efficiency of services provided by the hospitals involved. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 5, 7, 18, 19, 20, 21, 26, 27, and 28.

In addition, to provide greater assurance that these commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may wish to consider imposing additional conditions requiring the Applicants to:

- With respect to commitment 5:
  - o Develop and submit to the Commissioner for approval a plan describing how the New Health System will participate meaningfully in a health information exchange or a cooperative arrangement whereby privacy protected personal health information may be shared with community-based providers for the purpose of providing seamless patient care; and

[92] *Id*. at 13.
[93] *Id.* at 5.
[94] *Id*. at 14.
[95] Authority Report at 161.

- Ensure that any imposition of fees or costs for access by Independent Physicians or other health care providers shall comply with federal anti-kickback statutes and rules, and shall be a minimal amount that shall not exceed what is reasonable based on comparisons with other communities offering such services.

5. Improvements in the utilization of hospital resources and equipment

The consolidation or closure of facilities or services that avoid duplication would immediately improve utilization of resources but could also possibly decrease accessibility and convenience for patients. Except for in the City of Norton and surrounding area, each of the Applicants' hospitals that operate in Virginia does so as a sole community provider with a near monopolistic local market. As such, each hospital captures the majority of the local population seeking hospital care, maximizing the utilization of resources as much as they can be given the population. To consolidate resources more regionally would improve per unit utilization but possibly at the cost of increasing travel time for care.

Based on certificate of public need (COPN) service expansion standards, with the exception of CT services, Norton Community Hospital, operated by Mountain States in the City of Norton, has adequate excess capacity in most services to continue to provide the patient service volumes at current levels and to also provide the patient service volumes currently provided by Wellmont Mountain View Regional Medical Center, also in Norton and within a few minutes-drive of Norton Community Hospital. The services that are duplicated in Norton are medical/surgical and adult ICU inpatient beds, CT, MRI and general surgery. As shown in Table 2, if Wellmont Mountain View Regional Medical Center were to discontinue providing these services except for CT, the efficiency of the utilization of these services at Norton Community Hospital would improve within the reasonable available capacity. CT volumes in acute care inpatient facilities frequently exceed the COPN standards because the standards assume a 40-hour work week and hospitals operate 24 hours a day seven days a week with CT as the basic diagnostic imaging modality.

Table 2 Patient Service Volumes as Percent of COPN Service Expansion Standards

Facility Volumes	Med/Surg Beds	ICU Beds	MRI	General Surgery	CT
Norton Community Hospital	25.5%	44.4%	43.1%	21.1%	141.8%
Norton Community with Mountain View Patient Service Volumes Added	30.0%	72.1%	60.9%	51.1%	215.6%

Source: Virginia Health Information 2015

As previously described as part of consideration number 3, the Applicants have committed to maintain all hospitals in operation on the effective date of the merger as clinical and health care institutions for at least five years and, if any acute care hospitals are repurposed, to provide "essential services" including helicopter or high-acuity transport to tertiary care centers (commitment 21).[96] The Applicants have also committed to maintain a minimum of three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available in proximity to where the population lives (commitment 22).[97] The Applicants, however, have not committed to the precise mix

[96] Revised NHS Virginia Commitments – October 9, 2017 at 14-15.
[97] *Id*. at 15.

of higher lever services that will be provided, and have acknowledged that there will be consolidation of Level 1 trauma services in order to reduce unnecessary redundancy and cost. The Applicants currently maintain two Level 1 trauma centers, one in Kingsport and one in Johnson City. The Kingsport facility is closer to the Virginia state line than is the facility in Johnson City. There is a substantial utilization of flight services in the southwest Virginia region due to the terrain and travel time; if at all possible patients are flown to Level 1 trauma centers as opposed to using ground transport. Should Level 1 trauma services be consolidated at Johnson City, current transport time via flight would not change very much. However, if a flight service cannot fly due to weather conditions or other circumstances and a ground transport is necessary, the transport time would be increased up to 30 minutes or greater depending on location.[98] Given the importance of minimizing transport time to a Level 1 trauma center in order to promote and protect the health of Virginians, it will be critical to ensure that any decision of the New Health System to consolidate Level 1 trauma services is made in close coordination and as part of a structured planning process with the Southwest Virginia Emergency Medical Services Council. Similarly, it will be critical to ensure that any decision of the New Health System to repurpose a hospital emergency department should be made in close coordination, and as part of a structured planning process, with the Southwest Virginia Emergency Medical Services Council. The Applicants have committed to address, as part of their Rural Health Services Plan, the New Health System's approach to emergency services access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia Emergency Medical Services Council (commitment 26).[99] However, the potential for consolidated Level 1 trauma services to be located farther from the Virginia portion of the geographic service area than is currently the case is a gap that lessens the likelihood for a benefit of improvement in the utilization in hospital resources and equipment. Similar concerns would exist for the potential consolidation of other service lines.

As previously described as part of consideration number 1, the Applicants have committed to establish a common clinical information technology platform. The Applicants state that the common clinical information technology platform will help to improve the utilization of hospital-related services (commitment 20).[100]

The Applicants have made several other commitments in order to improve the utilization of hospital resources and equipment. These include commitments to partner with the Virginia Department of Medical Assistance Services (DMAS) to develop, pilot, or implement value-based payment programs in the region (commitment 7), establish annual priorities related to quality improvement (commitment 8) and provide "essential services" in any county in which a hospital is repurposed (commitment 21).[101] In addition, commitments made by the Applicants to increase access to substance abuse and mental health services (commitment 27) and to improve population health in the region (commitment 28) could also help improve utilization of hospital resources and equipment by supporting efforts to reduce unnecessary emergency department utilization.[102]

During its review of the Application, the Authority engaged in a significant amount of discussion regarding this consideration, especially related to the rural hospitals. In particular, the issue was

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[98] VDH Office of Emergency Medical Services Analysis, October 2, 2017.
[99] Revised NHS Virginia Commitments – October 9, 2017 at 17.
[100] *Id.* at 13.
[101] *Id.* at 6-7, 14.
[102] *Id.* at 17-19.

discussed by the Authority's Access Working Group. It was stated that, over time, people in the region had noticed that resources were utilized for one system to obtain equipment simply because the other system had the equipment, not necessarily to expand services in the community. The Authority passed a resolution finding that the benefit of improvements in the utilization of the hospital resources and equipment would likely exist as a result of the cooperative agreement.[103]

VDH staff concludes that if the Application is approved and the Applicants meet their commitments, utilization of hospital resources and equipment is likely to be improved. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 7, 8, 20, 21, 22, 26, 27, and 28.

In addition, to provide greater assurance that these commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may want to consider imposing conditions requiring the Applicants to:

- With respect to commitment 21, prior to adjusting the scope of services or service lines, or repurposing any hospital, provide the Commissioner with nine months of advance notice and with a plan for approval demonstrating how "essential services" will continue to be provided in the city or county in which the hospital is located and in any contiguous city or county.

6. Avoidance of duplication of hospital resources

The Applicants have stated throughout the application review process that merging of the two systems will allow the New Health System to eliminate or at least reduce the amount of duplicative services and benefit from the resulting cost savings.[104] As stated in the State Medical Facilities Plan, excess capacity or underutilization of medical facilities is detrimental to both cost effectiveness and quality of medical services.[105] The Advisory Board, a consultant retained by the Applicants, recognized this principle when it stated in its report that "duplication is not a wise use of limited resources. Instead, the sharing of resources across the entire spectrum of services deployed by Mountain States and Wellmont would be a sensible optimization of investments and would leave more resources available for services and the front-line care necessary to accomplish the objectives of the merger."[106]

In addressing the possible benefits of the proposed merger related to improving utilization and avoiding duplication of hospital resources, the Applicants have committed that hospitals in operation on the effective date of the merger will remain operational as clinical and health care institutions for at least five years following the date of the merger (commitment 21).[107] This commitment would allow health care service lines at particular facilities to be consolidated or closed in order to gain cost efficiencies as long as "essential services" are maintained. For example, Norton Community Hospital, owned by Mountain States, and Mountain View Hospital, owned by Wellmont, are within a 3.5-minute drive of each other in the City of Norton. Wellmont Lonesome Pine Hospital, in neighboring Wise County, is within a 17-minute drive of the hospitals in Norton. Multiple services are duplicated among these facilities. If the Application is approved, the New Health System will be able to pursue opportunities to

[103] Authority Report at 161.
[104] Ballad Health Alignment Overview, Exhibit T-32A at 4, 16, and 17.
[105] 12VAC5-230-30.
[106] Advisory Board Report at 6-7.
[107] Revised NHS Virginia Commitments – October 9, 2017 at 14.

improve utilization and patient occupancy by discontinuation of duplicated hospital service lines without diminishing access to "essential services." If the Application is not approved, there will be few, if any, opportunities to avoid duplication of hospital resources, or improve utilization through increasing patient occupancy and service utilization or through discontinuation of redundant service lines.

VDH staff concludes that if the Application is approved and the Applicants meet their commitments, the cooperative agreement would result in the benefit of avoidance of duplication of hospital resources. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment number 21.

In addition, to provide greater assurance that these commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may want to consider a condition requiring the Applicants to:

- With respect to commitment number 21, prior to adjusting the scope of services or services lines, or repurposing any hospital, provide the Commissioner with nine months of advance notice and with a plan for approval demonstrating how "essential services" will continue to be provided in the city or county in which the hospital is located or any contiguous city or county.

7. Participation in the state Medicaid program

Medicaid[108] participation is important throughout Virginia. It is especially crucial in rural areas such as southwest Virginia. Mountain States and Wellmont are the primary providers for Medicare and Medicaid in the overall region, and operate the primary system of access for children and for behavioral health services.[109]

Participation in the State Medicaid program is not limited to stating that the Applicants will continue to treat individuals with Medicaid coverage. The fee-for-service model of recipients enrolled directly with Virginia Medicaid has decreased, with an increase in members being enrolled with a Medicaid Managed Care Organization (MMCO).[110] Virginia Medicaid's managed care is currently primarily operated through two programs: Medallion 3.0 and Commonwealth Coordinated Care Plus (CCC Plus).[111] Medallion 3.0 has five MMCOs operating in the region and CCC Plus will have six MMCOs when it is implemented on November 1, 2017 in southwest Virginia.

Through the use of Medicaid managed care programs, the Commonwealth has a better ability to predict the budget of the Medicaid program.[112] The MMCO receives a capitated payment from DMAS each month that covers a comprehensive set of services, regardless of how much care is used by a

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[108] For the purposes of this document, the term "Medicaid" includes all related programs administered by DMAS, such as Virginia's health insurance program for children known as "FAMIS" (Family Access to Medical Insurance Security).
[109] Application at 32.
[110] *See* 2016 Medallion 3.0 Report at 3: www.dmas.virginia.gov/Content_atchs/mc/MAR%202_9_17%20v1.pdf.
[111] *See* DMAS Medicaid Memo, March 27, 2017, "Commonwealth Coordinated Care Plus Program – Update."
[112] 2016 Medallion 3.0 Report at 3.

member.[113] The use of managed care also allows for increased access to services and coordination of care, which helps to enhance the health of the population.[114] All MMCOs must meet federal and state network adequacy requirements in order to be an MMCO in all regions.[115] The MMCOs also take part in DMAS initiatives to reduce costs and increase quality of care, such as value-based payments.[116] DMAS summarized managed care by stating "at the heart of managed care is the principle that coordinating care improves both the experience and outcomes for individuals while controlling cost to the health care system and taxpayers."[117]

One major concern not addressed in the Application was whether the Applicants would contract with all MMCOs in the region. Choosing to only enter into contracts with a selected few MMCOs would affect access for Medicaid recipients. Additionally, with no other facility options to meet network adequacy requirements, the MMCOs without contracts would not be able to participate in the region, even though DMAS determined they were best qualified to serve Medicaid beneficiaries in southwest Virginia. In response to additional information requested by the Commissioner, the Applicants committed "to execute a contract with all [MMCOs] no later than the latest expiration date of either [Wellmont's] or [Mountain States'] contract . . . [including] Medallion and [Managed Long Term Services and Supports]/CCC Plus."[118] This has been formally included by the Applicants under commitment 39.[119] The Applicants' commitment, however, does not extend to contracts with all Medicare Dual Eligible Special Needs Plans, despite the fact that those health plans will serve individuals who are also enrolled in an MMCO. In addition, the Applicants' commitments do not extend to entering into a participation agreement with DMAS as the New Health System or contracting with the Program of All-Inclusive Care for the Elderly (PACE). These are gaps that lessen the likelihood of a benefit related to participation in the State Medicaid program.

Another major concern for the MMCOs is negotiation of contract rates; the Applicants would undoubtedly have substantially greater bargaining power if the Application is approved. The Applicants have set forth a proposed rate cap in combined commitments 1 and 2,[120] as well as agree to negotiate in good faith in commitment 3.[121] Furthermore, in response to a growing trend towards value and risk-based payment models, the Applicants provided detailed information, including an expert report written by the Advisory Board, regarding each of the Applicants' recent history with these payment models and how they believe they can more successfully transition to them as a combined entity.[122] The Applicants have committed to "partner with the Virginia DMAS to develop, pilot, or implement value-based payment programs in the region as appropriate, including programs allowing the New Health System to accept direct capitation from DMAS for Medicaid enrollees in the Geographic Service Area" (commitment 7).[123]

[113] *Id*. at 4.
[114] *Id*.
[115] 42 C.F.R. § 438.68
[116] 2016 Medallion 3.0 Report at 13.
[117] *Id*. at 3.
[118] Joint Response No. 9 to VDH Additional Questions, question V.K.1., February 8, 2017 at 1.
[119] Revised NHS Virginia Commitments – October 9, 2017 at 22.
[120] *Id.* at 1-4.
[121] *Id*. at 4.
[122] Advisory Board Report at 6-31; *see also* Joint Response No. 4 to VDH Additional Questions, question V.O.9., January 20, 2017 at 3-13.
[123] Revised NHS Virginia Commitments – October 9, 2017 at 6.

In order to ensure access to care, the Applicants have committed to not closing the three tertiary hospitals in Tennessee and also keeping all hospitals open as clinical and health care institutions for at least five years (commitments 21 and 22).[124] In the event that a hospital is repurposed, the Applicants have committed to providing "essential services" in each community (commitment 21).[125] The Applicants have also committed to developing a Rural Health Services Plan (commitment 26).[126] The Applicants note that the population health commitments will directly benefit the Medicaid population served.[127] The Applicants have also committed to spending up to $140 million over 10 years in part on behavioral health services, including new capacity for residential addiction recovery services and community-based mental health resources (commitment 27).[128] Likewise, the Applicants have committed to participating in DMAS' Addiction and Recovery Treatment Services (ARTS) Program (commitment 37).[129] In addition, the Applicants have committed to continue long-term care pre-admission screening for Virginia DMAS beneficiaries at New Health System hospitals (commitment 39).[130]

Further, the Applicants have made a commitment specific to access to care in Lee County. As part of commitment 21, if an acute care hospital is opened in Lee County, and subsequently fails or ceases to operate, the New Health System will provide "essential services" for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System. Such terms must include the appropriate access to space, located within the existing hospital facility, based upon reasonable terms. If an acute care hospital is not open and operational under a partnership with the Lee County Hospital Authority by December 31, 2018, the New Health System will provide "essential services" for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System until such time as a hospital is open and fully operational.[131]

The commitments as presented contain certain gaps. Although the Applicants agree to partner with DMAS for value-based payment in commitment 7, the commitment is vague and lacks sufficient detail to determine the benefit it would provide to the Medicaid program for both cost efficiency and quality of care. DMAS is developing a value-based payment roadmap.[132] DMAS has referenced the Health Care Payment Learning and Action Network's Alternative Payment Strategy framework.[133] Moving towards placing an emphasis on categories 3 or 4 of that framework will result in improvements in quality and efficiency. Commitment 21 does not guarantee that the facilities will remain open as hospitals, but instead states that the hospitals will remain operational as "clinical and health care institutions" as defined in that commitment.[134] Closing hospitals or reducing services can affect access to care and the ability of MMCOs to meet federally and state mandated network adequacy requirements. Also, the list of essential services limits obstetrical care to "emergent obstetrical care" and qualifies behavioral health as only requiring "access" to a health network of services through a coordinated system

[124] *Id*. at 14-15.
[125] *Id.* at 14.
[126] *Id*. at 16-17.
[127] Application at 32-33.
[128] Revised NHS Virginia Commitments – October 9, 2017 at 17-18.
[129] *Id.* at 21.
[130] *Id.* at 22.
[131] *Id*. at 14-15.
[132] *See* DMAS "Value Based Purchasing Strategy" (http://www.dmas.virginia.gov/Content_pgs/mc-home.aspx).
[133] *Id*.
[134] Revised NHS Virginia Commitments – October 9, 2017 at 14.

of care.[135] The list of items to address in the Rural Health Services Plan includes services to support maternal and prenatal health, but does not commit to maintaining the current level of care for those services. Additionally, although not required to do so, contracts with MMCOs are often negotiated based on a percentage of what Virginia Medicaid pays under fee-for-service.[136] The pricing commitments by the Applicants do not appear to factor in this type of contractual arrangement.[137] Furthermore, although the Applicants have committed to contract with all of the MMCOs in the region, commitment 3 is subject to undefined terms such as agreeing to "reasonable" rates. Containing the rates is necessary in order to ensure that the DMAS managed care program is successful and continues to provide access to health care services. These are all gaps that lessen the likelihood that a benefit related to participation in the State Medicaid program will result from the cooperative agreement if approved. The recommendations below for additional conditions would provide ample assurances that DMAS, the MMCOs, and Medicaid recipients will be protected.

The FTC states that:

> The [Applicants] have not adequately explained why the merger is necessary to continue or expand their participation in the state Medicaid program or why alternatives to the cooperative agreement would not suffice to continue or expand their participation. [The Applicants] have made unsubstantiated claims that the merged system's scale [would] allow the applicants to optimize access for the Medicaid population. [Cite omitted.] . . . [The Applicants] are already integrated health systems with sufficient scale to achieve their claimed benefits independently.[138]

Overall, however, the Applicants' commitments offer benefits to the Medicaid program that do not currently exist. For example, if the merger does not occur, there is no guarantee that each Applicant will contract with all MMCOs or participate in other DMAS initiatives such as the ARTS Program and value-based payments. The Applicants have also stated that without the merger, facilities are likely to close, without any protections in place for maintaining services in the affected region(s).[139] Therefore, while each Applicant may continue its participation in Medicaid without the merger as the FTC notes, it is likely that participation and access will be more robust if the merger occurs than not.

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[135] *Id.*
[136] Summary of Meeting between VDH staff and Representatives of Wellmont Health System and Mountain States Health Alliance, October 4, 2017: www.vdh.virginia.gov/content/uploads/sites/96/2017/10/October-4-Summary-Final.pdf.
[137] Alternatively, if the Applicants' intent is to include all MMCO contracts under combined commitments 1 and 2, applying the Cumulative Hospital Inflation Adjustment to the contract structure of paying at a percentage of Virginia Medicaid's payment rate may more rapidly increase inflation than has traditionally occurred under this type of contract structure. The Virginia Medicaid payment rate is not currently tied to the Medicare Market Basket. Therefore, using the Medicare Market Basket with the applicable quality component percentage added may be higher over time than Virginia Medicaid's rate adjustments. This could ultimately result in the New Health System demanding higher rates from MMCOs, which will result in increases to Virginia Medicaid's managed care expenditures.
[138] Federal Trade Commission Submission to the Southwest Virginia Health Authority and Virginia Department of Health Regarding Cooperative Agreement Application of Mountain States and Wellmont, September 30, 2016 (the "First FTC Staff Submission") at 45-46.
[139] Application at 8, 80-81.

VDH staff concludes that if the Application is approved and the Applicants meet their commitments, the cooperative agreement is likely to result in the benefit of continued and enhanced participation in the Virginia Medicaid program. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 3, 7, 21, 22, 26, 27, 37, and 39.

In addition, in order to provide greater assurance that these commitments achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may wish to consider imposing conditions requiring the Applicants to:

- With respect to commitment 7:
    - Enter into contracts with MMCOs that promote VBP arrangements that move the New Health System away from fee-for-service reimbursement structures for its Medicaid and Medicaid/Medicare Dual Eligible patient populations, and that materially support DMAS goals and timetables under the Virginia VBP Roadmap (in development) and facilitate successful implementation of such goals within the timelines prescribed by DMAS for MMCOs operating in the New Health System's region. In the event that the New Health System does not engage in VBP arrangements that materially support such goals and timetables, DMAS will notify the Commissioner. The Commissioner may require a plan to cure the noncompliance. Material support means the New Health System will provide an allocation of resources (financial and otherwise), staff, and leadership direction sufficient to achieve relevant DMAS goals and timetables for the New Health System's patient population.
    - Work with MMCOs operating in its region to adopt a VBP approach(s) that places emphasis on alternative payment models classified under categories 3 or 4 of the Health Care Payment Learning and Action Network's (HCP-LAN) Alternative Payment Model Framework version 2017.
    - Adopt VBP arrangements put forward by DMAS as prescriptive models, meaning VBP models for which DMAS has developed specific guidelines, features, operational frameworks, and/or performance metrics for implementation by providers serving Virginia Medicaid enrollees. This applies to both fee-for-service and managed care.
- With respect to commitment 21, not close facilities or discontinue services in such a manner that would affect the ability of MMCOs to meet network adequacy and access requirements, such as distance and drive time parameters;
- With respect to commitment 26, require the Rural Health Services Plan to address maintaining and enhancing services to support maternal and prenatal health;
- With respect to commitment 39:
    - Contract with all Medicare Dual Eligible Special Needs Plans as these health plans will serve individuals that are also enrolled with a MMCO;
    - Enter a participation agreement with DMAS as the New Health System;
    - Contract with the PACE;
    - Ensure that prices for all renewed MMCO/PACE contracts do not exceed the Applicants' current negotiated percentage of Virginia Medicaid's payment rate for the service unless both the contracting MMCO/PACE and the New Health System agree to alternative prices or reimbursement arrangement;
    - Ensure that prices for new MMCO/PACE contracts are no higher than the average percentage of Virginia Medicaid's payment rate for the service in the Applicants' existing

MMCO/PACE contracts unless both the contracting MMCO/PACE and the New Health System agree to alternative prices or reimbursement arrangements;
    - For existing MMCO/PACE contracts that are not based on a percentage of Virginia Medicaid's payment rate, require the New Health System to calculate a percentage of Virginia Medicaid's payment rate. To determine the current percentage of Medicaid, the New Health System must divide utilization in the base year repriced at Medicaid rates by expenditures in the 2017 base year under the current rates. Future negotiated rates for these contracts shall not exceed this calculated percentage of Virginia Medicaid's payment rate.
- With respect to commitments 7, 21, 22, 26, 27, 37, and 39:
    - Require the New Health System to participate in quarterly teleconferences with DMAS for the life of the cooperative agreement to address, *inter alia*, the New Health System's progress towards meeting DMAS goals for participation in the ARTS Program; the New Health System's progress towards implementing value-based payment with Medicaid Managed Care Organizations; ensuring continued access to obstetrical and maternity services for Medicaid recipients; managed care contracting; and any complaints regarding the New Health System received by DMAS from Medicaid providers or recipients.

8. Total cost of care.

Central to the Applicants' approach to address the total cost is a commitment to a limitation on pricing growth intended to ensure that consumers are protected from pricing increases that could otherwise result from the elimination of competition. Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is expected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay.[140]

Effective on the closing date of the merger, the New Health System commits to not adjust hospital negotiated rates in managed care contracts by more than the Cumulative Hospital Inflation Adjustment (HIA) (combined commitment 1 and 2). According to the commitment, the HIA is equal to the latest CMS-approved Medicare Market basket amount, which is 2.7% effective October 1, 2017, plus 0.25%. The HIA will also include, for payers who do not offer a quality component in their fee schedules, an additional payment known as a Quality Adjustment Factor. For contract years beginning in 2018, the Quality Adjustment Factor will be 1.25%.[141] The New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the Cumulative HIA without the Quality Adjustment Factor. The Applicants estimate that this commitment will result in an $80 million reduction in health care costs over the first 10 years.[142]

The Applicants' commitment also places limits on the ability of the New Health System to engage in balance billing. Under the commitment, if either the New Health System or any Payer terminates a Payer contract, the New Health System will be subject to the pricing limitations, even if the New Health System goes out-of-network with a Payer. In that event, there will be no balance billing of patients over and above the following amount: the Hospital Inflation Adjustment and Physician Inflation

[140] Application at 29.
[141] Revised NHS Virginia Commitments – October 9, 2017 at 1-4.
[142] *Id.* at 4.

Adjustment with respect to such Payer shall be multiplied by two (2x) in the first two years the Payer is out of network and multiplied by one (1x) each year thereafter.[143]

This was not the Applicants' original price limitation commitment. Initially, the Applicants had agreed to reduce existing commercial contracted fixed rate percentage increases by 50% for all Principal Payers for the first full fiscal contract year following the first contract year after the formation of the New Health System. They had also agreed not to adjust hospital negotiated rates by more than the hospital Consumer Price Index (CPI) for the previous year minus 0.25%, while negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical CPI minus 0.25%.[144]

VDH staff identified several issues with the initial pricing commitments, including that a relatively small percentage of insurance contracts entered into by Mountain States and Wellmont actually had provisions allowing for fixed rate percentage increases,[145] their definition of "Principal Payer" excluded 163 payers from the commitment[146], and the competitive market had in many cases achieved annual fixed rate percentage increases lower than the proposed rate cap.[147]

During its review of the Application, Tennessee developed the pricing limitation proposal on which the Applicants' revised commitment is based, and included the pricing limitation provision in Article V and Addendum 1 of the Terms of Certification (Attachment D).[148] Following approval of the Tennessee Terms of Certification, the Applicants submitted the revised pricing commitment, based on the annual percentage increase in Medicare Market Basket, to Virginia. From 2002 through 2016, the annual percentage increase of the Medicare Market Basket has generally been lower than the annual percentage increase of either the Hospital and Related Services CPI or the Medical Care CPI. However, missing from the revised commitment is a provision, included in the Tennessee Terms of Certification, for the establishment and reporting to the Commissioner of Payment Indices which are to be compared to post-Closing Allowed Amounts from the same Payers in order to determine whether the New Health System's pricing has impermissibly increased. Nor is there a provision, as is found in the Tennessee Terms of Certification, requiring a refund of Excess Payments to the Payers and patients at issue.[149] These are gaps that lessen the likelihood of a benefit to total cost of care. Given the requirement for the Commissioner to provide active, ongoing supervision to an approved cooperative agreement, and given that the New Health System will operate in both Virginia and Tennessee, it would be beneficial for there to be a single set of price limitation requirements for the New Health System—as opposed to different requirements in each state.

The Tennessee Terms of Certification create an exception under which Allowed Amounts that are tested against Payment Indices to determine if payments are excessive shall not include that portion of Managed Care Contract payments for attaining quality targets or goals, so long as quality or value-based

[143] *Id.* at 2.
[144] Application at 30.
[145] First FTC Staff Submission, Attachment at 1.
[146] Response No. 2 dated January 10, 2017, to Request dated December 22, 2016 at 64.
[147] Wellmont Response No. 6 to VDH Additional Questions, Exhibit M-21B, January 27, 2017 and Mountain States Response No. 2 to VDH Questions, Exhibit T-10A, January 10, 2017.
[148] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health, Article V and Addendum 1.
[149] *Id.*, Addendum 1 at 3-15.

contracts are reported to the Tennessee COPA Monitor and the COPA Monitor has not objected. According to the Tennessee Terms of Certification, this exception is intended to encourage value-based contracting but, if such contracting is abused or results in anti-competitive conduct, the Tennessee Department of Health may take enforcement action.[150] Anthem has stated that this exception is problematic because without pricing limitations on value-based models, the New Health System could effectively use its new monopoly power "to strong arm payers" into one-sided value-based payment models that circumvent the price limitations.[151] Also exempt from the price limits under the Applicants' commitment are bundled payment items and services in which a hospital operated by the New Health System and/or the New Health System assumes risk for care provided by other providers (such as post-acute providers like a skilled nursing facility or home health agency) involving value-based payment on an episodic basis. This exemption is also included in the Tennessee Terms of Certification.[152]

The Applicants have stated that their vision is to advance the process of value-based payment design with payers, which will require the New Health System to assume more risk for quality, cost, and outcomes.[153] The Applicants have further indicated to the Commissioner that, during the first two years of the merger, they will focus on the development of infrastructure and other key components to enable a successful transition from fee-for-service contracting to value and risk-based contracting. This would include "work to facilitate aligned incentives between providers and payers to achieve a shared approach to quality metrics, service metrics, cost metrics and access metrics."[154]

Under the terms of the Applicants' revised commitments 1 and 2, certain hospital, physician, ancillary, and other healthcare services may be reimbursed on a percentage of a health care provider's charge for such services. For hospital inpatient and outpatient, non-hospital outpatient, and physician services and any other services billed to payers based upon charges, the New Health System shall limit the impact of charge increases to the Cumulative Hospital Inflation Adjustment. This provision does apply to outliers for the purpose of adjusting the outlier threshold and any percentage of charge payment. This is a ceiling in rate adjustments; nothing in the commitment establishes these adjustments as the floor on rates.[155]

According to revised commitments 1 and 2, the pricing limitation only applies to managed care contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. In addition to the previously described exclusions, this limitation also does not apply to:

- Pass-through items in managed care contracts.
- Post-acute care providers such as skilled nursing facilities, home health agencies, hospices and durable medical equipment providers owned by the New Health System.
- Items for which the hospital and/or the New Health System as applicable have accepted risk in the form of a capitated payment or percentage of premiums.

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[150] *Id*. at 16.
[151] Supplemental Submission of Anthem Health Plans of Virginia to the Commissioner, October 12, 2017 at 8.
[152] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health, Addendum 1 at 16.
[153] Ballad Health Alignment Overview, Exhibit T-32A at 23.
[154] *Id.* at 25.
[155] Revised NHS Virginia Commitments – October 9, 2017 at 1-4.

- Pharmacies owned or controlled by the New Health System.
- Contract pricing terms which were negotiated pre-Closing.[156]

As part of commitments 1 and 2, the New Health System agrees that managed care contract structures may include rates being tied to a percentage of Medicare, or may establish base rates with annual inflators or quality incentives. The New Health System will not refuse to enter into any of these types of structures on the basis of the structure and will negotiate the rate structure in good faith.[157]

The Applicants provided as part of their commitment a sample calculation showing how the rate cap/hospital inflation adjustment will be applied:

To determine the rate cap for a payer that offers a quality component in its fee schedule:
1. Determine the latest CMS-approved Medicare Market Basket amount (currently 2.7%)
2. Add .25%
3. The rate cap/Hospital Inflation Adjustment is ascertained by adding the amounts in #1 and #2 above: 2.7% + .25%= 2.95%.

To determine the rate cap for a payer that does not offer a quality component in its fee schedule:
1. Determine the latest CMS-approved Medicare Market Basket amount (currently 2.7%)
2. Add .25%
3. Add 1.25% Adjustment for absence of a quality component
4. The rate cap/Hospital Inflation Adjustment is ascertained by adding the amounts in #1, #2, and #3 above: 2.7%+.25%+1.25%=4.2%.[158]

The commitment also states that subject to the Commissioner's approval, the commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the Hospital Inflation Adjustment. If following such approval, the New Health System and a payer are unable to reach agreement on a negotiated rate or other contract terms, the New Health System agrees to mediation as a process to resolve any disputes. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer updates to the Commissioner on the progress of such mediation. The Chief Financial Officer of the New Health System shall certify the New Health System's compliance with the terms of this combined commitment 1 and 2 in each Annual Report.[159]

The following definitions apply to commitments 1 and 2:[160]

"Cumulative Hospital Inflation Adjustment" – The compounded increases of the Hospital Inflation Adjustments from 2017 through the end of the contract year or fiscal year, as applicable.

[156] *Id.*
[157] *Id.*
[158] *Id.*
[159] *Id.*
[160] *Id.*

"Hospital Inflation Adjustment" or ("HIA") – For the year being tested, the most recently available annual inpatient percentage of increase by Medicare, commonly referred to as the Market Basket and reported by CMS in the Federal Register as part of the Final Rules of the Inpatient Prospective Payment System, plus 0.25%. The HIA will not include the multifactor productivity adjustment, statutory adjustment, adjustments for failure to be a meaningful electronic health record user or failure to submit quality data, or any other positive or negative adjustments required by law or regulation. Effective October 1, 2017, the Market Basket is 2.70%. HIA will also include, for Payers who do not offer a quality component in their fee schedule or payment structures an additional payment ("Quality Adjustment Factor). If a Payer does not offer as its fee schedules or rate structures a payment for quality or pay-for-performance incentives, the HIA will be increased based upon the difference between the schedule below and the quality component offered by the Payer.

Contract Year Beginning	Adjustment of Absence of Quality
2018	1.25%

"Physician Inflation Adjustment" means the Hospital Inflation Adjustment without the Quality Adjustment Factor. Medicare's annual physician market basket update factor is currently limited by law to 0.50. When and if Medicare begins using an inflation-based update to the physician fee schedule, the Physician Inflation Adjustment used herein will be the Medicare physician market basket rate of increase plus 0.25%.

"Payer" means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any New Health System hospital or other medical providers' medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payers which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payers and health plans which negotiate the payment or rate of payment for hospital or medical services, supplies and/or items. Payer includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare payers or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the term of the cooperative agreement.

"Large Network Payer" means a Payer which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges ("Gross Revenue") for the New Health System. The same Payer may have several networks, each of which utilize different fee schedules, and each of which could constitute 2% or more of the Gross Revenue; each network attaining the 2% threshold would constitute a separate Large Network Payer. Conversely, several Payers may only constitute one network, because they use a common fee schedule. An example would be PHCS Multiplan.

The Tennessee Terms of Certification allow for the use of alternative methodologies, different from the methodology prescribed in Addendum 1, for measuring compliance with the limitations on rate increases. The Tennessee Terms of Certification state, with respect to any contract year, "if a Large Network Payer and the New Health System agree on an alternative methodology for measuring

compliance . . . the New Health System shall use that agreed methodology for such year."[161] Subsequently, if a Large Network Payer and the New Health System certify to the Tennessee Department of Health that the New Health System has complied with the price limitation requirements, "the comparisons and reporting with respect to such Large Network Payer shall be deemed to have been satisfied for such Contract Year."[162]

The FTC has opined that the proposed merger of Mountain States and Wellmont is likely to have a negative overall effect on total cost of care for several reasons, including a series of practical issues and the loss of insurers' bargaining strength in negotiating insurance coverage arrangements for residents of southwest Virginia.[163] It is also observed that market forces are already effective in controlling rates, and that the language of the pricing commitments could provide the Applicants with a basis for increasing rates above those that have been produced as a result of competitive market forces.[164]

The Applicants' commitment number 3 states that they will continue to negotiate in good faith with Large Network Payers to include the New Health System in health plans offered in the service area on commercially-reasonable terms and rates. The term "Large Network Payer" is not used in any other section of that commitment, such that the remainder of commitment applies to all payers. For example, commitment 3 states that the New Health System will not "unreasonably refuse to negotiate with potential new Payer entrants to the market or with any Payer as long as the Payer has demonstrable experience, a reputation for fair dealing and timely payment, and negotiates in good faith."[165] The Applicants have further committed to resolve through mediation any disputes as to whether this commitment applies to the proposed terms of a health plan. Furthermore, if a payer and the New Health System cannot agree on rates or any other contract terms, and mediation fails to resolve the dispute, the Applicants have agreed that the Commissioner may require the New Health System to participate in "Final Offer Arbitration." Costs and reasonable attorneys' fees of the arbitration would be awarded to the prevailing party.[166]

The Applicants estimate that the New Health System should achieve cost savings in the areas of non-labor expenditures, enhanced labor productivity, and clinical program and facility modifications equating to $366 million over the first five years of its existence as a merged entity, with annual recurring savings of $121 million available after year five.[167] In its assessment of the Applicants' ability to achieve their stated goals as a merged integrated service delivery system, the Advisory Board stated that "[a]bsent a merger, there is no legal or practical way that two competitors would be willing to share . . . underlying cost data and ultimately be able to take unnecessary costs out of the region's health care delivery system and lower overall costs for consumers."[168] The Advisory Board stated further that if the merger occurred it was confident that, once variance in cost is identified, " lean management principles will be able to be applied in a way that will rapidly address root cause of variance and remove waste from the system."[169]

[161] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health, Addendum 1 at 4.
[162] *Id.*
[163] First FTC Staff Submission at 54-56.
[164] This comment was made by the FTC concerning the Applicants' initial pricing commitment.
[165] Revised NHS Virginia Commitments – October 9, 2017 at 4.
[166] *Id.*
[167] Report on Potential Efficiencies Gained Through the Combination of Mountain States Health Alliance and Wellmont Health System, FTI Consulting, February 15, 2016 at 2.
[168] Advisory Board Report at 27.
[169] *Id*. at 28.

The Applicants are cognizant of the implications of the long-term trend in the health care industry away from fee for service contracts, and towards value and risk-based contracts, and of the intricacies involved in successfully navigating that transition. According to the Advisory Board's assessment, Mountain States and Wellmont together "[h]ave the core capabilities to succeed in their pursuit of population health management and optimal risk-based contracting performance. Uniting their capabilities through the proposed merger will allow them to scale their collective strengths across the region, pursue value-based arrangements, and maintain their viability." [170]

The appropriate provision of care to the indigent and uninsured can be an important component to addressing the total cost of care. Wellmont and Mountain States have their own charity care and related policies. As a merged entity, the New Health System commits to adopting a charity care policy that is more charitable than the existing policy of either Applicant, and that is consistent with IRS rule 501(r) (commitment 9).[171] Specifically, individuals with income up to 225% of the federal poverty level would receive a 100% discount. Individuals with income between 225 and 400% of the federal poverty level, and whose account balance is greater than 50% of the patient's annual household income, would be expected to pay at most an amount equal to 15% of their household income to settle the account.[172] However, the Applicants' commitment does not address whether or how they will ensure that the baseline amount of charity care provided post-merger is at least equal to—if not greater than—the total amount of charity care provided by Wellmont and Mountain States pre-merger. This is a gap that lessens the likelihood of a benefit related to the total cost of care.

In order to reduce the total cost of care, the Applicants have committed to collaborate in good faith with independent physician groups to develop a local, region-wide clinical services network to share data, best practices, and efforts to improve outcomes for patients and to deliver such outcomes at the highest possible value (commitment 6).[173]

The Applicants have further committed that uninsured or underinsured individuals who do not qualify for assistance under the charity care policy will receive a discount off hospital charges based on their ability to pay (commitment 10).[174] However, the definition of "underinsured" in commitment 10 is narrower than the definition in the Tennessee Terms of Certification. In commitment 10, underinsured is defined as insured patients who receive Eligible Health Care Services that are determined to be non-covered services. Tennessee defines underinsured as any health care plan that does not meet the "minimum essential coverage standard as defined under the Affordable Care Act in existence as of July 1, 2017."[175] This is a gap that lessens the likelihood of a benefit related to the total cost of care.

The Applicants have also made several commitments intended to benefit the Virginia Medicaid program. These include commitments to participate in the Addiction Recovery and Treatment Services Program (commitment 37), to continue to treat Virginia Medicaid beneficiaries in Tennessee hospitals and facilities, and to participate in all Virginia Medicaid managed care programs (commitment 39). [176]

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[170] *Id*. at 31.
[171] Revised NHS Virginia Commitments – October 9, 2017 at 7.
[172] *Id*.
[173] *Id*. at 5.
[174] *Id*. at 7-8.
[175] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 9.
[176] Revised NHS Virginia Commitments – October 9, 2017 at 21-22.

The commitments described in this section are intended by the Applicants to mitigate the negative effect the merger could have on the total cost of care. The Authority found that a benefit to the cost of care may result if the cooperative agreement is approved. VDH staff is uncertain whether a benefit to the total cost of care will be produced by the merger even if the Applicants meet their commitments and the conditions recommended below are imposed. VDH staff believes, however, that if the cooperative agreement is approved, the conditions recommended below must be imposed to both reduce any negative effect that may result and increase the chances that a benefit to the total cost of care will occur.

If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 1 and 2 (combined), 3, 6, 9, 10, 37, and 39.

In addition, to provide greater assurance that these commitments will achieve the desired benefits and improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, and mitigate any disadvantages, the Commissioner may want to consider imposing conditions requiring the Applicants to:

- With respect to combined commitment 1 and 2, comply with the same requirements contained in Article V and Addendum 1 of the Tennessee Terms of Certification, including establishment of payment indices, excess payment testing, and refund of excess payments;
- With respect to commitment 3, continue to negotiate in good faith with all payers to include the New Health System in health plans offered in the Virginia service area on commercially reasonable terms and rates;
- With respect to commitment 9, provide charity care at a rate at or above the rate provided by the Applicants 12 months prior to approval of the cooperative agreement; and
- With respect to commitment 10, require that "underinsured" be defined in the same way as the term is defined in the Tennessee Terms of Certification.

9. 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 payers to negotiate reasonable payment and service arrangements with hospitals, physicians, allied health care professionals, or other health care providers

The FTC explains that "[c]urrently, prices for inpatient, outpatient, and physician services provided by Mountain States and Wellmont are set via separate negotiations between each hospital system and insurers . . . . Each side in these negotiations has some bargaining power."[177] When hospitals, or hospital systems, gain greater bargaining leverage (as they do after even a less monopolistic merger than that proposed) they are able to negotiate higher reimbursement rates with insurers, which pass these higher prices on to consumers in the form of higher premiums, copayments, deductibles and other out-of-pocket expenses.[178] The FTC staff has stated that "[c]ompetition is the most reliable and effective mechanism for controlling health care costs while preserving quality of care, including in rural areas facing economic challenges."[179] Public comment from citizens of Virginia received during the July 2017

[177] First FTC Staff Submission at 17-18.
[178] *Id*. at 18, 65; *see also* Michael Doane and Luke Froeb, An Economic Analysis of the Proposed Merger Between Wellmont Health System and Mountain States Health Alliance (January 2015) at 18.
[179] First FTC Staff Submission at 2.

Remote Area Medical (RAM) clinic also included a concern regarding the loss of competition possibly leading to increased prices.[180]

The Applicants offered commitments in an effort to mitigate this disadvantage. As previously described as part of consideration number 8, effective on the closing date of the merger, the New Health System will commit to not adjust hospital negotiated rates in managed care contracts by more than the Cumulative HIA. New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the Cumulative HIA without the Quality Adjustment Factor.[181] Additionally, commitment 3 states that "the New Health System will continue to negotiate in good faith with Large Network Payers to include the New Health System in health plans offered on commercially reasonable terms and rates."[182] As previously described as part of consideration 8, there remains a gap in commitment 3 concerning the use of the term "Large Network Payer." Additionally, in order for conditions to be effective in controlling rates, the conditions must be communicated to payers negotiating with the New Health System.

A report written by Compass Lexecon concluded that the Applicants "would face substantial constraints and ultimately be unsuccessful if the organization tried to exercise market power when negotiating rates or service arrangements."[183] Compass Lexecon also noted that the Applicants have committed to not engage in most favored nation pricing (see commitment 35) and not requiring as a condition for entering into a contract that the Applicants be the exclusive network provider to any health plan, including any commercial, Medicare Advantage, or Medicaid insurer (see commitment 4).[184]

In reviewing this factor, the Authority found that a disadvantage may exist.[185] The report went on to state that "[t]he Chairman noted that many members felt that the commitments would mitigate the concern [about self-insured groups] and that several people who spoke at the public hearing were self-insurers who spoke in favor of the cooperative agreement."[186]

VDH staff agrees with the FTC that price commitments are unlikely to completely replicate the benefits of competition and are difficult to construct, monitor, and enforce.[187] Although a disadvantage may exist, the Applicants have made specific commitments that would mitigate the extent of any reduction in the ability of health care payers to negotiate reasonable payment and service arrangements. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers: combined 1 and 2, 3, 4, and 35.

In addition, to provide greater assurance that these commitments will mitigate any disadvantage related to an adverse impact on the ability of payers to negotiate reasonable payment and service arrangements and achieve the improvements in population health, access to health care services, quality,

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[180] Summary of public comment received at Remote Area Medical Clinic, Wise, Virginia on July 21 and 22, 2017: www.vdh.virginia.gov/content/uploads/sites/96/2017/08/RAM-responses-summary.pdf.
[181] Revised NHS Virginia Commitments – October 9, 2017 at 1.
[182] *Id*. at 4.
[183] Independent Assessment of the Benefits and Disadvantages in the Proposed Merger of Mountain States Health Alliance and Wellmont Health System, Compass Lexecon, April 11, 2017 (the "Compass Lexecon Report") at 18.
[184] *Id*.
[185] Authority Report at 164.
[186] *Id*. at 164-165.
[187] FTC Staff Supplemental Submission, January 13, 2017, commitment chart comments at 1.

and cost efficiencies identified by the Applicants, the Commissioner may want to consider imposing conditions requiring the Applicants to:

- With respect to combined commitment 1 and 2, comply with the same requirements contained in Article V and Addendum 1 of the Tennessee Terms of Certification, including establishment of payment indices, excess payment testing, and refund of excess payments;
- With respect to commitment 3:
    - Continue to negotiate in good faith with all payers to include the New Health System in health plans offered in the Virginia service area on commercially reasonable terms and rates; and
    - Prior to initiating any such negotiations, provide in either electronic or hard copy format a complete copy of these commitments to all payers negotiating managed care contracts with the New Health System.

10. The extent of any reduction in competition among physicians, allied health care 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

Each Applicant is the other's greatest, or only, competitor, having competed with each other over the past two decades, as indicated by exceptionally high levels borne out by the FTC's "diversion ratio" analysis. The diversion ratio measures the degree of lost competition likely to result from a proposed merger by comparing the number of patients of a hospital that consider a competitor's hospital as their next-best choice for care to the number of the competitor's patients that consider the competitor's hospital as the next-best choice. The FTC staff's calculations find that 85% of Mountain States' patients view Wellmont hospitals as their next-best choice and that 90% of Wellmont's patients view Mountain States' hospitals as their next-best choice.[188] The FTC states that diversion ratios of this large magnitude indicate that Mountain States and Wellmont are extremely close substitutes and competitors, and that the merger would likely lead to significant price increases, as well as reduced incentives to maintain or improve quality.[189]

The merger would eliminate competition between the Applicants. The effect would concentrate market share, and power, in the resulting New Health System. The FTC notes that the "[c]ourts and antitrust agencies use a standard measure of market concentration," known as the Herfindahl-Hirschman Index (the "HHI").[190] Application of the HHI, to the relative shares of like firms in a defined geographic market (the overlapping regional area involved)[191], squared, results in a figure ranging from zero to

[188] First FTC Staff Submission at 3.
[189] *Id.* *Cf.* "[The Applicants] significantly understate the competitive risks from the combination [*i.e.*, merger] by downplaying the extent to which they compete today." Submission of Anthem Health Plans of Virginia, Inc. to the Southwest Virginia Health Authority on the Review of Application for a Letter Authorizing Cooperative Agreement from Wellmont and Mountain States, September 30, 2016 (the "First Anthem Submission") at 2.
[190] First FTC Staff Submission at 13.
[191] The FTC questions the Applicants' identification of a 21-county combined service area, suggesting it is "potentially broader than a market defined for antitrust purposes, meaning the shares [of the hospital systems serving that area and] listed [in Table 1 of the First FTC Staff Submission] . . . are conservative and likely to understate the competitive impact." *Id.* at 16.

10,000. Market concentration is signified by an increase in the HHI. The closer a market is to exhibiting a monopoly, the higher the market's concentration and the higher the HHI due to demonstrably lower prevailing competition. Mergers resulting in an HHI above 2,500 and an increase of more than 200 points are presumed to enhance greatly the merged entity's market power, reflect a highly concentrated market, and be anticompetitive.[192]

According to the FTC's analysis of the proposed merger of the Applicants, across both Tennessee and Virginia,[193] the New Health System would have a market share of approximately 71% for inpatient hospital services, and similarly high concentration in outpatient imaging services, ambulatory surgery services, cancer treatment services, occupational medicine, and pulmonary services. The New Health System would have an even higher concentration of physician services such as cardiology, hematology, and oncology services.[194]

The FTC's analysis indicates that the post-merger HHI would be 5,161 for the defined market—over double the "highly concentrated level" of 2,500,[195] and showing an increase in the HHI of 2,441 points. With the HHI currently at 2,720, already above the "highly concentrated level" of 2,500, there currently exists a concentrated market for healthcare in southwest Virginia. It is unclear if additional concentration would significantly impact competition in an already concentrated market. According to the FTC, these figures "approach monopoly levels and far exceed those that would create a presumption of illegality." These levels also exceed those in prior hospital mergers "that courts have found to be anticompetitive and have blocked."[196]

Currently, the Applicants compete on quality and services, inclusion of service lines, technological innovation, and various other vital healthcare metrics. For example, competition between the Applicants has led to the adoption of robotic surgery; enhanced rehabilitation care for patients recovering from strokes, brain and spinal cord injuries; improved care for cardiac, pulmonary, and orthopedic conditions; and urgent care services at both hospital systems. As the FTC advises,

> [t]hese non-price dimensions of competition greatly benefit patients and are among the factors by which employers and consumers evaluate the desirability of a provider network. [The] threat of losing patients and physician referrals to a rival system incentivizes each system to provide the best possible quality and patient experience . . . ."[197]

Conditions addressing pricing, market entry, quality measures, community charity obligations, employee policies, and maintenance of appropriate services may mitigate the adverse effects of the loss of competition. As previously described as part of consideration 8, to ensure that the cooperative agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, effective on the closing date of the merger, the New Health System commits in combined commitment 1

[192] First FTC Staff Submission at 13.
[193] No evidence indicates that a Virginia-only perspective of the effect of the proposed merger would differ significantly.
[194] First FTC Staff Submission at 14, 16.
[195] *Id.* at 14.
[196] *Id.* at 13-14. *Accord* First Anthem Submission at 7.
[197] First FTC Staff Submission at 22-23.

and 2 to not adjust hospital negotiated rates in managed care contracts by more than the Cumulative Hospital Inflation Adjustment (HIA) plus 0.25%, with an additional 1.25% quality adjustment factor in certain instances. New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the Cumulative HIA without the Quality Adjustment Factor.[198] According to the Applicants' estimate, this should equate to $80 million in lower health care costs over 10 years.

Lack of competition impacts physicians, as well as other health care professionals and providers by potentially limiting employment opportunities over the service area. Physicians generally must have access to hospitals into which to admit their patients, and hospitals allow such access through a process where physicians gain admitting "privileges." In monopoly markets the potential exists for hospitals to control the admitting privileges to the detriment of individual physician practices. Additionally, provision of ancillary, home, and outpatient services can be controlled by a dominant provider, either through exclusionary contracts or by use of market power to control the patient referral stream.

The Tennessee Terms of Certification contain a provision, subject to certain exceptions and waiver, stating that "not more than 35% of the physicians practicing at any COPA hospital that is not a Rural Hospital at any time may be Employed Physicians."[199] This provision refers to physicians employed by the New Health System. The Tennessee Terms of Certification also require that "The New Health System shall not bargain for or insist upon restrictions upon its suppliers, vendors or group purchasing organizations preventing or impairing such persons from doing business with entities that compete with the New Health System."[200] The Applicants did not make these commitments to Virginia. This is a gap that increases the likelihood of a reduction in competition among physicians, allied health care 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.

The Applicants have made several commitments intended to assure that health care providers in southwest Virginia who are not affiliated with the New Health System may continue to operate competitively. These include:

- The New Health System will not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer (commitment 4);
- The New Health System will maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff at each facility, and subject to possible exceptions for certain hospital departments or services as determined by the New Health System Board of Directors or the hospital board. (commitment 23);
- The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities (commitment 24);
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice (commitment 25); and

[198] Revised NHS Virginia Commitments – October 9, 2017 at 1.
[199] Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health at 36.
[200] *Id.*

- The New Health System will not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors (commitment 36).[201]

The Applicants have made specific commitments that would mitigate the extent of any reduction in competition among providers and those furnishing goods and services in the market. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 1 and 2, 4, 23, 24, 25, and 36.

In addition, to provide greater assurance that these commitments will mitigate any disadvantage related to a reduction in competition among providers and achieve the improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may want to consider imposing conditions requiring the Applicants to:

- With respect to commitment 23, comply with the provisions of § 5.05 of the Tennessee Terms of Certification.

11. The extent of any likely adverse impact on patients in the quality, availability and price of health care services

A substantial amount of research-based literature finds, overall, that competition between hospitals improves quality. Citing a finding that eight out of eleven selected mergers resulted in decreased overall quality, Dr. Kizer states that "[t]here is little, if any, experiential or empirical evidence that shows quality of care improves as a result of facility mergers or consolidation of services when the [Applicants] are already providing high quality care."[202]

If the enhanced bargaining power and negotiation leverage of the New Health System, in relation to a health care insurer, causes a failure to reach an agreement, all hospitals and other facilities now owned or operated by both Mountain States and Wellmont would be lost from the insurer's network, making it nearly impossible for such an insurer to assemble a viable local service provider network without contracting with the New Health System. As the FTC maintains, such a circumstance would give the New Health System "the ability to extract substantially higher reimbursement rates from health insurers during contract negotiations."[203] Competition from distant hospitals cannot remedy the circumstance. Currently, the bargaining leverage of each hospital system is limited by the availability of the other system as an alternative to employers and residents; a high diversion ratio exists between the systems. Anthem has stated that if the cooperative agreement were approved, higher prices and diminished availability and quality of health services for southwest Virginia employers and residents would inevitably result.[204]

Although these adverse impacts could result, other factors may diminish their likelihood. For instance, the Applicants have care delivery and management capabilities that will complement and strengthen each other in a combined system. Both systems have tied quality measure performance to

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[201] Revised NHS Virginia Commitments – October 9, 2017 at 5, 15-16, 21.
[202] Kizer Assessment at 17; *accord* First Anthem Submission at 1.
[203] First FTC Staff Submission at 19.
[204] First Anthem Submission at 8.

provider compensation and have begun independent efforts to reduce unwarranted clinical variation. These efforts can be tapped into and scaled for significant impact across the combined entity.[205] According to Compass Lexecon, by combining, the Applicants will be able to align incentives across the New Health System to achieve cost savings, allocate resources more efficiently, and improve care coordination to reduce cost trends.[206]

According to the Advisory Board, the New Health System will have a critical mass of employed primary care providers to continue the transition to value-based care and also will present an even greater opportunity for engagement with independent providers. Combined, the system will have a complement of assets and network relationships that will allow it to span the full-continuum necessary for successful population health management and risk-based contracting. The Advisory Board stated that the combined system will be even better positioned to address the needs of the service area and make continued investments to address gaps in access to care.[207]

According to the Advisory Board, the New Health System will also have a strong commitment to reduce system-wide care variation that will accelerate high-quality, consistent care delivery across the New Health System. In addition, according to the Advisory Board, care management teams at Mountain States and Wellmont offer complementary skill sets that, when brought together, will provide comprehensive care across the continuum. In addition, the Advisory Board observes that the New Health System plans to invest in IT tools that support care management resources to enable more effective risk stratification and delivery of care.[208]

The Applicants have also made commitments intended to improve healthcare affordability, quality and access and to mitigate or limit any potential disadvantages to the proposed cooperative agreement. The Applicants commit $140 million for investment intended to expand access to clinical services (commitments 26 and 27).[209] The Applicants commit to establish annual priorities related to quality improvement and publicly report these quality measures in an easy-to-understand manner for use by patients, employers, and insurers, and expand quality reporting on a timely basis so the public can easily evaluate their performance (commitment 8).[210] Given the importance of quality, the Applicant's annual priorities for quality improvement should be established within six months of the date of an approval.

In addition, the Applicants have committed to keep all hospitals in operation at the effective date of the merger operational as clinical and health care institutions for at least five years, ultimately preserving access for the short term (commitment 21).[211] Furthermore, as previously described as part of consideration 8, to ensure that the cooperative agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, effective on the closing date of the merger, the New Health System commits to not adjust hospital negotiated rates in managed care contracts by more than the Cumulative HIA plus 0.25%, with an additional 1.25% quality adjustment factor in certain

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[205] Advisory Board Report at 14.
[206] Compass Lexecon Report at 10.
[207] Advisory Board Report at 10.
[208] *Id*.
[209] Revised NHS Virginia Commitments – October 9, 2017 at 16-18.
[210] *Id*. at 6-7.
[211] *Id.* at 14.

instances. New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the Cumulative HIA without the Quality Adjustment Factor (commitments 1and 2).[212] Per the Applicants' assertion, this should equate to $80 million in lower health care costs over 10 years.[213]

The Applicants commit to partner with DMAS to develop, pilot, or implement value-based payment programs in the region, as appropriate, including programs allowing the Applicants to accept direct capitation from DMAS for the Medicaid enrollees in the service area (commitment 7).[214] The Applicants commit to adopt a charity care policy that is more charitable than the existing policies of both Applicants (commitment 9).[215] The Applicants state they will adopt, within three months after closing on the merger, a policy to include a 100% discount for inpatient hospital and clinic services to patients with incomes below 225% of the Federal Poverty Level (FPL) (commitment 9).[216] For those patients between 225-400% of FPL and whose account balance (after all insurances have processed or uninsured discount has been applied) is equal to or greater than 50% of the patient's total annual household income, the maximum a patient would be expected to pay to settle an account balance would be 15% of household income (commitment 9).[217] The Applicants further commit that uninsured or underinsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay (commitment 10).[218]

The Applicants have acknowledged an understanding that access to vision and dental services in southwest Virginia is lacking, and that lack of access to such services is a significant reason for the continued presence of the RAM Clinic and Mission of Mercy (MOM) dental clinic in the New Health System's service area each year. The Applicants have committed to include in their Rural Health Services Plan the New Health System's approach to improve access to preventive and restorative dental and corrective vision services (commitment 26).[219]

The Applicants have made specific commitments that would mitigate the potential for adverse impacts on patients related to quality, availability, and price of care. In prior sections of this document, gaps with respect to certain of these commitments (i.e. commitments 7, 8, 9, 10, and 26) have been identified and discussed. VDH has recommended that these gaps be closed through imposition of additional conditions, such that the commitments would be expected to mitigate any disadvantage. If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 1 and 2 (combined), 7, 8, 9, 10, 21, 26, and 27.

In addition, in order to provide greater assurance that these commitments mitigate any adverse impact on patients in the quality, availability, and price of health care services and achieve the

[212] *Id*. at 1-4.
[213] *Id*. at 4.
[214] *Id*. at 6.
[215] *Id*. at 7.
[216] *Id*.
[217] *Id*.
[218] *Id*. at 7-8.
[219] *Id.* at 16.

improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants, the Commissioner may consider imposing conditions requiring the Applicants to:

- With respect to commitment number 8,
  - Establish annual priorities related to quality improvement applicable to all facilities within the first six months of approval of the cooperative agreement;
  - Seek input from, and approval of, the Commissioner in the selection of quality measures;
  - Meet the published annual quality goals/priorities and show improvement at the individual facility and system level over time; and
  - Provide quality measure reporting by locality and individual facility level, as well as in aggregate for the system.

12. 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

Although many of the benefits touted by the Applicants, such as improved organization and integration of care and population health improvement, could possibly be achieved without the proposed merger, the health challenges of southwest Virginia are multi-layered and require significant resources and commitments to effectively address them—resources and commitments that no system or hospital alone has been able to devote.[220] The Applicants state that they have been unable to collaborate with respect to quality improvement methodologies and related projects due to the competitive environment, inability to share proprietary information, and the lack of a common clinical information technology system.[221]

It has been noted that both Wellmont and Mountain States are already large, integrated health systems, not independent hospitals. It has been observed that the benefits that the Applicants envision accruing from the merger could be achieved by each of the systems working independently. The Applicants may be able to achieve the same benefits by entering into joint ventures or other arrangements. For example, the Applicants could work in collaboration with each other as independent entities, or with other entities, such as other community hospitals or hospital systems in the extended southwest Virginia-northeast Tennessee region[222] or health care providers that do not currently serve the region. Such arrangements may benefit all the participating entities, and their patients and the patients' employers, without the degree of antitrust dissonance currently presented.[223]

According to the FTC, both Applicants already have functional electronic health records systems and "engage in population health management initiatives and value-based payment models." The FTC adds that many opportunities for joint venturing and similar contractual arrangements "to coordinate and

[220] Application at 96.
[221] *Id.* at 24.
[222] *Accord* First Anthem Submission at 3.
[223] *Id.* at 9.

standardize clinical healthcare services" between the Applicants remain unexplored.[224] The FTC also notes that the Applicants could merge or affiliate with alternative hospital systems "that raise fewer antitrust concerns."[225]

The Applicants contend that a merger with a different entity "would fall well short of the New Health System's potential for realizing the major integrative efficiencies . . . which, in turn, will help fund and sustain the [Applicants'] unprecedented and enforceable commitments to health care cost control and quality improvements in the Geographic Service Area."[226]

The Applicants acknowledge that in April 2014, Wellmont requested proposals from 22 health systems that it believed might be interested in a partnership; and that nine actually submitted proposals. However, in the Application, the Applicants do not fully compare the details and potential benefits of those offers with the claimed benefits of this merger. Nor do they discuss, in any meaningful detail, any other affiliations or other arrangements that might provide comparable benefits with the same, less, or even no competitive harm. Furthermore, as determined by the Tennessee Department of Health, the sale by one of the Applicants "to a for-profit entity would have resulted in the establishment of a foundation of at least comparable size to the funds proposed in the [A]pplication for community benefits."[227]

As part of its independent assessment of the proposed merger, Compass Lexecon commented concerning the likelihood of alternative arrangements that would yield the same or comparable opportunities for benefits. The Mountain States proposal was the only one that matched Wellmont's vision for improving healthcare and health in the region. It was important to Wellmont that its merger partner share the goals of providing a full set of healthcare services to the region, focusing on the population's particular health needs and avoiding higher costs to the extent possible. Mountain States proposed that the two health systems combine their resources and invest the savings from available synergies to "move the needle on population health." [228]

Compass Lexecon stated further that "[v]arious third parties have proposed the status quo, joint ventures, and a merger with an out-of-market health system as possible alternatives. The [Applicants] have provided extensive commentary on each of these, and their information and conclusions are consistent, in our view, with the economics of the region, the health challenges, the opportunities for significant efficiencies and resource savings through [the New Health System], and the complexities associated with contracting arrangements and loose affiliations."[229]

According to Compass Lexecon, it "reviewed the information on plausible alternative out-of-area transactions. These do not appear to be able to accomplish the same benefits as the in-market approach proposed by the [Applicants]. [They] would not involve the specific commitments for efficiencies, resource savings and investments in specific programs that drive the benefits of the proposed merger, nor would there be the same opportunities for in-market changes. Based on our experience and review of the transaction, Compass Lexecon does not believe that there are any known alternatives that would be less

[224] First FTC Staff Submission at 25.
[225] *Id*.
[226] Application at 97.
[227] Letter from J. Ockerman to C. Haltom and R. Cooper, Nov. 22, 2016 at 4.
[228] Compass Lexecon Report at 7.
[229] *Id*. at 23.

restrictive to competition and offer the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition than the proposed State-supervised merger of Mountain States and Wellmont."[230]

VDH staff concurs with the FTC staff and Anthem that many of the benefits the Applicants envision as accruing from the merger could possibly be achieved without the proposed merger. However, the Applicants have provided commitments intended to create a more favorable balance of benefits over disadvantages from the merger than from other alternatives.

Other Considerations

The Applicants have made additional commitments that address aspects of supervision going forward if the cooperative agreement is approved. Such commitments are intended to ensure that the Commissioner is made aware of changes in circumstances, material adverse events, or noncompliance in a prompt manner and that solutions are developed to ensure that disadvantages that would result from noncompliance or changes in circumstances can be appropriately mitigated to ensure that the benefits of the cooperative agreement continue to outweigh the disadvantages.

The Applicants' commitment 11 requires that any notices of a material default that the New Health System or an affiliate receives under bond or other debt document, for debt in excess of $7.5 million, must be furnished to the Authority and the Commonwealth.[231] Under commitment 12, if the New Health System records a liability for a Material Adverse Event, it shall notify the Commissioner and the Authority within 30 days of making such a determination.[232] However, given the Commissioner's responsibility to provide active supervision of the cooperative agreement, the Commissioner should be notified immediately upon the New Health System becoming aware of a Material Adverse Event, and regardless of whether a liability is actually recorded.

The Applicants have committed to endeavor to cure any non-compliance with respect to its commitments by using a process described in commitment 13.[233] However, commitment 13 is unduly complicated and does not commit to notification within an appropriately short period of time. Notification of the Commissioner within 24 hours of the New Health System becoming aware of a potential or actual noncompliance with respect to any condition is essential.

In its commitments, the Applicants included two recommendations from the Authority. According to the first recommendation, if the New Health System "produces evidence that changes in circumstances have materially affected its ability to meet the commitments and that its inability is not affected by deficiencies in management, either the Commissioner or the New Health System may petition the other to amend the commitments to reduce the burden or cost of the commitments to a level that may be more sustainable" (A. Revision of Commitments).[234] This recommendation also states that "the Commissioner may require the New Health System to engage an independent consultant to prepare a report validating that the changes have adversely the New Health System, the extent to which this has

[230] *Id.*
[231] Revised NHS Virginia Commitments – October 9, 2017 at 8.
[232] *Id.* at 8-9.
[233] *Id.* at 9-10.
[234] *Id.* at 23.

occurred, and validating that the changes in circumstances are not related to the effectiveness of management."[235] Any such independent consultant should be retained by the Commissioner to determine the extent to which there has been a change in circumstances and the reasons for those changes, with reasonable costs paid for by the New Health System.

According to the second recommendation, prior to the end of 2026, the New Health System and the Commissioner "should review how well the formation and operation of the New Health System has served the overall interests of Virginians and Virginia businesses in the area"(B. Ten-Year Review of Cooperative Agreement).[236] Based on the results of the review, new or revised commitments may be appropriate. It should be noted that the Commissioner is required to review the cooperative agreement each year. *See* 12VAC5-221-110(F).

Finally, the Authority expressed concern regarding the cost to the New Health System of compliance with the Tennessee Terms of Certification. In order to address this concern, the Applicants made commitment 41. To ensure that the Virginia operations are allocated an appropriate amount of the New Health System's ongoing and annual compliance costs, the New Health System has committed to adopt an allocation methodology that takes into account the differences in ongoing and annual compliance requirements between Tennessee and Virginia (commitment 41).[237]

If approved, the Commissioner should consider imposing conditions that ensure the Applicants meet commitment numbers 11, 12, 13, and 41.

In addition, to provide greater assurance that these commitments mitigate disadvantages that may result from the proposed cooperative agreement, the Commissioner may wish to consider imposing conditions requiring the Applicants to:

- With respect to commitment 12, notify the Commissioner immediately upon becoming aware of a Material Adverse Event, regardless of whether or not a liability is recorded.
- With respect to commitment 13:
  - Notify the Commissioner within 24 hours of becoming aware of any potential or actual noncompliance with any condition of the cooperative agreement; and
  - Submit a plan to cure the noncompliance within a time frame to be prescribed by the Commissioner.

Staff Analysis and Recommendation

Under Virginia Code § 15.2-5384.1(F)(2), the Commissioner shall approve a proposed cooperative agreement if she finds after considering the factors in § 15.2-5384.1(E) 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. In addition, the Commissioner may reasonably condition approval of the proposed cooperative agreement upon the Applicants' commitments to achieving the improvements in population health, access to health care services, quality, and cost efficiencies identified by the Applicants in support of their Application.[238]

[235] *Id.* at 23-24.
[236] *Id.* at 24.
[237] *Id*. at 23.
[238] Va. Code § 15.2-5384.1(F)(2).

After reviewing the statutory factors as analyzed above, VDH staff concludes by a preponderance of the evidence that if conditions are imposed as recommended throughout the analysis above, and the Applicants meet those conditions, 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.

The Application and the Authority Report both emphasize that southwest Virginia is a unique region of the Commonwealth and one that is experiencing significant challenges with respect to delivery of health care services and population health status. VDH data confirms these observations. Despite the presence of strong competition between Mountain States and Wellmont, the people of southwest Virginia continue to struggle with issues pertaining to access to primary and specialty care, and with pervasive challenges to population health improvement. Competition in the health care marketplace, while certainly desirable and useful overall, has failed in certain respects to provide meaningful, visible benefits to the people of southwest Virginia in terms of access to care and improvements in their own health status. One highly visible example of this failure is the "success" of the RAM and MOM clinics that provide episodic services to those who are otherwise unable to afford or access care in the region.

Wellmont and Mountain States operate on business models that are primarily fee-for-service. In general, this business model provides little incentive for focusing on improving the health of the region's population, decreasing preventable hospitalizations through better ambulatory management of chronic conditions, or improving care quality or efficiency. However, the Applicants have both expressed a desire and intent to adopt new business models that emphasize risk-based and value-based contracting. VDH staff recommends conditioning approval on the requirement that the New Health System obtain at least 30% of its total contract revenue from risk or value-based contracts by 2021 to provide a strong, necessary financial incentive to quickly move the New Health System to a risk-based and value-based model. This business model evolution is essential in order for the people of southwest Virginia to benefit from population health improvement initiatives that the New Health System commits to embrace and implement.

The New Health System has committed to significant limitations, beyond what it initially proposed, on its ability to increase the prices it charges to payers. Additional requirements for excess payment testing and refund of excess payments serve to solidify rate increase protections for customers of the New Health System. While limits on fixed rate percentage increases are an important component to addressing the total cost of care, utilization of services is another key component. Although the Applicants did not offer any specific commitments directly concerning utilization, they did offer several commitments, including establishment of value-based payment models, development of a common clinical information technology platform, and establishment of annual priorities related to quality improvement which, if fulfilled, would help to reduce inappropriate utilization of services. These commitments are also expected to promote more timely utilization of services, for example, improving access to ambulatory care.

The Applicants have estimated that substantial cost savings will result from the merger due to efficiencies to be achieved across the operations of the New Health System. While the financial investments that the Applicants have committed to are not dependent on the amount of cost savings realized, VDH staff does agree that cost savings through increased efficiencies and avoidance of duplication of hospital resources, are likely to result. The requirement that the New Health System move expeditiously toward a greater volume of value-based contracting should also serve to promote cost-efficiency.

While there can be a trade-off between avoiding duplication of health care resources and maintaining access to care, commitments that the Applicants have made to enhance access to critical or currently limited health care services in the region are likely to provide a benefit to the people of southwest Virginia. These include commitments to create new capacity for residential addiction recovery services, develop new community-based mental health resources, and develop pediatric specialty centers and emergency rooms.

At a time when the continued operation of many rural health care facilities is at risk, the commitments made by the Applicants to keep all of their hospitals open for at least five years is a significant commitment toward preserving access to care. While the New Health System would be allowed to repurpose those hospitals as clinical and health care institutions, the recommended conditions will assure that the Commissioner has a strong, defined role, along with significant advance notice, in approving any proposed re-purposing of a hospital. Furthermore, essential services would have to be provided in any county—along with all contiguous counties—where a hospital has been repurposed. The Applicants' commitments to maintain three tertiary care hospitals in Tennessee, implement a charity care policy covering individuals with incomes up to 400% of the federal poverty level, provide a discount off hospital charges for uninsured and underinsured individuals who do not qualify under the charity care policy, and develop a comprehensive physician/physician extender needs assessment and recruitment plan represent other significant commitments to improving and preserving access to care.

Like many other health care payers, DMAS is focused on expanding its approach to value-based purchasing. The Applicants committed to partner with DMAS on value-based payment programs, but the extent of the commitment was vague. In order to strengthen that commitment, it is recommended that the New Health System be required to enter into contracts with MMCOs that promote value-based payment arrangements for DMAS' Medicaid and Medicaid/Medicare Dual Eligible patient populations. It is also recommended that the New Health System be required to contract with PACE. Furthermore, an additional recommended condition would restrict the ability of the New Health System to increase prices on renewed MMCO/PACE contracts beyond the current negotiated percentage of Virginia's Medicaid payment rate for the services. In addition, these recommended conditions clarify that the New Health System will not be permitted to close facilities or discontinue services in such a manner as to affect the ability of an MMCO to meet network adequacy and access requirements. The Applicants have committed to participate in the DMAS Addiction Recovery and Treatment Services Program, and to continue to provide pre-admission screening for Medicaid long-term care services. Overall, with these recommended conditions, VDH staff believes that the New Health System will participate in the Virginia Medicaid Program in a manner that is protective of the program and beneficial to the people of southwest Virginia.

There appears to be a strong desire among key stakeholders throughout southwest Virginia to collaborate and coordinate with the New Health System on population health improvement initiatives that will make a difference in the lives of the people of the region. This desire, coupled with the Applicants' commitment to establish an ACC and its commitment to fund population health improvement efforts over a 10-year period, would be expected to help produce improved population health status in the region.

There is mixed evidence concerning whether hospital and health system mergers result in provision of higher quality health care. The Applicants have committed to participate meaningfully in, and fund, a regional health information exchange. This, along with the required transition to value-based contracting quality measures that the Applicants have committed to and development of a system-wide Clinical Council should serve to promote improved quality of care for the people of southwest Virginia.

Payers in Virginia have provided VDH with comments that approval of the cooperative agreement will create an adverse impact on their ability to negotiate reasonable payment and service arrangements with the New Health System. Without restrictions being placed upon the New Health System, its significant market share resulting from the merger makes it likely that there would be an adverse impact on payers. While the New Health System has committed to continue to negotiate in good faith with payers, as well as to adhere to limitations on its ability to increase rates, those commitments would only partially mitigate an adverse impact. In order to strengthen that commitment, VDH staff also recommends the condition that the New Health System be required to comply with all of the provisions of the managed care pricing limitations contained in Article V and Addendum 1 of the Tennessee Terms of Certification. This recommended condition only acknowledges something to which the Applicants have already agreed to with Tennessee. VDH staff believes that this will limit any adverse impact on payers, such that a disadvantage is not likely to occur.

In order to limit the reduction in competition among providers likely to occur as a result of the cooperative agreement, the Tennessee Terms of Certification include provisions which place limits on the ability of the New Health System to employ physicians and mid-level physician extenders; and prevent the New Health System from restricting the ability of its vendors, suppliers, and contractors from contracting with New Health System competitors. The Applicants did not include these restrictions in their commitments to Virginia. VDH staff recommends that these terms be added as conditions to limit the reduction in competition among physicians and other health care providers in Virginia such that a disadvantage is not likely to occur.

Given the severe and long-standing health challenges that confront the people of southwest Virginia, it is imperative that approval of the cooperative agreement not result in an adverse impact on patients as it relates to quality, availability and price of services. Many of the Applicants' commitments, strengthened in numerous instances if the recommended conditions are imposed, would be protective of the interests of patients. These include commitments to keep hospitals open as clinical and health care institutions, to maintain three tertiary care hospitals, to fund expanded access to health care services, establish an ACC, participate meaningfully in a regional health information exchange, establish priorities for quality improvement, and adhere to limitations on their ability to increase prices. These commitments, if adhered to and implemented, will serve to greatly limit the risk of adverse impact on patients, such that a disadvantage is not likely to occur.

Many of the benefits stated in the Application, including those pertaining to population health improvement, could possibly be achieved with alternative arrangements that are less restrictive to competition. However, the Applicants—being competitors—have largely failed to collaborate or cooperate on a sufficient scale to bring about the types of benefits that the people of southwest Virginia need in order to overcome substantial health care and health status problems. VDH staff has no reason to believe that the Applicants would suddenly express interest in creating such benefits for southwest Virginia in the absence of a cooperative agreement. In addition, alternative arrangements outside of a cooperative agreement would not be certain to contain conditions that provide protections and benefits for the people of southwest Virginia. Consequently, VDH staff does not believe that there are alternative arrangements less restrictive to competition that could provide 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.

VDH staff concludes that if the conditions set forth below are imposed and met, 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. Thus, VDH staff recommends that the Commissioner approve the Application with the conditions set forth below.

Recommended Conditions

1. Wellmont and Mountain States shall not discontinue, close, repurpose, merge, or align service lines or facilities, or terminate employees, except for cause, during the period of time between approval of the Application (Approval Date) and the effective date of the Applicants' merger.

2. All conditions imposed in the Order are absolute and are not dependent on the Applicants achieving the actual savings and efficiencies the Applicants envision arising from the merger.

3. The financial investments committed to by the Applicants, in conditions 8, 23, 33, 34, 35, and 36, shall be incremental, monetary obligations that constitute additions to the Applicants' annual baseline spending levels as of the Approval Date in the applicable categories. The Applicants shall provide annual baseline spending levels to the Commissioner at the same time that such information is provided to Tennessee.

4. All plans or other reports required by a condition shall be subject to the review and approval of the Commissioner as follows:

   Acceptance. With respect to each plan to be submitted to the Commissioner for approval, the Commissioner shall approve or propose modification to the plan within 30 days of receipt of the plan. If the Commissioner proposes a modification to any such plan, the New Health System shall have 30 days following receipt of notice thereof to respond. Failure to timely respond to a proposed modification shall constitute acceptance. The Commissioner shall have 15 days following receipt of the New Health System's response to approve or deny the plan. The Commissioner's decision constitutes a case decision pursuant to the Administrative Process Act (Virginia Code § 2.2-4000 *et seq*.).

   Replacement Plans. With respect to each three-year plan, no later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan.

   Modification. Following the approval and adoption of each plan, the New Health System may, from time to time, request a meeting with the Commissioner to discuss possible modifications to any such plan. Such discussions may include, among other things, proposals to revise the timing (but not the aggregate amount) of the spending commitments set forth in Attachment C. The New Health System shall not implement any modification to a plan until such modification has been approved by the Commissioner. To the extent any adopted plan is modified, the New Health System shall accordingly amend and restate the plan to be effective on a prospective basis.

5. The New Health System shall comply with all provisions contained in Article V, and Addendum 1, of the "Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health Pursuant to the Master Affiliation Agreement and Plan of Integration

By and Between Wellmont Health System and Mountain States Health Alliance" dated September 18, 2017, attached hereto as Attachment D.

6. The New Health System shall continue to negotiate in good faith with all Payers to include the New Health System in health plans offered in the area served by the Authority on commercially reasonable terms and rates, and will not refuse to negotiate with potential new Payer entrants to the market or with any payer as long as the Payer has demonstrable experience, a reputation for fair-dealing and timely payment, and negotiates in good faith. Prior to initiating any such negotiations, the New Health System shall provide in either electronic or hard copy format a complete copy of these conditions to all payers with whom it is negotiating managed care contracts. The New Health System will resolve through mediation any disputes that arise during negotiations to which this condition is applicable. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this condition if the Payer has insureds (or members) in the Commonwealth of Virginia, and shall offer to the Commissioner updates on the progress of such mediation. If a Payer and the New Health System cannot agree on rates or any other contract terms, and mediation fails to resolve the dispute, the Commissioner may require the New Health System to participate in "Final Offer Arbitration" with the Payer unless the Commissioner agrees to an alternative manner of arbitration. Costs and reasonable attorneys' fees of the arbitration shall be awarded to the prevailing party of the arbitration if "Final Offer Arbitration" or other types of arbitration are utilized.

   For purposes of these conditions, "Payer" means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any New Health System hospital or other medical providers' medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payers which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payers and health plans which negotiate the payment or rate of payment for hospital or medical services, supplies and/or items. Payer includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare payers or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the term of the cooperative agreement.

7. The New Health System shall not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or Medicaid Managed Care Organization. Nothing herein shall be construed as to impede the discretion of the payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System's service area.

8. Within 36 months of the closing date of the merger, the New Health System shall participate meaningfully, as determined by the Commissioner, in a regional health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with independent physicians and other community-based providers for the purpose of providing seamless patient care. Any imposition of fees or costs for access to the health information

exchange or cooperative arrangement shall comply with federal anti-kickback statutes and rules, and shall be a minimal amount that shall not exceed what is reasonable based on comparisons with other communities offering such services. In addition, the New Health System shall participate in the Commonwealth's ConnectVirginia health information exchange, in particular ConnectVirginia's Emergency Department Care Coordination Program and Immunization Registry. Further, the New Health System shall participate in Virginia's Prescription Monitoring Program. The New Health System shall spend a minimum of $8,000,000 over the 10 fiscal years beginning July 1, 2018 in developing and providing readily and easily accessible access to patient electronic health information, consistent with the regional annual incremental spending amounts in Attachment C.

Within 12 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a plan for the expenditure of such funds during the first three full fiscal years after the closing date of the merger. The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall demonstrate (A) how the planned expenditure of funds will result in the New Health System's meaningful participation in a regional health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with independent physicians and other community-based providers for the purpose of providing seamless patient care, (B) how imposition of any fees or costs for access to the health information exchange or cooperative arrangement complies with federal anti-kickback statutes and rules, and is a minimal amount not exceeding what is reasonable compared to other communities offering such services, (C) how the New Health System will participate in the Commonwealth's ConnectVirginia health information exchange, ConnectVirginia's Emergency Department Care Coordination Program and Immunization Registry, and Virginia's Prescription Monitoring Program, (D) how the New Health System has established the foundation for data acquisition and exchange in a manner that would promote and support population health improvement efforts, and (E) that it has a high likelihood of preventing unnecessary and redundant care. The plan shall include milestones and outcome metrics.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, in accordance with condition 4.

9. The New Health System shall collaborate in good faith with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices, and efforts to improve outcomes for patients and to deliver such outcomes at the highest possible value.

10. The New Health System, subject to the agreement of Payers as defined herein, shall establish payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers as follows:
    1. All risk-based model components of existing Wellmont and Mountain States contracts shall continue from the date of closing into the future upon their terms.
    2. At least one new risk-based model contract shall commence no later than January 1, 2020.
    3. At least a second new risk-based model contract shall commence no later than January 1, 2021.

4. The New Health System shall initiate risk-based model contracts for any remaining Large Network Payers that do not already have at least one risk-based model component in their contracts by no later than January 1, 2022.

By January 1, 2021, at least 30% of the New Health System's total health insurance contract revenue shall be from risk-based model contracts. By January 1, 2022, all of the Large Network Payers are expected to have a risk-based model/population health/partnership relationship with the New Health System that includes aligned incentives. The risk-based components in each contract shall be based on the unique priorities and timelines agreed upon by each payer, Large Network Payer and the New Health System.

For purposes of this condition, "risk-based model" shall be defined as contracts which contain elements of reimbursement tied to incentives for quality, value-based care, shared savings or alignment of financial incentives between Payers, the New Health System, employers and patients.

11. The New Health System shall work with DMAS to develop and implement value-based payment programs in the region, including:

The New Health System shall enter into contracts with MMCOs that promote value-based payment (VBP) arrangements that move the New Health System away from fee-for-service reimbursement structures for its Medicaid and Medicaid/Medicare Dual Eligible patient populations. Such VBP arrangements shall materially support DMAS goals and timetables under the Virginia VBP Roadmap (in development) and facilitate successful implementation of such goals within the timelines prescribed by DMAS for MMCOs operating in the New Health System's region. Material support means the New Health System shall provide an allocation of resources (financial and otherwise), staff, and leadership direction sufficient to achieve relevant DMAS goals and timetables for the New Health System's patient population. In the event that the New Health System does not engage in VBP arrangements that materially support such goals and timetables, DMAS will notify the Commissioner. The Commissioner may require a plan to cure the noncompliance in accordance with condition 17.

As a large, integrated system, the New Health System shall work with MMCOs operating in its region to adopt a VBP approach(s) that places emphasis on alternative payment models classified under categories 3 or 4 of the Health Care Payment Learning and Action Network's Alternative Payment Model Framework version 2017.

The New Health System shall adopt VBP arrangements put forward by DMAS as prescriptive models, meaning VBP models for which DMAS has developed specific guidelines, features, operational frameworks, and/or performance metrics for implementation by providers serving Virginia Medicaid enrollees. This applies to both fee-for-service and managed care.

12. The New Health System shall develop a robust quality improvement program, to include outcomes and measures, consistent with the aim of improving the health and well-being of the residents of southwest Virginia. The quality outcomes and measures will be developed with the input and approval of the Commissioner. The New Health System shall establish annual priorities related to quality improvement applicable to all facilities within the first six months of

the closing date of the merger and publicly report quality measures related to the annual priorities. The New Health System shall track the performance of the health system in meeting these quality priorities, outcomes and measures at both the system and individual hospital levels. The New Health System shall post the quality measures and actual performance against the measures on its website accessible to the public. The New Health System shall timely report and include on its website its performance compared to the Medicare quality measures including readmission statistics. The New Health System shall give notice to the Authority of the metrics that it is prioritizing and will include input from the Authority in establishing or modifying its priorities. A monthly report, at the individual facility as well as system level, shall be presented to the Commissioner and the Technical Advisory Panel.

13. Each hospital operated by the New Health System that is subject to Joint Commission, or other CMS-accepted accreditation body, accreditation shall at all times be fully accredited by the CMS-accepted accreditation body, and at all times maintain compliance with Medicare conditions of participation. The New Health System shall notify the Commissioner of any deficiencies or other noncompliance cited by the Joint Commission or Medicare within five days of receiving notice of the deficiency or noncompliance from the accepted accreditation body or Medicare. The New Health System shall submit a plan of correction correcting any such deficiencies or noncompliance within the time provided by a Medicare accreditation program approved by CMS, and notify the Commissioner upon completion.

14. Within three months of the closing date of the merger, the New Health System shall adopt a charity care policy for the hospitals that is compliant with applicable law, that is more charitable than the existing policies of either of the Applicants, and that is consistent with Section 501(r) of the Internal Revenue Code. The New Health System shall furnish a copy of its policies relating to charity care to the Commissioner no later than the end of the third month following the closing date of the merger. Thereafter, the New Health System shall furnish to the Commissioner a copy of any revisions to such policies immediately upon the effective date of such revisions. These policies shall provide for the full write-off of amounts owed for services by patients with incomes at or below 225% of the federal poverty level. For patients who are between 225% and 400% of the federal poverty level but whose account balance (after all insurances have processed or uninsured discount has been applied) is equal to or greater than 50% of the patient's total annual household income, the maximum a patient would be expected to pay to settle an account balance shall be 15% of household income. The New Health System shall inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site and on the separate web sites for all provider components that are part of the New Health System. The value of charity care will be set as defined in Virginia Code § 32.1-102.4. The New Health System shall continue to provide charity care at a rate at or above the rate provided by the Applicants 12 months prior to the approval of the cooperative agreement.

15. Immediately upon closing of the merger, the New Health System shall adopt a policy pursuant to which uninsured and underinsured individuals who do not qualify under the charity care policy shall receive a discount off hospital charges based on their ability to pay. This discount shall comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that section governing not for-profit organizations, and payment provisions shall be based on the specific circumstances of each individual/family. Such policy shall be

implemented immediately upon closing of the merger. The New Health System shall seek to connect individuals to coverage when possible.

"Uninsured" patients are those with no level of insurance or third-party assistance to assist with meeting his/her payment obligations. "Underinsured" patients shall mean insured patients who have a health plan that does not meet the "Minimum Essential Coverage" standard as defined under the Affordable Care Act in existence as of July 1, 2017. These patients shall not be charged more than amounts generally billed (AGB) to individuals who have insurance covering such care in case of Emergency or other Medically Necessary Services. AGB percentage is determined using the look-back method utilizing the lowest percentage for all facilities per the IRS regulatory guidelines set forth in 501(r). Emergency Services are defined in accordance with the definition of "Emergency Medical Conditions" in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). Medically Necessary Services are defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury and are services not included in the list of "particular services excluded from coverage" in 42 CFR § 411.15. Financial assistance eligibility shall be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Financial assistance determinations are based on National Poverty Guidelines for the applicable year. The New Health System shall adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

16. The New Health System shall furnish any notices of a material default, that the New Health System, or an affiliate, receives under bond or other debt documents for debt in excess of $7,500,000 to the Authority and the Commissioner.

17. If the New Health System becomes aware of a Material Adverse Event, the New Health System shall immediately notify the Commissioner and the Authority.

    For purposes of these conditions, a "Material Adverse Event" means any fact, event, change, development or occurrence that, individually or together with any other event, change, development or occurrence, is or is reasonably likely to be, materially adverse to the business, condition (financial or otherwise), assets, operations or results of operations of the New Health System, taken as a whole, or on the ongoing ability of the New Health System to comply with any condition. "Material Adverse Event" includes noncompliance with any condition of the cooperative agreement.

    Upon becoming aware of any potential or actual noncompliance with any condition of the cooperative agreement, the New Health System shall notify the Commissioner within 24 hours. A plan to cure the noncompliance shall be submitted to the Commissioner within the time frame prescribed by the Commissioner. This condition shall not limit the Commissioner's authority to initiate a proceeding to determine if the cooperative agreement should be revoked at any time.

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

19. As soon as practicable after closing of the merger but no later than the end of the first full fiscal year after the closing date of the merger, the New Health System shall create and begin the implementation of a plan to spend a minimum of $70 million over 10 years to eliminate differences in salary/pay rates and employee benefit structures among the employees of the New Health System. The plan shall account for differences in salary/pay rates and employee benefit structures applicable to all levels of employees such that the New Health System offers competitive compensation and benefits for all employees of the New Health System.

20. The New Health System shall provide to the Commissioner, within two months of the closing date of the merger, a severance policy addressing how employees will be compensated if they are not retained by the New Health System or any of its subsidiaries or affiliates. This policy shall not affect termination of employees if the termination was for-cause. The severance policy shall consider several factors, including but not limited to, each individual's position within his/her current organization and years of service. The policy shall also address outplacement support to be provided to any such employee. This provision shall not be construed to create a right of action for any individual employee. This condition shall continue for five years from the closing of the merger.

21. Between the Approval Date and the closing date of the merger, and during the 24-month period commencing with the closing date of the merger, the New Health System shall not terminate any employee of any hospital in Virginia, whether or not such employee is classified as clinical personnel, nor require any such employee to enter into an early retirement package or otherwise resign in lieu of termination, except in either case for cause. In addition, during the same time period, the New Health System shall not require any such employee of any hospital in Virginia to transfer his or her principal place of employment to a location more than 30 miles from the location of such employee's principal place of employment as a condition to his or her continued employment. Any employee's refusal to accept a transfer to a location more than 30 miles from his or her principal place of employment shall not constitute cause for termination. Thereafter (A) if the New Health System decides to terminate an employee without cause it shall provide prior notice to the Commissioner and (B) if the New Health System desires to commence a reduction of 50 or more employees, whether in a single act or a series of related acts, in any 90-day period, it shall provide the Commissioner with at least 60-days advance notice prior to implementing the reduction action. The notice shall include a severance policy addressing how employees will be compensated if they are not retained in connection with such action.

22. The New Health System shall combine the best of the career development programs of Wellmont and Mountain States in order to ensure maximum opportunity for career enhancement and training.

23. The New Health System shall spend a minimum of $85,000,000 over the 10 fiscal years beginning July 1, 2018 on Health Research and Graduate Medical Education benefitting the communities served by the New Health System, consistent with the regional annual incremental spending amounts in Attachment C.

24. Within 12 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a plan for post-graduate training of

physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia. The New Health System shall develop the plan in collaboration with at least its current academic partners. The plan shall be for the first three full fiscal years after the closing date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that is consistent with the regional annual incremental spending amounts in Attachment C. The plan shall also include, but not be limited to, how it will address the Authority's Blueprint access, quality, and population health goals, the structure of an ongoing academic collaborative, and how training will be deployed in Virginia based on an evidence-based assessment of needs, clinical capacity, and availability of programs. In addition, the plan shall address:

- Establishment of a new, community-based, rural-training track, primary-care residency or preventive medicine residency in Virginia;
- Collaboration with existing psychiatry residency programs to establish community psychiatry rotations in southwest Virginia; and
- Incentives for clinical employees to pursue terminal clinical degrees through loan forgiveness, clinic rotation sites, clinical hours, and preceptorship.

The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) have been developed collaboratively with key Virginia stakeholders; (B) effectively address the access, quality, and population health goals of the Authority's Blueprint for Health Improvement & Health-Enabled Prosperity; (C) establish an appropriate structure for an ongoing academic collaborative; (D) set forth how training in Virginia, deployed based on an evidence-based assessment of needs, clinical capacity, and program availability will be developed; (E) set forth how a new community-based, rural training track, primary-care residency, or preventive medicine residency in Virginia will be established; (F) set forth how community psychiatry rotations in southwest Virginia will be established in collaboration with existing psychiatry residency programs; (G) set forth how incentives for clinical employees to pursue clinical degrees will be developed through such mechanisms as, for example, loan forgiveness, clinical rotation sites, clinical hours, and preceptorship; and (H) include a methodology for allocation of funds between Virginia and Tennessee. The plan shall include milestones and outcome metrics.

The New Health System shall implement the plan in collaboration with at least its current academic partners.

No less than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

Within 45 days of the closure of the merger, the New Health System shall convene the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. Furthermore, and contingent on continued funding for existing programs from federal and state sources, the New Health System shall not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved

within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area.

25. Within 12 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a plan for investment in the research enterprise in the Virginia service area. The New Health System shall develop the plan in collaboration with at least its current academic partners. Within 45 days of the closing date of the merger, the New Health System shall convene the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. The plan shall be for the first three full fiscal years following the closing date of the merger and shall include a time schedule for implementing the plan and expenditures under the plan for the second and third full fiscal years after the closing of the merger that are consistent with the regional annual incremental spending amounts in Attachment C. The plan shall also include, but not be limited to, how it will address the Authority's Blueprint goals, the structure of an ongoing research collaborative, and the criteria according to which research funding available as a result of the Virginia cooperative agreement and Tennessee COPA will be deployed in Virginia based on community needs, matching opportunities, economic return to the region, and overall competitiveness of the research proposals.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) have been developed collaboratively with key Virginia stakeholders, (B) effectively address the goals of the Authority's Blueprint for Health Improvement & Health-Enabled Prosperity and contain metrics that will be evaluated periodically to determine if the goals are met, (C) establish an appropriate structure for an ongoing academic collaborative, (D) include a methodology for allocation of funds between Virginia and Tennessee, and (E) include appropriate evidence-based criteria pursuant to which research funding made available as a result of the cooperative agreement will be deployed in Virginia based on community needs, matching opportunities, economic return to the region, and overall competitiveness of the research proposals. The plan shall include milestones and outcome metrics.

    The New Health System shall implement the plan in collaboration with at least its current academic partners.

    No less than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

26. Within 48 months of the closing of the merger, the New Health System shall adopt a Common Clinical IT Platform. This fully integrated medical information system shall allow for better coordinated care between patients and their doctors, hospitals, and post-acute care and outpatient services and facilitate the move to value-based contracting. The New Health System shall make access to the IT Platform available on reasonable terms to all physicians in the service area. Subject to confidentiality laws and rules, the New Health System shall grant reasonable access to the data collected in its Common Clinical IT Platform to researchers with credible credentials who have entered into Business Associate Agreements for the purpose of conducting research in partnership with the New Health System.

27. All hospitals operated by the Applicants on the Approval Date shall remain operational as clinical and health care institutions for at least five years. "Clinical and health care institutions" may include, but are not limited to, acute care hospitals, behavioral health hospitals, rehabilitation hospitals, freestanding emergency rooms, surgery centers, skilled nursing facilities, assisted living centers, and any combination thereof. Immediately from the Approval Date and during the life of the cooperative agreement, the New Health System shall continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and other investment in outpatient health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or hospital service lines, or repurpose any hospital. In the event the New Health System repurposes any hospital or adjusts scope of services or service lines, it shall continue to provide essential services in the city or county where the hospital is located and in any contiguous city or county. Prior to adjusting the scope of services or service lines or repurposing any hospital, the New Health System shall provide the Commissioner with nine months advance notice. Within 30 days of such notification, the New Health System shall submit a plan to the Commissioner for approval detailing how essential services will continue to be provided in the city or county in which the hospital is located and in any contiguous city or county. The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) have been provided to the Commissioner within 30 days of timely notice that such adjustment in scope of service or service lines or repurposing was to occur, (B) demonstrate that the proposed action is consistent with, and would not adversely impact, the Population Health Plan, the Rural Health Services Plan, the Children's Health Services Plan, and the Behavioral Health Services Plan, (C) set forth how essential services will continue to be provided in the Virginia city or county where the hospital facility is currently located, as well as in any contiguous Virginia city or county, and (D) demonstrate how population health will be improved for the people in the Virginia service area. The plan shall include milestones and outcome metrics. If the New Health System desires to repurpose a hospital emergency department or consolidate trauma service lines, the plan submitted to the Commissioner shall be developed in coordination with the Southwest Virginia Emergency Medical Services Council and shall also address emergency medical services transport times and assurance of appropriate patient care. The New Health System shall not close facilities or discontinue services in such a manner that would affect the ability of Medicaid managed care organizations to meet network adequacy and access requirements, such as distance and drive time parameters.

For purposes of this condition, "service lines" means the following service lines at a hospital: Orthopedics, Pediatrics, Surgery, Obstetrics/Gynecology, Cardiovascular/Heart, Cancer, Emergency Medicine, Neurology/Neurosurgical, Psychiatric/Behavioral Health, Neonatal, and Trauma.

For purposes of this condition, the following services are considered "essential services:"

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;
- Rotating clinic or telemedicine access to specialty care consultants as needed in the community;
- Helicopter or high acuity transport to tertiary care centers;

- Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings;
- Primary care services, including lab services;
- Physical therapy rehabilitation services;
- Care coordination service;
- Access to a behavioral health network of services through a coordinated system of care; and
- Community-based education, prevention and disease management services for prioritized programs of emphasis based on goals established in collaboration with the Commissioner and the Authority.

If an acute care hospital is opened in Lee County, and subsequently fails or ceases to operate, the New Health System shall provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System. Such terms shall include the appropriate access to space, located within the existing hospital facility, based upon reasonable terms. If an acute care hospital is not open and operational under a partnership with the Lee County Hospital Authority by December 31, 2018, the New Health System shall provide essential services in Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System until such time as a hospital is open and fully operational.

28. The New Health System shall maintain, for the Virginia and Tennessee service areas, a minimum of three full-service tertiary referral hospitals located in Johnson City, Kingsport, and Bristol, to ensure higher-level services are available in close proximity to where the population lives.

29. The New Health System shall maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital departments or services as determined by the New Health System's Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.

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

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

32. The New Health System shall complete a comprehensive physician/physician extender needs assessment and recruitment plan every three years, starting within the first full fiscal year, in each Virginia community served by the New Health System. The New Health System shall consult with the Authority in development and implementation of the plan. The New Health System shall employ physicians and physician extenders primarily in HPSAs designated by the U.S. Health Resources and Services Administration and tracked by the VDH Office of Primary Care, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding, and in locations where needs are not being met. The New Health System shall promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.

33. The New Health System shall spend a minimum of $28,000,000 over the 10 fiscal years beginning July 1, 2018 on rural health services benefitting the communities in the area served by the New Health System consistent with the regional annual incremental spending amounts in Attachment C. Within six months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a Rural Health Services Plan for the first three full fiscal years after the closing date of the merger that shall include a time schedule for implementing the plan and expenditures under the plan that are consistent with Attachment C. The plan shall, at a minimum, address the New Health System's approach to the following components:
    - Primary Care Services, with a plan for same day access, which may include telemedicine and other technology based access;
    - Maintain and enhance services to support maternal and prenatal health;
    - Pediatrics and regional pediatric specialty access;
    - Specialty care and regional specialty care access, with a plan for access within five days,
    - Access to "essential services" (as defined in condition 27);
    - Improved access to preventive and restorative dental and corrective vision services; and
    - Emergency service access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia Emergency Medical Services Council.

    The Rural Health Services Plan shall also address collaboration with local businesses, school districts, and industry on community development necessary to attract and retain providers in the Virginia service area.

    The Rural Health Services Plan will be focused, along with the Population Health Plan, on managing the burden of disease and breaking the cycle of disease according to the priorities set forth by the Authority and the Commissioner.

    The Rural Health Services Plan will account for needed workforce development strategies in consultation with the Southwest Area Health Education Center and regional educational institutions. The Rural Health Services Plan shall also address the development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) effectively address and detail how meaningful and measurable improvements and enhancement in the Virginia service area to same-day access for primary care services, access to specialty care within five days, access to maternal and prenatal health services, access to pediatric and pediatric specialty services, access to "essential services" as defined in condition 27, preventive and restorative dental services, corrective vision services, and access to emergency services will be achieved; (B) detail how active and effective collaboration with local businesses, school divisions, and industry on community development necessary to attract and retain providers in the Virginia service area will be achieved; (C) have an active and effective focus on managing the burden of disease and breaking the cycle of disease based on the priorities set forth by the Authority and the Commissioner; (D) detail how the New Health System will actively and effectively consult with the Southwest Area Health Education Center and regional educational institutions on the development of workforce

development strategies; (E) detail how effective development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops will be achieved; and (F) include a methodology for allocation of funds between Virginia and Tennessee. The plan shall include milestones and outcome metrics consistent with those approved by the Commissioner after receipt of the recommendations from the Technical Advisory Panel.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan.

34. The New Health System shall spend a minimum of $85,000,000 over the 10 fiscal years beginning July 1, 2018 on behavioral health services benefitting the communities served by the New Health System, consistent with the regional annual incremental spending amounts in Attachment C. The New Health System shall (A) create new capacity for residential addiction recovery services serving the people of southwest Virginia and (B) shall develop community-based mental health resources, such as mobile heath crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration, and other out-of-home placements throughout the Virginia service area. Within 6 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner for review and approval a Behavioral Health Services Plan for the first three full fiscal years after the closing date of the merger that encompasses A and B above. The plan shall include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Attachment C.

    The Behavioral Health Services Plan shall also consider the goals set forth in the Virginia DMAS ARTS Program and by the community services boards in the Virginia service area.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) detail how new capacity for residential addiction recovery services will be created to meet the current and expected future needs of the people of southwest Virginia; (B) detail how community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration, and other out-of-home placements, will be developed throughout the Virginia service area; (C) appropriately and adequately consider the goals set forth in the Virginia DMAS ARTS Program and by the community services boards in the Virginia service area; and (D) include a methodology for allocation of funds between Virginia and Tennessee.

    No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

35. The New Health System shall spend a minimum of $27,000,000 over the 10 fiscal years beginning July 1, 2018 on children's health services benefitting the communities in the area served by the New Health System, consistent with the regional annual incremental spending

amounts in Attachment C. The New Health System shall develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right settings in close proximity to patients' homes. Within six months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner for review and approval a Children's Health Services Plan for the first three full fiscal years after the closing date of the merger encompassing the above which shall include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Attachment C.

Some elements of the Children's Health Plan may also be included in the Rural Health Services Plan.

The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) detail how pediatric specialty centers and Emergency Rooms in Kingsport and Bristol will be developed to meet the current and expected future needs of the people in the geographic service area, (B) detail how pediatric telemedicine and rotating specialty clinics in rural hospitals will be staffed and utilized to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes, and (C) include a methodology for allocation of funds between Virginia and Tennessee. The plan shall include milestones and outcome metrics.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

36. The New Health System shall spend a minimum of $75,000,000 over the 10 fiscal years beginning July 1, 2018 on population health improvement for the area served by the New Health System, consistent with the regional annual incremental spending amounts in Attachment C. The distribution of funding across the total population of the area served by the New Health System shall consider the relative population of the counties and communities within the area served by the New Health System, the relative per-capita cost of interventions within each community and the relative value of the intervention towards improving overall population health. Of this amount, the New Health System shall spend an amount necessary to support the creation of, and shall take the lead to formally establish, at least one regional Accountable Care Community (ACC) organization that includes the entire Virginia service area. Membership of the ACC will include members of the New Health System, the Authority, and other local, state or federal agencies, payers, service providers, and community groups who wish to participate.

    Within 90 days of the closing date of the merger, the New Health System shall recruit and convene the ACC's initial leadership team to help develop the Population Health Plan. After consultation with the ACC and within six months of the closing date of the merger, the New Health System shall submit to the Commissioner, for review and approval, a Population Health Plan for the first three full fiscal years after the closing date of the merger to improve the scores of the southwest Virginia population on measures to be approved by the Commissioner following receipt of recommendations from the Technical Advisory Panel. The Plan will

include a time schedule for implementing expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Attachment C. The submission of the Plan, the process measures associated with the implementation of each component, and the achievement of population health improvement for each measure, shall be evaluated according to the quantitative measures and methodology determined by the Commissioner after receipt of the recommendations of the Technical Advisory Panel.

The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the Plan shall (A) set forth how population health will be improved in southwest Virginia in accordance with the Authority's Blueprint for Health Improvement & Health-Enabled Prosperity and the Virginia Plan for Well-Being and (B) include process measures associated with implementation of each component of the plan.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

No later than six months after the closing date of the merger, the New Health System shall establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing the Population Health Plan and improving the overall health of the population served by the New Health System. This department shall be staffed with leaders charged with financial compliance, physician relations, and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the New Health System's Board of Directors.

37. The New Health System shall reimburse the Authority for costs associated with the various regional health planning efforts cited within these conditions in an amount up to $75,000 annually, with CPI increases each year. No reimbursable costs shall be paid toward compensation for any member of the Authority's Board or Directors.

38. The Board of Directors of the New Health System shall operate such that each Board member must exercise the Duty of Care, Loyalty and Obedience to the New Health System required by law, and all Board members must adhere to the strict fiduciary policies established by the Board. It is recognized that governance of the New Health System should reflect the region, including both Virginia and Tennessee. As such,
    - On the date of closing of the merger and for the life of the cooperative agreement, three members of the 11-member New Health System Board of Directors shall be Virginia residents;
    - The New Health System shall ensure membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce; and
    - Not less than 30% of the composition of the Community Benefit/Population Health committee shall reside in Virginia (this committee will be the Board committee responsible for the oversight of the compliance of the cooperative agreement).

39. Any report or information required to be submitted to the Commissioner shall be accompanied by a verified statement signed by the chairperson of the Board or the Chief Executive Officer attesting to the accuracy and completeness of the report or information.

40. The New Health System shall provide information on a quarterly basis of the key financial metrics and the balance sheet comparing performance to the similar prior year period and year to date. This information shall be provided on the same timetable as what is publicly reported through Electronic Municipal Market Access.

41. The New Health System shall adhere to the New Health System Alignment Policy [Exhibit 12.1 of the Application] setting forth relevant considerations and the process for closing a facility should it be necessary and otherwise in compliance with the conditions of the cooperative agreement. This policy shall remain in effect unless the change is agreed to by the Commissioner.

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

43. The New Health System shall not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.

44. The New Health System shall participate in the Virginia DMAS ARTS Program.

45. The New Health System shall establish a system-wide, physician-led clinical council (the "Clinical Council").
    - The Clinical Council shall be composed of (A) Independent Physicians, (B) Employed Physicians, (C) the Chief Medical Officer of the New Health System and (D) a Chief Nursing Officer of one of the Applicants. The Clinical Council shall include representatives of the New Health System's management but the majority shall be composed of physicians. The membership of the Clinical Council shall be representative of the distribution of physicians across the geographic service area.
    - The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.
    - The Chair of the Clinical Council shall be a physician member of the active medical staff(s) of one or more New Health System Entities chosen by members of the Clinical Council. The Chair shall serve on the Quality, Service and Safety Committee of the Board of the New Health System and shall provide ongoing reports on the activities of the Clinical Council through the Quality, Service and Safety Committee of the Board.
    - The Clinical Council shall be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review when appropriate and quality performance standards and best practices requirements for the New Health System, all of which shall be documented as applicable and required by the Commissioner.
    - The Clinical Council shall provide input to the New Health System on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System.
    - The Clinical Council shall advise the Board of Directors of the New Health System on target quality measures based on quality improvement priorities of the New Health System.

46. The New Health System shall continue to treat Virginia Medicaid beneficiaries in Virginia hospitals, Tennessee hospitals, and other New Health System facilities. The New Health System shall also continue to perform pre-admission screening assessments to determine if an individual meets the functional criteria to receive Medicaid-funded long terms services or supports. The New Health System shall enter into a participation agreement with DMAS. The New Health System shall contract with all Virginia MMCOs that provide coverage to Medicaid beneficiaries in the New Health System's service area. This includes MMCOs in the Medallion program, Commonwealth Coordinated Care program, CCC Plus program, and any other Virginia Medicaid managed care program that is implemented during the term of the cooperative agreement. The New Health System shall contract with all Medicare Dual Eligible Special Needs Plans as these health plans will serve individuals that are also enrolled with a MMCO. Additionally, the New Health System shall contract with the PACE. The following conditions are placed on MMCO and PACE contracting during the life of the cooperative agreement, and apply to all service types existing under such contracts:

    Prices for all renewed contracts shall not exceed the Applicants' current negotiated percentage of Virginia Medicaid's payment rate for the service unless both the contracting MMCO/PACE and the New Health System agree to alternative prices or reimbursement arrangement.

    Prices for new MMCO/PACE contracts shall be no higher than the average percentage of Virginia Medicaid's payment rate for the service in the Applicants' existing MMCO/PACE contracts unless both the contracting MMCO/PACE and the New Health System agree to alternative prices or reimbursement arrangements.

    If existing MMCO/PACE contracts are not based on a percentage of Virginia Medicaid's payment rate, then the New Health System shall calculate a percentage of Virginia Medicaid's payment rate based on current contract terms and 2017 utilization. To determine the current percentage of Medicaid, the New Health System shall divide utilization in the base year repriced at Medicaid rates by expenditures in the 2017 base year under the current rates. Future negotiated rates for these contracts shall not exceed this calculated percentage of Virginia Medicaid's payment rate.

47. The New Health System shall participate in quarterly teleconferences with DMAS each year. The teleconferences will address, *inter alia*, the New Health System's progress towards meeting DMAS goals for participation in the ARTS Program; the New Health System's progress towards implementing value-based payment with Medicaid Managed Care Organizations; ensuring continued access to obstetrical and maternity services for Medicaid recipients; managed care contracting; and any complaints regarding the New Health System received by DMAS from Medicaid providers or recipients. At least one executive-level member of the New Health System shall participate in each teleconference. The frequency of the teleconferences may be reduced by DMAS.

48. In order to ensure that the Virginia operations are allocated an appropriate amount of the New Health System's ongoing and annual compliance costs, the New Health System shall adopt an allocation methodology that takes into account the differences in ongoing and annual compliance requirements between the State of Tennessee and the Commonwealth of Virginia.

49. These conditions are intended to remain effective for the life of the cooperative agreement. Nevertheless, there may be changes in circumstances that arise which affect the feasibility or the meaningfulness of the conditions and which are not possible to foresee presently. Accordingly, if the New Health System produces evidence that changes in circumstances have materially affected its ability to meet a condition and that its inability is not affected by deficiencies in management, the New Health System may request the Commissioner amend the condition to reduce the burden or cost of the condition to a level that may be more sustainable. In the event that the New Health System requests the Commissioner to amend a condition, the Commissioner may engage an independent consultant to determine whether the changes in circumstances have adversely affected the New Health System, the extent to which this has occurred, and whether the changes in circumstances are related to the effectiveness of management. The New Health System shall pay all charges, not to exceed $250,000 (as adjusted by the CPI from the date of the closing of the merger), for the cost of such an independent consultant engagement. The Commissioner shall determine whether it is necessary to amend, retain, or remove the condition in order for the benefits of the cooperative agreement to continue to outweigh the disadvantages likely to result from a reduction in competition and take appropriate action regarding the condition.

Attachment A

Blueprint for Health Improvement & Health- Enabled Prosperity
Approved January 7, 2016 by the Southwest Virginia Health Authority

The *Blueprint for Health Improvement & Health – Enabled Prosperity* reflects the collaborative work of community members and organizations in identifying priority goals and strategies for population health improvement in Southwest Virginia. The aims and goals outlined in this document are ambitious, achievable, measurable, and intended to be attained by 2020. They apply to a geographic "region" that includes the counties of Lee, Scott, Wise, Dickenson, Buchanan, Tazewell, Russell, Washington, Smyth, and cities of Norton and Bristol.

Aim 1.0: Healthy Starts for Children

Goal 1.1: Decrease by .5% across the region, the percent of children who do not meet the PALS K benchmarks in the fall of kindergarten and require literacy interventions, with no jurisdiction exceeding 20% failure to meet the benchmark

Goal 1.2: Increase percent of third graders who pass the Standards of Learning third grade reading assessment to 80% or better, with no sustained decline in any jurisdiction

Goal 1.3: Increase the percentage of children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella and pneumococcal conjugate vaccine (PCV) to 80%

Goal 1.4: Increase percent of boys and girls, age 13-17, who receive three doses of HPV vaccine, to 80%

Goal 1.5: Increase number of children, ages 1-18, who receive preventive oral health services

Goal 1.6: Decrease rate of child abuse and neglect across the region

Goal 1.7: Decrease infant mortality rate across the region

Goal 1.8: Decrease total preterm births across the region

Goal 1.9: Increase percent of women who receive early (first trimester) and adequate prenatal care to 80%

Goal 1.10: Decrease percent of women who use alcohol and/or tobacco use during pregnancy

Goal 1.11: Decrease number of children born with Neonatal Abstinence Syndrome

Goal 1.12: Decrease teen pregnancy rate by 25% in all jurisdictions, with no jurisdiction trending upward

Goal 1.13: Increase percent of women who initiate breastfeeding

Aim 2.0: Healthy Minds

Goal 2.1: Increase the number of certified or licensed professionals treating mental health and substance use disorders (SUD), including core mental health professionals, as defined by HRSA, sufficient to eliminate the Mental Health Professions Shortage Area Designation in the region. Core mental health professionals as defined by HRSA include psychiatrists, clinical psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists.

Goal 2.2: Increase access to diverse services for SUD treatment, including intensive outpatient, inpatient and residential

Goal 2.3: Increase the number of people who receive specialty treatment for SUD in the region

Goal 2.4: Decrease number of drug/poison deaths in the region

Goal 2.5: Decrease suicide rate to equal or below state rate of 12.9 per 100,000

Aim 3.0: Healthy Behaviors

Goal 3.1: Increase the percent of adults who receive an annual influenza vaccine to 70%

Goal 3.2: Decrease percent of adults in the region who are overweight or obese to equal or below the state goal of 63%.

Goal 3.3: Decrease percent of children in the region who are overweight, or obese (BMI > 85% for age and gender)

Goal 3.4: Decrease percent of adults who did not participate in any physical activity during the last 30 days to no more than 20% across the region

Goal 3.5: Increase percent of high school graduates who are enrolled in an institute of higher education within 16 months after graduation to equal the state goal of 75%. Institutes of higher education can include, but are not limited to, universities, colleges, institutes of technology, vocational schools and trade schools.

Goal 3.6: Decrease the percent of adults who report using tobacco to no more than 12% across the region

Goal 3.7: Decrease initiation of alcohol, tobacco, and other drugs (ATOD), including e-cigs in adolescents

Goal 3.8: Increase access to oral health care services using traditional and innovative models of oral health care delivery, to include a sufficient number of dentists to eliminate the Dental Health Professions Shortage Area Designation.

Goal 3.9: Decrease rate of avoidable deaths from heart disease, stroke, or hypertensive disease in the region equal to or below the state goal of 40 per 100,000

Goal 3.10: Decrease morbidity and mortality (age-adjusted) related to diabetes

Aim 4.0: Healthy Communities

Goal 4.1: Decrease rate of unemployment across the region

Goal 4.2: Increase households with access to high speed internet to equal or above the state goal of 72%

Goal 4.3: Decrease percent of households that are food insecure for some part of the year to no greater than 10%

Goal 4.4: Create a model for collaboration across agencies and organizations to share data and resources for the purpose of population health improvement

Goal 4.5: Increase number of communities that adopt policies, environmental and systems changes (PES) to support healthy living

Aim 5.0: Effective System of Health Care

Goal 5.1: Increase access to certified specialty care providers, with a focus on endocrinology, cardiology, pulmonary, and oncology

Goal 5.2: Increase percent of adults appropriately screened for colon, cervical, and breast cancer based on standards of care

Goal 5.3: Increase the number of hospitals in the region meeting the state goal for prevention of hospital-onset *C.difficile* infections to 100%

Goal 5.4: Decrease hospitalizations for ambulatory care sensitive conditions to no greater than 1100 per 100,000

Goal 5.5: Increase Health Information Exchange (HIE) in regional health systems serving upper east Tennessee and Southwest Virginia

Attachment B
Revised New Health System Virginia Commitments
Dated October 9, 2017

General: Notwithstanding anything contained in these Commitments to the contrary, the Commissioner shall retain the final authority with respect to conclusions reached by the Commonwealth or actions to be taken by the Commonwealth.

1. **Combined Commitment 1 and 2**
2. **Commitment:** To ensure the Cooperative Agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, the New Health System shall honor all existing Payer contract terms and not unilaterally terminate without cause any such existing contract prior to its stated expiration date. In addition, a limit on pricing growth is applied for each year. Effective on the closing date of the merger, the New Health System will commit to not adjust hospital negotiated rates in managed care contracts by more than the Cumulative Hospital Inflation Adjustment, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the Cumulative Hospital Inflation Adjustment without the Quality Adjustment Factor (defined below). Certain hospital, physician, ancillary and other healthcare services may be reimbursed on a percentage of a health care provider's charge for such services. For hospital inpatient and outpatient, non-hospital outpatient, and physician services and any other services billed to Payers based upon charges, the New Health System shall limit the impact of charge increases to the Cumulative Hospital Inflation Adjustment. This provision does apply to outliers for the purpose of adjusting the outlier threshold and any percentage of charge payment. This is a ceiling in rate adjustments; nothing herein establishes these adjustments as the floor on rates.

   This provision only applies to managed care contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental Payers. This limitation does not apply to:

   (a) That portion of managed care contract payments for attaining quality targets or goals.
   (b) Pass-through items in managed care contracts.
   (c) Post-acute care providers such as skilled nursing facilities, home health agencies, hospices and durable medical equipment providers owned by the New Health System.
   (d) Bundled payment items and services in which a hospital and/or the New Health System as applicable assumes risks for care provided by other providers (such as post-acute care providers like a skilled nursing facility or home health agency), involving a value-based payment on an episodic basis.
   (e) Items for which the hospital and/or the New Health System as applicable have accepted risk in the form of a capitated payment or percentage of premiums.
   (f) Pharmacies owned or controlled by the New Health System.
   (g) Contract pricing terms which were negotiated pre-Closing.

   The New Health System agrees that managed care contract structures may include rates being tied to a percentage of Medicare, or may establish base rates with annual inflators or quality

incentives. The New Health System will not refuse to enter into any of these types of structures on the basis of the structure and will negotiate the rate structure in good faith.

Below is a sample calculation showing how the rate cap/hospital inflation adjustment will be applied:

To determine the rate cap for a Payer that offers a quality component in its fee schedule:

1. Determine the latest CMS approved Medicare Market Basket amount (currently 2.7%)
2. Add .25%
3. The rate cap/Hospital Inflation Adjustment is ascertained by adding the amounts in #1 and #2 above: 2.7% + .25%= 2.95%.

To determine the rate cap for a Payer that does not offer a quality component in its fee schedule:

1. Determine the latest CMS approved Medicare Market Basket amount (currently 2.7%)
2. Add .25%
3. Add 1.25% Adjustment for absence of a quality component
4. The rate cap/Hospital Inflation Adjustment is ascertained by adding the amounts in #1, #2, and #3 above: 2.7%+.25%+1.25%=4.2%.

Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the Hospital Inflation Adjustment. If following such approval, the New Health System and a Payer are unable to reach agreement on a negotiated rate or other contract terms, the New Health System agrees to mediation as a process to resolve any disputes. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the payer has insureds (or members) in the Commonwealth of Virginia, and shall offer updates to the Commissioner on the progress of such mediation. The Chief Financial Officer of the New Health System shall certify the New Health System's compliance with the terms of this combined Commitment 1 and 2 in each Annual Report.

If either the New Health System or any Payer terminates a Payer contract, the New Health System will be subject to the pricing limitations of this Commitment. That is, this Commitment will apply, with the increased pricing limitation listed below, even if the New Health System goes out-of-network with a Payer. In this event, there will be no balance billing of patients over and above the following amount:

- The provisions of this Commitment shall apply to any Payer which has a managed care contract with NHS, MSHA or WHS and subsequently goes out-of-network; provided, however, that the Hospital Inflation Adjustment and Physician Inflation Adjustment with respect to such Payer shall be multiplied by two (2x) in the first two (2) years the Payer is out of network and multiplied by one (1x) each year thereafter.

The following definitions will apply to this combined Commitment 1 and 2, and when used in other Commitments:

"Cumulative Hospital Inflation Adjustment" - The compounded increases of the Hospital Inflation Adjustments from 2017 through the end of the contract year or Fiscal Year, as applicable.

"Hospital Inflation Adjustment" or ("HIA") – For the year being tested, the most recently available annual inpatient percentage of increase by Medicare, commonly referred to as the Market Basket and reported by CMS in the Federal Register as part of the Final Rules of the Inpatient Prospective Payment System, plus 0.25 percent. The HIA will not include the multifactor productivity adjustment, statutory adjustment, adjustments for failure to be a meaningful electronic health record user or failure to submit quality data, or any other positive or negative adjustments required by law or regulation. Effective October 1, 2017, the Market Basket is 2.70 percent.

HIA will also include, for Payers who do not offer a quality component in their fee schedules or payment structures at least equal to the adjustment in the schedule below, an additional payment ("Quality Adjustment Factor"). If a Payer does not offer as part of its fee schedules or rate structures a payment for quality or pay-for-performance incentives, the HIA will be increased based upon the difference between the schedule below and the quality component offered by the Payer.

Contract Year Beginning	Adjustment for Absence of Quality
2018	1.25%

"Physician Inflation Adjustment" means the Hospital Inflation Adjustment without the Quality Adjustment Factor. Medicare's annual physician market basket update factor is currently limited by law to 0.50. When and if Medicare begins using an inflation-based update to the physician fee schedule, the Physician Inflation Adjustment used herein will be the Medicare physician market basket rate of increase plus 0.25 percent.

"Payer" means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any New Health System hospital or other medical providers' medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payers which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payers and health plans which negotiate the payment or rate of payment for hospital or medical services, supplies and/or items. Payer includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare payers or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of

Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the term of the Cooperative Agreement.

"Large Network Payer" means a Payer which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges ("Gross Revenue") for the New Health System. The same Payer may have several networks, each of which utilize different fee schedules, and each of which could constitute 2% or more of the Gross Revenue; each network attaining the 2% threshold would constitute a separate Large Network Payer. Conversely, several Payers may only constitute one network, because they use a common fee schedule. An example would be PHCS Multiplan.

Timing: Subsequent contract years.

Amount: The estimated annual savings to consumers for the combined Commitment 1 and 2 are $80 million in lower health care costs over the first ten years.

Metric: Easily verifiable.

3. **Commitment:** In order to minimize any adverse impact on the ability of insurance companies to contract with the hospitals, and while this Cooperative Agreement ensures open access and choice for all consumers to choose any hospital in the region, it also remains the intent of the Cooperative Agreement that consumers and businesses enjoy a competitive market for insurance. As such, the New Health System will continue to negotiate in good faith with Large Network Payers to include the New Health System in health plans offered in the Geographic Service Area on commercially reasonable terms and rates (subject to the limitations herein). The New Health System will not unreasonably refuse to negotiate with potential new Payer entrants to the market or with any Payer as long as the Payer has demonstrable experience, a reputation for fair-dealing and timely payment, and negotiates in good faith. New Health System will resolve through mediation any disputes as to whether this commitment applies to the proposed terms of a health plan contract. If a Payer and the New Health System cannot agree on rates or any other contract terms, and mediation fails to resolve the dispute, the Commissioner may require the New Health System to participate in "Final Offer Arbitration" with the payer unless the Commissioner agrees to an alternative manner of arbitration. Costs and reasonable attorneys' fees of the arbitration would be awarded to the prevailing party of the arbitration if "Final Offer Arbitration" or other types of arbitration are utilized. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this commitment if the Payer has insureds (or members) in the Commonwealth of Virginia, and shall offer to the Commissioner updates on the progress of such mediation.

   Timing: Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new Payers coming into area, and ongoing.

   Amount: No cost.

   Metric: Complaints from Payers and credible report by the New Health System.

4. **Commitment:** In order to ensure providers in the region not affiliated with the New Health System may continue to operate competitively, and to ensure new provider entrants to the market are not disadvantaged by the New Health System, the New Health System will not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer. Nothing herein shall be construed as to impede the discretion of the Payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System's service area.

   Timing: Immediately upon closing of the merger and then upon expiration of existing contracts or with contracts with any new Payers coming into area, and ongoing.

   Amount: No cost.

   Metric: Easily verifiable.

5. **Commitment:** In order to improve quality for patients, ensure seamless access to needed patient information, and to support the efforts of the local physician community to access needed information in order to provide high quality patient care, the New Health System will participate meaningfully in a regional health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with community-based providers for the purpose of providing seamless patient care. In addition, the New Health System will participate in the Commonwealth's ConnectVirginia health information exchange, in particular ConnectVirginia's Emergency Department Care Coordination Program and Immunization Registry. In addition, the New Health System will participate in Virginia's Prescription Monitoring Program.

   Timing: No later than 36 months after closing.

   Amount: Up to $8 million over 10 years, consistent with the regional annual incremental spending amounts in Exhibit B.

   Metric: The New Health System shall report annually to the Commissioner on mileposts toward meeting this commitment.

6. **Commitment:** In order to enhance quality and decrease the total cost of care, the New Health System will collaborate in good faith with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and to deliver such outcomes at the highest possible value.

   Timing: No later than 36 months after closing.

   Metric: The New Health System shall report to the Commissioner on the mileposts toward meeting this commitment.

7. **Commitment:** In order to enhance quality, improve cost-efficiency, reduce unnecessary utilization of hospital services, and more fully align the New Health System, Payers, the business community, patients and the public, the New Health System, subject to the agreement of Payers as defined herein, will establish payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers as follows:

   1. All risk-based model components of existing WHS and MSHA contracts would continue from the date of closing into the future upon their terms.
   2. One new risk-based model contract would commence no later than January 1, 2020.
   3. A second new risk-based model contract would commence no later than January 1, 2021.
   4. The New Health System would initiate risk-based model contracts for any remaining Large Network Payers that do not already have at least one risk-based model component in their contracts by no later than January 1, 2022.

   By January of 2022, all of the Large Network Payers are expected to have a risk-based model/population health/partnership relationship with the New Health System that includes aligned incentives. The risk-based components in each contract will be based on the unique priorities and timelines agreed upon by each Large Network Payer and the New Health System.

   For purposes of this section, “risk-based model” shall be defined as contracts which contain elements of reimbursement tied to incentives for quality, value-based care, shared savings or alignment of financial incentives between Payers, the New Health System, employers and patients.

   The New Health System will partner with the Virginia DMAS to develop, pilot, or implement value-based payment programs in the region as appropriate, including programs allowing the New Health System to accept direct capitation from DMAS for the Medicaid enrollees in the Geographic Service Area.

   Timing: Immediately upon closing of the merger and continuing through January 1, 2022.

   Amount: No cost.

   Metric: The New Health System shall report annually to the Commissioner on the mileposts toward meeting this Commitment.

8. **Commitment:** In order to enhance quality of patient care through greater transparency, improve utilization of hospital resources, and to ensure the population health of the region is consistent with goals established by the Authority, the New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers. Such reporting shall include posting of quality measures and actual performance on New Health System’s website accessible to the public. The New Health System shall report such data timely so the public can easily evaluate the performance of the New Health System as compared to its competitors, and ensure consumers retain the option to seek services where the quality is demonstrably the

highest. In addition, the New Health System will timely report and include on its web site its performance compared to the Medicare quality measures including readmission statistics. The New Health System will give notice to the Authority of the metrics the New Health System is prioritizing, and will, in good faith, include input from the Authority in establishing or modifying its priorities.

Timing: Annually, based upon when the New Health System establishes its annual quality goals.

Metric: Compliance with commitment as agreed upon and modified subsequently.

9. **Commitment:** In order to prevent low income patients who are uninsured from being adversely impacted, the NHS shall adopt a charity care policy for the hospitals that is compliant with applicable law, that is more charitable than the existing policies of both Applicants, and that is consistent with the 501 (r) rule. The NHS shall furnish a copy of its policies relating to charity care to the Commissioner no later than the end of the third (3rd) month following the closing of the merger. Thereafter, New Health System shall furnish to the Commissioner a copy of any revisions to such policies immediately upon the effective date of such revisions. These policies shall provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred twenty-five percent (225%) of the federal poverty level. In addition to increasing the 100% discount for services at 225% of Federal Poverty Level, the NHS also agrees that for patients who are between 225% and 400% of the federal poverty guidelines but whose account balance (after all insurances have processed or uninsured discount has been applied) is equal to or greater than 50% of the patient's total annual household income, the maximum a patient would be expected to pay to settle an account balance would be 15% of household income. The New Health System shall inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site and on the separate web sites for all provider components that are part of the New Health System.

   Timing: Policy adopted within 3 months of closing, with implementation immediately thereafter and ongoing.

   Amount: Extent of additional cost is unknown but is not immaterial.

   Metric: Charity care costs as measured in cost of care furnished. For hospital services the number will be taken from the Form 990, Schedule H, Line 7a "Financial Assistance at Cost" (from the Community Benefit Section). New Health System's annual report to the Commissioner shall also include data on the number of individuals receiving uncompensated care and compare that number to prior fiscal years when the New Health System was in operation. The cost for charity care for nonhospital services may be estimated using the cost to charge ratio aggregated for all nonhospital services.

10. **Commitment:** In order to ensure low income patients are not adversely impacted due to pricing, uninsured or underinsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that

Section governing not for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible.

“Uninsured” patients are those with no level of insurance or third-party assistance to assist with meeting his/her payment obligations. “Underinsured” patients shall mean insured patients who receive Eligible Health Care Services that are determined to be non-covered services." These patients will not be charged more than amounts generally billed (AGB) to individuals who have insurance covering such care in case of Emergency or other Medically Necessary Services.” AGB percentage is determined using the look-back method utilizing the lowest percentage for all facilities per the IRS regulatory guidelines set forth in 501(r). Emergency Services are defined in accordance with the definition of “Emergency Medical Conditions” in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). Medically Necessary Services are defined by Medicare as services of items reasonable and necessary for the diagnosis or treatment of illness or injury and are Services not included in the list of “particular services excluded from coverage” in 42 CFR § 411.15). Financial assistance eligibility will be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Financial assistance determinations are based on National Poverty Guidelines for the applicable year. The New Health System shall adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

Timing: Immediately upon closing and ongoing.

Metric: Credible report.

11. **Commitment:** In order to demonstrate the New Health System maintains the financial viability to fulfill its commitments of this Cooperative Agreement, and to ensure proper state supervision, any notices of a material default, that the New Health System, or an affiliate, receives under bond or other debt documents for debt in excess of $7,500,000, must be furnished to the Authority and the Commonwealth.

    Timing: Ongoing.

    Amount: No cost.

    Metric: Credible report.

12. **Commitment:** In order to demonstrate the New Health System maintains the financial viability to fulfill its commitments of this Cooperative Agreement, and to ensure proper state supervision, If the New Health System records a liability for a Material Adverse Event, the New Health System will notify the Commissioner and the Authority within 30 days of making such a determination.

    For purposes of these commitments, a "Material Adverse Event” means any fact, event, change, development or occurrence that, individually or together with any other event, change, development or occurrence, is or is reasonably likely to be, materially adverse to the business,

condition (financial or otherwise), assets, operations or results of operations of the New Health System, taken as a whole, or on the ongoing ability of the New Health System to comply in all material respects with the commitments.

13. **Commitment:** With respect to any potential non-compliance with these Commitments, the New Health System shall endeavor to cure any such non-compliance in accordance with the process outlined herein.

    In connection with any noncompliance reported by the New Health System or identified and noticed by the Commissioner generally, the New Health System shall have sixty (60) days from the date of notice to Cure, or, if not curable within sixty (60) days, to demonstrate substantial progress toward a complete Cure of, the noncompliance, unless (i) the Noncompliance is not Curable, or (ii) the Noncompliance is due to a Force Majeure Event, in which case the New Health System shall have sixty (60) days from the end of the Force Majeure Event to cure the Noncompliance. The Commissioner (and his/her designees/agents) shall be provided full access, at reasonable times and upon reasonable notice, to all non-privileged documents and information of the New Health System and its personnel necessary to make a determination concerning the noncompliance, any Cure thereof, and, if applicable, any Force Majeure Event.

    For purposes of these commitments, "Cure" means (1) if the noncompliance arose due to failure to spend and pay, in full, the amount specified by a monetary commitment, to pay the amount that remains to be spent and paid, in immediately available funds, either toward the initiative or plan that was the subject of the monetary commitment and/or, as applicable and as agreed by the Commissioner, to enter into a Cooperative Agreement modification as proposed by either the New Health System or the Commissioner, and (2) if the Noncompliance arose due to a nonfulfillment of a non-monetary commitment, to fully perform such non-monetary commitment and/or, as applicable and as agreed by the Commissioner, to enter into a Cooperative Agreement modification as proposed by the New Health System or the Commissioner.

    With respect to any noncompliance that is not Cured or is not Curable, the Commissioner shall have the right to invoke one or more corrective actions, which may include, without limitation, the following: (1) a Cooperative Agreement modification; (2) equitable relief, including a temporary restraining order, an injunction, specific performance and any other relief that may be available from a court of competent jurisdiction; and (3) if public advantage is not evident, termination of the Cooperative Agreement.

    For purposes of these commitments, “Force Majeure Event” means any failure or delay by the New Health System to fulfill or perform any of the commitments when and to the extent such failure or delay is caused by or results from an act beyond the New Health System's reasonable control, including, without limitation, (a) acts of God; (b) flood, fire, earthquake, or explosion; (c) war, invasion, hostilities (whether war is declared or not), terrorist threats or acts, riot, or other civil unrest; (d) change in applicable law (other than Virginia Code § 15.2-5384.1 et seq. or

governmental order pursuant to Virginia Code § 15.2-5384.1 et seq.), including a major structural change to the federal payment system such that it materially changes the needs of the region and the New Health System's ability to meet those needs, and a substantial and material reduction in federal reimbursement; (e) actions, embargoes, or blockades in effect after the issuance of the Cooperative Agreement; (f) action by any governmental authority, other than the Virginia Department of Health or any other Virginia entity (with legal standing) acting to enforce the Cooperative Agreement; and (g) any national or regional emergency. If the New Health System suffers or believes it is reasonably likely to suffer a Force Majeure Event, the New Health System shall (y) give notice to the Commissioner within ten (10) days after knowledge of the existence or reasonable likelihood thereof by the New Health System, stating the period of time the failure or delay is expected to continue, and (z) use diligent efforts to end the failure or delay and minimize the effects of such Force Majeure Event.

Timing: Ongoing.

Amount: No cost.

Metric: Credible report and easy to determine.

14. **Commitment:** In order to ensure employees are properly recognized for their years of service, and to protect the benefits they have earned over time, the New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.

    Timing: First year.

    Metric: Easily verifiable.

15. **Commitment:** In order to ensure a uniform system of compensation, and to ensure competitiveness of pay for attracting and retaining employees, the New Health System will work as quickly as practicable after completion of the merger to invest up to $70 million over 10 years addressing differences in salary/pay rates and employee benefit structures between Wellmont and Mountain States. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.

    Timing: By the end of the first full fiscal year upon closing of the merger.

    Amount: The estimated incremental investment in addressing salary/pay rate differences is approximately $70 million over 10 years.

    Metric: Credible report which shall be provided confidentially in order to preserve a competitive employment environment. Such report will include if there were grievances filed by employees with respect to pay adjustments related to the merger and how the grievances were addressed.

16. **Commitment:** In order to ensure employees are treated fairly in the event there is a facility closure or termination of services related directly and demonstrably to the merger, including any repurposing of facilities in Wise County, Virginia and the independent city of Norton, Virginia, the New Health System will provide to the Commissioner, within two (2) months of closing, a severance policy addressing how employees will be compensated if they are not retained by the New Health System or any of its subsidiaries or affiliates. This policy shall not affect termination of employees if the termination was for-cause or related to the routine operation of such facility. The severance policy shall consider several factors, including but not limited to, each individual's position within his/her current organization and years of service. The policy will also address outplacement support to be provided to any such employee. Compliance with this commitment in Virginia shall be judged solely by the Commissioner and corrective action required for noncompliance shall be determined solely by the Commissioner. This provision shall not be construed to create a right of action for any individual employee.

    Timing: 5 years.

    Amount: Severance cost is estimated to be approximately $5 million from the closing of the merger to the end of the first full fiscal year after the closing of the merger, attributable mostly to corporate level synergies. Severance cost thereafter is not easily calculable due to unknown variables in the market, including ongoing attrition in the workforce as inpatient hospital use rates continue to decline.

    Metric: Confidential annual report for the first five full fiscal years after the closing of the merger reporting on the total number of involuntary employee terminations due to merger-related reductions, the number of such terminations for which severance compensation was paid, and the aggregate cost of such severance compensation. Importantly, it is also recognized that there will be new employment created as the New Health System makes the committed investments in research, academics, new specialties and services and population health. The New Health System may also provide as part of the annual report the number of new jobs created due to such investments, and approximate incremental payroll costs resulting.

17. **Commitment:** In order to invest in the advancement of employees, and to assist employees in achieving growth in their careers, the New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

    Timing: No later than 24 months after closing.

    Metric: Credible report.

18. **Commitment:** In order to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop and implement, in collaboration with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals and in Virginia and Tennessee. The plan will be delivered within

12 months of the closing date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan will also include, but not be limited to, how it will address the Authority's Blueprint access, quality and population health goals, the structure of an ongoing academic collaborative, and how training will be deployed in Virginia and Tennessee based on an evidence based assessment of needs, clinical capacity and availability of programs. Within 45 days of the closing of the merger, the New Health System will have convened the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. Furthermore, and contingent on continued funding for existing programs from federal and state sources, the New Health System will not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area. Notwithstanding the foregoing, minor and temporary decreases in the number of full time equivalent residents working at Virginia hospitals may reflect year-to-year variations in residents applying for such training, dropping out of such training, electing to rotate to other hospitals, or transferring to another residency program, and shall not be deemed to violate this agreement.

Timing: 10 years.

Amount: Combination of commitments 18 and 19 total $85 million.

Metric: Completed convening of the collaborative within 45 days and delivery of 10 year plan within 12 months of merger closing. The plan shall set forth the targeted number of persons to be trained by physician specialty or health care professional category, the location(s) of such training, the schedule for starting such training, and the expected gross annual expenditure relating to such training. In addition, on an annual basis the New Health System will report to the Commissioner: the number of accredited resident positions for each residency program operated in Virginia and the number of such positions that are filled, and shall furnish copies of the relevant pages of the Medicare cost reports showing the number of full time equivalent residents. The annual report shall also include a description of any affiliation agreements moving resident "slots" from one hospital to another pursuant to Medicare rules, resident programs moved from one hospital to another, and new programs started. It is acknowledged that the service area for the New Health System extends across state boundaries and patients, employees, and vendors freely cross those state lines. Accordingly, the Commissioner will not apply a fixed ratio to determine whether each year's expenditure set forth on Exhibit B under commitments number 18 and 19 is appropriately shared in by Virginia. The Commissioner will review expenditures made pursuant to this commitment for adherence to the 10-year plan and the appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

19. **Commitment:** In order to create opportunities for investment in research at Virginia's academic institutions, the New Health System will develop and implement, in collaboration with at least its current academic partners, a 10-year plan for investment in the research enterprise in the Virginia and Tennessee service area. The plan will be delivered within 12 months of the closing

date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan will also include, but not be limited to, how it will address the Authority's Blueprint goals, the structure of an ongoing research collaborative, and the criteria according to which research funding available as a result of the Virginia Cooperative Agreement and Tennessee COPA will be deployed in Virginia and Tennessee based on community needs, matching opportunities, economic return to the region, and overall competitiveness of the research proposals. Within 45 days of the closing of the merger, the New Health System will have convened the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee.

Timing: 10 years.

Amount: Combination of commitments 18 and 19 total $85 million.

Metric: Completed convening of a research collaborative within 45 days and delivery of 10-year plan within 12 months of merger closing. In this plan the New Health System will present a plan for research expenditures for the second and third full fiscal years after the closing of the merger. Thereafter, the New Health System must annually update its plan to address subsequent fiscal years. An annual report should include a description of research topics, the entities engaged in the research, the principal researcher(s) who is/are responsible for each project, any grant money applied for or expected, and the anticipated expenditures. Annual reports for full fiscal years two through ten should report on the outcome of previously reported research projects including references to any published results. The Commissioner will annually review expenditures made pursuant to this commitment for adherence to the most recently updated plan and the appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

20. Commitment: In order to enhance hospital quality, improve cost-efficiency, improve the utilization of hospital-related services, and to enhance opportunities in research, the New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. The New Health System will make access to the IT Platform available on reasonable terms to all physicians in the service area. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, and post-acute care and outpatient services and facilitate the move to value-based contracting. Subject to confidentiality laws and rules, the New Health System will grant reasonable access to the data collected in its Common Clinical IT Platform to researchers with credible credentials who have entered into Business Associate Agreements for the purpose of conducting research in partnership with the New Health System.

Timing: Implementation No later than 48 months after closing.

Amount: Up to $150 million.

Metric: Implementation of promised system with mileposts along the way. The mileposts shall be proposed by New Health System no later than three months after the closing of the merger

or June 30, 2017, whichever is later. The New Health System will report in each annual report its progress toward implementing the Common Clinical IT Platform, and after implementation, any material enhancements or changes. The New Health System will also include in the annual report the researchers (by individual or by group for those working together) who have entered into Business Associate Agreements for purposes of conducting research.

21. **Commitment:** In order to preserve traditionally hospital-based services in geographical proximity to the communities in the Geographic Service Area served by such facilities, to ensure access to care, and to improve the utilization of hospital resources and equipment, all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. "Clinical and health care institutions" may include, but are not limited to acute care hospitals, behavioral health hospitals, rehabilitation hospitals, freestanding emergency rooms, surgery centers, skilled nursing facilities, assisted living centers and any combination thereof. Immediately from the effective date of the merger and during the life of the Cooperative Agreement, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and other investment in outpatient health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. In the event that the New Health System repurposes any acute care hospital, it will continue to provide essential services in the county where currently located. For purposes of this commitment, the following services are considered "essential services":

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

    If an acute care hospital is opened in Lee County, and subsequently fails or ceases to operate, the New Health System will provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System. Such terms must include the appropriate access to space, located within the existing

hospital facility, based upon reasonable terms. If an acute care hospital is not open and operational under a partnership with the Lee County Hospital Authority by December 31, 2018, the New Health System will provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System until such time as a hospital is open and fully operational.

Timing: Ongoing.

Amount: The net cost varies depending on annual operating losses. The current annual operating losses for the predecessors of the New Health System for Virginia hospitals that are losing money are approximately $11 million.

Metric: Each year, the operating results for the Virginia hospitals and sites furnishing "essential services" as defined above will be reported to the Commissioner. The annual report to the Commonwealth will also outline services provided in each community by the hospitals or other sites furnishing "essential services" as specified in this commitment.

22. **Commitment:** In order to ensure preservation of hospital facilities and tertiary services in geographical proximity to the communities traditionally served by those facilities, the New Health System will maintain, for the Virginia and Tennessee service areas, a minimum of the three full-service tertiary referral hospitals located in Johnson City, Kingsport, and Bristol, to ensure higher-level services are available in close proximity to where the population lives.

    Timing: Immediately upon closing of the merger and ongoing.

    Amount: Not applicable.

    Metric: Easily verifiable. The New Health System must report immediately to the Commissioner the closing of any of the above referenced three full-service tertiary referral hospitals and must also report any reduction in the capability of any of the three tertiary referrals hospitals so that they can no longer be credibly viewed as tertiary referral hospitals.

23. **Commitment:** In order to ensure choice of providers for consumers and to ensure physicians are free to practice medicine without any adverse effect from the merger, the New Health System will maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital departments or services as determined by the New Health System's Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.

    Timing: Immediate upon closing of the merger and ongoing, subject to current contractual obligations.

    Amount: No cost.

    Metric: Easily verifiable.

24. **Commitment:** In order to ensure physicians and patients maintain their choice of facilities, and to ensure independent physicians can maintain their independent practice of medicine, the New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.

    Timing: Immediate upon closing of the merger and ongoing.

    Amount: No cost.

    Metric: Easily verifiable.

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

    Timing: Immediate upon closing of the merger and ongoing.

    Amount: No cost.

    Metric: Easily verifiable.

26. **Commitment:** In order to enhance access to services for patients, and to ensure robust choices remain in the market for physicians in the various specialties needed throughout the region, the New Health System will (i) commit to the development of a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by the New Health System. The New Health System will consult with the Authority in development of the plan. (ii) The New Health System will employ physicians and physician extenders primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding. (iii) The New Health System will promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment. These elements will become components of the Rural Health Services Plan for the Geographic Service Area, including aspects of focus in Virginia. The Plan will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The Plan will be focused, along with the Population Health Plan, on managing the burden of disease and breaking the cycle of disease according to the priorities set forth by the Southwest Virginia Health Authority and the Virginia Department of Health. The Plan shall, at a minimum, include the New Health System's approach to the following:
    - Primary Care Services, with a plan for same day access, which may include telemedicine and other technology based access
    - Services to support maternal and prenatal health
    - Pediatrics and regional pediatric specialty access
    - Specialty care and regional specialty care access
    - Access to essential services (as defined under Commitment 21)
    - Improved access to preventive and restorative dental and corrective vision services

- Emergency service access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia EMS Council

The Rural Health Services Plan will account for needed workforce development strategies in consultation with the Southwest Area Health Education Center (AHEC) and regional educational institutions. It will also support the development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops.

Timing: The Rural Health Services Plan will be developed in the first six months after closing and the physician and provider needs assessment will be conducted every 3 years, starting within the first full fiscal year.

Amount: Costs of recruitment related to implementation of the recruitment plan shall be part of the $140 million commitment referenced below in number 27. Expenditures incurred in the development of the community needs assessment and the recruitment plan shall not be credited toward that $140 million commitment.

Metric: Credible evidence of the Rural Health Services Plan, which identifies needs, priorities and recruitment strategies and timelines. The first community needs assessment and physician/physician extender recruitment plan results shall be presented to the Commissioner as part of the Rural Health Services Plan no later than in the annual report submitted after the end of the first full fiscal year after closing of the merger, and thereafter at three (3) year intervals (or more frequently if the plan is amended). In each annual report, the New Health System shall report on progress toward its Rural Health Services Plan goals including the number of recruited physicians by specialty, and related data such as recruitment efforts, interviews conducted, the number of offers extended, and the elements of the Rural Health Services Plan set forth in the commitment above. To the extent that rural service plans identified are not met in 600 days or more (measured at the end of each full fiscal year), the New Health System shall include an explanation of the feasibility of meeting the plan for the unfilled position(s), additional steps, if any, that management believes are appropriate to take, and consideration of alternatives such as building relationships with centers of excellence to improve the availability of the missing specialty to patients in the region. In order to preserve competition, this annual reporting requirement will be treated as confidential.

27. **Commitment:** Enhancing healthcare services:
    a. In an effort to enhance treatment of substance abuse in the region, the New Health System will create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee.
    b. Because improved mental health services is a priority of the Authority and the law, the New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements throughout the Virginia and Tennessee service area.

c. As part of the priority of preserving hospital services in geographical proximity to the communities traditionally served by the facilities, and to ensure access to care, the New Health System will develop pediatric specialty centers and Emergency Rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes.

Timing: A Behavioral Health Plan, encompassing items a. and b. above, will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The Behavioral Health Plan will also consider the goals set forth in the Virginia DMAS Addiction and Recovery Treatment Services program and the Community Service Boards in the Virginia Geographic Service Area. A Children's Health Plan, encompassing item c. above, will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. Some elements of the Children's Health Plan may also be included in the Rural Health Services Plan.

Amount: $140 million over 10 years including physician recruitment referenced in number 26 above.

Metric: The New Health System will include in the annual report for the second full fiscal year the plan for enhancing healthcare services, and in that report and each following, shall include in the annual report progress in implementing the plans and expenditures made.

28. **Commitment:** To enhance population health status consistent with the regional health goals established by the Authority and the Virginia Department of Health, the New Health System will invest not less than $75 million over ten years in population health improvement for the Geographic Service Area, consistent with the regional annual incremental spending amounts in Exhibit B. The distribution of the funding across the total population of the GSA shall consider the relative population of the counties and communities within the GSA, the relative per-capita cost of interventions within each community and the relative value of the intervention towards improving overall population health. Of this amount, the New Health System will commit to spending an amount necessary to support the creation of at least one regional Accountable Care Community organization. The New Health System will take the lead to formally establish this ACC. The ACC's membership will include members of the New Health System, the Authority, and other local, state or federal agencies, payers, service providers and community groups who wish to participate. Within 90 days of the closing of the merger, the New Health System will recruit and convene the ACC's initial leadership team to help develop the Population Health Plan. After consultation with the ACC and within 6 months of closing, the New Health System will submit to the Commissioner a Population Health Plan to improve the scores of the Southwest Virginia population on these measures. The Plan will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The submission of the Plan, the process measures associated with the implementation of each component, and the achievement of population health improvement for each measure, will be evaluated according to the index

scoring methodology described in the New Health System's Quantitative Measures and Scoring Mechanism. A draft set of Quantitative Measures and associated scoring is submitted as Exhibit A.

No later than six (6) months after the merger closing, the New Health System will establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing the Population Health Plan and improving the overall health of the GSA population. This department shall be shall be staffed with leaders charged with financial compliance, physician relations and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the NHS Board of Directors.

The New Health System is committed to pursuing an approach in Southwest Virginia which focuses on a limited number of interventions that will have a disproportionate impact on breaking the cycle of poor health and reducing the future burden of disease. These interventions will be consistent with priorities set forth in the Authority's Blueprint for Health Improvement and Health-Enabled Prosperity and Virginia's Plan for Well-Being. Quantitative Measures will be established for each intervention as informed by the Technical Advisory Panel process with final approval by the Commissioner of Health.

Timing: 10 years.

Amount: $75 million.

Metric: The submission of the Population Health Plan, the process measures associated with the implementation of each component, and the achievement of population health improvement for each measure, will be evaluated according to the index scoring methodology described in the New Health System's Quantitative Measures and Scoring Mechanism. A draft set of Quantitative Measures and associated scoring is submitted as Exhibit A.

Discussion: The expenditures of $75 million throughout the region have the greatest positive impact only if those dollars are spent in a prioritized way in collaboration with the state health plan and the regional priorities as established by the Authority, and in partnership with efforts already underway through community based assets.

29. **Commitment:** In support of the Authority's role in promoting population health improvement under the Commonwealth's Cooperative Agreement with the New Health System, the New Health System shall reimburse the Authority for costs associated with the various planning efforts cited above in an amount up to $75,000 annually, with CPI increases each year. No reimbursable costs shall be paid toward compensation for any member of the Authority's Board or Directors.

Timing: Annual.

Amount: Up to $75,000 annually as part of the $75 million for population health improvement, with annual CPI increases.

Metric: Reimbursement is made or is not made. All amounts paid to the Authority shall be included in the annual report submitted to the Commissioner.

30. **Commitment:** Best practice governance of the New Health System is critical to the success of the efforts outlined in the Cooperative Agreement. As such, the Board of Directors of the New Health System will operate such that each Board member must exercise the Duty of Care, Loyalty and Obedience to the New Health System required by law, and all Board members must adhere to the strict fiduciary policies established by the Board. It is recognized that governance of the New Health System should reflect the region, including both Virginia and Tennessee. As such, the New Health System makes the following commitments related to governance:
    - At closing, three members of the 11-member Board of Directors will be Virginia residents. After the second anniversary of the closing of the merger creating the New Health System, not less than two members of the Board shall be Virginia residents;
    - The New Health System will ensure membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce; and
    - The New Health System will ensure than not less than 30 percent of the composition of the Community Benefit/Population Health committee will reside in Virginia (committee will be the Board committee responsible for the oversight of the compliance of the Cooperative Agreement).

    Timing: Ongoing.

    Amount: No dollar cost.

    Metric: Easily verifiable.

31. **Commitment:** The New Health System expects that the conditions under which the Cooperative Agreement is granted will be set forth in an order issued by the Commissioner, and it is expected an annual report will be required by the Commissioner. Any report will be attested to by the appropriate leadership of the New Health System, including the Senior Executive.

    Timing: Annual.

    Amount: No material cost.

    Metric: Receipt of compliant report.

32. **Commitment:** The New Health System will provide information on a quarterly basis of the key financial metrics and the balance sheet comparing performance to the similar prior year period and year to date. This information will be provided on the same timetable as what is publicly reported through EMMA (Electronic Municipal Market Access).

Timing: Annual and quarterly.

Amount: No material cost.

Metric: Easily verified.

33. **Commitment:** The New Health System will adhere to Exhibit 12.1 setting forth relevant considerations and the process for closing a facility should it be necessary. This policy will remain in effect unless the change is agreed to by the Commissioner.

    Timing: If closing a facility is considered.

    Amount:

    Metric: Annual report will provide evidence of compliance with policy.

34. **Commitment:** The New Health System shall create, together with the Southwest Virginia Health Authority, a Joint Task Force comprised of four members, two from the New Health System and two from the Southwest Virginia Health Authority. The Task Force shall meet at least annually to guide the collaboration between the Authority and the New Health System, and to track the progress of the New Health System toward meeting the commitments of the Cooperative Agreement and shall report such progress to the Authority. The Task Force shall be chaired by a member of the Authority. The members appointed by the Authority may not have a conflict of interest.

    Timing: Immediate upon closing of the merger.

    Amount: No cost.

    Metric: Creation of a Joint Task Force.

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

36. **Commitment:** The New Health System will not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.

37. **Commitment:** In order to support access to needed services and benefit Virginia Medicaid patients, where it offers addiction recovery services serving Virginia residents, the New Health System will participate in the Virginia DMAS Addiction and Recovery Treatment Services Program.

    Timing: As soon as practicable

    Metric: Easily verifiable

38. **Commitment:** In order to ensure that physician leadership is the core of the Ballad Health clinical enterprise, the New Health System shall establish a system-wide, physician-led clinical council (the "Clinical Council").
    i. The Clinical Council shall be composed of (A) Independent Physicians, (B) Employed Physicians, (C) the Chief Medical Officer of the New Health System and (D) a Chief Nursing Officer of one of the COPA Parties. The Clinical Council shall include representatives of the New Health System's management but the majority will be composed of physicians.
    ii. The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.
    iii. The Chair of the Clinical Council shall be a physician member of the active medical staff(s) of one or more NHS Entities chosen by members of the Clinical Council. The Chair shall serve on the Quality, Service and Safety Committee of the Board of the New Health System and shall provide ongoing reports on the activities of the Clinical Council through the Quality, Service and Safety Committee of the Board.
    iv. The Clinical Council shall be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review when appropriate and quality performance standards and best practices requirements for the New Health System, all of which shall be documented as applicable and required by the Commissioner.
    v. The Clinical Council shall also provide input to the New Health System on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System.
    vi. The Clinical Council shall advise the Board of Directors of the New Health System on target quality measures based on quality improvement priorities of the New Health System.

    Timing: Within six months after closing

    Amount: Minimal cost

    Metric: Annual reporting of activities and progress

39. In order to ensure that Virginia Medicaid patients will continue to be served by the New Health System, (a) the New Health System will continue to treat VA Medicaid beneficiaries in Tennessee hospitals and other NHS facilities, and (b) the New Health System will accept and participate in all Medicaid managed care plans such as Medallion Three, CCC, and CCC Plus. In addition, for Virginia DMAS beneficiaries, the New Health System will continue pre-admission screening at the New Health System hospitals for long-term care.

    Timing: Immediately upon closing of the merger.

    Amount: No cost.

    Metric: Easily verifiable.

40. To ensure the Cooperative Agreement addresses the measurement focus areas set forth in the Virginia Cooperative Agreement regulations, the New Health System proposes the Quantitative Measures in the attached Exhibit A, including the associated scoring and weighting mechanisms set forth in Exhibit A, and commits to fulfill the Quantitative Measures set forth in Exhibit A. The New Health System acknowledges that final Quantitative Measures applicable to the Cooperative Agreement will be developed in accordance with the provisions of the Virginia Cooperative Agreement regulations, 12VAC5-221-10, *et seq.*

41. In order to ensure that the Virginia operations are allocated an appropriate amount of the New Health System's ongoing and annual compliance costs, the New Health System agrees to adopt an allocation methodology that takes into account the differences in ongoing and annual compliance requirements between the State of Tennessee and the Commonwealth of Virginia.

A. Revision of Commitments – Recommendations by the Authority to the Commissioner

These commitments have been negotiated and drafted with the intent of them remaining in place for ten (10) years. Nevertheless, there may be changes in circumstances that arise, including but not limited to, a Material Adverse Event, which affect the feasibility or the meaningfulness of the commitments and which are not possible to foresee presently. For example,[1] a major structural change to the federal payment system could, depending on how it is implemented, materially change both the needs of the region and the New Health System's ability to meet those needs. Other events which may have a material effect include, but are not limited to, substantial and material reductions in federal reimbursement, repeal of Certificate of Public Need, labor shortages causing significant and material increases in labor expense, significant reductions in inpatient hospital use rates which cause a material decrease in revenue (and which may be demonstrated to reduce the total cost of care), or an act of God. It is the interest of the Commonwealth that the region's hospitals maintain their financial viability, that they are of sound credit worthiness and that they are capable of reinvesting capital. Accordingly, if the New Health System produces evidence that changes in circumstances have materially affected its ability to meet the commitments and that its inability is not affected by deficiencies in management, either the Commissioner or the New Health System may petition the other to amend the commitments to reduce the burden or cost of the commitments to a level that may be more sustainable. In the event that the New Health System petitions the Commissioner for amendment of the Cooperative Agreement, the Commissioner may require the New Health System to engage an independent consultant to prepare a report validating that the changes in circumstances have adversely affected the New Health System, the extent to which this has occurred, and validating that the changes in circumstances are not related to the effectiveness

[1] These are examples only and are not intended to be exclusive basis for amending the agreement, but simply as an illustration of a possible change in circumstances that may have a material impact.

of management. The cost of such an independent consultant engagement shall not exceed $250,000 (as adjusted by the CPI from the date of the closing of the merger). The amendment process should not be used to increase the overall level of burden or cost on the New Health System, although the parties acknowledge that depending on the change in circumstance, measuring the change in the level of burden or cost may be subject to reasonable ranges and disagreement of the impact within a range. If either party petitions for amending the commitments and the parties cannot come to agreement, the parties shall agree on a dispute resolution process in order to reach agreement.

B. Ten-Year Review of Cooperative Agreement – Recommendations by the Authority to the Commissioner

These commitments have been created with the intent of them remaining in place for ten (10) years. Before the end of calendar year 2026, the New Health System and the Commissioner shall review how well the formation and operation of the New Health System has served the overall interests of Virginians and Virginia businesses in the area. That review will consider all the elements set forth in Section 15.2-5384.1, Code of Virginia, and will also consider New Health System's profitability. It is the opinion of the Authority that the citizens of the region and the Commonwealth are well-served when the health system generates the resources necessary to be sustainable, of good credit, and capable of meeting its commitments as a community-based health system in the region. It is the hope of the Authority that the New Health System achieves financial sustainability that exceeds national or regional averages. If, however, it appears negotiated payment rates to the New Health System have increased more rapidly than national or regional averages for comparable health systems, new or additional commitments may be appropriate. Conversely, if the New Health System is unable to attain sufficient profitability notwithstanding effective management, reducing the burden of the commitments would be appropriate. Likewise, if the New Health System is not maintaining its support of population health, subsidizing money-losing services, medical education, research, and physician recruitment, new commitments may be appropriate. In the event that an extension of the existing cooperative agreement or negotiation of a new or amended agreement is not achieved, the Commonwealth should withdraw its support for the cooperative agreement.

Exhibit A

Virginia Quantitative Measures

Exhibit B

Regional Monetary Commitments Under the Virginia Cooperative Agreement and Tennessee COPA

EXHIBIT B
REGIONAL MONETARY COMMITMENTS UNDER THE VIRGINIA COOPERATIVE AGREEMENT AND TENNESSEE COPA

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Expanded Access to HealthCare Services	Behavioral Health Services	$1,000,000	$4,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	**$85,000,000**
	Children's Services	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**27,000,000**
	Rural Health Services	1,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**28,000,000**
Health Research & Graduate Medical Education		3,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**85,000,000**
Population Health Improvement		1,000,000	2,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**75,000,000**
Region-wide Health Information Exchange		1,000,000	1,000,000	750,000	750,000	750,000	750,000	750,000	750,000	750,000	750,000	**8,000,000**
Totals		$8,000,000	$17,000,000	$28,750,000	$33,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	**$308,000,000**

Attachment D

ARTICLE V

MANAGED CARE CONTRACTS AND PRICING LIMITATIONS

5.01. General. During the COPA Term, the New Health System shall fulfill the obligations, commitments and covenants set forth in this Article V, which are intended generally to minimize any adverse impact caused by the Affiliation, on the ability of Payors to negotiate appropriate payment and service arrangements with the New Health System, and to ensure that post-Closing pricing is fair to both consumers and Payors.

5.02. Health Plan Negotiations and Restrictions.

(a) For Payor Contracts which are repriced, renegotiated or executed post-Closing, the terms of Addendum 1 attached to these Terms of Certification, entitled "COPA Managed Care Contract Pricing Limitations," shall govern all pricing during the COPA Term. The Chief Financial Officer of the New Health System shall certify the New Health System's compliance with the terms of Addendum 1 in each Annual Report.

(b) The New Health System shall negotiate in good faith with all Payors to include the New Health System in health plans offered in the Geographic Service Area, and the New Health System shall comply with the provisions of Addendum 1 when negotiating and executing contracts with Payors. The New Health System shall agree to resolve, through mediation, any disputes in health plan contracting with Payors. The New Health System shall promptly notify the Department of any mediation occurring pursuant to this commitment and shall update the Department on the progress of such mediation. If mediation is not successful, then the New Health System shall proceed to arbitration with the Payor as set forth in Section 5.08.

(c) The New Health System shall not unreasonably refuse to negotiate with potential new Payor entrants to the market or Payors that have small market shares.

(d) The New Health System shall not make it a condition of contracting or otherwise request that it be the exclusive network provider to any Payor.

(e) The New Health System shall not bargain for or insist upon anti-tiering or anti-steering clauses in any Payor Contracts.

(f) The New Health System shall attempt to include in Payor Contracts provisions for improved quality and other value-based incentives based upon priorities agreed upon with each Payor, and such provisions shall be commercially reasonable.

(g) The New Health System shall not include as a condition in any Payor Contract a requirement that a Payor shall (i) not contract with other providers or hospitals in the Geographic Service Area, or in

any county contiguous thereto, or (ii) exclusively contract with any or all affiliates of the New Health System.

(h) The New Health System shall also be prohibited from entering into an exclusive arrangement with a sole healthcare provider of any service in the Geographic Service Area without prior approval from the Department. Hospital-based physicians including anesthesiologists, radiologists, pathologists, emergency department physicians, radiation oncologists, pediatric specialties (including neonatology and intensivists), behavioral health physicians and extenders, and hospitalists are excepted from this requirement.

(i) The New Health System shall not restrict the ability of physicians to see their patients admitted to a COPA Hospital.

(j) Except for Integrated Solutions Health Network, LLC, the New Health System shall not contract with Payors on behalf of any Independent Physicians. Notwithstanding the foregoing, nothing herein shall prohibit any NHS Entity from contracting on behalf of Independent Physicians in a clinically integrated network agreement in compliance with federal antitrust laws.

(k) The New Health System shall not bargain or insist on "most favored nations" or similar clauses in Payor Contracts.

(l) The New Health System shall be prohibited from owning, operating, controlling, or licensing any health plan.

5.03. Managed Care Contract Terms.

(a) The New Health System shall honor all Payor Contract terms and not unilaterally terminate without cause any such contract prior to its stated expiration date.

(b) If either the New Health System or any Payor terminates a Payor Contract, the New Health System shall be subject to the pricing limitations in Addendum 1. That is, Addendum 1 applies, with the increased pricing limitation, even if the New Health System goes out-of-network with a Payor. In such event, there shall be no balance billing of patients over and above the amounts set forth in Part XII(e) and (f) of Addendum 1.

(c) The New Health System shall negotiate with Payors in good faith and shall attempt in good faith to contract with all Payors that offer terms on a capitated basis, percentage of premium revenue basis or on other terms that require the New Health System to assume risk.

5.04. Competing Services.

(a) The New Health System shall compile with respect to each COPA Hospital a list of Ancillary Services and Post-Acute Services offered at the applicable time by providers competitive with the New Health System, including at least three (3) competitors for each category of service, if, to the Knowledge of the New Health System, such competitors exist in the county in which such COPA Hospital is located

or in any contiguous county thereto. The New Health System shall send all such lists to the Department and the COPA Monitor within thirty (30) days of the Issue Date, and thereafter shall provide the COPA Monitor an updated version of such lists on a quarterly basis.

(b) If a discharged patient, whether an inpatient or outpatient, needs Ancillary Services, Post-Acute Services or other follow-up medical services or supplies at the time of discharge, then the applicable COPA Hospital (via its employees, contractors, and medical staff) shall comply with federal laws governing patient choice. Such COPA Hospital shall not engage in the regular practice of guiding or directing patients to providers (not covered by federal laws governing patient choice) in which any NHS Entity has a material financial or governance interest without first providing to such patients the current list of Ancillary Services and Post-Acute Services referred to in Section 5.04(a). Notwithstanding the foregoing, to the extent the New Health System is engaged in risk-based, value-based or shared savings arrangements with Payors, the New Health System may coordinate care within its network of services to ensure continuity of care and lower cost.

(c) The New Health System shall not oppose the award of a certificate of need in the Geographic Service Area of any healthcare provider seeking to provide inpatient or outpatient or any other services similar to or which compete with the services provided by the New Health System, unless such applicant for the certificate of need does not consistently accept inpatient Medicaid patients or uninsured patients. In the event the New Health System desires to oppose an application for a certificate of need in the Geographic Service Area, the New Health System shall prepare the relevant materials opposing such application and deliver such materials to the COPA Monitor. The COPA Monitor shall deliver the relevant materials to the Department for its consideration, and such materials shall be included within any administrative record.

5.05. Physician Services.

(a) The New Health System shall not contractually or otherwise restrict physicians or other healthcare providers from performing services outside the New Health System, except as set forth in this Section 5.05(a). Except for Employed Physicians and mid-level physician extenders employed or controlled by an NHS Entity, the New Health System shall release, upon Closing, any physician, non-physician employee, mid-level extender, or other affiliated healthcare provider from any covenant not to compete or similar restriction in favor of any NHS Entity. The New Health System shall not thereafter seek to obtain or enforce (as the case may be) any covenant not to compete from any such person or entity, except any Employed Physician or mid-level physician extender employed or controlled by the New Health System, and then only during the term of his or her employment. Nothing in this Section shall require the New Health System to release any such person or entity from a covenant (i) not to solicit the New Health System's employees, or (ii) not to misappropriate trade secrets or confidential information. Further, the New Health System may reasonably require (A) Employed Physicians and (B) physicians under contract for medical directorships or co-management agreements to keep strictly confidential any competitively-sensitive information about the New Health System.

(b) The New Health System shall not prohibit any Independent Physicians with staff privileges at the New Health System from participating in any networks, health plans, or Payor Contracts.

(c) The New Health System shall not require any physician, or group of physicians, or other healthcare providers other than Employed Physicians and mid-level physician extenders employed or controlled by an NHS Entity, to render services only at the New Health System, except as provided in Section 5.02(h). The New Health System may petition the Department for approval to enter into exclusive contracts with any other physicians and specialists, but if approved, no specialty contract shall have a term exceeding three (3) years.

(d) The New Health System shall provide an open medical staff offering equal access to all qualified physicians according to the criteria of the Joint Commission and the medical staff bylaws.

(e) No more than thirty-five percent (35%) of the physicians practicing in any specialty at any COPA Hospital that is not a Rural Hospital at any time may be Employed Physicians. This thirty-five percent (35%) limit shall not apply to the hospital-based physicians listed in Section 5.02(h). In the interest of continued access to services, the Department agrees to waive this requirement for specific specialties upon issuance of the COPA provided that (i) the New Health System provides to the Department a list of each specialty in which the New Health System exceeded this percentage limitation as of the Approval Date, and (ii) there have been no additional hires in any such specialty since the Approval Date. Thereafter, the New Health System may apply to the Department for any exceptions to this requirement. In calculating this percentage, the Department will account equitably for physicians practicing at multiple COPA Hospitals. In no event should the number of Employed Physicians in any specialty reach a level that would materially and adversely affect existing competition.

(f) The New Health System shall provide an open medical staff at each NHS Entity, ensuring equal access to all qualified physicians in the Geographic Service Area according to the criteria of the Joint Commission and the medical staff bylaws of each such entity.

(g) Independent Physicians with privileges at any NHS Entity may obtain privileges at other hospitals or providers and join competing networks or health systems, or health insurance networks, and not jeopardize their privileges at any NHS Entity. Any action with respect to their privileges taken by an NHS Entity shall be based upon the provisions of its medical staff bylaws which govern quality of care and appropriate peer governance.

5.06. Vendor Contracts.

(a) The purchase of equipment and supplies used at the New Health System shall be made with the goal of effectuating the lowest cost consistent with required quality, compatibility and efficiency.

(b) The New Health System shall not bargain for or insist upon restrictions upon its suppliers, vendors or group purchasing organizations preventing or impairing such persons from doing business with entities that compete with the New Health System.

(c) The New Health System shall not require that any vendor include a "most favored nations" or similar clause in contracts. Nothing herein, however, is intended to prohibit the New Health System from entering into group purchasing organization contracts and other joint purchasing agreements that include "most favored nations" clauses as standard provisions thereof.

5.07. Communication with Payors.

(a) Prior to initiating negotiations, the New Health System shall provide, in either electronic or hard copy form, a complete copy of these Terms of Certification to all Payors negotiating Managed Care Contracts with the New Health System.

(b) The Department, as part of its Active Supervision, will investigate complaints from Payors regarding the Managed Care Contracting process and resulting prices, and the Department may take appropriate Corrective Action as a result of any anti-competitive, unreasonable, or bad faith actions on the part of the New Health System.

5.08. Arbitration. Notwithstanding Section 9.11(c), if a Payor and the New Health System cannot agree on rates or any other contract terms, and mediation fails to resolve the dispute, the Department reserves the right to require the New Health System to participate in "Final Offer Arbitration" with the Payor unless the Department agrees to an alternative manner of arbitration. Costs and reasonable attorneys' fees of the arbitration would be awarded to the prevailing party of the arbitration if "Final Offer Arbitration" or other types of arbitration are utilized.

5.09. Economic Sub-Index. The New Health System's ongoing compliance with the provisions of this Article V and Addendum 1 shall constitute Measures within the Economic Sub-Index.

ADDENDUM 1

COPA MANAGED CARE CONTRACT PRICING LIMITATIONS

AND EXCESS PAYMENT TESTING

PART I

DEFINITIONS AND GENERAL

1.1 Definitions

In addition to the terms defined in Article I of the Terms of Certification to which this is attached, and terms defined elsewhere in this Addendum 1, the following definitions shall apply to this Addendum 1:

"Allowed Amount" – The amount a Payor will pay for a covered medical service, supply or item after adjustment for any contractual allowance or discounts with a healthcare provider. The Allowed Amount includes the amount due from both the Payor as well as the patient via the cost-sharing provisions of a patient's health plan.

"APC" – Ambulatory Payment Classifications, a grouping of HCPCS Codes established by Medicare to determine the payment amount for services or items with similar costs.

"APC Relative Weights" – The value or weighting factor assigned to each APC by either Medicare or a Payor. Sometimes also referred to as "APC Weights."

"Contract Year" - With respect to any Large Network Payor, the one year period beginning on the effective date of its Managed Care Contract with the New Health System, or on the effective date of any renewal year thereafter.

"Cumulative Hospital Inflation Adjustment" - The compounded increases of the Hospital Inflation Adjustments from 2017 through the end of the Contract Year or Fiscal Year, as applicable, for which Allowed Amounts are to be compared to the applicable Payment Indices.

"Cumulative Physician Inflation Adjustment" - The compounded increases of the Physician Inflation Adjustments from 2017 through the end of the Contract Year or Fiscal Year, as applicable, for which Allowed Amounts are to be compared to the applicable Payment Indices.

"DRG Methodology" – Payment methodology which classifies inpatient hospital discharges into Diagnosis Related Groups ("DRGs") based upon diagnoses, procedures, complications, comorbidities, age and other factors.

"DRG Weights" – The value or weighting factor assigned to various DRGs by Medicare or a Payor.

"Hospital Inflation Adjustment" or ("HIA") – For the year being tested, the most recently available annual inpatient percentage of increase by Medicare, commonly referred to as the Market Basket and reported by CMS in the Federal Register as part of the Final Rules of the Inpatient Prospective Payment System, plus 0.25 percent. The HIA will not include the multifactor productivity adjustment, statutory adjustment, adjustments for failure to be a meaningful electronic health record user or failure to submit quality data, or any other positive or negative adjustments required by law or regulation. Effective October 1, 2017, the Market Basket is 2.70 percent.

HIA will also include for Payors, who do not offer a quality component in their fee schedules or payment structures at least equal to the adjustment in the schedule below, an additional payment ("Quality Adjustment Factor"). If a Payor does not offer as part of its fee schedules or rate structures a payment for quality or pay-for-performance incentives, the HIA will be increased based upon the difference between the schedule below and the quality component offered by the Payor.

Contract Year Beginning	Adjustment for Absence of Quality
2018	1.25%

The HIA shall be applied to hospital inpatient and outpatient services and ambulatory surgery center services rendered by the New Health System.

"Large Network Payor" – A Payor which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges ("Gross Revenue") for the New Health System. The same Payor may have several networks, each of which utilize different fee schedules, and each of which could constitute 2% or more of the Gross Revenue; each network attaining the 2% threshold would constitute a separate Large Network Payor. Conversely, several Payors may only constitute one network, because they use a common fee schedule. An example would be PHCS Multiplan.

"Payment Indices" - The indices of 2017 Allowed Amounts which were established for pre-Closing pricing, adjusted as provided herein.

"Physician Inflation Adjustment" – The Hospital Inflation Adjustment without the Quality Adjustment Factor.

Medicare's annual physician market basket update factor is currently limited by law to 0.50. When and if Medicare begins using an inflation-based update to the physician fee schedule, the Physician Inflation Adjustment used herein will be the Medicare physician market basket rate of increase plus 0.25 percent.

"RVUs" (Relative Value Units) –Weighting factors which are used to establish a relative value scale in which the value of physician work for a particular service is rated relative to the value of work for other physician services.

1.2 Compliance with Managed Care Pricing Limitations

In order to protect patients, employers, Payors and others who utilize the services of or contract with the New Health System, this Addendum 1 shall provide for limits upon, measurement, and reporting of price increases for specific services, including hospital inpatient and outpatient, non-hospital outpatient, physician and physician extender, charge-based and cost-based services. See Tenn. Code Ann. § 68-11-1303(e)(3)(A)-(C). The pricing limitations set forth herein shall apply to both existing Managed Care Contracts which are renegotiated, repriced, or terminated post-Closing, as well as any future Managed Care Contracts created and executed post-Closing with new Payors. The pricing limitations set forth herein are in addition to the COPA Parties' other commitments set forth in Article V of the Terms of Certification.

1.3 Payment Indices and Excess Payment Testing

For Payors, the New Health System shall establish and report to the Department the Payment Indices which can be compared to post-Closing Allowed Amounts from the same Payors in order to determine whether the New Health System's pricing has impermissibly increased. If the New Health System's post-Closing pricing increases to the point of becoming an "Excess Payment," as defined below, a refund of such payments will be repaid to the Payor(s) and patients at issue.

1.4 Payors' post-Closing Allowed Amounts Shall be Measured Against the Payment Indices

(a) Annual comparisons of pre-Closing and post-Closing pricing for Large Network Payors shall be measured against the Payment Indices. Other Payors which shall also be measured against the Payment

Indices are all commercial Payors, Medicare Advantage Payors, Tennessee Medicaid Payors (including TennCare), and Virginia Medicaid Payors which do not qualify as Large Network Payors but nevertheless negotiate rates of payment with the New Health System. Such Payors shall be hereinafter collectively referred to as "Small Commercial Payors," "Small Medicare Advantage Payors," "Small Tennessee Medicaid Payors," and "Small Virginia Medicaid Payors" respectively. Large Network Payors, Small Commercial Payors, Small Medicare Advantage Payors, Small Tennessee Medicaid Payors, and Small Virginia Medicaid Payors are referred to collectively as "Measured Payors".

(b) Comparisons of Payment Indices to post-Closing Allowed Amounts shall be performed individually for each Payor that constitutes a Large Network Payor. Allowed Amounts for each of the Small Commercial Payors, Small Medicare Advantage Payors, Small Tennessee Medicaid Payors, and Small Virginia Medicaid Payors shall be added together within these respective four (4) groupings for purposes of calculating the Payment Indices as well as measuring post-Closing pricing. The Allowed Amounts for Payors within these four (4) groups will be aggregated together, because each individual Payor within the respective groupings will have a relatively small percentage of the market share. Allowed Amounts shall include outlier payments. Accordingly, Payment Indices and/or post-Closing pricing comparisons thereto could be skewed by small sample sizes. Should any Small Commercial Payor, Small Medicare Advantage Payor, Small Tennessee Medicaid Payor, or Small Virginia Medicaid Payor obtain enough market share to become a Large Network Payor, such Payor will be individually tested along with other Large Network Payors. If any Payor becomes a Large Network Payor, the Large Network Payor test shall be applied to the first Contract Year with at least six months of experience after being deemed a Large Payor Network. If a Large Network Payor is determined to no longer be a Large Network Payor during a Fiscal Year, such Payor shall be included in the applicable small Payor group for the first full Fiscal Year after such Payor is no longer a Large Network Payor.

(c) The baseline Payment Indices will be increased each year, by any amount of increase in a negotiated contract entered into prior to the Closing. For any such existing contract that is renegotiated, repriced or terminated after the Closing, the increased baseline amount will be increased by the Cumulative Hospital Inflation Adjustment effective on such renewal date. In addition, Allowed Amounts tested against the Payment Indices shall not include payments to the COPA Hospitals for achieving quality metrics, so long as quality payments are reported to the Department.

(d) Notwithstanding anything in this Addendum 1 to the contrary, with respect to any Contract Year, if a Large Network Payor and the New Health System agree on an alternative methodology for measuring compliance by the New Health System with the limitations on rate increases set forth herein, the New Health System shall use that agreed methodology for such year.

(e) Notwithstanding anything in this Addendum 1 to the contrary, if a Large Network Payor and the New Health System certify to the Department that for any Contract Year the New Health System has complied with the requirements of this Addendum 1, the comparisons and reporting with respect to such Large Network Payor shall be deemed to have been satisfied for such Contract Year.

PART II

INPATIENT SERVICES

2.1 Inpatient Payment Indices and Inpatient Payment Deviation

The New Health System shall calculate and establish Payment Indices for the New Health System of 2017 Allowed Amounts for inpatient services on a case mix adjusted basis per hospital discharge ("Inpatient Payment Indices"). Calculations and Payment Indices will be presented to the COPA Monitor for review and approval. The deviation of post-Closing average adjusted inpatient pricing per unit of DRG Weight from the Inpatient Payment Indices as increased by the Cumulative Hospital Inflation Adjustment, whether greater or lesser, constitutes the "Inpatient Payment Deviation."

2.2 Inpatient Payment Indices and Inpatient Deviation For Large Network Payors

(a) The Inpatient Payment Indices shall be calculated for individual Large Network Payors by dividing the New Health System's 2017 inpatient Allowed Amounts for each Large Network Payor, by the sum of all DRG Relative Weights associated with such Allowed Amounts. The calculations, will provide a 2017 pre-Closing index of the respective Payors' average inpatient price per unit of DRG Weight. The Inpatient Payment Indices for each Large Network Payor shall be calculated as follows:

Each Large Network Payor's

2017 inpatient Allowed Amounts

sum of each Large Network Payor's

2017 Allowed DRG Weights

=

2017 price per unit of DRG Weight

(b) The Inpatient Payment Deviation for each Large Network Payor shall be calculated in two steps as follows:

(i)

Each Large Network Payor's [year being tested] inpatient Allowed Amounts

sum of each Large Network Payor's [year being tested] Allowed DRG Weights

= [year being tested] price per unit of DRG Weight

(ii)

[year being tested] price per unit of DRG Weight - (2017 price per unit of DRG Weight x Cumulative HIA)

= Inpatient Payment Deviation

2.3 Inpatient Payment Indices and Inpatient Payment Deviation For Small Commercial Payors, Small Medicare Advantage Payors, Small Tennessee Medicaid Payors, and Small Virginia Medicaid Payors

(a) The Inpatient Payment Indices shall be calculated separately for each of the four (4) groupings of Small Commercial Payors, Small Medicare Advantage Payors, Small Tennessee Medicaid Payors, and Small Virginia Medicaid Payors by adding all 2017 inpatient Allowed Amounts for all Payors within each of the groupings, and then dividing by the sum of all 2017 DRG Relative Weights associated with each group's Allowed Amounts. Stated differently, all, e.g., Small Commercial Payors will be grouped together and tested collectively. The calculation, which shall be computed for the New Health System, is as follows:

Small [applicable] Payors'

2017 inpatient Allowed Amounts

Sum of Small [applicable] Payors'

2017 Allowed DRG Weights = 2017 price per unit of DRG Weight

(a) The Inpatient Payment Deviations for each of the four (4) groups shall be calculated in two steps as follows:

(i)

Small [applicable] Payors' [year

being tested] inpatient Allowed Amounts

Sum of Small [applicable] Payors'[year being tested] Allowed DRG Weights = [year being tested] price per unit of DRG Weight

(ii)

[year being tested] price per unit of DRG Weight - (2017 price per unit of DRG Weight x Cumulative HIA)

= Inpatient Payment Deviation

2.4 Changes to DRG Weights

The New Health System shall not negotiate changes to DRG Weights with Payors without first notifying the COPA Monitor. The New Health System shall also provide to the COPA Monitor for review and approval an analysis of the impact on revenue resulting from the new DRG Weights and any proposed adjustments to the Payment Indices. The purpose of restricting changes to DRG Weights is to retain the integrity of the calculation above since changes or modifications in DRG Weights could mask increases in pricing. Notification need not be made to the Department for recalibration to DRG Weights implemented by Payors across their entire network of contracted providers in the normal course of business. When DRG Weight changes are made by Payors, such changes will be utilized in the calculations above.

2.5 Calculation of Inpatient Payment Indices and Inpatient Payment Deviation For Measured Payors Which Do Not Utilize a DRG Methodology

For any and all Measured Payors which do not reimburse on a DRG Methodology, the New Health System will nevertheless assign a DRG to such Payor(s)' 2017 discharges (if not already assigned) and will utilize Medicare's DRG Weights, or a specific commercial Payor's DRG Weights agreed upon in advance, in existence in 2017 so that Inpatient Payment Indices can be calculated for such Payors. The New Health System will continue to assign DRG Weights to inpatient services rendered in years subsequent to 2017 so that an Inpatient Payment Deviation can be calculated for the year being tested. When calculating the Inpatient Payment Deviation, the annual Medicare DRG Weights or agreed upon commercial DRG Weights for the year being tested shall be used.

PART III

OUTPATIENT SERVICES

This Addendum 1 is intended to control and limit outpatient pricing using a similar methodology to that set forth above limiting inpatient pricing increases. The APC Relative Weights assigned by Medicare for the relevant HCPCS codes, however, will take the place of DRG Weights for outpatient services. The New Health System shall calculate and establish Payment Indices, for the New Health System as a whole of 2017 Allowed Amounts for outpatient services on a weighted basis per hospital visit ("Outpatient Payment Indices"). The Outpatient Payment Indices shall be provided to the COPA Monitor for review and approval. The deviation of post-Closing outpatient Allowed Amounts calculated on a weighted basis per hospital visit, from the Outpatient Payment Indices as increased by Cumulative Hospital Inflation Adjustment, whether greater or lesser ("Outpatient Payment Deviation"), will be utilized in determining whether post-Closing pricing is excessive.

3.1 Outpatient Payment Indices and Outpatient Deviations for Large Network Payors

(a) The Outpatient Payment Indices shall be calculated individually for each Large Network Payor by dividing the New Health System's 2017 outpatient Allowed Amounts by the sum of all APC Relative Weights associated with such Allowed Amounts. The calculation is as follows:

each Large Network Payors'

2017 outpatient Allowed Amounts

sum of each Large Network Payors'

2017 Allowed APC Relative Weights = 2017 price per unit of APC Weight

(b) The Outpatient Payment Deviation for each of the Large Network Payors shall be calculated in two steps as follows:

(i)

each Large Network Payors' [year

being tested] Outpatient Allowed Amounts

sum of each Large Network Payors' [year being tested] allowed APC Relative Weights = [year being tested] price per unit of APC Weight

(ii)

[year being tested] price per unit of APC Weight - (2017 price per unit of APC Weight x Cumulative HIA)

= Outpatient Payment Deviation

3.2 Outpatient Payment Indices and Outpatient Deviations For Small Commercial Payors, Small Medicare Advantage Payors, Small Tennessee Medicaid Payors, and Small Virginia Medicaid Payors

(a) The Outpatient Payment Indices shall be calculated for Small Commercial Payors, Small Medicare Advantage Payors, Small Tennessee Medicaid Payors, and Small Virginia Medicaid Payors by adding all 2017 outpatient Allowed Amounts for all of the Payors within each of the four groupings, and then dividing by the sum of all 2017 APC Relative Weights associated with each group's Allowed Amounts. The Outpatient Payment Indices shall be calculated as follows:

Small [applicable] Payors'

2017 outpatient Allowed Amounts

sum of Small [applicable] Payors'

2017 APC Relative Weights = 2017 price per unit of APC Weight

(b) The Outpatient Payment Deviation for each of the four groups shall be calculated in two steps as follows:

(i)

Small [applicable] Payors' [year

being tested] outpatient Allowed Amounts

sum of Small [applicable] Payors'

[year being tested] APC Relative Weights = [year being tested] price per unit of APC Weight

(ii)

[year being tested] price per unit of APC Weight - (2017 price per unit of APC Weight x Cumulative HIA)

= Outpatient Payment Deviation

3.3 Calculation of Outpatient Payment Indices and Outpatient Payment Deviations For Outpatient Services Which Do Not Have Assigned APC Relative Weights

(a) Certain outpatient services such as laboratory and therapy do not have an APC or assigned APC Relative Weights by Medicare. Accordingly, for these and any other outpatient services which do not have assigned APC Relative Weights, a substitute (or "proxy") for APC Relative Weights must be utilized in order to calculate the Outpatient Payment Indices and Outpatient Payment Deviations discussed above.

(b) The proxy will be the Tennessee Medicare Part B fee schedule for such services (for hospitals in Tennessee) and the Virginia Medicare Part B fee schedule (for hospitals in Virginia) in effect on January 1, 2017, divided by the APC payment rate published annually in the Federal Register and adjusted for the wage index for the Metropolitan Statistical Area located in the Geographic Service Area ("APC Proxy"). The APC Proxy calculation for the denominator of the Outpatient Payment Indices above is as follows:

2017 Medicare Part B [applicable

Tennessee/Virginia] fee schedule amounts for services for which there is no APC Relative Weight

2017 published Medicare APC payment rate adjusted for applicable urban wage index = APC Proxy

(c) Similarly, when calculating the Outpatient Payment Deviation for services with no APC Relative Weight, the Tennessee and Virginia Medicare Part B fee schedules and the published APC payment rate shall be those in effect on January 1 for the year being reviewed and tested. The APC Proxy calculation to be used in the denominator of the Outpatient Payment Deviation calculations above is as follows:

[year being tested] Medicare Part B [applicable

Tennessee/Virginia] fee schedule amounts for

services for which there is no APC Relative Weight

[year being tested] published Medicare APC payment rate adjusted for applicable urban wage index
= APC Proxy for [year being tested]

The results of these calculations are utilized/combined in the outpatient calculations above.

3.4 Excess Payment and Refunding Payors and Patients

In order to determine if the New Health System's hospital pricing is excessive, both the Inpatient Payment Deviation and the Outpatient Payment Deviation (discussed above) must first be converted to a dollar value for the respective Payor or Payor groups as follows:

[Inpatient/Outpatient] Payment Deviation x [year being tested] sum of Allowed [DRG Weights/APC Weights] for [Large Network Payor/ Small Commercial Payors/Small Medicare Advantage Payors/ Small Tennessee Medicaid/Small Virginia Medicaid Payors]

= [Inpatient/Outpatient] Deviation Dollar Value

The Inpatient Payment Deviation Dollar Value and Outpatient Payment Deviation Dollar Value are then added together. If the sum of the Inpatient Deviation Dollar Value and Outpatient Deviation Dollar Value for the applicable Large Network Payor or small Payor group is positive, then there is an "Excess Payment" from the Payor which must be refunded. This process is referred to herein as "Excess Payment Testing." The refund shall be paid to the applicable Payor(s) as set forth in subsections (a) and (b) below, and to patients as set forth in subsection (c) below. In addition, future Allowed Amounts shall be reduced with the goal of preventing future Excess Payments from recurring. Future Allowed Amounts shall be reduced by the Excess Payment divided by the Actual Payment (sum of Inpatient and Outpatient Dollar Value), after future Allowed Amounts are adjusted for inflation using the Cumulative Hospital Inflation Adjustment and Cumulative Hospital Inflation Adjustment rates for each respective service type.

(a) Large Network Payors. Excess Payment shall be refunded to Large Network Payors according to the following formula:

Inpatient Deviation Dollar Value + Outpatient Deviation Dollar Value

= $ Excess Payment refunded to Large Payor [if a positive number

(b) Small Commercial, Medicare Advantage and Tennessee Medicaid and Virginia Medicaid Payors. The Excess Payment shall be refunded to individual Payors within the Small Commercial, Small Medicare Advantage and Small Tennessee and Small Virginia Medicaid groups of Payors in direct proportion to the percentage of the Allowed Amount which each individual Payor within the groups occupies in relation to the Allowed Amounts of all other Payors. If there is an Excess Payment due and owing to one of the four Payor groups, then the refund shall be issued to each member of the group according to the following formula:

Excess Payment x sum of [year being tested] inpatient and outpatient Allowed Amounts of individual Payor in Small [applicable] Payors

sum of [year being tested] inpatient and outpatient Allowed Amounts of all Payors in Small [applicable] Payors

= $ [Excess Payment refunded to individual Payor in the group of Small [applicable] Payors]

Alternatively, the New Health System may identify the individual Payor(s) from which the Excess Payment originated and direct refunds to that Payor(s) and shall notify the COPA Monitor of such refunds.

(b) Patients. The Excess Payment refunds due Payors in subsections (a) and (b) above shall be first assigned to any specific group(s) of patients determined to have been directly impacted by the Excess Payment, and then further allocated by the New Health System between Payors and patients in direct proportion to the percentage of the Allowed Amounts paid by the Payor and patients respectively. For example, if patients of a particular Payor paid 10% of the Allowed Amounts in the year 2025, they shall receive 10% of the refund due the Payor as a result of an Excess Payment. No refund will be made to a patient who has not actually paid the patient portion of the Allowed Amount.

PART IV

NON-HOSPITAL OUTPATIENT SERVICES

It is the intent of this Addendum 1 to govern, for Measured Payors, all non-hospital outpatient services provided by outpatient diagnostic centers, ambulatory surgery centers, or any other non-hospital outpatient settings for COPA Hospitals and other providers for which the New Health System exercises control or influence over managed care contracting, excluding providers described in Part X(c) below. The New Health System will provide a list of entities that the New Health System does not exercise control or influence over managed care contracting. The COPA Monitor will be immediately notified of any change in the list. Non-hospital outpatient pricing and payment in these settings shall be subject to the same calculations set forth above for hospital outpatient services, with the exception that the non-hospital Outpatient Payment Deviation will not be netted against an inpatient deviation (because there

are no applicable inpatient services against which to net). Thus, a positive non-hospital Outpatient Payment Deviation Dollar Value also equals the amount of any Excess Payment which is due to be refunded to Payors and patients. Determining how much of an Excess Payment is due Measured Payors and patients shall be calculated as set forth above. The New Health System shall not move or convert or shift non-hospital services to hospital services where such service is not hospital based for Medicare without first notifying the COPA Monitor so that indices can be established for such services.

PART V

PHYSICIAN SERVICES

The terms of this Addendum 1 shall apply to services rendered by Employed Physicians, as well as mid-levels, physician extenders and allied health professionals whose practices are owned, controlled, or managed, in whole or in part, by the New Health System, or for which the New Health System receives any portion of the profits or revenue (collectively, "Physician Services"). Physician Services shall be subject to the same indices and Excess Payment Testing and refund process set forth above, except that Physician Services pricing shall be measured in terms of RVUs. In addition, the indices shall be updated every year using the Cumulative Physician Inflation Adjustment. If individual Measured Payors have their own RVUs, then such Payor specific RVUs shall be utilized in lieu of Medicare RVUs.

PART VI

CHARGE-BASED ITEMS OR SERVICES

(a) Certain hospital, physician, ancillary and other healthcare services may be reimbursed on a percentage of a health care provider's charge for such services. Common examples in hospital Managed Care Contracts include, but are not limited to, services not otherwise covered by a Payor's fee schedule and items where the charge may vary based upon the underlying cost such as high cost drugs and implants in the hospital. In addition, some Managed Care Contracts pay for all hospital services based upon a hospital's charges for services. Such contracts often provide for a discount (for example 50%) from a hospital's chargemaster rates for the item or service at issue. This Addendum 1 is intended to place limits upon increases in the New Health System's charges and/or the impact of those increases, upon individuals and entities who utilize the New Health System's services. For hospital inpatient and outpatient, non-hospital outpatient, and Physician Services and any other services billed to Payors based upon charges, the New Health System shall limit the impact of charge increases as set forth below. This provision does apply to outliers for the purpose of adjusting the outlier threshold and any percentage of charge payment. Outlier payments are further tested as part of the Allowed Amounts for the payment indices and payment deviation calculations set forth above.

(b) Charges established in a COPA Hospital chargemaster may be adjusted at the discretion of the New Health System. The New Health System acknowledges, however, that increases in excess of the Hospital Inflation Adjustment will impact contracts which base reimbursement on a percentage of charges and certain cost-based items, discussed below. Accordingly, the New Health System agrees to have its charge increases reviewed each year by the COPA Monitor. The review of the annual charge

increase will consider whether or not the increase applied across the applicable COPA Hospital or varied by department, service or line item. If the charge increase is not applied uniformly across the entire chargemaster, other than cost-based items (addressed below), the New Health System will calculate and implement in its chargemaster a weighted average charge increase by considering the volume of the various departments, service lines or line items and the respective increase in charges. For example, if $10 million of charges is increased 10%, another $10 million is increased 5%, and a third group of $10 million was increased 0%, the weighted average would be 5%. The weighted average charge increase is then compared to the Hospital Inflation Adjustment.

(c) To the extent that the total charge increase exceeds the annual Hospital Inflation Adjustment, the New Health System will be required immediately to report any excess increase to all Payors whose payments are impacted by charges and to reduce the payment to charge ratio so that it does not exceed the Hospital Inflation Adjustment. An exemplar calculation is set forth in Appendix 1. In addition, any payments received which were based upon charges which exceed the Hospital Inflation Adjustment in any year being tested or measured must be refunded on a claim by claim basis, to the respective Payors and patients. See Appendix 1.

(d) This Part VI shall not apply to cost-based items which are addressed below.

PART VII

COST-BASED ITEMS

(a) Some items are reimbursed based upon the cost of the item to the hospital or medical provider ("Cost-Based Items"). Hospitals and other health care providers maintain "mark-up" policies which typically set the charge to Payors as the cost of the item plus some specified mark-up or percentage over and above the cost of the item.

(b) The New Health System agrees to maintain the mark-up policies in effect for the COPA Parties as of January 1, 2017 as the baseline for measuring its post-Closing mark-ups on Cost-Based Items covered by such mark-up policies.

(c) The New Health System agrees not to adjust the mark-up policy without the approval of the COPA Monitor, including adjustments to the mark-up policy which are required to migrate the systems of the COPA Parties to a single system. The New Health System may, however, increase or decrease its charges for items covered by its mark-up policy in effect on January 1, 2017, based upon changes in the underlying cost of a given supply or item (e.g., a drug). Items that have a mark-up based upon a fixed dollar amount (e.g., cost plus $1.00) may change in cost anytime and the fixed price mark-up may also change once per year by an amount not to exceed the Hospital Inflation Adjustment.

(d) The mark-up for cost for Cost-Based Items must remain constant, however, during the COPA Term. If the item is a cost plus a fixed increase, the fixed increase can be adjusted by the Hospital Inflation Adjustment. If the item is cost plus a percentage mark-up, the mark-up percentage must similarly remain constant during the COPA Term. If the increase in the COPA Hospital mark-up exceeds

the Hospital Inflation Adjustment in any given year, a refund is due impacted Payors and patients consistent with Part VI (c) above for Charge-Based Items or services refunds.

(e) Items which are medical devices or supplies which were not covered by a particular COPA Hospital's mark-up policy (by way of example only, new items which did not exist under such policy but are required to be tested for pricing compliance, shall be reported to the COPA Monitor within 90 days of the New Health System furnishing the item.

PART VIII

APPLICATION TO POST-CLOSING MANAGED CARE CONTRACTS

Contracts which the New Health System executes with new Payors post-Closing are governed by the terms of this Addendum 1. The new Managed Care Contracts will be subject to the Excess Payment Testing set forth above. Since new Payors who execute post-Closing contracts with the New Health System will necessarily not have pre-Closing, 2017 payment data available for use as Payment Indices, an alternative methodology must be employed to serve as a substitute for 2017, pre-Closing payment data. For new, post-Closing contracts, post-Closing Allowed Amounts shall be compared to pre-Closing 2017 Allowed Amounts for peer Payors. The New Health System shall propose peer Payors to the COPA Monitor based on factors including contract terms, quality components offered to the New Health System by such Payor, the number of covered lives, the experience of such Payor in other markets, information related to the performance of such Payor, and the financial stability of such Payor. The peer Payors utilized for comparison purposes shall be selected by the COPA Monitor. The first year post-Closing Managed Care Contracts shall be measured for compliance with this Addendum 1 is one complete Contract year after the respective hospitals have operated under such contracts.

PART IX

TIMING FOR REPORTING, AND EXCESS PAYMENT REFUNDS

9.1 Timing for Reporting

(a) Reporting Contracts and Financial Information to the Department. All contracts subject to Excess Payment Testing shall be made available to the Department upon the Department's request. In addition, the New Health System shall timely provide all information needed by the Department to verify the New Health System's calculations including but not limited to: Allowable Amounts from claims data; case mix; admissions and discharge data; DRG Relative Weights; APC Relative Weights; APC Proxy calculations; RVUs; Payor mix; utilization; gross and net revenues by Payor; audited financial statements; and any other information requested by the Department which, in the Department's sole discretion, would be beneficial to the Department in measuring the New Health System's compliance with this Addendum 1.

(b) Reporting Payment Indices. All Payment Indices shall be calculated and reported to the Department by April 30, 2018 or within four (4) months of the Closing, whichever shall occur later.

(c) Reporting of Excess Payment Testing. For Large Network Payors, compliance with this Addendum 1 shall be measured by Contract Year and reported to the COPA Monitor within four (4) months after the conclusion of each full Contract Year after the Closing. For small Payors, compliance with this Addendum 1 shall be measured by the New Health System's Fiscal Year and reported to the COPA Monitor within four (4) months after the conclusion of each full Fiscal Year after the Closing.

(d) Annual Report to the Department. By November 30, 2019, and by each November 30 thereafter during the COPA Term, the New Health System shall provide a report to the Department to include the following information with respect to the Fiscal Year ended in that calendar year:

(i) A summary comparison by COPA Hospital or other applicable healthcare providers affiliated with the New Health System, by Payor and by inpatient and outpatient of price increases from the New Health System to Measured Payors;

(ii) The same report in (i) set forth above, however, showing any price decreases to Measured Payors;

(iii) A summary comparison by Payor and by the relevant the New Health System provider, showing gross revenue and net revenue for Measured Payors;

(iv) A list of any new Payors which executed Managed Care Contracts during each calendar year and a verified certification from the New Health System's Chief Financial Officer that the pricing for such contracts complies with this Addendum 1;

(v) A report showing all charges and charge increases for non-hospital outpatient services, Physician Services, Charge-Based Items and Cost-Based Items for Measured Payors;

(i) A report of chargemaster increases for such year by provider, showing the impact on Measured Payors of such increases to the extent increases require an adjustment described in Part VI or VII above; and

(vi) A summary of all value-based payments, broken out by COPA Hospital and by Payor, and including a comparison of such payments to the prior Fiscal Year's value-based payments from such Payors.

(e) Electronic Format. The New Health System shall provide the foregoing information in electronic format acceptable to the Department including the header level data, revenue level data and required data fields requested by the Department.

9.2 Timing of Refunds

The New Health System shall develop a plan for paying refunds due to Measured Payors and/or patients as a result of Excess Payment Testing, including a reasonable process for addressing small payment amounts, and shall provide such plan to the COPA Monitor within sixty (60) days of identification. Any refunds due and owing to Measured Payors and/or patients as a result of Excess Payment Testing shall

be made within sixty (60) days after such plan is submitted to the COPA Monitor, except as required by applicable law.

9.3 Timing of Fee Schedule Adjustments and Additional Refunds

Any fee schedule adjustments which are necessary in order to prevent any Excess Payments from recurring in the balance of a Contract Year or Fiscal Year, as applicable, shall be made within sixty (60) days after identification. Such fee schedule adjustments shall include any Excess Payment received by the New Health System during the first six (6) months of the Contract Year or Fiscal Year following the applicable year, if during this time, contract prices were not adjusted by the New Health System to account for and prevent Excess Payments. Alternatively, the New Health System may make an additional refund to Measured Payors and patients to account for any Excess Payment received during the first six (6) months of such following Contract Year or Fiscal Year. If the New Health System elects to make an additional Excess Payment refund rather than a fee schedule adjustment, to account for the first six (6) months of such following Contract Year or Fiscal Year, it shall make such additional refund to Payors and patients within sixty (60) days.

9.4 Recurring Annual Deadlines

The deadlines set forth above shall be annual deadlines based upon the Contract Year or Fiscal Year, as applicable.

9.5 Additional Time

If the New Health System needs additional time to perform any of the obligations in this Addendum 1, it may request, in writing, additional time from the COPA Monitor. A request will be considered timely if received by the COPA Monitor within one (1) week of a deadline.

PART X

EXCEPTIONS TO PRICE LIMITATION RULES

The Excess Payment Testing set forth above does not apply to the following:

(a) That portion of Managed Care Contract payments for attaining quality targets or goals, so long as quality or value-based contracts are reported to the COPA Monitor and the COPA Monitor has not objected.

(b) Pass-through items in Payor contracts governed by a COPA Hospital mark-up policy or other method, so long as they are priced consistently with Part VII.

(c) Post-acute care providers such as SNFs, home health agencies, hospices and durable medical equipment providers owned by the New Health System. Because these providers' Payor mixes are primarily governmental, and not negotiated with the New Health System, these providers have been excepted from the terms of this Addendum 1.

(d) Bundled payment items and services in which a COPA Hospital and/or the New Health System as applicable assumes risks for care provided by other providers (such as post-acute care providers like a SNF or home health agency), involving a value-based payment on an episodic basis. Excepting Allowed Amounts and/or payments for this type of risk-based contracting is intended to encourage such contracting. The Parties shall submit the description of bundled payment items and services to the COPA Monitor for review, along with a copy of all related contractual agreements, including the New Health System's base pricing of its services included in the bundle. If such contracting is abused or results in anti-competitive conduct, the Department may take enforcement action.

(e) Items for which the COPA Hospital and/or the New Health System as applicable have accepted risk in the form of a capitated payment or percentage of premiums.

(f) Pharmacies owned or controlled by a COPA Hospital or the New Health System unless the hospital or the New Health System no longer contracts with pharmacy benefit managers, or competition is otherwise reduced in the area of pharmaceuticals or pharmacy services. These services have been excepted, because it is believed that competition exists for these services notwithstanding the Affiliation.

(g) Contract pricing terms which were negotiated pre-Closing. Allowed Amounts which were negotiated with Payors prior to the Closing need not be tested.

PART XI

PERIODIC REVIEW

No later than six (6) months before the end of the fourth anniversary of the Issue Date, the New Health System and the COPA Monitor shall meet to review the application and operation of this Addendum 1 in the maintenance of ongoing Public Advantage. If it appears the New Health System (a) has generated operating margin, as defined by Moody's Investors Service, during one or more of the preceding three (3) years that is above the 75th percentile of health systems rated A+ by Moody's Investors Service, or (b) has generated an average operating margin during one or more of the preceding three (3) years that is below the 50th percentile of health systems rated BBB+ by Moody's Investors Service, then modification of this Addendum 1 may be appropriate. If the New Health System proposes an Addendum 1 modification pursuant to this Part XI, the COPA Monitor shall review and make a recommendation to the Department with respect to the proposed modification. In addition, the COPA Monitor may independently propose an Addendum 1 modification to the Department. The Department may accept, decline or revise any proposed Addendum 1 modification referred to it by the COPA Monitor. The Department, however, shall accept a proposed modification only to the extent the Department determines, in its discretion, that it is necessary to retain, or otherwise not impair, Public Advantage. If any such modification is not agreed upon prior to the beginning of the fifth anniversary of the Issue Date, the Department may consider it a material factor in its Annual Review pursuant to Section 7.02 of the Terms of Certification. Such review of this Addendum 1 shall be repeated every three (3) years thereafter during the COPA Term.

PART XII

GENERAL TERMS

(a) All Payor claims, billing, and other rules will be followed. It is not the intent of this Addendum 1 to supplant contract terms in any COPA Hospital's or the New Health System's Managed Care Contracts other than specifically addressed herein.

(b) Should the New Health System have an Excess Payment for any Payor for two consecutive years, the New Health System agrees to perform a root cause analysis audit and provide a report to the COPA Monitor setting forth its plan to address and prevent future Excess Payments.

(c) With respect to any year in which an Excess Payment occurs, the Department may assess a remedial payment against the New Health System in an amount in the Department's discretion but not to exceed five hundred thousand dollars ($500,000). Any such remedial payment will be paid as directed by the Department.

(d) Neither this Addendum 1 nor any other provision of the COPA or the Terms of Certification creates a private right of action.

(e) The provisions of this Addendum 1 shall apply to any Payor which has a Managed Care Contract with any COPA Party and subsequently goes out-of-network; provided, however, that the Hospital Inflation Adjustment and Physician Inflation Adjustment with respect to such Payor shall be multiplied by two (2x) in the first two (2) years the Payor is out of network and multiplied by one (1x) each year thereafter. Excess Payment Testing with respect to such Payors shall be conducted separately pursuant to Parts II through V above, as applicable.

(f) If a Payor never had a Managed Care Contract with any COPA Party and was therefore never in-network, pricing for services rendered to such Payors and their patients shall be a percentage of charges calculated for the applicable COPA Party (until such time as the New Health System migrates to a single chargemaster) by dividing the payments received for such cases by the corresponding charges for such Payors during calendar year 2017 (the "Never Contracted Out of Network Percentage"). When the New Health System migrates to a single chargemaster, the New Health System shall recalculate the Never Contracted Out of Network Percentage, which shall be approved by the COPA Monitor. The Never Contracted Out of Network Percentage will be reported to the COPA Monitor along with the Payment Indices. The Never Contracted Out of Network Percentage will be adjusted annually in accordance with Part VI.

PART XIII

RESERVATION OF RIGHTS

(a) Notwithstanding the provisions of Part XI, the Department reserves the right to change the price limits included herein from time to time if a Payor does not offer quality-based incentives, or for any other reasonable, and not arbitrary and capricious reason.

(b) Notwithstanding the provisions of Part XI, the Department reserves the right, from time to time, in its reasonable, and not arbitrary and capricious discretion, to change the definitions herein, to add or subtract Payors from Excess Payment Testing, to add or subtract service lines of the New Health System, including but not limited to SNFs or pharmacies, and to otherwise change the measurement indices utilized to compare pre-Closing and post-Closing prices. The Department reserves such right depending upon changes in the utilization, Payor mix, method of reimbursement such as value-based contracts, or for any other reasons which cause the Excess Payment Testing herein ineffective in retaining Public Advantage.

ATTACHMENT 2

CONDITIONS

1. Wellmont and Mountain States shall not discontinue, close, repurpose, merge, or align service lines or facilities, or terminate employees, except for cause, during the period of time between approval of the Application (Approval Date) and the effective date of the Applicants' merger.

2. All conditions imposed in the Order are absolute and are not dependent on the Applicants achieving the actual savings and efficiencies the Applicants envision arising from the merger.

3. The financial investments committed to by the Applicants, in conditions 8, 23, 33, 34, 35, and 36, shall be incremental, monetary obligations that constitute additions to the Applicants' annual baseline spending levels as of the Approval Date in the applicable categories. The Applicants shall provide annual baseline spending levels to the Commissioner at the same time that such information is provided to Tennessee.

4. All plans or other reports required by a condition shall be subject to the review and approval of the Commissioner as follows:

   Acceptance. With respect to each plan to be submitted to the Commissioner for approval, the Commissioner shall approve or propose modification to the plan within 30 days of receipt of the plan. If the Commissioner proposes a modification to any such plan, the New Health System shall have 30 days following receipt of notice thereof to respond. Failure to timely respond to a proposed modification shall constitute acceptance. The Commissioner shall have 15 days following receipt of the New Health System's response to approve or deny the plan. The Commissioner's decision constitutes a case decision pursuant to the Administrative Process Act (Virginia Code § 2.2-4000 *et seq*.).

   Replacement Plans. With respect to each three-year plan, no later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan.

   Modification. Following the approval and adoption of each plan, the New Health System may, from time to time, request a meeting with the Commissioner to discuss possible modifications to any such plan. Such discussions may include, among other things, proposals to revise the timing (but not the aggregate amount) of the spending commitments set forth in Exhibit B of the Applicants' Revised New Health System Virginia Commitments dated October 9, 2017 ("Exhibit B"). The New Health System shall not implement any modification to a plan until such modification has been approved by the Commissioner. To the extent any adopted plan is modified, the New Health System shall accordingly amend and restate the plan to be effective on a prospective basis.

5. The New Health System shall comply with all provisions contained in Article V, and Addendum 1, of the "Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health Pursuant to the Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance" dated September 18, 2017.

6. The New Health System shall continue to negotiate in good faith with all Payers to include the New Health System in health plans offered in the area served by the Southwest Virginia Health Authority ("Authority") on commercially reasonable terms and rates, and will not refuse to negotiate with potential new Payer entrants to the market or with any payer as long as the Payer

has demonstrable experience, a reputation for fair-dealing and timely payment, and negotiates in good faith. Prior to initiating any such negotiations, the New Health System shall provide in either electronic or hard copy format a complete copy of these conditions to all payers with whom it is negotiating managed care contracts. The New Health System will resolve through mediation any disputes that arise during negotiations to which this condition is applicable. The New Health System shall timely notify the Commissioner of any mediation occurring pursuant to this condition if the Payer has insureds (or members) in the Commonwealth of Virginia, and shall offer to the Commissioner updates on the progress of such mediation. If a Payer and the New Health System cannot agree on rates or any other contract terms, and mediation fails to resolve the dispute, the Commissioner may require the New Health System to participate in "Final Offer Arbitration" with the Payer unless the Commissioner agrees to an alternative manner of arbitration. Costs and reasonable attorneys' fees of the arbitration shall be awarded to the prevailing party of the arbitration if "Final Offer Arbitration" or other types of arbitration are utilized.

For purposes of these conditions, "Payer" means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any New Health System hospital or other medical providers' medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payers which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payers and health plans which negotiate the payment or rate of payment for hospital or medical services, supplies and/or items. Payer includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare payers or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the term of the cooperative agreement.

7. The New Health System shall not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or Medicaid Managed Care Organization. Nothing herein shall be construed as to impede the discretion of the payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System's service area.

8. Within 36 months of the closing date of the merger, the New Health System shall participate meaningfully, as determined by the Commissioner, in a regional health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with independent physicians and other community-based providers for the purpose of providing seamless patient care. Any imposition of fees or costs for access to the health information exchange or cooperative arrangement shall comply with federal anti-kickback statutes and rules, and shall be a minimal amount that shall not exceed what is reasonable based on comparisons with other communities offering such services. In addition, the New Health System shall participate in the Commonwealth's ConnectVirginia health information exchange, in particular ConnectVirginia's Emergency Department Care Coordination Program and Immunization Registry. Further, the New Health System shall participate in Virginia's Prescription Monitoring Program. The New Health System shall spend a minimum of $8,000,000 over the 10 fiscal years beginning July 1, 2018 in developing and providing readily

and easily accessible access to patient electronic health information, consistent with the regional annual incremental spending amounts in Exhibit B.

Within 12 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a plan for the expenditure of such funds during the first three full fiscal years after the closing date of the merger. The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall demonstrate (A) how the planned expenditure of funds will result in the New Health System's meaningful participation in a regional health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with independent physicians and other community-based providers for the purpose of providing seamless patient care, (B) how imposition of any fees or costs for access to the health information exchange or cooperative arrangement complies with federal anti-kickback statutes and rules, and is a minimal amount not exceeding what is reasonable compared to other communities offering such services, (C) how the New Health System will participate in the Commonwealth's ConnectVirginia health information exchange, ConnectVirginia's Emergency Department Care Coordination Program and Immunization Registry, and Virginia's Prescription Monitoring Program, (D) how the New Health System has established the foundation for data acquisition and exchange in a manner that would promote and support population health improvement efforts, and (E) that it has a high likelihood of preventing unnecessary and redundant care. The plan shall include milestones and outcome metrics.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, in accordance with condition 4.

9. The New Health System shall collaborate in good faith with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices, and efforts to improve outcomes for patients and to deliver such outcomes at the highest possible value.

10. The New Health System, subject to the agreement of Payers as defined herein, shall establish payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers as follows:
    1. All risk-based model components of existing Wellmont and Mountain States contracts shall continue from the date of closing into the future upon their terms.
    2. At least one new risk-based model contract shall commence no later than January 1, 2020.
    3. At least a second new risk-based model contract shall commence no later than January 1, 2021.
    4. The New Health System shall initiate risk-based model contracts for any remaining Large Network Payers that do not already have at least one risk-based model component in their contracts by no later than January 1, 2022.

    By January 1, 2021, at least 30% of the New Health System's total health insurance contract revenue shall be from risk-based model contracts. By January 1, 2022, all of the Large Network Payers are expected to have a risk-based model/population health/partnership relationship with the New Health System that includes aligned incentives. The risk-based components in each contract shall be based on the unique priorities and timelines agreed upon by each payer, Large Network Payer and the New Health System.

    For purposes of this condition, "risk-based model" shall be defined as contracts which contain elements of reimbursement tied to incentives for quality, value-based care, shared savings or

alignment of financial incentives between Payers, the New Health System, employers and patients.

11. The New Health System shall work with the Virginia Department of Medical Assistance Services (DMAS) to develop and implement value-based payment programs in the region, including:

    The New Health System shall enter into contracts with Medicaid Managed Care Organizations (MMCOs) that promote value-based payment (VBP) arrangements that move the New Health System away from fee-for-service reimbursement structures for its Medicaid and Medicaid/Medicare Dual Eligible patient populations. Such VBP arrangements shall materially support DMAS goals and timetables under the Virginia VBP Roadmap (in development) and facilitate successful implementation of such goals within the timelines prescribed by DMAS for MMCOs operating in the New Health System's region. Material support means the New Health System shall provide an allocation of resources (financial and otherwise), staff, and leadership direction sufficient to achieve relevant DMAS goals and timetables for the New Health System's patient population. In the event that the New Health System does not engage in VBP arrangements that materially support such goals and timetables, DMAS will notify the Commissioner. The Commissioner may require a plan to cure the noncompliance in accordance with condition 17.

    As a large, integrated system, the New Health System shall work with MMCOs operating in its region to adopt a VBP approach(s) that places emphasis on alternative payment models classified under categories 3 or 4 of the Health Care Payment Learning and Action Network's Alternative Payment Model Framework version 2017.

    The New Health System shall adopt VBP arrangements put forward by DMAS as prescriptive models, meaning VBP models for which DMAS has developed specific guidelines, features, operational frameworks, and/or performance metrics for implementation by providers serving Virginia Medicaid enrollees. This applies to both fee-for-service and managed care.

12. The New Health System shall develop a robust quality improvement program, to include outcomes and measures, consistent with the aim of improving the health and well-being of the residents of southwest Virginia. The quality outcomes and measures will be developed with the input and approval of the Commissioner. The New Health System shall establish annual priorities related to quality improvement applicable to all facilities within the first six months of the closing date of the merger and publicly report quality measures related to the annual priorities. The New Health System shall track the performance of the health system in meeting these quality priorities, outcomes and measures at both the system and individual hospital levels. The New Health System shall post the quality measures and actual performance against the measures on its website accessible to the public. The New Health System shall timely report and include on its website its performance compared to the Medicare quality measures including readmission statistics. The New Health System shall give notice to the Authority of the metrics that it is prioritizing and will include input from the Authority in establishing or modifying its priorities. A monthly report, at the individual facility as well as system level, shall be presented to the Commissioner and the Technical Advisory Panel.

13. Each hospital operated by the New Health System that is subject to Joint Commission, or other Centers for Medicare and Medicaid Services (CMS)-accepted accreditation body, accreditation shall at all times be fully accredited by the CMS-accepted accreditation body, and at all times maintain compliance with Medicare conditions of participation. The New Health System shall

notify the Commissioner of any deficiencies or other noncompliance cited by the Joint Commission or Medicare within five days of receiving notice of the deficiency or noncompliance from the accepted accreditation body or Medicare. The New Health System shall submit a plan of correction correcting any such deficiencies or noncompliance within the time provided by a Medicare accreditation program approved by CMS, and notify the Commissioner upon completion.

14. Within three months of the closing date of the merger, the New Health System shall adopt a charity care policy for the hospitals that is compliant with applicable law, that is more charitable than the existing policies of either of the Applicants, and that is consistent with Section 501(r) of the Internal Revenue Code. The New Health System shall furnish a copy of its policies relating to charity care to the Commissioner no later than the end of the third month following the closing date of the merger. Thereafter, the New Health System shall furnish to the Commissioner a copy of any revisions to such policies immediately upon the effective date of such revisions. These policies shall provide for the full write-off of amounts owed for services by patients with incomes at or below 225% of the federal poverty level. For patients who are between 225% and 400% of the federal poverty level but whose account balance (after all insurances have processed or uninsured discount has been applied) is equal to or greater than 50% of the patient's total annual household income, the maximum a patient would be expected to pay to settle an account balance shall be 15% of household income. The New Health System shall inform the public of its charity care and discounting policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site and on the separate web sites for all provider components that are part of the New Health System. The value of charity care will be set as defined in Virginia Code § 32.1-102.4. The New Health System shall continue to provide charity care at a rate at or above the rate provided by the Applicants 12 months prior to the approval of the cooperative agreement.

15. Immediately upon closing of the merger, the New Health System shall adopt a policy pursuant to which uninsured and underinsured individuals who do not qualify under the charity care policy shall receive a discount off hospital charges based on their ability to pay. This discount shall comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that section governing not for-profit organizations, and payment provisions shall be based on the specific circumstances of each individual/family. Such policy shall be implemented immediately upon closing of the merger. The New Health System shall seek to connect individuals to coverage when possible.

    "Uninsured" patients are those with no level of insurance or third-party assistance to assist with meeting his/her payment obligations. "Underinsured" patients shall mean insured patients who have a health plan that does not meet the "Minimum Essential Coverage" standard as defined under the Affordable Care Act in existence as of July 1, 2017. These patients shall not be charged more than amounts generally billed (AGB) to individuals who have insurance covering such care in case of Emergency or other Medically Necessary Services. AGB percentage is determined using the look-back method utilizing the lowest percentage for all facilities per the IRS regulatory guidelines set forth in 501(r). Emergency Services are defined in accordance with the definition of "Emergency Medical Conditions" in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). Medically Necessary Services are defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury and are services not included in the list of "particular services excluded from coverage" in 42 CFR § 411.15. Financial assistance eligibility shall be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Financial assistance

determinations are based on National Poverty Guidelines for the applicable year. The New Health System shall adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

16. The New Health System shall furnish any notices of a material default, that the New Health System, or an affiliate, receives under bond or other debt documents for debt in excess of $7,500,000 to the Authority and the Commissioner.

17. If the New Health System becomes aware of a Material Adverse Event, the New Health System shall immediately notify the Commissioner and the Authority.

    For purposes of these conditions, a "Material Adverse Event" means any fact, event, change, development or occurrence that, individually or together with any other event, change, development or occurrence, is or is reasonably likely to be, materially adverse to the business, condition (financial or otherwise), assets, operations or results of operations of the New Health System, taken as a whole, or on the ongoing ability of the New Health System to comply with any condition. "Material Adverse Event" includes noncompliance with any condition of the cooperative agreement.

    Upon becoming aware of any potential or actual noncompliance with any condition of the cooperative agreement, the New Health System shall notify the Commissioner within 24 hours. A plan to cure the noncompliance shall be submitted to the Commissioner within the time frame prescribed by the Commissioner. This condition shall not limit the Commissioner's authority to initiate a proceeding to determine if the cooperative agreement should be revoked at any time.

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

19. As soon as practicable after closing of the merger but no later than the end of the first full fiscal year after the closing date of the merger, the New Health System shall create and begin the implementation of a plan to spend a minimum of $70 million over 10 years to eliminate differences in salary/pay rates and employee benefit structures among the employees of the New Health System. The plan shall account for differences in salary/pay rates and employee benefit structures applicable to all levels of employees such that the New Health System offers competitive compensation and benefits for all employees of the New Health System.

20. The New Health System shall provide to the Commissioner, within two months of the closing date of the merger, a severance policy addressing how employees will be compensated if they are not retained by the New Health System or any of its subsidiaries or affiliates. This policy shall not affect termination of employees if the termination was for-cause. The severance policy shall consider several factors, including but not limited to, each individual's position within his/her current organization and years of service. The policy shall also address outplacement support to be provided to any such employee. This provision shall not be construed to create a right of action for any individual employee. This condition shall continue for five years from the closing of the merger.

21. Between the Approval Date and the closing date of the merger, and during the 24-month period commencing with the closing date of the merger, the New Health System shall not terminate

any employee of any hospital in Virginia, whether or not such employee is classified as clinical personnel, nor require any such employee to enter into an early retirement package or otherwise resign in lieu of termination, except in either case for cause. In addition, during the same time period, the New Health System shall not require any such employee of any hospital in Virginia to transfer his or her principal place of employment to a location more than 30 miles from the location of such employee's principal place of employment as a condition to his or her continued employment. Any employee's refusal to accept a transfer to a location more than 30 miles from his or her principal place of employment shall not constitute cause for termination. Thereafter (A) if the New Health System decides to terminate an employee without cause it shall provide prior notice to the Commissioner and (B) if the New Health System desires to commence a reduction of 50 or more employees, whether in a single act or a series of related acts, in any 90-day period, it shall provide the Commissioner with at least 60-days advance notice prior to implementing the reduction action. The notice shall include a severance policy addressing how employees will be compensated if they are not retained in connection with such action.

22. The New Health System shall combine the best of the career development programs of Wellmont and Mountain States in order to ensure maximum opportunity for career enhancement and training.

23. The New Health System shall spend a minimum of $85,000,000 over the 10 fiscal years beginning July 1, 2018 on Health Research and Graduate Medical Education benefitting the communities served by the New Health System, consistent with the regional annual incremental spending amounts in Exhibit B.

24. Within 12 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a plan for post-graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia. The New Health System shall develop the plan in collaboration with at least its current academic partners. The plan shall be for the first three full fiscal years after the closing date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that is consistent with the regional annual incremental spending amounts in Exhibit B. The plan shall also include, but not be limited to, how it will address the Authority's Blueprint access, quality, and population health goals, the structure of an ongoing academic collaborative, and how training will be deployed in Virginia based on an evidence-based assessment of needs, clinical capacity, and availability of programs. In addition, the plan shall address:

    - Establishment of a new, community-based, rural-training track, primary-care residency or preventive medicine residency in Virginia;
    - Collaboration with existing psychiatry residency programs to establish community psychiatry rotations in southwest Virginia; and
    - Incentives for clinical employees to pursue terminal clinical degrees through loan forgiveness, clinic rotation sites, clinical hours, and preceptorship.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) have been developed collaboratively with key Virginia stakeholders; (B) effectively address the access, quality, and population health goals of the Authority's Blueprint for Health Improvement & Health-Enabled Prosperity; (C) establish an appropriate structure for an ongoing academic collaborative; (D) set forth how training in

Virginia, deployed based on an evidence-based assessment of needs, clinical capacity, and program availability will be developed; (E) set forth how a new community-based, rural training track, primary-care residency, or preventive medicine residency in Virginia will be established; (F) set forth how community psychiatry rotations in southwest Virginia will be established in collaboration with existing psychiatry residency programs; (G) set forth how incentives for clinical employees to pursue clinical degrees will be developed through such mechanisms as, for example, loan forgiveness, clinical rotation sites, clinical hours, and preceptorship; and (H) include a methodology for allocation of funds between Virginia and Tennessee. The plan shall include milestones and outcome metrics.

The New Health System shall implement the plan in collaboration with at least its current academic partners.

No less than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

Within 45 days of the closure of the merger, the New Health System shall convene the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. Furthermore, and contingent on continued funding for existing programs from federal and state sources, the New Health System shall not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area.

25. Within 12 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a plan for investment in the research enterprise in the Virginia service area. The New Health System shall develop the plan in collaboration with at least its current academic partners. Within 45 days of the closing date of the merger, the New Health System shall convene the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. The plan shall be for the first three full fiscal years following the closing date of the merger and shall include a time schedule for implementing the plan and expenditures under the plan for the second and third full fiscal years after the closing of the merger that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan shall also include, but not be limited to, how it will address the Authority's Blueprint goals, the structure of an ongoing research collaborative, and the criteria according to which research funding available as a result of the Virginia cooperative agreement and Tennessee COPA will be deployed in Virginia based on community needs, matching opportunities, economic return to the region, and overall competitiveness of the research proposals.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) have been developed collaboratively with key Virginia stakeholders, (B) effectively address the goals of the Authority's Blueprint for Health Improvement & Health-Enabled Prosperity and contain metrics that will be evaluated periodically to determine if the goals are met, (C) establish an appropriate structure for an ongoing academic collaborative, (D) include a methodology for allocation of funds between Virginia and Tennessee, and (E) include appropriate evidence-based criteria pursuant to which research funding made available as a result of the cooperative agreement will be deployed in Virginia based on community needs, matching opportunities, economic return to the region,

and overall competitiveness of the research proposals. The plan shall include milestones and outcome metrics.

The New Health System shall implement the plan in collaboration with at least its current academic partners.

No less than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

26. Within 48 months of the closing of the merger, the New Health System shall adopt a Common Clinical IT Platform. This fully integrated medical information system shall allow for better coordinated care between patients and their doctors, hospitals, and post-acute care and outpatient services and facilitate the move to value-based contracting. The New Health System shall make access to the IT Platform available on reasonable terms to all physicians in the service area. Subject to confidentiality laws and rules, the New Health System shall grant reasonable access to the data collected in its Common Clinical IT Platform to researchers with credible credentials who have entered into Business Associate Agreements for the purpose of conducting research in partnership with the New Health System.

27. All hospitals operated by the Applicants on the Approval Date shall remain operational as clinical and health care institutions for at least five years. "Clinical and health care institutions" may include, but are not limited to, acute care hospitals, behavioral health hospitals, rehabilitation hospitals, freestanding emergency rooms, surgery centers, skilled nursing facilities, assisted living centers, and any combination thereof. Immediately from the Approval Date and during the life of the cooperative agreement, the New Health System shall continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and other investment in outpatient health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or hospital service lines, or repurpose any hospital. In the event the New Health System repurposes any hospital or adjusts scope of services or service lines, it shall continue to provide essential services in the city or county where the hospital is located and in any contiguous city or county. Prior to adjusting the scope of services or service lines or repurposing any hospital, the New Health System shall provide the Commissioner with nine months advance notice. Within 30 days of such notification, the New Health System shall submit a plan to the Commissioner for approval detailing how essential services will continue to be provided in the city or county in which the hospital is located and in any contiguous city or county. The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) have been provided to the Commissioner within 30 days of timely notice that such adjustment in scope of service or service lines or repurposing was to occur, (B) demonstrate that the proposed action is consistent with, and would not adversely impact, the Population Health Plan, the Rural Health Services Plan, the Children's Health Services Plan, and the Behavioral Health Services Plan, (C) set forth how essential services will continue to be provided in the Virginia city or county where the hospital facility is currently located, as well as in any contiguous Virginia city or county, and (D) demonstrate how population health will be improved for the people in the Virginia service area. The plan shall include milestones and outcome metrics. If the New Health System desires to repurpose a hospital emergency department or consolidate trauma service lines, the plan submitted to the Commissioner shall be developed in coordination with the Southwest Virginia Emergency Medical Services Council and shall also address emergency medical services transport times and assurance of appropriate patient care.

The New Health System shall not close facilities or discontinue services in such a manner that would affect the ability of Medicaid managed care organizations to meet network adequacy and access requirements, such as distance and drive time parameters.

For purposes of this condition, “service lines” means the following service lines at a hospital: Orthopedics, Pediatrics, Surgery, Obstetrics/Gynecology, Cardiovascular/Heart, Cancer, Emergency Medicine, Neurology/Neurosurgical, Psychiatric/Behavioral Health, Neonatal, and Trauma.

For purposes of this condition, the following services are considered “essential services:”

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

If an acute care hospital is opened in Lee County, and subsequently fails or ceases to operate, the New Health System shall provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System. Such terms shall include the appropriate access to space, located within the existing hospital facility, based upon reasonable terms. If an acute care hospital is not open and operational under a partnership with the Lee County Hospital Authority by December 31, 2018, the New Health System shall provide essential services in Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System until such time as a hospital is open and fully operational.

28. The New Health System shall maintain, for the Virginia and Tennessee service areas, a minimum of three full-service tertiary referral hospitals located in Johnson City, Kingsport, and Bristol, to ensure higher-level services are available in close proximity to where the population lives.

29. The New Health System shall maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital departments or services as determined by the New Health System’s Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.

30. The New Health System shall not require independent physicians to practice exclusively at the New Health System’s hospitals and other facilities.

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

32. The New Health System shall complete a comprehensive physician/physician extender needs assessment and recruitment plan every three years, starting within the first full fiscal year, in each Virginia community served by the New Health System. The New Health System shall consult with the Authority in development and implementation of the plan. The New Health System shall employ physicians and physician extenders primarily in Health Professional Shortage Areas designated by the U.S. Health Resources and Services Administration and tracked by the Virginia Department of Health Office of Primary Care, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding, and in locations where needs are not being met. The New Health System shall promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.

33. The New Health System shall spend a minimum of $28,000,000 over the 10 fiscal years beginning July 1, 2018 on rural health services benefitting the communities in the area served by the New Health System consistent with the regional annual incremental spending amounts in Exhibit B. Within six months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner, for review and approval, a Rural Health Services Plan for the first three full fiscal years after the closing date of the merger that shall include a time schedule for implementing the plan and expenditures under the plan that are consistent with Exhibit B. The plan shall, at a minimum, address the New Health System's approach to the following components:
    - Primary Care Services, with a plan for same day access, which may include telemedicine and other technology based access;
    - Maintain and enhance services to support maternal and prenatal health;
    - Pediatrics and regional pediatric specialty access;
    - Specialty care and regional specialty care access, with a plan for access within five days,
    - Access to "essential services" (as defined in condition 27);
    - Improved access to preventive and restorative dental and corrective vision services; and
    - Emergency service access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia Emergency Medical Services Council.

    The Rural Health Services Plan shall also address collaboration with local businesses, school districts, and industry on community development necessary to attract and retain providers in the Virginia service area.

    The Rural Health Services Plan will be focused, along with the Population Health Plan, on managing the burden of disease and breaking the cycle of disease according to the priorities set forth by the Authority and the Commissioner.

    The Rural Health Services Plan will account for needed workforce development strategies in consultation with the Southwest Area Health Education Center and regional educational institutions. The Rural Health Services Plan shall also address the development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops.

The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) effectively address and detail how meaningful and measurable improvements and enhancement in the Virginia service area to same-day access for primary care services, access to specialty care within five days, access to maternal and prenatal health services, access to pediatric and pediatric specialty services, access to "essential services" as defined in condition 27, preventive and restorative dental services, corrective vision services, and access to emergency services will be achieved; (B) detail how active and effective collaboration with local businesses, school divisions, and industry on community development necessary to attract and retain providers in the Virginia service area will be achieved; (C) have an active and effective focus on managing the burden of disease and breaking the cycle of disease based on the priorities set forth by the Authority and the Commissioner; (D) detail how the New Health System will actively and effectively consult with the Southwest Area Health Education Center and regional educational institutions on the development of workforce development strategies; (E) detail how effective development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops will be achieved; and (F) include a methodology for allocation of funds between Virginia and Tennessee. The plan shall include milestones and outcome metrics consistent with those approved by the Commissioner after receipt of the recommendations from the Technical Advisory Panel.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan.

34. The New Health System shall spend a minimum of $85,000,000 over the 10 fiscal years beginning July 1, 2018 on behavioral health services benefitting the communities served by the New Health System, consistent with the regional annual incremental spending amounts in Exhibit B. The New Health System shall (A) create new capacity for residential addiction recovery services serving the people of southwest Virginia and (B) shall develop community-based mental health resources, such as mobile heath crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration, and other out-of-home placements throughout the Virginia service area. Within 6 months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner for review and approval a Behavioral Health Services Plan for the first three full fiscal years after the closing date of the merger that encompasses A and B above. The plan shall include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B.

    The Behavioral Health Services Plan shall also consider the goals set forth in the Virginia DMAS Addiction and Recovery Treatment Services (ARTS) Program and by the community services boards in the Virginia service area.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) detail how new capacity for residential addiction recovery services will be created to meet the current and expected future needs of the people of southwest Virginia; (B) detail how community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration, and other out-of-home placements, will be developed throughout the Virginia

service area; (C) appropriately and adequately consider the goals set forth in the Virginia DMAS ARTS Program and by the community services boards in the Virginia service area; and (D) include a methodology for allocation of funds between Virginia and Tennessee.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

35. The New Health System shall spend a minimum of $27,000,000 over the 10 fiscal years beginning July 1, 2018 on children's health services benefitting the communities in the area served by the New Health System, consistent with the regional annual incremental spending amounts in Exhibit B. The New Health System shall develop pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right settings in close proximity to patients' homes. Within six months of the closing date of the merger, the New Health System shall develop and submit to the Commissioner for review and approval a Children's Health Services Plan for the first three full fiscal years after the closing date of the merger encompassing the above which shall include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B.

    Some elements of the Children's Health Plan may also be included in the Rural Health Services Plan.

    The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the plan shall (A) detail how pediatric specialty centers and Emergency Rooms in Kingsport and Bristol will be developed to meet the current and expected future needs of the people in the geographic service area, (B) detail how pediatric telemedicine and rotating specialty clinics in rural hospitals will be staffed and utilized to ensure quick diagnosis and treatment in the right setting in close proximity to patients' homes, and (C) include a methodology for allocation of funds between Virginia and Tennessee. The plan shall include milestones and outcome metrics.

    No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

36. The New Health System shall spend a minimum of $75,000,000 over the 10 fiscal years beginning July 1, 2018 on population health improvement for the area served by the New Health System, consistent with the regional annual incremental spending amounts in Exhibit B. The distribution of funding across the total population of the area served by the New Health System shall consider the relative population of the counties and communities within the area served by the New Health System, the relative per-capita cost of interventions within each community and the relative value of the intervention towards improving overall population health. Of this amount, the New Health System shall spend an amount necessary to support the creation of, and shall take the lead to formally establish, at least one regional Accountable Care Community (ACC) organization that includes the entire Virginia service area. Membership of the ACC will include members of the New Health System, the Authority, and other local, state or federal agencies, payers, service providers, and community groups who wish to participate.

Within 90 days of the closing date of the merger, the New Health System shall recruit and convene the ACC's initial leadership team to help develop the Population Health Plan. After consultation with the ACC and within six months of the closing date of the merger, the New Health System shall submit to the Commissioner, for review and approval, a Population Health Plan for the first three full fiscal years after the closing date of the merger to improve the scores of the southwest Virginia population on measures to be approved by the Commissioner following receipt of recommendations from the Technical Advisory Panel. The Plan will include a time schedule for implementing expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The submission of the Plan, the process measures associated with the implementation of each component, and the achievement of population health improvement for each measure, shall be evaluated according to the quantitative measures and methodology determined by the Commissioner after receipt of the recommendations of the Technical Advisory Panel.

The Commissioner's review of the plan shall be performed in accordance with Condition 4. To be approved, the Plan shall (A) set forth how population health will be improved in southwest Virginia in accordance with the Authority's Blueprint for Health Improvement & Health-Enabled Prosperity and the Virginia Plan for Well-Being and (B) include process measures associated with implementation of each component of the plan.

No later than 90 days prior to the expiration of such plan, the New Health System shall develop and submit to the Commissioner for approval a new plan for the next three full fiscal years to replace such expiring plan, as described in condition 4.

No later than six months after the closing date of the merger, the New Health System shall establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing the Population Health Plan and improving the overall health of the population served by the New Health System. This department shall be staffed with leaders charged with financial compliance, physician relations, and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the New Health System's Board of Directors.

37. The New Health System shall reimburse the Southwest Virginia Health Authority for costs associated with the various regional health planning efforts cited within these conditions in an amount up to $75,000 annually, with Consumer Price Index (CPI) increases each year. No reimbursable costs shall be paid toward compensation for any member of the Authority's Board or Directors.

38. The Board of Directors of the New Health System shall operate such that each Board member must exercise the Duty of Care, Loyalty and Obedience to the New Health System required by law, and all Board members must adhere to the strict fiduciary policies established by the Board. It is recognized that governance of the New Health System should reflect the region, including both Virginia and Tennessee. As such,
    - On the date of closing of the merger and for the life of the cooperative agreement, three members of the 11-member New Health System Board of Directors shall be Virginia residents;
    - The New Health System shall ensure membership from Virginia on the following Board committees, with full voting privileges: Finance, Audit and Compliance, Quality, Community Benefit/Population Health, and Workforce; and

- Not less than 30% of the composition of the Community Benefit/Population Health committee shall reside in Virginia (this committee will be the Board committee responsible for the oversight of the compliance of the cooperative agreement).

39. Any report or information required to be submitted to the Commissioner shall be accompanied by a verified statement signed by the chairperson of the Board or the Chief Executive Officer attesting to the accuracy and completeness of the report or information.

40. The New Health System shall provide information on a quarterly basis of the key financial metrics and the balance sheet comparing performance to the similar prior year period and year to date. This information shall be provided on the same timetable as what is publicly reported through Electronic Municipal Market Access.

41. The New Health System shall adhere to the New Health System Alignment Policy [Exhibit 12.1 of the Application] setting forth relevant considerations and the process for closing a facility should it be necessary and otherwise in compliance with the conditions of the cooperative agreement. This policy shall remain in effect unless the change is agreed to by the Commissioner.

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

43. The New Health System shall not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.

44. The New Health System shall participate in the Virginia DMAS ARTS Program.

45. The New Health System shall establish a system-wide, physician-led clinical council (the "Clinical Council").
    - The Clinical Council shall be composed of (A) Independent Physicians, (B) Employed Physicians, (C) the Chief Medical Officer of the New Health System and (D) a Chief Nursing Officer of one of the Applicants. The Clinical Council shall include representatives of the New Health System's management but the majority shall be composed of physicians. The membership of the Clinical Council shall be representative of the distribution of physicians across the geographic service area.
    - The Clinical Council may be supported by other clinicians, subject matter experts, and senior management.
    - The Chair of the Clinical Council shall be a physician member of the active medical staff(s) of one or more New Health System Entities chosen by members of the Clinical Council. The Chair shall serve on the Quality, Service and Safety Committee of the Board of the New Health System and shall provide ongoing reports on the activities of the Clinical Council through the Quality, Service and Safety Committee of the Board.
    - The Clinical Council shall be responsible for establishing a common standard of care, credentialing standards, consistent multidisciplinary peer review when appropriate and quality performance standards and best practices requirements for the New Health System, all of which shall be documented as applicable and required by the Commissioner.
    - The Clinical Council shall provide input to the New Health System on issues related to clinical integration, and shall support the goals established by the Board of Directors of the New Health System.

- The Clinical Council shall advise the Board of Directors of the New Health System on target quality measures based on quality improvement priorities of the New Health System.

46. The New Health System shall continue to treat Virginia Medicaid beneficiaries in Virginia hospitals, Tennessee hospitals, and other New Health System facilities. The New Health System shall also continue to perform pre-admission screening assessments to determine if an individual meets the functional criteria to receive Medicaid-funded long terms services or supports. The New Health System shall enter into a participation agreement with DMAS. The New Health System shall contract with all Virginia MMCOs that provide coverage to Medicaid beneficiaries in the New Health System's service area. This includes MMCOs in the Medallion program, Commonwealth Coordinated Care program, CCC Plus program, and any other Virginia Medicaid managed care program that is implemented during the term of the cooperative agreement. The New Health System shall contract with all Medicare Dual Eligible Special Needs Plans as these health plans will serve individuals that are also enrolled with a MMCO. Additionally, the New Health System shall contract with the Program of All-Inclusive Care for the Elderly (PACE). The following conditions are placed on MMCO and PACE contracting during the life of the cooperative agreement, and apply to all service types existing under such contracts:

    Prices for all renewed contracts shall not exceed the Applicants' current negotiated percentage of Virginia Medicaid's payment rate for the service unless both the contracting MMCO/PACE and the New Health System agree to alternative prices or reimbursement arrangement.

    Prices for new MMCO/PACE contracts shall be no higher than the average percentage of Virginia Medicaid's payment rate for the service in the Applicants' existing MMCO/PACE contracts unless both the contracting MMCO/PACE and the New Health System agree to alternative prices or reimbursement arrangements.

    If existing MMCO/PACE contracts are not based on a percentage of Virginia Medicaid's payment rate, then the New Health System shall calculate a percentage of Virginia Medicaid's payment rate based on current contract terms and 2017 utilization. To determine the current percentage of Medicaid, the New Health System shall divide utilization in the base year repriced at Medicaid rates by expenditures in the 2017 base year under the current rates. Future negotiated rates for these contracts shall not exceed this calculated percentage of Virginia Medicaid's payment rate.

47. The New Health System shall participate in quarterly teleconferences with DMAS each year. The teleconferences will address, *inter alia*, the New Health System's progress towards meeting DMAS goals for participation in the ARTS Program; the New Health System's progress towards implementing value-based payment with Medicaid Managed Care Organizations; ensuring continued access to obstetrical and maternity services for Medicaid recipients; managed care contracting; and any complaints regarding the New Health System received by DMAS from Medicaid providers or recipients. At least one executive-level member of the New Health System shall participate in each teleconference. The frequency of the teleconferences may be reduced by DMAS.

48. In order to ensure that the Virginia operations are allocated an appropriate amount of the New Health System's ongoing and annual compliance costs, the New Health System shall adopt an allocation methodology that takes into account the differences in ongoing and annual compliance requirements between the State of Tennessee and the Commonwealth of Virginia.

49. These conditions are intended to remain effective for the life of the cooperative agreement. Nevertheless, there may be changes in circumstances that arise which affect the feasibility or the meaningfulness of the conditions and which are not possible to foresee presently. Accordingly, if the New Health System produces evidence that changes in circumstances have materially affected its ability to meet a condition and that its inability is not affected by deficiencies in management, the New Health System may request the Commissioner amend the condition to reduce the burden or cost of the condition to a level that may be more sustainable. In the event that the New Health System requests the Commissioner to amend a condition, the Commissioner may engage an independent consultant to determine whether the changes in circumstances have adversely affected the New Health System, the extent to which this has occurred, and whether the changes in circumstances are related to the effectiveness of management. The New Health System shall pay all charges, not to exceed $250,000 (as adjusted by the CPI from the date of the closing of the merger), for the cost of such an independent consultant engagement. The Commissioner shall determine whether it is necessary to amend, retain, or remove the condition in order for the benefits of the cooperative agreement to continue to outweigh the disadvantages likely to result from a reduction in competition and take appropriate action regarding the condition.