Technical Advisory Panel of the Cooperative Agreement
Agenda
November 14, 2017 – 10:00 a.m.
Southwest Virginia Higher Education Center, Room CR222
One Partnership Circle
Abingdon, Virginia

Welcome and Introductions	Dr. Norm Oliver
Draft Policy on Electronic Attendance	Dr. Oliver
Southwest Virginia's Blueprint for Health	Dr. Sue Cantrell
Addressing Health-Related Social Needs	Pete Knox
Presentation of Short- and Long-Term Measures	Dr. Oliver
Discussion	Panel Members
Break	
Working Lunch	
Break	
Discussion	Panel Members
Next Steps	Dr. Oliver
Adjourn	

Technical Advisory Panel of the Cooperative Agreement
E-Meeting Policy

It is the policy of the Technical Advisory Panel ("the Panel") that individual Panel members may participate in meetings of the Panel or committees of the Panel by electronic means as permitted by Virginia Code § 2.2-3708.1. This policy shall apply to the entire membership and without regard to the identity of the member requesting remote participation or the matters that will be considered or voted on at the meeting.

Whenever an individual member wishes to participate from a remote location, the law requires a quorum of the Panel or committee to be physically assembled at the primary or central meeting location, and there must be arrangements for the voice of the remote participant to be heard by all persons at the primary or central meeting location. The reason that the member is unable to attend the meeting and the remote location from which the member participates must be recorded in the meeting minutes. When such individual participation is due to an emergency or personal matter, such participation is limited by law to two meetings per member each calendar year.

Individual participation from a remote location shall be approved by the chair unless such participation would violate this policy or the provisions of the Virginia Freedom of Information Act. If a member's participation from a remote location is challenged, then the Panel or committee that is meeting shall vote whether to allow such participation. If the Panel or committee votes to disapprove of the member's participation because such participation would violate this policy, such disapproval shall be recorded in the minutes with specificity.

This policy applies to all committees and subcommittees of the Technical Advisory Panel.

DRAFT

New System Short Term Expectations

Outcome 1: Create Value in the Marketplace

Conditions: 6-7-8-9-10-11-26-29-30-31-42-43-44

-Complete analysis of all current payer contracts and provide historic and baseline performance on cost, quality and experience

-Complete comprehensive five-year plan regarding payer strategies and payer relationships incorporating the shift to a goal of 30% risk based payment by 2021

-Complete the comprehensive plan to finalize the clinically integrated network organization and move toward 80% independent physician participation

-Complete the comprehensive IT and analytics plan including the transition of independent physicians onto the new platform

-Complete the plan to transition purchasing to local and regional suppliers

Outcome 2: Improve health and well being for a population

Conditions: 14-15

-Complete the comprehensive population health plan including specific plan for Southwest Virginia

-Determine and report baseline measures for all population health metrics including a carve out for Southwest Virginia

-Define charity care plan with annual targets including an itemized allocation with specific details for Southwest Virginia

-Define current length of life and quality of life comparisons for the serviced region and clearly link the plan for improvement for Southwest Virginia (if necessary) to the population health plan

Outcome 3: Equitable access to services across the region

Conditions: 1-27-28-41-46

-Complete the short and long term plan for improvement in scope of services in Southwest Virginia

-Compile baseline for all access measures including details for Southwest Virginia and link to plan for improvement

-Complete analysis and baseline data for per capita spending, quality and service for residents of Southwest Virginia compared to other communities in the serviced region and define plan for improvement

-Compile data on primary care and specialty access for residents of Southwest Virginia and define plan of improvement

Outcome 4: Adequate providers to provide equitable services throughout the region

Conditions: 24-32

-Complete the comprehensive clinical staff development plan including needs in Southwest Virginia

-Establish year over year targets for filling the needs in Southwest Virginia

-Complete the post -graduate training plan

Outcome 5: Benchmark operating performance

Conditions: 12-13-16-17-40-45

-Provide history of adverse events and provide plan to achieve zero harm

-Provide historic and current financial metrics with projections over the next five-year period

-Complete long-term financial plan to achieve defined five-year targets

-Provide historic and baseline performance on all quality and service metrics with targets for the next five -year period

-Complete comprehensive quality and service plan to achieve defined quality and service targets

Outcome 6: Strong vibrant culture

Conditions: 18-20-21-22-38

-Complete comprehensive human resource plan articulating management of employee target levels and reduction in turnover rates

-Conduct board engagement survey that includes a comparative component and develop plan for improvement

-Complete comprehensive employee development plan for all staff

Outcome 7: Strong academics and research impacting the region

Conditions: 25

-Complete the short and long term research plan indicating alignment with the top regional issues

-Complete the relationship plan with regional partners to accomplish the proposed research agenda

Outcome 8: Monetary commitment

Conditions: 3-19-23-33-34-35-36-37

-Complete the short and long term monetary spending plan including dollars to be allocated to Southwest Virginia with specific goals defined

-Establish the ongoing tracking mechanism for spending including dollars spent in Southwest Virginia

Conditions related to all outcomes: 2-4-5-39-47-48-49

Note: All plans to include detailed aims, goals, guiding principles, measurement, strategies, tactics and six- month milestones along with project plan. Historic data provided for all plans.

Active Supervision of the COPA Agreement: Draft Measures and Performance Indicators

Outcomes	Conditions	Measures	Performance Indicators
1 Create value in the market-place	Relevant Conditions 6-7-8-9-10-11-26-29-30-31-42-43-44 Integrated delivery system *Payer strategies *Health information network *IT and analytics *Non-employed health plan participation	-Triple aim for all at risk contract populations -Risk revenue as a percentage of overall revenue -Advancement of clinically integrated network -IT plan implementation -Economic impact in region	- Satisfaction of rate cap conditions -Comprehensive plan for managing payer relationships with six month milestones complete and approved by the health commissioner on an annual basis -Plan to include specific strategies and tactics for payer relationships in Southwest Virginia -Ongoing review of six month milestones -Comprehensive plan for the new infrastructure to support a risk based business model with six month milestones complete and approved by the health commissioner on an annual basis -Initial infrastructure plan to be a five year view -Ongoing review of milestones -Total cost of care measured by PMPY for all risk based contracts increasing at half the regional trend for similar populations on an annual basis -Improved year over year quality and satisfaction performance in agreed upon indicators in all risk based agreements -Increasing percentage of overall revenue coming from risk based agreements achieving 30% by 2021 -Comprehensive IT and analytics plan complete within one year of agreement being signed with defined six months milestones. Milestones achieved on a rolling six-month basis. -Increasing percentage of independent physicians participating in the clinically integrated network achieving 80% by 2021 -Increasing percentage of independent physicians on the common IT platform achieving 80% by 2021 -Improved overall health and experience while reducing cost for employee and family population -Cost on PMPY minimum of half the regional trend -Quality metrics for employee populations at upper quartile performance -Experience metrics for employee populations at upper quartile -Increasing relationships with employers in the region with new customers added each year -Demonstrated improvement in cost control, quality and experience for employer customers year over year

<table>
<tr>
<td></td>
<td></td>
<td></td>
<td>-Cost on PMPY minimum of half the regional trend
-Quality metrics for employee populations at upper quartile performance
-Experience metrics for employee populations at upper quartile performance

-Increased spending by new system on ongoing operations with regional suppliers year over year to a minimum of 70% by 2021</td>
</tr>
<tr>
<td>2
Improve health and well-being for a population</td>
<td>Relevant Conditions 14-15

Population health

*Charity Care</td>
<td>-Social - determinants of health

-Amount of charity care

-Length and Quality of life</td>
<td>-Comprehensive plan for improving health of the population with six month milestones complete and approved by the health commissioner within six months after signing date
-Ongoing review of six month milestones achieving target 90% of the time

-Year over year improvement in defined measures of health achieving upper quartile performance in all metrics by 2021

Table 2: Measures, Descriptions, and Sources
<table>
<tr><th></th><th>Measure</th><th>Description</th><th>Source</th></tr>
<tr><td>1</td><td>Smoking
#</td><td>Percentage of adults who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).</td><td>Behavioral Risk Factor Surveillance System</td></tr>
<tr><td>2</td><td>Smoking in higher density counties</td><td>Percentage of adults higher density counties who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).</td><td>Behavioral Risk Factor Surveillance System</td></tr>
<tr><td>3</td><td>Smoking in lower density counties</td><td>Percentage of adults in lower density counties who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).</td><td>Behavioral Risk Factor Surveillance System</td></tr>
<tr><td>4</td><td>Smoking among those with less than a high school education</td><td>Percentage of adults with less than a high school education who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).</td><td>Behavioral Risk Factor Surveillance System</td></tr>
<tr><td>5</td><td>Smoking among those with a high school education or more</td><td>Percentage of adults with high school education or more who are self-reported smokers (smoked at least 100 cigarettes in their lifetime and currently smoke).</td><td>Behavioral Risk Factor Surveillance System</td></tr>
</table>
</td>
</tr>
</table>

6 #	Mothers who smoke during pregnancy	Percentage of mothers who report smoking during pregnancy (%).	VDH Division of Health Stats – Birth Certificate Data

7 * #	Youth Tobacco Use	Percentage of High School Students who self-reported currently using tobacco (used cigarettes, cigars, chewing tobacco, snuff, or pipe tobacco within the 30 days before the survey).	National Survey on Drug Use and Health
8	Youth - Ever Tried Cigarette Smoking	Percentage of High School Students who self-reported ever trying cigarette smoking, even one or two puffs.	Virginia Youth Survey
9 #	Physically Active Adults	Adults who reported participating in physical activity such as running, calisthenics, golf, gardening, or walking for exercise over the past month.	Behavioral Risk Factor Surveillance System
10 * #	Physically Active Students	Percentage of High School Students who were not physically active 60+ minutes per day for 5 or more days in last 7 days.	Virginia Youth Survey
11	Adult Obesity	Percentage of adults with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
12	Obesity in higher density counties	Percentage of adults in higher density counties with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
13	Obesity in lower density counties	Percentage of adults in lower density counties with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
14	Obesity among those with less than a high school education	Percentage of adults with less than a high school education with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
15	Obesity among those with a high school education or more	Percentage of adults with a high school education or more with a body mass index of 30.0 or higher based on reported height and weight.	Behavioral Risk Factor Surveillance System
16 * #	Obesity Subpopulation Measure	Increase the proportion of physician office visits that include counseling or education related to weight and physical activity.	Data Collection to be led by the New Health System

17 #	Overweight and obesity prevalence among TN public school students	Proportion of public school students in grades kindergarten, 2, 4, 6, 8, and one year of high school found to be overweight or obese during the school year.	Coordinated School Health Annual Report

			18 #	Average mPINC Score	Maternity Practices in Infant and Nutrition Care survey score based on seven birth facility policies and practices with higher scores denoting better maternity care practices and policies.	CDC Survey of Maternity Practices in Infant Nutrition and Care (mPINC)
			19 #	Breastfeeding Initiation	Percent of live births whose birth certificates report that baby is breastfed. US Value: Proportion of infants who are ever breastfed.	VDH Division of Health Stats – Birth Certificate Data CDC National Immunization Survey
			20 #	Infants breastfed at six (6) months	Percent of infants aged six (6) months whose guardians report at well-child visits they continue to be breastfed.	Data Collection to be led by the New Health System
			21	High School Students - Fruit	Percent of high school students who reported not eating fruit or drinking 100% fruit juice during the past 7 days.	Virginia Youth Survey
			22	High School Students – Vegetables	Percent of high school students who reported not eating vegetables during the past 7 days.	Virginia Youth Survey
			23	High School Students – Soda	Percent of high school students who report drinking one or more sodas per day for the past 7 days.	Virginia Youth Survey
			24 #	NAS (Neonatal Abstinence Syndrome) Births	Number of reported cases with clinical signs of withdrawal per 1,000 Virginia resident live births.	Active case reports submitted by clinicians OR through VDH's inpatient hospitalization database (VHI data)
			25 #	Drug Deaths	All drug overdose deaths of caused by acute poisonings, regardless of intent.	Virginia death certificate data
			26	Drug Overdoses	Non-fatal overdoses of Virginia residents caused by acute poisonings, regardless of intent.	VDH's inpatient hospitalization database (VHI data); also may have data from ESSENCE on ED visits
			27	Painkiller Prescriptions	Opioid prescriptions for pain to patients in Virginia.	VA PDMP data provided to VDH by Appriss, through agreement with DHP
			28	High School Students – Prescription Drugs	Percent of high school students who report ever taking prescription drugs without a doctor's prescription (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax, one or more times during their life).	National Survey on Drug Use and Health

				29 #	Adults – Prescription Drugs	Adults who report using prescription drugs not prescribed by the doctor during the past 30 days.	National Survey on Drug Use and Health	
				30 #	Children – On-time Vaccinations	Children receiving on-time vaccinations (% of children aged 24 months receiving 4:3:1:FS:3:1:4 series).	Virginia Immunization Information System	
				31 * #	Vaccinations – HPV Females	Percentage of females aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System	
				32 * #	Vaccinations – HPV Males	Percentage of males aged 13 to 17 years who received ≥3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent.	Data Collection to be led by the New Health System	
				33	Vaccinations – Meningococcal	Percentage of adolescents aged 13 to 17 years who received ≥1 dose of meningococcal conjugate vaccine (MenACWY).	Data Collection to be led by the New Health System	
				34	Vaccinations - Tdap	Percentage of adolescents aged 13 to 17 years who received ≥1 dose of tetanus-diphtheria-acellular pertussis (Tdap) vaccine since age 10 years.	Data Collection to be led by the New Health System	
				35 * #	Vaccinations - Flu Vaccine, Older Adults	Percent of adults aged 65 and over who self-reported receiving a flu shot or flu vaccine sprayed in nose in the past 12 months.	Behavioral Risk Factor Surveillance System	
				36	Vaccinations – Flu Vaccine, Adults	Percent of adults aged 18 and over who self-reported receiving a flu shot or flu vaccine sprayed in nose in the past 12 months.	Behavioral Risk Factor Surveillance System	
				37 * #	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years.	VDH Division of Health Stats – Birth Certificate Data	
				38 * #	Third Grade Reading Level	3rd graders scoring “proficient” or “advanced” on reading assessment (%).	Fourth grade reading level is available through KIDS COUNT data center	
				39	Fluoridated Water	Percent of population on community water systems (CWS) receiving fluoridated water.	CDC, My Water’s Fluoride	
				40 * #	Children receiving dental sealants	Children receiving dental sealants on permanent first molar teeth (%, 6–9 years).	Data Collection to be led by the New Health System	
				41	Adolescents receiving dental sealants	Adolescents receiving dental sealants on their first and second permanent molars (%, 13–15 years).	Data Collection to be led by the New Health System	
				42 #	Frequent Mental Distress	Percentage of adults who reported their mental health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System	
				43	Frequent Physical Distress	Percentage of adults who reported their physical health was not good 14 or more days in the past 30 days.	Behavioral Risk Factor Surveillance System	

			44 * #	Infant Mortality	Number of infant deaths (before age 1) per 1,000 live births.	VDH Division of Health Stats – Birth Certificate Data
			45 #	Low Birthweight	Percentage of infants weighing less than 2,500 grams (5 pounds, 8 ounces) at birth.	VDH Division of Health Stats – Birth Certificate Data
			46	Child Mortality	Number of deaths per 100,000 children aged 1 to 18 years.	Virginia death certificate data
			47	Deaths from Diseases of the Heart	Number of deaths due to diseases of the heart per 100,000 population.	Virginia death certificate data
			48	Cancer Deaths	Number of deaths due to all causes of cancer per 100,000 population.	Virginia death certificate data
			49	Diabetes Deaths	Number of deaths due to diabetes per 100,000 population.	Virginia death certificate data
			50	Suicide Deaths	Number of deaths due to intentional self-harm per 100,000 population.	Virginia death certificate data
			51 #	Premature Death Ratio	Ratio of years lost before age 75 per 100,000 population for higher density counties to lower density counties.	Virginia death certificate data

Note:* represents 10 measures proposed by new system
represent 25 measures proposed by Tennessee

-Targets achieved in defined charity care dollars year over year

-Length of life and quality of life in Southwest Virginia equal to the highest level of any community within the serviced region

-Essential services provided at a scope and scale in Southwest Virginia equal to best practices in any community within the serviced region

-Comprehensive plan complete and approved by the health commissioner on an annual basis

Essential Services For Repurposed COPA Hospitals

- Emergency room stabilization for patients;
- Emergent obstetrical care;
- Outpatient diagnostics needed to support emergency stabilization of patients;

3 Equitable access to services across the region	Relevant Conditions 1-27-28-41-46 Regional Services *Tertiary hospitals *Mental health services *Specialty services	-Equity of service levels -Essential services -Access to services -Primary care and specialty care access	• 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 Department. -Comprehensive access plan including all defined measures, spending rates on key services, quality and experience on key services, length and quality of life and primary and specialty care access with six month milestones complete and approved by the health commissioner on an annual basis -Ongoing review of six month milestones Year over year improvement in all metrics achieving target established in plan **Table 1: Measures, Descriptions, and Sources** **Measure** / **Description** / **Source** 1 / Population within 10 miles of an urgent care center (%) / Population within 10 miles of any urgent care center; urgent care centers may be owned by the New Health System or a competitor and may or may not be located in the geographic service area / U.S. Census Population Data 2010; Facility Addresses

				2	Population within 10 miles of an urgent care center open nights and weekends (%)	Population within ten (10) miles of any urgent care center open at least three (3) hours after 5pm Monday to Friday and open at least five (5) hours on Saturday and Sunday; urgent care center may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses	
				3	Population within 10 miles of an urgent care facility or emergency department (%)	Population within 10 miles of any urgent care center or emergency room; urgent care centers and emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses	
				4	Population within 15 miles of an emergency department (%)	Population within 15 miles of any emergency room; emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses	
				5	Population within 15 miles of an acute care hospital (%)	Population within 15 miles of any acute care hospital; acute care hospital may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	U.S. Census Population Data 2010; Facility Addresses	
				6	Pediatric Readiness of Emergency Department	Average score of New Health System Emergency Departments on the National Pediatric Readiness Project Survey from the National EMSC Data Analysis Resource Center	Self-assessment performed by New Health System	
				7	Excessive Emergency Department Wait Times	Percentage of all hospital emergency department visits in which the wait time to see an emergency department clinician exceeds the recommended timeframe.	New Health System Records; CDC National Center for Health Statistics National Hospital Ambulatory Care Survey	
				8	Specialist Recruitment and Retention	Percentage of recruitment and retention targets set in the Physician Needs Assessment for specialists and subspecialists to address identified regional shortages	New Health System Records	
				9	Personal Care Provider	Percentage of adults who reported having one person they think of as a personal doctor or health care provider	Behavioral Risk Factor Surveillance System	
				10	Preventable Hospitalizations – Medicare	Number of discharges for ambulatory care-sensitive conditions per 1,000 Medicare enrollees	Hospital Discharge Data	

				11	Preventable Hospitalizations – Adults	Number of discharges for ambulatory care-sensitive conditions per 1,000 adults aged 18 years and older	Hospital Discharge Data	
				12	Screening – Breast Cancer	Percentage of women aged 50-74 who reported having a mammogram within the past two years	Behavioral Risk Factor Surveillance System	
				13	Screening – Cervical Cancer	Percentage of women aged 21-65 who reported having had a pap test in the past three years	Behavioral Risk Factor Surveillance System	
				14	Screening - Colorectal Cancer	Percentage of adults who meet U.S. Preventive Services Task Force recommendations for colorectal cancer screening	Behavioral Risk Factor Surveillance System	
				15	Screening – Diabetes	Percentage of diabetes screenings performed by the New Health System for residents aged 40 to 70 who are overweight or obese; Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	New Health System Records	
				16	Screening – Hypertension	Percentage of hypertension screenings performed by the New Health System for residents aged 18 or older	New Health System Records	
				17	Asthma ED Visits – Age 0-4	Asthma Emergency Department Visits Per 10,000 (Age 0-4)	Hospital Discharge Data	
				18	Asthma ED Visits – Age 5-14	Asthma Emergency Department Visits Per 10,000 (Age 5-14)	Hospital Discharge Data	
				19	Prenatal care in the first trimester	Percentage of live births in which the mother received prenatal care in the first trimester		
				20	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and had an outpatient visit, and intensive outpatient encounter or a partial hospitalization with a mental health practitioner within seven (7) days post-discharge	New Health System Records; NCQA *The State of Health Care Quality Report*	
				21	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and had an outpatient visit, and	New Health System Records; NCQA *The State of Health Care Quality Report*	

		intensive outpatient encounter or a partial hospitalization with a mental health practitioner within thirty (30) days post-discharge	
22	Antidepressant Medication Management – Effective Acute Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 84 days (12 weeks)	New Health System Records; NCQA *The State of Health Care Quality Report*
23	Antidepressant Medication Management – Effective Continuation Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 180 days (6 months)	New Health System Records; NCQA *The State of Health Care Quality Report*
24	Engagement of Alcohol or Drug Treatment	Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug dependence within 30 days of the initiation visit.	New Health System Records; NCQA *The State of Health Care Quality Report*
25	SBIRT administration - hospital admissions	Percentage of patients admitted to a New Health System hospital who are screened for alcohol and substance abuse, provided a brief intervention, and referred to treatment (SBIRT)	New Health System Records
26	Rate of SBIRT administration - ED visits	Percentage of patients admitted to a New Health System emergency department who are screened for alcohol and substance abuse, provided a brief intervention, and referred to treatment (SBIRT)	New Health System Records
27	Patient Satisfaction and Access Surveys	Successful completion of patient satisfaction and access surveys, according to Section 4.02(c)(iii)	New Health System Records
28	Patient Satisfaction and Access Survey – Response Report	Report documents a satisfactory plan for the New Health System to address deficiencies and opportunities for improvement related to perceived access to care services and documents satisfactory progress towards the plan.	New Health System Records

			-Spending per capita, on a risk adjusted basis, in six major service categories in Southwest Virginia equal to the highest level in any community in the serviced region *Primary Care *Mental health *Heart and vascular *Muscular skeletal *GI *Cancer -Quality and experience measures in the six major service categories in Southwest Virginia equal to the highest level in any community in serviced region -Same day access to primary care for all residents of Southwest Virginia measured by 3rd available appointment -Specialty access to all six major service categories at 5 days or less for all residents of Southwest Virginia measured by 3rd available appointment
4 Adequate providers to provide equitable services throughout the region	Relevant Conditions 24-32 Post graduate training of clinical staff Residency program Recruitment plan	-Ratio of providers by discipline to serve the population by community -Trained and prepared clinical staff	**-Comprehensive clinical staff development plan and needs assessment with six month milestones complete and approved by the health commissioner on an annual basis** **-Plan to include specific strategies and tactics for Southwest Virginia** **-Progress in closure of clinical staff gaps in Southwest Virginia year over year with all gaps closed by 2021** **-Post graduate training plan developed including six month milestones defined approved by health commissioner within 12 months of signed agreement** **-Six month milestones achieved as defined**

5 Bench-mark operating performance	Relevant Conditions 12-13-16-17-40-45 Annual quality metrics Adverse events Operating results	Operating performance against benchmark for quality, finance and adverse events	**-Comprehensive operating plan for finance, quality and experience with six month milestones complete and approved by the health commissioner on an annual basis** **-Plan to include specific strategies and tactics for Southwest Virginia** **-Ongoing review of six month milestones** **-Targets set for reduction of adverse events. Targets achieved on an annual basis** **-Upper quartile performance in financial metrics achieved in regional, sate and national comparisons** **-Maintained bed occupancy** **-Operating margin** **-Ebida margin** **-Return on assets** **-Annual operating margin growth** **-Annual operating expense growth** **-Capital spending growth** **-Total debt to capitalization** **-Annual debt service coverage** **-Debt to cash flow** **-Cash on hand** **-Accounts receivable** **-Average age of plant** **-Hospital adjusted expense per inpatient day** **-Bad debt as percentage of patient revenue** **-Ambulatory operating performance** **-Fully allocated financial performance per physician- primary/specialist** **-System wide best practices identified on an annual basis with no fewer than 3 being spread throughout the system** **-Upper quartile performance in all quality and satisfaction measures in regional, state and national comparisons** **Table 1: Quality Monitoring Measures**

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
	General information- Structural measures		

			1	SM-PART-NURSE	Participation in a systematic database for nursing sensitive care	Nursing Care Registry	
			2	ACS-REGISTRY	Participation in a multispecialty surgical registry	Multispecialty Surgical Registry	
			3	SM-PART-GEN-SURG	Participation in general surgery registry	General Surgery Registry	
			4	OP-12	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data	Able to receive lab results electronically	
			5	OP-17	Tracking Clinical Results between Visits	Able to track patients' lab results, tests, and referrals electronically between visits	
			6	OP-25	Safe surgery checklist use (outpatient)	Uses outpatient safe surgery checklist	
			7	SM-SS-CHECK	Safe surgery checklist use (inpatient)	Uses inpatient safe surgery checklist	
				Survey of patient's experiences- Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)			
			8	H-COMP-1-A-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Always" communicated well	
			9	H-COMP-1-U-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Usually" communicated well	
			10	H-COMP-1-SN-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Sometimes" or "Never" communicated well	
			11	H-COMP-2-A-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Always" communicated well	
			12	H-COMP-2-U-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Usually" communicated well	
			13	H-COMP-2-SN-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Sometimes" or "Never" communicated well	

			14	H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Always" received help as soon as they wanted
			15	H-COMP-3-U-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Usually" received help as soon as they wanted
			16	H-COMP-3-SN-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted
			17	H-COMP-4-A-P	Pain management (composite measure)	Patients who reported that their pain was "Always" well controlled
			18	H-COMP-4-U-P	Pain management (composite measure)	Patients who reported that their pain was "Usually" well controlled
			19	H-COMP-4-SN-P	Pain management (composite measure)	Patients who reported that their pain was "Sometimes" or "Never" well controlled
			20	H-COMP-5-A-P	Communication about medicines (composite measure)	Patients who reported that staff "Always" explained about medicines before giving it to them
			21	H-COMP-5-U-P	Communication about medicines (composite measure)	Patients who reported that staff "Usually" explained about medicines before giving it to them
			22	H-COMP-5-SN-P	Communication about medicines (composite measure)	Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them
			23	H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Always" clean
			24	H-CLEAN-HSP-U-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Usually" clean
			25	H-CLEAN-HSP-SN-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were "Sometimes" or "Never" clean

			26	H-QUIET-HSP-A-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was "Always" quiet at night
			27	H-QUIET-HSP-U-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was "Usually" quiet at night
			28	H-QUIET-HSP-SN-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night
			29	H-COMP-6-Y-P	Discharge information (composite measure)	Patients who reported that YES, they were given information about what to do during their recovery at home
			30	H-COMP-6-N-P	Discharge information (composite measure)	Patients who reported that NO, they were not given information about what to do during their recovery at home
			31	H-COMP-7-SA	Care Transition (composite measure)	Patients who "Strongly Agree" they understood their care when they left the hospital
			32	H-COMP-7-A	Care Transition (composite measure)	Patients who "Agree" they understood their care when they left the hospital
			33	H-COMP-7-D-SD	Care Transition (composite measure)	Patients who "Disagree" or "Strongly Disagree" they understood their care when they left the hospital
			34	H-HSP-RATING-9-10	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
			35	H-HSP-RATING-7-8	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)
			36	H-HSP-RATING-0-6	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)

			37	H-RECMND-DY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would definitely recommend the hospital
			38	H-RECMND-PY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would probably recommend the hospital
			39	H-RECMND-DN	Willingness to recommend the hospital (global measure)	Patients who reported NO, they would probably not or definitely not recommend the hospita
				Timely & effective care- Colonoscopy follow-up		
			41	OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy
			42	OP-30	Endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous polyps - avoidance of inappropriate use	Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe
				Timely & effective care- Heart attack		
			43	OP-3b	Median time to transfer to another facility for acute coronary intervention	Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital
			44	OP-5	Median time to ECG	Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG
			45	OP-2	Fibrinolytic therapy received within 30 minutes of emergency department arrival	Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival
			46	OP-4	Aspirin at arrival	Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department

	Timely & effective care- Emergency department (ED) throughput		
47	EDV	Emergency department volume	Emergency department volume
48	ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients	Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient
49	ED-2b	Admit decision time to emergency department departure time for admitted patient	Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room
50	OP-18b	Median time from emergency department arrival to emergency department departure for discharged emergency department patients	Average (median) time patients spent in the emergency department before leaving from the visit
51	OP-20	Door to diagnostic evaluation by a qualified medical professional	Average (median) time patients spent in the emergency department before they were seen by a healthcare professional
52	OP-21	Median time to pain medication for long bone fractures	Average (median) time patients who came to the emergency department with broken bones had to wait before getting pain medication

			53	OP-22	Patient left without being seen	Percentage of patients who left the emergency department before being seen	
			54	OP-23	Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	
				Timely & effective care- Preventive care			
			55	IMM-2	Immunization for influenza	Patients assessed and given influenza vaccination	
			56	IMM-3-OP-27-FAC-ADHPCT	Influenza Vaccination Coverage among Healthcare Personnel	Healthcare workers given influenza vaccination	
				Timely & effective care- Stroke care			
			57	STK-4	Thrombolytic Therapy	Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started	
				Timely & effective care- Blood clot prevention & treatment			
			58	VTE-6	Hospital acquired potentially preventable venous thromboembolism	Patients who developed a blood clot while in the hospital who *did not* get treatment that could have prevented it	
			59	VTE-5	Warfarin therapy discharge instructions	Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine	
				Timely & effective care- Pregnancy & delivery care			
			60	PC-01	Elective delivery	Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary	

				Complications- Surgical complications		
			61	COMP-HIP-KNEE	Hospital level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Rate of complications for hip/knee replacement patients
			62	PSI-90-SAFETY	Complication/patient safety for selected indicators (composite)	Serious complications
			63	PSI-4-SURG-COMP	Death rate among surgical inpatients with serious treatable complications	Deaths among patients with serious treatable complications after surgery
				Complications- Healthcare-associated infections (HAI)		
				Readmissions & deaths- 30 day rates of readmission		
			64	READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients
			65	READM-30-AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Rate of readmission for heart attack patients
			66	READM-30-HF	Heart failure (HF) 30-day readmission rate	Rate of readmission for heart failure patients
			67	READM-30-PN	Pneumonia (PN) 30-day readmission rate	Rate of readmission for pneumonia patients
			68	READM-30-STK	Stroke 30-day readmission rate	Rate of readmission for stroke patients
			69	READM-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day readmission rate	Rate of readmission for coronary artery bypass graft (CABG) surgery patients
			70	READM-30-HIP-KNEE	30-day readmission rate following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	Rate of readmission after hip/knee replacement
			71	READM-30-HOSP-WIDE	30-day hospital-wide all- cause unplanned readmission (HWR)	Rate of readmission after discharge from hospital (hospital-wide)
				Readmissions & deaths- 30-day death (mortality) rates		
			72	MORT-30-COPD	COPD 30-day mortality rate	Death rate for COPD patients
			73	MORT-30-AMI	Acute myocardial infarction (AMI) 30-day mortality rate	Death rate for heart attack patients
			74	MORT-30-HF	Heart failure (HF) 30-day mortality rate	Death rate for heart failure patients
			75	MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Death rate for pneumonia patients

			76	MORT-30-STK	Stroke 30-day mortality rate	Death rate for stroke patients	
			77	MORT-30-CABG	Coronary artery bypass graft (CABG) surgery 30-day mortality rate	Death rate for CABG surgery patients	
				Use of medical imaging- Outpatient imaging efficiency			
			78	OP-8	MRI Lumbar Spine for Low Back Pain	Outpatients with low-back pain who had an MRI without trying recommended treatments (such as physical therapy) first. If a number is high, it may mean the facility is doing too many unnecessary MRIs for low-back pain.	
			79	OP-9	Mammography Follow-Up Rates	Outpatients who had a follow-up mammogram, ultrasound, or MRI within the 45 days after a screening mammogram	
			80	OP-10	Abdomen CT - Use of Contrast Material	Outpatient CT scans of the abdomen that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).	
			81	OP-11	Thorax CT - Use of Contrast Material	Outpatient CT scans of the chest that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).	

			82	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (if a number is high, it may mean that too many cardiac scans were done prior to low-risk surgeries).	
			83	OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	Outpatients with brain CT scans who got a sinus CT scan at the same time (if a number is high, it may mean that too many patients have both a brain and sinus scan, when a single scan is all they need).	
6 Strong, vibrant culture	Relevant Conditions 18-20-21-22-38 Employee management Strong medical staff Strong board of directors	-Attrition management -Medical staff make-up -Board of directors survey -Employee development	-Comprehensive human resource plan with six month milestones complete and approved by the health commissioner on an annual basis -Plan to include specific strategies and tactics for Southwest Virginia -Ongoing review of six month milestones -Employment level targets achieved using attrition management with no layoffs, reported on a quarterly basis -Reduction in annual turnover rates achieving and maintaining top quartile performance for health systems nationally -Improved employee satisfaction year over year achieving top 10% performance on a comparative basis by 2021 -Improved board relationships year over year measured by an annual board survey -Employee development dollars defined in annual budget with targets achieved				

			-Goals defined and achieved for employee development year over year
7 Strong academics and research impacting regional issues	Relevant Conditions 25 Academics and research	Dollars and impact of research	-Comprehensive Research plan with six month milestones complete and approved by health commissioner on an annual basis -Research dollars align with the top five health issues in the region 90% of the time with demonstrated long term impact on the region defined and measured -Achievement of six month milestones on a rolling basis

8 Monetary commitment	Relevant Conditions 3-19-23-33-34-35-36-37 All	Target spreading in defined areas of commitment	**-Target spending by community defined and achieved on an annual basis with demonstrated equal allocation to SW Virgina and the specific issues faced by the region** **-Goals of spending in SW Virginia with specific measures of performance success defined and reported on a quarterly basis** **Monetary Commitments and Annual Baseline Spending Levels** **MONETARY COMMITMENTS**

		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**

Conditions related to all outcomes: 2-4-5-39-47-48-49

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.