COPN-Covered Services	PD 1	PD 2	PD 3	Health Planning Region III
CT	Potential Need	(X) No Need Demonstrated	(X) No Need Demonstrated	
MRI	(X) No Need Demonstrated	Potential Need	(X) No Need Demonstrated	
MSI	No Hospital Qualifies	No Hospital Qualifies	No Hospital Qualifies	
PET or PET/CT	(X) No Need Demonstrated	(X) No Need Demonstrated	(X) No Need Demonstrated	
Noncardiac Nuclear Imaging	(X) No Need Demonstrated	(X) No Need Demonstrated	(X) No Need Demonstrated	
Radiation Therapy	(X) No Need Demonstrated	(X) No Need Demonstrated	(X) No Need Demonstrated	
Stereotactic Radiosurgery	Assessed by Region			(X) No Need Demonstrated
Cardiac Cath	(X) No Need Demonstrated	(X) No Need Demonstrated	(X) No Need Demonstrated	
Pediatric Cardiac Cath	No Hospital Qualifies	No Hospital Qualifies	No Hospital Qualifies	
Open Heart Surgery	No Hospital Qualifies	No Hospital Qualifies	No Hospital Qualifies	
Pediatric Open Heart Surgery	No Hospital Qualifies	No Hospital Qualifies	No Hospital Qualifies	
General Surgery Services	Potential Need	Potential Need	(X) No Need Demonstrated	
Inpatient Beds (Med Surg)	Potential Need	(X) No Need Demonstrated	(X) No Need Demonstrated	
Inpatient Beds (ICU)	Potential Need	(X) No Need Demonstrated	(X) No Need Demonstrated	
LTACH	Potential Need	Potential Need	Potential Need	
Nursing Facility Beds	(X) No Need Demonstrated	(X) No Need Demonstrated	(X) No Need Demonstrated	
Lithotripsy	Potential Need	Potential Need	(X) No Need Demonstrated	
Organ Transplant	N/A	N/A	N/A	
Medical Rehabilitation	(X) No Need Demonstrated.	(X) No Need Demonstrated.	(X) No Need Demonstrated.	
Acute Psych & Sub Abuse	Potential Need	Potential Need	(X) No Need Demonstrated	
ICF/MR Facilities	Potential Need	Potential Need	Potential Need	
OB	Potential Need	Potential Need	(X) No Need Demonstrated	
Neonatal Special Care				
Intermediate Level Newborn	Potential Need	Potential Need	(X) No Need Demonstrated	
Specialty Level Newborn	(X) No Need Demonstrated	(X) No Need Demonstrated	Potential Need	
Subspecialty Level Newborn	(X) No Need Demonstrated	(X) No Need Demonstrated	(X) No Need Demonstrated	

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March 22, 2017

BY EMAIL (erik.bodin@vdh.virginia.gov) ONLY
Mr. Erik O. Bodin, Director
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, VA 23233-1485

Re: Request for Additional Information – Response # 14

Dear Mr. Bodin,

Response # 14 to the questions received from your office on December 22, 2016, has been uploaded to the Citrix ShareFile platform.

Please contact me if you have any difficulty or questions in accessing the Citrix ShareFile platform. As permitted under Virginia Code § 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D), the material that the parties believe to be proprietary is clearly marked and submitted in separate electronic files for confidential treatment.

Responses to the following questions are submitted as part of Response # 14:

Section V. Additional Information

K. Questions Specific to Virginia Medicaid
   7
O. The Virginia Facilities
   4
P. Population Health
   5

I would bring to your attention that certain responses contain cross-references to T-14. T-14 is under review and will be submitted promptly following final approval.

Additional responses will be provided as soon as possible. Please let me know if you or your staff has any questions related to the enclosed documents.

Sincerely,

Jennifer Light McGrath

cc: Peter Boswell
Allyson K. Tysinger

879777/1

RESPONSE #14

TO QUESTIONS

SUBMITTED DECEMBER 22, 2016

BY

VIRGINIA DEPARTMENT OF HEALTH

IN CONNECTION WITH

APPLICATION FOR LETTER AUTHORIZING COOPERATIVE AGREEMENT

Pursuant to Virginia Code § 15.2-5384.1

and the regulations promulgated thereunder at 12VAC5-221-10 *et seq.*

Submitted by: Mountain States Health Alliance

Wellmont Health System

Date: March 22, 2017

V.K.7.

7. **Please describe in detail the parties' current status, plans, and proposed commitments for the following:**
   a. **Providing community health support services, such as federally qualified health centers and mobile health/free care clinics, as well as any other means of treatment in rural areas.**
   b. **Engaging in care management services for Medicaid patients and their families.**
   c. **Having Medicaid eligibility workers in facilities.**
   d. **Access to primary care services.**
   e. **Contracting with the health insurers participating in the healthcare exchange.**
   f. **Selecting/accepting interns and residents (including, if applicable, any restriction placed on where interns and residents will be accepted from).**
   g. **Admission privileges for physicians/healthcare providers who are not employed/associated with the New Health Plan.**
   h. **Any limits placed on specialty/subspecialty treatment for Virginia Medicaid enrollees.**

JOINT RESPONSE:

Overview

The goal of the NHS is to provide equitable care to all populations and to institute a best practice standard in regard to serving disadvantaged populations. Ballad Health will accomplish these objectives through (i) the establishment of an integrated health delivery system with a focus on population health that includes strategies for equitable access and care coordination to reduce disparity; (ii) a more liberal charity care and self-pay policy than exists today in either system and that is consistent with the IRS 501(r) regulations; and (iii) a cultural and linguistically appropriate approach to services that formalizes Ballad Health's expectations for all employees who interact with disadvantaged individuals and people living with disabilities.

The types of health care inequity that exist in the Geographic Service Area include similar factors to those that exist nationally including inequities resulting from race, disability, educational attainment, and economic status. In addition, there are distinct characteristics of the Geographic Service Area that contribute to disparity, especially characteristics that affect rural populations and their ability to access services. The region is also disproportionately impacted by low educational attainment levels and poverty in relation to other factors such as race or ethnicity. A locally based health system, governed by people who live, work, play, and pray in the community, has the best opportunity to address the unique needs of the region. By adapting national best practice interventions to the specific aspects of this area and its Southern Appalachian culture, Ballad Health has the opportunity to make meaningful improvement in an area plagued with health inequities.

Ballad Health strives to be a health care system that (i) operates effectively and efficiently to ensure all people get the care they need and (ii) invests in keeping them healthy. To do this, Ballad Health must specifically address the health inequities and inefficiencies in the region. Community Catalyst, a

national non-profit organization, has done extensive work on health inequities and recommends the following six reforms to reduce disparities in healthcare:

1) Expand coverage and access to care;
2) Improve data collection and metrics on disparities;
3) Implement socioeconomic risk adjustments in payment reform;
4) Ensure providers are culturally competent;
5) Reallocate resources to address social determinants of health; and
6) Promote a more diverse workforce and use of community-based providers such as Community Health Workers.

These policy recommendations provide guidance to the disparities strategy proposed for Ballad Health. Ultimately, a health system governed by people who live, work, play, and pray together has the best opportunity to address the unique needs of the region. Ballad Health will do this by adapting national best practice interventions to the specific aspects of our area and its Southern Appalachian culture.

Strategies for Equitable Access and Care

Ballad Health's approach to addressing disparities is shaped by the not-for-profit orientation of Wellmont and Mountain States—to meet the health care needs of patients regardless of their ability to pay, and provide outreach services to those who are geographically limited in their access. These efforts have been supported by a variety of efforts, including direct contributions of care by the systems, contributions of dollars by the systems to community-based organizations which organize access to care, and through our foundations, raising funds to meet non-medical patient needs which are often not met elsewhere through insurance coverage or government assistance programs. Both systems have also availed themselves of grant funding to provide assistance for vulnerable individuals. But these sources of funding are often inconsistent, often restricted to specific populations or problems, and are almost always too little regardless of the best intentions. The merger has the opportunity to create greater discretionary financial resources within Ballad Health as a result of the synergies generated. The Parties believe the new health system will be better positioned to proactively address health disparities experienced by patients and the broader population.

Though Wellmont and Mountain States collectively provide $164 million in charity care and support for self-pay patients, those resources primarily cover clinical care in our hospitals and clinics. To better address health disparities and increase the provision of equitable care, Ballad Health will use merger efficiencies to invest in systems of care coordination, including social screening, navigational, and case management resources that do not currently exist or cannot be appropriately scaled in the current resource constrained environment. These plans will be fulfilled through the $140 million of expanded services committed through the merger.

According to Kevin Fiscella in the *Annals of Family Medicine*, "Equitable health care means more than elimination of bias, it also means creation of patient-centered systems of care that support healing and caring relationships that are responsive to patients' needs, wishes, and context.

Improving equity requires aligning health care resources and capability with patient needs, particularly patients who have been historically underserved."

Like efforts nationally to build Health in All Policies, it is our intent to build disparities strategies into all clinical and business policies and processes throughout Ballad Health. To achieve this, Ballad Health plans to take the following steps:

- Use data and analytics to (i) not only identify vulnerable individuals in our patient population, but importantly to identify vulnerable individuals in the community who are not connected with a regular source of care and (ii) design strategies and services to reach individuals and motivate them to action and remove barriers in their way.
- Embed systems for equitable care within all administrative and clinical processes rather than considering health equity as the problem of the population health department. This includes creating work flows at hospital, clinic and urgent care registration as well as at the bedside to identify individual needs and translate them into navigation and case management action plans that connect people to community-based resources to help meet transportation, food, housing, behavioral health, and substance abuse needs.
- Develop and deliver education and prevention resources connected to the Community Health Improvement Plan including screenings and immunizations.
    - Develop, deliver, or connect people to family support services for early childhood development, perinatal resources, effective parenting, and Neonatal Abstinence Syndrome avoidance and treatment.
    - Connect people to primary care and medical home programs either within Ballad Health, the network of community physicians, Federally Qualified Health Centers or Rural Health Centers and incentivize providers to invest time in patient engagement around social needs.
    - Work with payers, especially Medicare and Medicaid managed care plans, to develop more cohesive systems of care coordination and to incentivize accessible, high-quality, and efficient care for these populations and reward effective management of social needs and determinants of health in addition to traditional payment for service.
    - Work specifically with vulnerable populations, such as the high-need, high-utilizing uninsured individuals suffering from mental health and addictions, including pregnant women, as noted in the Application.

Charity Care and Self-Pay Policies

In order to ensure low income patients who are uninsured or under-insured are not adversely impacted due to pricing, Ballad Health has committed to adopt a charity care policy that is substantially similar to the existing policies of both Parties and consistent with the Internal Revenue Service's final 501(r) rule. For patients who qualify, Ballad Health will provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred twenty-five percent (225%) of the federal poverty level. For patients who do not qualify for full write offs,[51] Ballad Health will discount services in compliance

[51] This is an increase over the amount set forth in revised Commitment 9 made in consultation with the Authority and listed on **Exhibit G-1A**, previously provided to the Commissioner on January 10, 2017 in Response #1. The amount set forth in original revised Commitment 9 (and shown on **Exhibit G-1A**) established a level at or below

with rule 501(r) according to the ability of individuals and families to pay and will communicate discounts according to policy prior to service delivery or at the point of service to avoid creating any barrier to essential care. Practices will include payment plans that are manageable for patients and their families according to their individual circumstances. Ballad Health will work to connect people to insurance coverage and state and federal programs for which they qualify. This commitment represents a higher level of charity care than Wellmont and Mountain States collectively offer now.

Ballad Health will 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. The activities related to charity care will occur immediately upon closing of the merger and will remain in place as long as the Certificate of Public Advantage remains in effect.

Ballad Health will also commit that neither Uninsured Patients nor Underinsured Patients will be charged more than amounts generally billed ("AGB") to individuals who have insurance covering such care in case of Emergency Services or other Medically Necessary Services.

Financial assistance eligibility for patients of Ballad Health will be determined by a review of the Application for Financial Assistance, documents to support the Application for Financial Assistance (i.e. income verification documentation), and verification of assets. Ballad Health's financial assistance determinations will be based on National Poverty Guidelines for the applicable year. Ballad Health will adhere to the IRS regulatory guidelines set forth in Section 501(r) of the Internal Revenue Code.

The commitments to patients who qualify for charity and the uninsured or underinsured will be implemented on a consistent basis across the Geographic Service Area and will apply to all Ballad Health facilities, thus ensuring equitable treatment for all.

Cultural and Linguistically Appropriate Approach to Services

Ballad Health is committed to building a culture of responsiveness and proactive engagement with underserved populations across the organization. This will require continuing education related to equitable care and redesign of associated processes as well as a deeper, more comprehensive understanding of the distinct characteristics of different populations in different geographic regions.

Ballad Health will use the National Standards for Culturally and Linguistically Appropriate Services in Health Care (the "National CLAS Standards") as a guide for this effort. According to the HHS Office of Minority Health, “The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations.”

200% of the federal poverty level, but the Parties have increased the amount to 225% of the federal poverty level to enhance this benefit for the region and the significant numbers of low income patients in Southwest Virginia. An amended **Exhibit G-1A** is provided to reflect this increase and the enhancement of our Commitment regarding the New Health System's charity care policies.

These fifteen standards are grouped according to one principal standard and three themes. The principal standard states the organization will strive to: *"Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs."*

The three themes of the remaining standards are (1) Governance, Leadership and Workforce, (2) Communication and Language Assistance and (3) Engagement, Continuous Improvement and Accountability.[52]

Within 12 months of closing, Ballad Health will complete an assessment of the organization's capability to meet these voluntary standards and assemble a work plan designed to advance the goal of the principal standard. The health system will work with the Offices of Minority Health and Health Equity in Virginia and the Office of Minority Health and Health Disparities Elimination in Tennessee to develop this work plan.

DETAILED JOINT RESPONSES

a. Providing community health support services, such as federally qualified health centers and mobile health/free care clinics, as well as any other means of treatment in rural areas.

Federally Qualified Health Centers: While Ballad Health has no current plans to operate an FQHC, we do partner with regional FQHCs to ensure effective access to preventative, primary, and dental care resources. Bryan Haynes, the CEO of Southwest Virginia Community Health Systems, a regional FQHC, is a member of the Smyth County Community Hospital board. We will continue and strengthen these partnerships to ensure a cohesive network of safety net services and will collaborate with these centers to strengthen their capabilities in areas such as care management, prevention services, social needs screening, and behavioral health resources so that shared patients can be connected to regional resources that help meet their direct health needs and the socio-economic and behavioral needs that support health and well-being. We will also work to ensure these centers have access to regional health information exchange and support their efforts to establish medical homes.

Mobile Health: Both Wellmont and Mountain States currently operate mobile health services utilizing buses that are outfitted to provide physicals, preventative screenings, vaccinations, mammograms and other cancer screenings, cardiovascular screenings, and health education. These services will continue and expand under Ballad Health to ensure access to services that may be out of reach because of economic, transportation, health or geographic reasons. Certain basic health services will be provided free of charge for those who cannot afford them, and we will partner with regional health departments to conduct community health fairs in areas that lack convenient access to health services.

Free Care Clinics: Both Mountain States and Wellmont currently partner with a variety of free or sliding scale clinics in addition to FQHCs through financial support. These relationships

[52] National CLAS Standards available at https://www.thinkculturalhealth.hhs.gov/clas/standards.

include the partnership with the Health Wagon for primary care services in the CareScope 360 project, described below. These relationships will be expanded in the future to help meet regional needs, especially for prevention and primary care. We will work to ensure that the safety net of clinics serving the uninsured is strong and capable of handling regional volumes and will also work with them to have a concerted and cohesive approach to the management of care for high utilizers of health services. In this regard, assistance will be offered to help connect regional resources more effectively to support the overall health and well-being of disadvantaged populations to get upstream of expensive and life-threatening health issues.

b. Engaging in care management services for Medicaid patients and their families.

d. Access to primary care services.

[The following response is a dual response to requests K-7b and K-7d.]

According to the Institute for Healthcare Improvement:

> *"The current infrastructure for primary care in the US is not sufficient to meet the population management needs of a primary care patient panel. Researchers have estimated that it would take 7.4 hours per working day to provide all recommended preventive care to a panel of 2,500 primary care patients (similar to the average US primary care panel of 2,300), plus 10.6 hours to adequately manage this panel's chronic conditions. If you include the estimate that it takes 4.6 hours per day for acute care, this adds up to 22.6 hours per day. It's also been estimated that an average of only 54.9% of adults in the United States received recommended care in each of those areas.* ***It is not possible to achieve improved population health without substantial (versus incremental) change****."*[53]

Nationally, there is less of a primary care physician shortage than there is a significant mal-distribution of these physicians. According to the American Academy of Family Physicians, in the U.S. as a whole there is one primary care physician per 1300 persons while in rural areas the ratio is one per primary care 1910 persons and 1 family practice physician per 2940 persons. The Future of Family Medicine benchmark is 1 family practice physician per 1200 persons[54]

The shortage of primary physicians in the region is significant – even using traditionally supply and demand analysis. Examining age adjusted supply, which removes physicians aged 65 and over, the parties have determined that every county in their Virginia and Tennessee service area has a shortage. Overall in Virginia, there is a 67 primary care FTE shortage. Or, looking at it another way, only 61% of the demand is being met.

[53] Cindy Hupke, INST. FOR HEALTHCARE IMPROVEMENT, *Team-Based Care: Optimizing Primary Care for Patients and Providers* (May 2014), *available at* http://www.ihi.org/communities/blogs/_layouts/ihi/community/blog/itemview.aspx?list=0f316db6-7f8a-430f-a63a-ed7602d1366a&id=29.

[54] http://www.aafp.org/about/policies/all/rural-practice-paper.html accessed on January 9, 2017

The systems have traditionally worked to employ, or preferably help private practices subsidize, primary care physicians in shortage areas. The shortage which exists is not for lack of effort, but recruitment efforts are difficult. For example, recently completed searches for two Family Practice physicians in Marion, Virginia took 890 days and 1760 days. A position in Chilhowie remains open at 970 days as of 12/31/2016.

As part of the commitments made to the Southwest Virginia Health Authority, the NHS will develop a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by the New Health System. The New Health System will consult with the Authority in development of the plan. In addition, to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop, in partnership with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee. The plan will include, but not be limited to, how it will address the Authority's goals and how training will be deployed in Virginia and Tennessee based on the assessed needs, clinical capacity and availability of programs.

Meeting the primary care access needs of the area will require more than training and increased recruitment of primary care physicians, nurse practitioners and physician assistants. It will also require new care team models which incorporate pharmacists, care managers, navigators and community health workers; new community partnerships which leverage first responders and social services agencies, and emerging technologies in telemedicine and remote monitoring.

Efforts to build a better care model have existed for some time. For example, in the 1990s, with input from national experts and support from the Robert Wood Johnson Foundation, The MacColl Center for Health Innovation produced the Chronic Care Model, which identifies the essential elements of a health care system that encourage high-quality chronic disease care. "These elements are the community, the health system, self-management support, delivery system design, decision support and clinical information systems. Evidence-based change concepts under each element, in combination, foster productive interactions between informed patients who take an active part in their care and providers with resources and expertise."[55]

Over time and with successful application of the CCM, it became clear that modifications were necessary for the model to be successfully applied in a population health context. The Expanded Chronic Care Model (ECCM) displayed in Figure 1 now integrates population health promotion into *prevention* & management of chronic disease. There is now more emphasis on

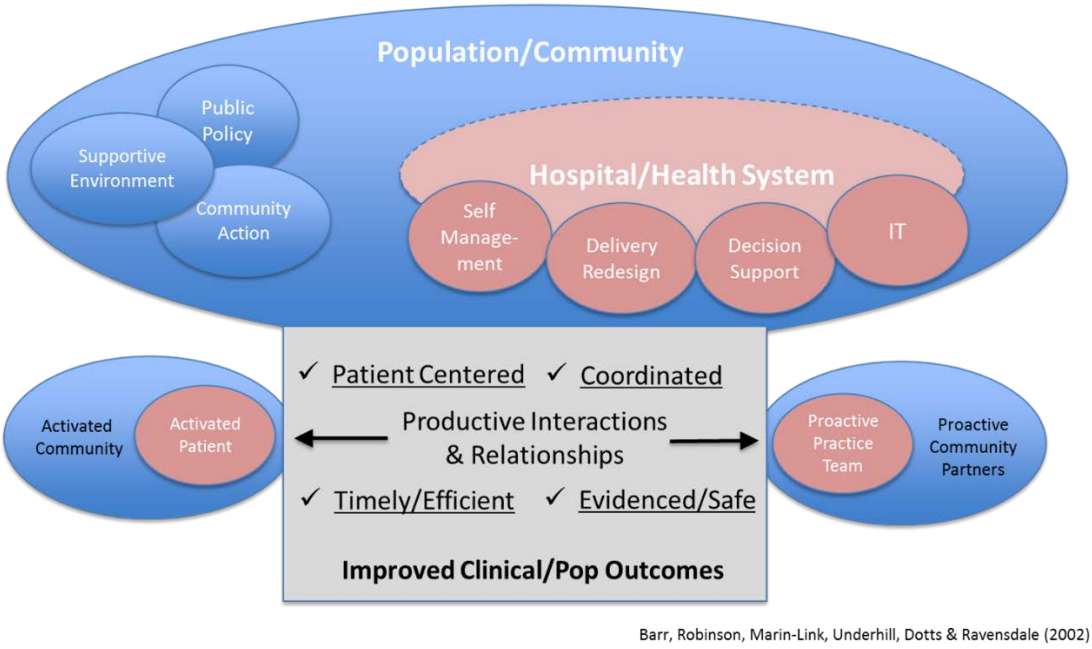
[55] GROUP HEALTH RESEARCH INST., THE CHRONIC CARE MODEL, *available at* http://www.improvingchroniccare.org/index.php?p=Model_Elements&s=18.

supporting people and communities to be healthy with greater focus on social determinants of health as well as delivering high-quality healthcare services.[56]

Although each component of the model deserves discussion, the proactive practice (care) teams' interaction with proactive community partners and activated patients and community is core to the ECCM's success. A widely accepted definition of "team-based care" is:

"The provision of comprehensive health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable."[57]

Figure 1: Expanded Chronic Care Model



Barr, Robinson, Marin-Link, Underhill, Dotts & Ravensdale (2002)

Productive interactions between a proactive practice team and the activated patient are crucial. In order to achieve success, the proactive practice team must have the information, decision support and resources need to deliver high quality care, and the activated patient must have the motivation, information, skills and confidence to effectively manage his or her health. A productive interaction should include:

- assessments of clinical status, self-management skills and confidence (possibly using a valid patient activation measure survey);

[56] Kathryn Kash, Jefferson School of Population Health, Address to the 11th Population Health & Care Coordination Colloquium, Pre-Conference Boot Camp (March 14, 2011) (slideshow), *available at* http://www.ehcca.com/presentations/pophealthsummit1/kash_pc.pdf.
[57] MD Naylor, et. al, *Team-Based Primary Care for Chronically Ill Adults: State of the Science, Advancing Team-Based Care* (American Board of Internal Medicine Foundation 2010).

- individualizing of clinical management potentially using stepped protocols;
- a care plan built by collaborative goal-setting and problem solving; and
- sustained follow-up.[58]

It is important to consider the expanded definition of the primary care team, which is necessary to achieve both better population health outcomes and individual clinical and functional outcomes. The ECCM specifically adds the support of proactive community partners to the clinical practice. Figure 2 depicts a model for this expanded concept of the primary care team developed as part of the MacColl Center *Learning from Effective Ambulatory Practices (LEAP)* project funded by the RWJ Foundation. A core team is collectively responsible for a defined patient panel linked with a specific provider, clinical assistants, RN, health coach, and front desk staff. This core is supported by extended team members who serve as shared resources available to patients of multiple core primary teams. An additional outer layer includes staff not employed by the practice but proactively included as part of an individual's care team through case management plans and formal links with community partners.[59]

Patient Centered Medical Home Participation

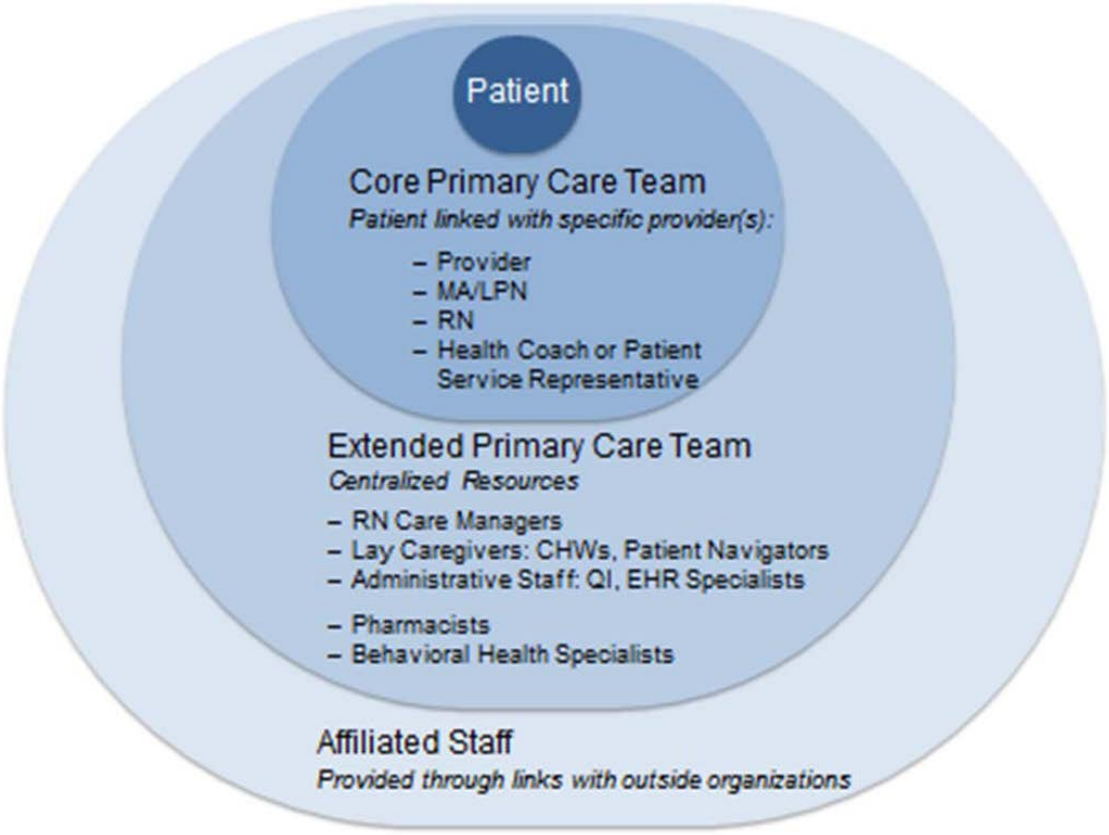
Both Wellmont and Mountain States operate NCQA Patient Centered Medical Home (PCMH) practices, which provide a baseline standard for a primary care team that is focused on better-coordinated management of patients. This certification was pursued over time as payers increasingly incentivized or required this, or similar, certification. NCQA PCMH certification has, over time, required more components of the ECCM with an emphasis on team-based care, focusing the patient as the center of care, consideration of social determinants of health, behavioral health integration, and care coordination and follow up with external support organizations. A number of roles listed above in the extended primary care team are increasingly utilized, including RN care management, patient navigators, QI specialists and pharmacists.

While there are multiple recognition entities, NCQA is the most recognized nationally and represents rigorous quality standards. In addition to this, each of the Parties' recognized primary care practices has been recognized at "Level 3." This is the highest level of recognition that NCQA awards.

[58] Kathryn Kash, Jefferson School of Population Health, Address to the 11th Population Health & Care Coordination Colloquium, Pre-Conference Boot Camp (March 14, 2011) (slideshow), *available at* http://www.ehcca.com/presentations/pophealthsummit1/kash_pc.pdf.

[59] ROBERT WOOD JOHNSON FOUNDATION: IMPROVING PRIMARY CARE, *The Primary Care Team: Conceptual Diagram* http://www.improvingprimarycare.org/sites/default/files/topics/Team-Step2-Care%20Team%20Conceptual%20Diagram-DC.pdf.

Figure 2: The LEAP Primary Care Team Conceptual Diagram



The Patient-Centered Medical Home concept places patients at the center of their care experience while the primary care office functions as a partner with the patient in the patient's care. This transforms the patient care experience from a reactive one, where the patient only gets care when he/ she accesses it, to a proactive one, where the clinical team reaches out to the patient and prepares for the patient visit in advance. Under this model, a team of health professionals led by the primary care provider (PCP) work together using modern technology and innovative care delivery models to provide patients with improved care coordination and guidance in meeting their health goals. Along with the PCP, the care team may include a nurse, a health educator and other health care professionals, such as a pharmacist or behavioral health resource.

Care management components of the PCMH care delivery model include:

- ✓ Patients in certain risk groups receive a disease-specific care plan
- ✓ Care planning process includes a discussion with the patient incorporating motivational interviewing to help the patient achieve care goals
- ✓ Certain vulnerable patients are assigned to a care manager who follows the patient's care in a proactive, ongoing fashion to help the patient improve his/ her health status
- ✓ MSMG has two Clinical Pharmacists who impart medication-related education to patients and work with the PCP to ensure all medications are appropriate

- ✓ MSMG has a Behavioral Health Care Navigator who makes home visits to certain high-risk, vulnerable patients and is able to complete a psycho-social assessment
- ✓ Gaps in care are presented to the provider for the patient at the point-of-care
- ✓ Patients who have been to the Emergency Room (ER) receive a follow-up call and information on appropriate ER utilization
- ✓ Patients with specific presenting diagnoses or symptoms have a follow-up with the PCP after a visit to the ER
- ✓ Records are obtained from ER visits for PCP review
- ✓ Patients who have been hospitalized receive a follow-up call to ensure the patient is receiving all needed services, medications have been filled and the patient has a timely hospital follow-up with the PCP
- ✓ Records are obtained prior to the hospital follow-up appointment for the PCP to review

Mountain States Medical Group has approximately 28,000 covered lives in medical home arrangements with payer partners. MSMG has a quality team infrastructure of 26 team members to assist in managing this population. The team consists of care coordinators, care managers, clinical pharmacists, report analyst, clinical leader, and a medical director of quality improvement. The practice is participating in TennCare's PCMH initiative which went live with Tennessee Medicaid Managed Care Organizations January 1, 2017.

Wellmont Medical Associates has approximately 6400 lives associated with Level 3 Patient Centered Medical Home practices and multiple payer partnerships that require medical home characteristics to be a component of the overall medical group philosophy of care beyond these three practices. The WMA quality and transitional care team includes care managers, data specialists, and partnering providers along with embedded care coordinators from payer partners.

Neither MSHA nor WHS are contracted to perform Medicaid care management in Virginia at this time. The combined practices of the NHS would welcome agreements of this type in Virginia.

<u>Integrated Health Solutions Network Medicaid Care Management</u>

Integrated Solutions Health Network (ISHN) is an affiliated company within Mountain States that provides network management and population health services. The AnewCare Collaborative subsidiary of ISHN in a separately governed Accountable Care Organization which provides analytics and care management services for a number of at-risk contracts within Mountain States, including a 14,000-life Medicare Share Savings Program (Track 1) in its fourth operating year in Virginia and Tennessee.

AnewCare has also contracted with Amerigroup in Tennessee, a subsidiary of Anthem, since January 2015 to provide network access and care coordination services to approximately 17,000 TennCare lives in Tennessee. About 80% of these Medicaid lives are categorized as TANF (Temporary Assistance to Needy Families), while the remaining 20% are disabled members. 10,000 of these lives are attributed to Mountain States Medical Group, and the remaining lives are distributed among several independent practices in Tennessee.

In its contract with Amerigroup, AnewCare provides "high touch" care coordination services to the high risk, chronic and complex population in collaboration with the Amerigroup care management staff. Amerigroup retains responsibility for chronic/complex case management. The AnewCare care management team works with the provider practices and Amerigroup to identify and close gaps in care which are aligned with the defined quality metrics in the contact.

AnewCare does not currently manage any Medicaid lives within the state of Virginia. However ISHN does have partnerships with Virginia Premier, Optima Sentara, InTotal Health and Aetna Better Health to provide network access services to Medicaid patients in southwest Virginia. These partnerships position the NHS in the future to provide meaningful care management services to improve the health of Medicaid patients in Virginia should the payers find value in these services or the state mandate them.

Additional Care Management Capabilities

Both health systems are pursuing further implementation of the ECCM and the LEAP Primary Care Team model described above which expands primary care access and care management services. Several examples are listed below.

A. CareScope 360

In anticipation of the merger, Mountain States and Wellmont applied for and received a $205,000 grant from the Virginia Health Care Foundation to provide care coordination and linkages to community resources for uninsured individuals with high utilization of the emergency department (ED) and at least one hospital admission at either Norton Community Hospital in Norton, VA (Mountain States Health Alliance), or Lonesome Pine Hospital in Big Stone Gap, VA (Wellmont Health System). The goal of the grant is to reduce ED utilization rates and avoidable hospital admissions by improving health status through better identification and management of medical needs and social barriers before they reach crisis stage. The timeframe is June 1, 2016, through November 20, 2017, and 175 individuals are expected to be served.

CareScope 360 takes a "360 degree view" of a patient's strengths and needs, both medical and social. The target population for this project is uninsured individuals with high utilization of the ED and who were ultimately admitted to the hospital on at least one occasion. Operating at the core of the program are dedicated care coordinators and one community health worker who work to connect each individual to primary care, behavioral health and social support services.

Our grant partners are the Health Wagon for primary care services, the Wise County Community Service Board and Frontier Health for behavioral health needs, and the Virginia Department of Health's Lenowisco Health District for training, education and other support for the community health worker. In addition, we are now working with Mountain Empire Older Citizens Area Agency on Aging (MEOC) to help with transportation issues with the CareScope 360 participants,

and the Stone Mountain Federally Qualified Health Center (FQHC) as a second primary care option that may be closer to their homes.

Care coordinators focus on identifying needs and creating a plan of care, and the community health worker works to facilitate the plans of care. Individuals meeting the selection criteria are contacted by the care coordinators and offered the chance to opt-in to the program. Those who can be reached and eventually enroll are screened for their unmet social needs (such as food and housing insecurity, domestic violence, lack of adequate transportation, etc.) and level of patient engagement in their own care. A second screening determines if the patient has a primary care physician, if they need medication assistance, and if they need more in-depth education on any current or chronic health conditions. Patients also receive a behavioral health screening to determine if a referral to Frontier Health is appropriate. Finally, patients will be screened for eligibility for Medicaid or for enrollment into a health plan on the Health Insurance Marketplace.

B. Primary Care - Behavioral Health Integration

Mountain States Medical Group has contracted with local behavioral health agency, Frontier Health, for the services of a behavioral health care navigator (BHCN) with extensive experience in the field. The BHCN is a part of the care management team working directly with the AnewCare Medicare Shared Savings Program population attributed to this practice. Currently this individual has 109 patients in her case load, 99 of which are associated with Virginia practices. Most of the BHCN interaction with patients is during home visits.

Providers, the nurse case manager or any member of the care team may refer patients to the BHCN. Once a referral is made, the BHCN does a chart review and assesses the behavioral health and social needs of the patient. The navigator provides an assessment of the referred individual's social determinants of health; strengths, needs, abilities and preferences (SNAP); and other relevant assessments to assist in identifying and accessing needed services that will maximize the individual's overall health and well-being. Major duties and responsibilities include:

- Conducting interviews with individuals and/or family members in a therapeutic manner so as to obtain critical and thorough information,
- Providing clinical assessments, service planning, crisis assistance, daily living assistance and linkage, referral and advocacy to/for referred individuals.
- Active involvement with primary care physicians, case managers, and other supportive staff to include ongoing communication and participating in integrated treatment team meetings.
- Providing in-home face to face connection to engage patient in needed services.
- Coordinating with community providers to assist and attend primary and behavioral health care, specialist, community resources, pharmacy, etc. and remaining current in knowledge of community resources and how to access those resources.
- Assisting and attending Primary and Behavioral Health Care appointments with consumers.

- Staying involved in the admission, hospital stay and discharge of individuals on caseload who are admitted to an inpatient primary/psychiatric facility.
- Attending and participating in regularly scheduled staff meetings, in-services and individual program planning staffing as needed.

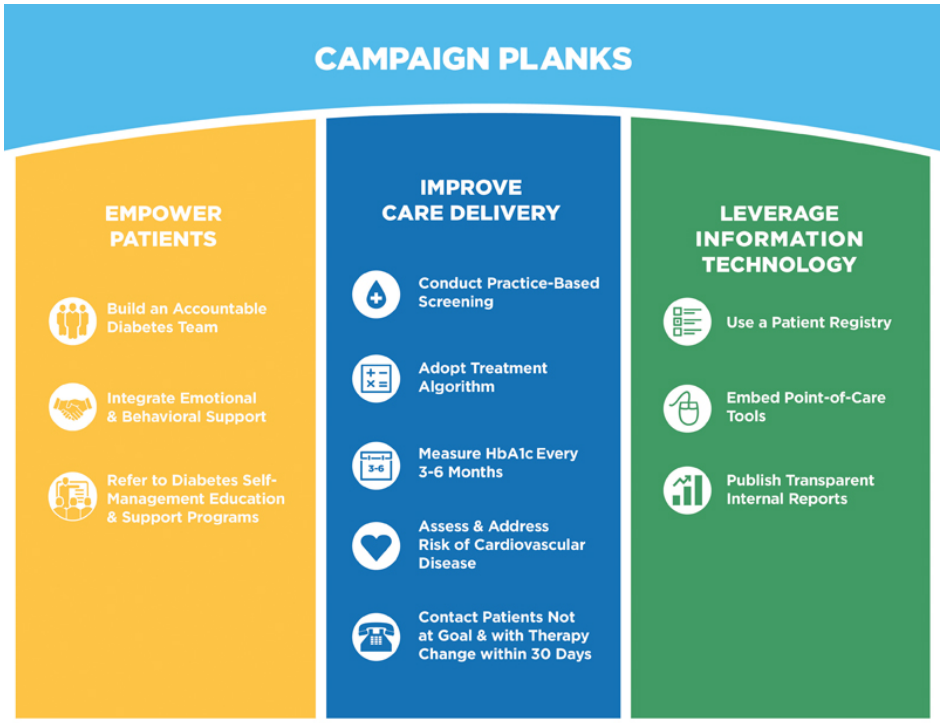
The BHCN addresses limited gap closure when he/she interacts with the patient. Examples include fall risk assessments and substance abuse screenings as may be deemed appropriate. The BHCN documents any interaction information and assessments within the electronic medical record and through the integrated "Social Determinants of Care Plan." The BHCN is an integral part of the team and interacts with care coordinators, nurses and physicians. The close connection to Frontier Health affords patients direct access to other behavioral health professionals. The cornerstone of the BHCN work is the focus on community outreach, and the majority of the contact with patients is through a home visit. This affords the primary care team the ability to learn about patient barriers that would almost never come up during a regular provider office visit.

C. Core Primary Care Team Example

To prepare primary care teams for their work in value-based performance models, Wellmont and Mountain States have worked significantly to re-orient and re-prioritize our approach to primary care and to work with payers to incentivize proactive care management to reduce health costs. Through the American Medical Group Association's Together 2 Goal initiative, Wellmont has adopted a set of primary care campaign planks and training around the model, along with transparent reporting of quality metrics and population risk scores across the medical group's primary care practices. Campaign planks are designed to empower patients to manage their own care, improve care delivery, and leverage information technology through an integrated approach that includes an accountable diabetes care team, integrated emotional and behavioral support, and diabetes self-management education. In addition, care delivery mechanisms are imported through concerted screenings, a uniform treatment algorithm, regular measurement of HbA1C levels, cardiovascular risk assessment, and communications and coaching for patients who are not achieving goal. A patient registry with point-of-care alerts and embedded tools is used along with transparent and frequent outcomes reported to drive performance.

In this environment, the patient-centered focus is enhanced and team-based care is embedded across all practices with commitment for adherence. The roles of the team include defined responsibilities and goals and the patient and family are considered part of the care team. The stage is set for cross-practice collaboration, especially with specialty practices that support co-related conditions such as cardiology and endocrinology in this example. And, everyone in the practice environment, including the patient, is involved in process improvement and evaluation. This is just one example of the many efforts currently employed by both Wellmont and Mountain States to coordinate and manage care through care teams. As the previous examples set forth, the next manifestation of this coordination under population health is to extend the

reach of coordination into community environments or across organizations to gain behavioral health support, social needs support, and deliver care and screening elements in community settings.



D. Pritikin Intensive Cardiac Rehabilitation

Wellmont's Pritikin program is an example of the development of care management teams in clinical settings extending engagement into personal and family dynamics to impact lifestyle and behavior change. The program has been proven to reduce the progression of heart disease in patients with diagnosed disease through a concerted program of education, exercise, diet, sleep, and stress management. Cardiologists and their office staffs reinforce the protocols in the total care regimen. The program also has application for other metabolic conditions where behavior modification is key to the prevention or progression of disease.

Health coordinators join with cardiac rehabilitation specialists and providers in a holistic approach that involves patients and family members both inside and outside of the clinical setting to empower behavior change and a supportive environment for continued success. The traditional exercise elements of cardiac rehab are bolstered by cooking classes, food shopping experiences, de-stressing activities such as yoga, meditation, and flexibility training and healthy sleeping habits. Social and relational reinforcement is also recognized as an important factor to

long-term success and participants join with groups of individuals facing similar health challenges for encouragement and shared successes.

E. Triumph Cancer Navigation

The Triumph Cancer Navigators program was established at Mountain States Health Alliance on October 27, 2015. The focus of the Triumph Cancer Navigators is to assist patients from the initial cancer diagnosis all the way through surgery, treatments, recovery, and survivorship regardless of payer source or source of care. Cancer navigators help with all aspects of the continuum of care, including communicating with medical providers, coordinating care, clinical education, and providing emotional support for patients. They also can help coordinate support services such as prosthesis selection and nutrition counseling, and identify resources for spiritual care, transportation, financial assistance, support groups, and other needs that may arise during treatment.

Triumph provides nurse navigators that assist breast, lung, gastrointestinal, head/neck, genitourinary, and hematological cancers as well as broad-based services that are beneficial for other cancer diagnoses. There are seven nurse navigators and three community navigators located throughout Tennessee and Virginia at the cancer centers. The Virginia facilities provide three nurse and two community navigators. These Virginia facilities include the Norton Community Hospital, Johnston Memorial Hospital, Russell County Medical Center, and Smyth County Community Hospital.

The program provides service throughout the 29 counties in our region. Triumph Cancer Navigators primary service areas are the following Virginia counties: Dickenson, Russell, Scott, Smyth, Washington and Wise; and in the following Tennessee counties: Carter, Greene, Hawkins, Johnson, Sullivan, Washington and Unicoi.

There were a total of 1,875 new cancer patients served by Triumph Navigators from October 2015 to October 2016 in Virginia and Tennessee. There were 983 outpatient Medicaid and Medicaid Managed Care cases served at Virginia facilities from July 1, 2015 to June 30, 2016.

Wellmont Cancer Institute's navigation services started in 1999 with one RN navigator that focused on lung and breast cancer. The program has grown to six dedicated RN navigators that cover inpatient and outpatient to ensure patients' needs are addressed across the continuum of care. Navigators are often referred to as the "glue" that guides patients through a complicated journey filled with a variety a specialists, frequent imaging, labs and decision making points. The role of the navigators is to be an educator, companion, and support while working to reduce gaps in care.

The navigators are an active participant in tumor boards to ensure continuity of care is maintained. The inpatient navigators hand off to the outpatient navigators and follow the patient throughout their journey and in to survivorship. The outpatient navigators are paired with patients by tumor site. Wellmont Cancer Institute is participating in the CMS Oncology Care Model 5 year demonstration project which is moving our navigator service model in the

direction of pairing to patients based on high-acuity, complex patients who have the greatest needs for services. In 2015 Wellmont Cancer Institute nurse navigators served 2,709 patients with 1,432 of those patients being in Virginia.

c. Having Medicaid eligibility workers in facilities. Both parties currently employ counselors to assist the uninsured and underinsured in acquiring insurance for which they qualify. This includes helping people identify Medicaid eligibility as well as eligibility for subsidized insurance under the exchanges. Both Wellmont and Mountain States have received navigation grants to ensure that people within the region who qualify are connected to insurance coverage. Regardless of these grants, this process will continue under Ballad Health and will connect to processes implemented for social screening needs within our facilities to better align the needs of those we serve with resources that can support their health goals along with the community health improvement goals of Ballad Health.

e. Contracting with the health insurers participating in the healthcare exchanges. Both Wellmont and Mountain States currently contract with all health insurers participating in the exchanges that serve our Geographic Service Area. This will continue under Ballad Health.

f. Selecting/accepting interns and residents (including, if applicable, any restriction placed on where interns and residents will be accepted from). The Graduate Medical Education (GME) programs of WHS and MSHA are responsible for interns and residents. As noted also in response V.-B-1, below is general information about the MSHA and WHS GME programs.[60]

- MSHA collaborates with three different academic institutions for its GME programs:
  - Edward Via College of Osteopathic Medicine in Blacksburg, VA at Johnston Memorial Hospital (JMH) in Abingdon, VA for programs in family medicine and internal medicine. The family medicine program at JMH consists of 12 residents, and the internal medicine program at JMH consists of five residents.
  - Lincoln Memorial University's DeBusk College of Osteopathic Medicine at Norton Community Hospital (NCH) in Norton, VA for its program in internal medicine. The GME program at NCH currently enrolls 25 internal medicine residents and has graduated 63 physicians over the 15-year course of the program.
  - East Tennessee State University's Quillen College of Medicine at Johnson City Medical Center (JCMC) for programs in family medicine, internal medicine, pediatrics and non-primary care.
  - MSHA also maintains an agreement with the Edward Via College of Osteopathic Medicine at JMH to provide clinical rotations for its third and fourth-year medical students.
- WHS collaborates with the following academic institutions for its GME programs:

[60] Additional detail on the Applicants' GME programs can be found in Response V.B-1 and other Section B responses and Exhibits.

- Lincoln Memorial University's DeBusk College of Osteopathic Medicine at Lonesome Pine Hospital (LPH) in Big Stone Gap, VA for its program in family medicine and at Holston Valley Medical Center (HVMC) in Kingsport, TN for its program in orthopedic surgery. The GME program at LPH currently enrolls 19 family medicine residents in Southwest Virginia, and the WHS GME program in orthopedic surgery at HVMC currently enrolls 11 residents.
- East Tennessee State University's Quillen College of Medicine at Bristol Regional Medical Center in Bristol, Tennessee and HVMC for programs in family medicine and internal medicine.
- WHS also maintains a number of agreements with institutions of higher learning and facilitates clinical learning experiences for training programs for various health professions, as well as medical student rotations. In particular, Wellmont's hospitals serve as a core training site for 3rd and 4th year medical students from Lincoln Memorial University's DeBusk College of Medicine to complete their training.

The GME programs at MSHA's NCH (internal medicine) and WHS' LPH (family medicine), in collaboration with partner Lincoln Memorial University, were founded on the need to narrow the gap in population health in Southwest Virginia, an area known for its severe shortage of primary care physicians and medical specialists. Similarly, the MSHA GME program at JMH, in collaboration with the Edward Via College of Osteopathic Medicine, trains residents with a focus in family medicine and internal medicine.

Exhibit K-7A outlines MSHA's GME recruitment, resident qualifications and selection, and written information provided to residency applicants. **Exhibit K-7B** outlines WHS' GME recruitment, resident qualifications and selection, and written information provided to residency applicants. Other than program criteria set forth in **Exhibits K-7A and K-7B**, the programs do not place limitations on academic institutions from which residents may be accepted.

The Applicants' current status, plans, and proposed commitments for selecting/accepting interns and residents is impacted by the funding provided by Medicare. Historically, Medicare provided substantial financial support of medical residency programs, but a significant change occurred in 1996 when Medicare limited the number of residents funded. MSHA's JCMC, in addressing a need for more rural primary care physicians, continued after 1996 to fund residency slots above the Medicare funds provided by CMS. In 2012, in the face of financial pressures, JCMC developed a six-year strategy with its GME partner East Tennessee State University (ETSU) to reduce residency slots to align with Medicare funding. The MSHA-ETSU plan involved reducing five (5) slots per year in each of Years 1-4 of the plan followed by ten (10) slots per year in each of Years 5 and 6, for a total reduction of forty (40) residency slots over 6 years at JCMC. Ten (10) JCMC residency slots were eliminated in accordance with the plan during

Years 1 and 2, but the reduction was stopped in light of the potential merger between MSHA and WHS. If the merger does not occur, MSHA anticipates that it will need to proceed with the plan to eliminate the additional thirty (30) residency slots at JCMC in accordance with the MSHA-ETSU plan.

MSHA's plans to reduce residency slots do not currently affect any of its Virginia facilities. The residency programs at JMH and NCH receive different funding from Medicare than the other MSHA residency programs. As long as adequate Medicare funding continues, MSHA has no plans to decrease slots at JMH or NCH, and, in fact, MSHA plans to grow the JMH family medicine and internal medicine programs to 18 and 15 residents, respectively, by 2017-18.

In the current environment, WHS and MSHA have been reducing the number of residency slots due to financial constraints. It is a goal of the New Health System to reverse this trend. Using savings obtained from merger-derived efficiencies, the New Health System will work with its academic partners and commit not less than $85 million over ten years to increase residency and training slots, create new specialty fellowship training opportunities, add faculty, and build and sustain research infrastructure. These are all critical to sustaining an active and competitive training program.

In furtherance of the goal to enhance GME programs, the NHS under the Cooperative Agreement has made the following Commitment to develop a coordinated long-term GME plan and, at a minimum, to maintain current Virginia residency slots, which includes the proposed metric for the Commissioner's active supervision of this Commitment:

> **Revised Commitment 17**: In order to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop, in partnership with at least its current academic partners, a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in Virginia and Tennessee. The plan will include, but not be limited to, how it will address the Authority's goals, how training will be deployed in Virginia and Tennessee based on the assessed needs, clinical capacity and availability of programs. Contingent on continued funding for existing programs from federal and state sources, the New Health System will not reduce or eliminate any medical residency programs or available resident positions presently operated by the Applicants at any Virginia facility provided, however, that such programs may be moved within Virginia, or substituted for residency training in Virginia in other specialties if that is in the best interests of the patient population in the area. Notwithstanding the foregoing, minor and temporary decreases in the number of full time equivalent residents working at Virginia hospitals may reflect year-to-year variations in residents applying for such training, dropping out of such training, electing to rotate to other hospitals, or transferring to another residency program, and shall not be deemed to violate this agreement.
>
> **Timing:** 10 years.

Amount: Combination of commitments 17 and 18[61] total $85 million.

Metric: Annually, the New Health System will report to the Commissioner: the number of accredited resident positions for each residency program operated in Virginia and the number of such positions that are filled, and shall furnish copies of the relevant pages of the Medicare cost reports showing the number of full time equivalent residents. An annual report shall also include a description of any affiliation agreements moving resident "slots" from one hospital to another pursuant to Medicare rules, resident programs moved from one hospital to another, and new programs started. No later than June 30, 2018, the New Health System will furnish to the Commissioner a plan for medical residency training programs and other health care professional training. The plan shall set forth the targeted number of persons to be trained by physician specialty or health care professional category, the location(s) of such training, the schedule for starting such training, and the expected gross annual expenditure relating to such training. It is acknowledged that the service area for the New Health System extends across state boundaries and patients, employees, and vendors freely cross those state lines. Accordingly, the Commissioner will not apply a fixed ratio to determine whether each year's expenditure under commitments number 17 and 18 is appropriately shared in by Virginia. On the other hand, the Commissioner will review expenditures made pursuant to this commitment for appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

As noted above, the Parties currently have relationships with a number of Virginia institutions of higher learning related to the education of nursing and allied health students, medical students and residents. As set forth in Revised Commitments 17 and 18, Ballad Health will work with all existing academic partners to establish the overall 10-year plans for both Academics and Research—with appropriate institutions involved in either the academics or research components of the plan. This includes the following academic partners in Virginia and Tennessee with whom we work closely to educate medical professionals or to collaborate on research initiatives:

- University of Virginia
- East Tennessee State University, Quillen College of Medicine
- Lincoln Memorial University, Debusk College of Osteopathic Medicine
- Edward Via College of Osteopathic Medicine
- Emory & Henry College
- Milligan College
- King University
- Tusculum College

[61] Revised Commitment 18 regarding the NHS commitment to develop a coordinated, 10-year research plan and invest in additional research opportunities.

- Northeast State Technical Community College
- Virginia Highlands Community College
- Southwest Virginia Community College
- Mountain Empire Community College

In the future, we will also explore options for collaboration with other Virginia institutions, especially those with ties to the region and those noted for research capability such as Virginia Tech and Virginia Commonwealth University.

Because GME and research are so closely connected, as part of the planning for Ballad Health, a Research & Academics Work Group was formed to make recommendations regarding the organization, infrastructure and collaborative governance necessary to grow research and academic activity in Southwest Virginia and Northeast Tennessee. The composition of this Work Group is attached as **Exhibit B-9**. Jake Schrum, President of Emory and Henry College, co-chaired this effort. As a result of the work of the Research & Academics Work Group, Ballad Health plans to pursue translational and public health research as a means to promote health in Southwest Virginia as well as creating more diversified economic development, and expects to work closely with established universities and colleges in Virginia to use the $85 million of incremental funding to attract additional private and federal research dollars to the region. See the response to Question C-1 (and **Exhibit C-1F**) for additional information about the initial report of the Research & Academics Work Group. The Work Group's initial recommendations are still being assessed, but the report is being used as a guide for the New Health System's plans and initiatives for academics and research growth.

While there are currently no specific plans for the allocation of these funds, the Parties have committed an incremental $85 million dollars in spending for academics and research in the first ten years and expect to spend the first year after the merger is approved developing a strategic plan for use of these funds. General proposed detail on the spending associated with academics and research is provided in **Exhibit O-5A,** the annual estimate of reinvestment from efficiencies. In regard to the sub-categories of spending on increasing residency and training slots, creating new specialty training opportunities, adding faculty, and research infrastructure —the Parties believe these plans must be developed together with their academic partners in Virginia and Tennessee, as recommended by the Authority. This process will include the development of the ten-year plan for post-graduate training of physicians, nurse practitioners, and physician assistants along with other allied health professions. The NHS will work closely with our current academic partners and other academic institutions in Virginia and Tennessee to develop and implement the ten-year plan for investment in health research and growth in the health research enterprise within the region. It is not possible for the Parties to develop these plans without the integral involvement of their academic partners in Virginia and Tennessee, and the Parties expect this process will take at least a year for these plans to be fully developed.

Strategically, a major part of the New Health System's emphasis will be on the development of academic research infrastructure and personnel which is needed to attract additional research funding from national sources—specifically in the area of translational research. The New Health System intends to allocate resources to priority research projects identified by the New Health System and academic partners in pursuit of this goal. Translational research projects that are focused on rural health care, population health management, health care transformation, and community health improvement will offer important insights to inform the New Health System's overall efforts in the region and to create national models.

Further, the Parties will focus on developing the academic infrastructure to ensure effective training for the next generation of health professionals that are needed to address the health care needs of this region. This will require a program gap analysis and the formation of program development plans. In addition, the Parties will work to identify fellowship training opportunities to support the regional base of sub-specialty physicians along with collaboration where professors and research leaders can work together to close gaps in regional specialty services or provide clinical oversight. The Parties expect that an offshoot of these comprehensive efforts will be the development of new medically and technically oriented businesses in the region, and the Parties plan to work with municipalities and economic development agencies to help incubate these opportunities and attract new opportunities to the region to support the regional economy.

MSHA believes that **Exhibit K-7A** is proprietary, confidential and competitively sensitive under federal antitrust laws. WHS believes that **Exhibit K-7B** is proprietary, confidential and competitively sensitive under federal antitrust laws. Each of MSHA and WHS will submit the Exhibit pertaining to it separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information that is required to remain confidential under Virginia Code Section 15.2-5384.1.C.1 and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).

INDEX OF DOCUMENTS:

- Exhibit K-7A MSHA GME Qualifications – **PROPRIETARY**
- Exhibit K-7B WHS GME Qualifications – **PROPRIETARY**

g. Admission privileges for physicians/healthcare providers who are not employed/associated with the New Health System. Both health systems currently collaborate with a variety of employed and independent physicians, including those community-based physicians who do not have active hospital privileges. Ballad Health has set forth as one of its guiding principles the goal to be one of the best health systems nationally for the practice of medicine. To that end, we will establish best practice working relationships with the physician community and many of

those physicians will have independent, volunteer leadership roles on hospital committees, through governance, on the Physician Clinical Council and in a variety of other ways. In addition, Ballad Health has made the following commitments which will ensure that our conduct supports regional access to physician services:

- In order to ensure choice of providers for consumers and to ensure physicians are free to practice medicine without any adverse effect from the merger, the New Health System will maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital departments or services as determined by the New Health System's Board of Directors or the hospital board if the hospital board is acting as the ultimate fiduciary body.
- In order to ensure providers in the region not affiliated with the New Health System may continue to operate competitively, and to ensure new provider entrants to the market are not disadvantaged by the New Health System, the New Health System will not require as a condition of entering into a contract that it shall be the exclusive network provider to any health plan, including any commercial, Medicare Advantage or managed Medicaid insurer. Nothing herein shall be construed as to impede the discretion of the payers in the market from designating the New Health System (or components thereof), as an exclusive network provider in all or part of the New Health System's service area.
- In order to ensure physicians and patients maintain their choice of facilities, and to ensure independent physicians can maintain their independent practice of medicine, the New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.
- The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.
- In order to improve quality for patients, ensure seamless access to needed patient information, and to support the efforts of the local physician community to access needed information in order to provide high quality patient care, the New Health System will participate meaningfully in a health information exchange or a cooperative arrangement whereby privacy protected health information may be shared with community-based providers for the purpose of providing seamless patient care.
- In order to enhance access to services for patients, and to ensure robust choices remain in the market for physicians in the various specialties needed throughout the region, the New Health System will commit to the development of a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by the New Health System. The New Health System will consult with the Authority in development of the plan. The New Health System will employ physicians and physician extenders primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such

specialties or expanding. The New Health System will promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment.

h. Any limits placed on specialty/subspecialty treatment for Virginia Medicaid enrollees. Currently all Mountain States Medical Group Virginia practices participate in Virginia Medicaid except for two dermatology practices in Abingdon. No participating MSMG practices place caps or other limitations on Virginia Medicaid patients.

Currently all Wellmont Medical Associate and Wellmont Cardiology Services practices participate in Virginia Medicaid. All practices are open except for WMA pain management clinics which are not accepting new Virginia Medicaid patients. WMA primary care practices have a limit of 250 Medicaid patients per physician, however, sufficient capacity exists in the system for Medicaid recipients to be seen.

Neither system places any limits on Virginia Medicaid patients for hospital based inpatient or outpatient services. There are no changes currently planned for these conditions under the New Health System.

V.O.4.

4. Detail appropriate quality and accessibility standards for each service offered or planned for the NHS. Provide data on these indicators for the five (5) year historical baseline period and YTD period. Provide a five (5) year and ten (10) year specific forecast for improvements based on current physical plant depreciation and useful life schedules.

JOINT RESPONSE: Wellmont and Mountain States anticipate improved access to health care under the Cooperative Agreement versus the status quo of no merger. Savings from efficiencies realized through the Cooperative Agreement will enable the hospitals to continue essential programs and services that are unprofitable and risk curtailment or elimination without the merger synergies, and the Applicants have made additional commitments that will enhance current service accessibility for the New Health System's patients.

Revised Commitment 20. In order to ensure continued access to health care in the region, the Parties have committed that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. In the event that the New Health System repurposes any hospital, it will continue to provide essential services in the community. For purposes of this commitment, the following services are considered "essential services":

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

If the New Health System becomes the primary health service partner of the Lee County Hospital Authority, the New Health System will be responsible for essential services as outlined above.[103]

Revised Commitment 25**.** In order to enhance access to services for patients, and to ensure robust choices remain in the market for physicians in the various specialties needed throughout the region, the New Health System will commit to the development of a comprehensive physician/physician extender needs assessment and recruitment plan every three years in each community served by the New Health System. The New Health System will consult with the Authority in development of the plan. The New Health System will employ physicians and physician extenders primarily in underserved areas and locations where needs are not being met, and where independent physician groups are not interested in, or capable of, adding such specialties or expanding. The New Health System will promote recruitment and retention of pediatric sub-specialists in accordance with the Niswonger Children's Hospital physician needs assessment….

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

Commitment 26: Enhancing health care services:

a. In an effort to enhance treatment of substance abuse in the region, the New Health System will create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee.

b. Because improved mental health services is a priority of the Authority and the law, the New Health System will develop community-based mental health resources, such as mobile health crisis management teams and intensive outpatient treatment and

[103] See NHS Revised Commitments, **Exhibit G-1A**.

addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements throughout the Virginia and Tennessee service area.

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

The New Health System will commit at least $140 million over ten years toward enhancing needed specialty services.

Many of our other Commitments and proposals are designed to allow the New Health System to enhance quality and access for patients in Southwest Virginia. These include (a) the adoption of a Common Clinical IT Platform, which will enhance hospital quality, improve cost-efficiency, improve the utilization of hospital-related services, and to enhance opportunities in research (Revised Commitment 19); (b) collaboration 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 (Revised Commitment 6); (c) establishment of a physician-led Clinical Council that will establish a wide range of clinical standards for the NHS, including quality performance standards for all NHS facilities; (d) identifying and publicly and timely reporting quality measures in an easy to understand manner for use by patients, employers and insurers, in accordance with annual priorities related to quality improvement (Revised Commitment 8); and (e) charity care and related policies to ensure continued access to health care for low income, uninsured or underinsured patients, who represent a large number of the patients in the Geographic Service Area (Revised Commitments 9 and 10).

In addition, the Alignment Policy (**Exhibit G-1B**) defines the process by which the NHS will make decisions related to the accessibility of services for the populations we serve. Accessibility of services is a key factor in our ability to achieve and sustain the population health improvement goals described in other Responses.[104]

Baseline standards for accessibility of key services are set under the Commonwealth's current Certificate of Public Need requirements. An assessment of the current access status of each key service in the planning districts and region served by Wellmont and Mountain States are included as **Exhibit O-4.** The Applicants propose that the commitments to preserve essential services would be evaluated against this standard. For physician services, it is proposed that the initial physician/physician extender needs assessment and recruitment plan detailed in Commitment 25 serve as the baseline for evaluation.

[104] See the following Section V. Responses for further description of the NHS' plans for population health improvement E-5, F-5, K-7, O-5a, O-9, P-8, Q-11, Q-15, T-14, T-16, T-23, T-28, including the Ballad Health Alignment Overview, Section 6 "The New Clinical System."

Health systems are subject to a wide-variety of requirements to report quality from government and commercial payers, accrediting agencies and licensing bodies. A considerable amount is publicly reported. Mountain States was a participant in the Commonwealth's State Innovation Model Lieutenant Governor's Roundtable on Quality, Payment Reform and HIT which identified that providers were subject to hundreds of disparate reporting metrics and it would be in the best interests of consumers, providers and payers if a common metric set was adopted and reported publicly. In this vein, the Applicants suggest that a quality scorecard be agreed to with the Department of Health based on currently collected measures. The base line for quality would begin in the first full year that data corresponding to the formation of the New Health System was available.

The NHS is committed through the Cooperative Agreement to ongoing financial support of the physical plant and capital needs associated with all of its facilities and their services. Historical and YTD capital expense statistics are provided in **Exhibit O-11A** (for MSHA) and **Exhibit O-11B** (for WHS). MSHA and WHS do not forecast capital expenses statistics for individual facilities, however please see the FTI Report and the New Health System 5-year projected budget (Excel format) in **Exhibit M-3C** for forecast information.

INDEX OF DOCUMENTS:

- **Exhibit O-4 COPN Needs Analysis**

V.P.5.

5. **The applicants state that, over ten years, $75 million will be invested in population improvements, $140 million will be invested to expand mental health, addiction recovery, and substance abuse prevention programs, $85 million will be invested in developing research opportunities, and $150 million will be invested in developing health information systems. Describe the strategy for making these investments. With whom will these investments be made? Are these amounts net increases? Provide a two (2) year historical baseline period analysis, YTD and a five (5) year forecast which clearly demonstrates the net amounts. Show amounts in Virginia and Tennessee. How much of these totals are allocated and expended by Virginia facilities to improve health care in Virginia alone? Provide a two (2) year baseline for each Virginia facility and a ten (10) year forecast. How does the merged system plan to periodically demonstrate its progress in these areas and show its accountability?**

JOINT RESPONSE: The requested information about each of these investments and programs can be found in the following responses and Exhibits:

Program	Responses	Exhibits
Population Health Improvement	F-5 – NHS partners to achieve goals K-7b/d – NHS current programs and plans for primary care O-5 – NHS plans for investments P-1 – NHS plans to develop integrated health care delivery system to impact population health T-14 – $75 million investment in population health improvements	O-5A – Year-by-Year Summary of Investments O-5B – NHS Template Community Health Improvement Plan Application Exhibits: 7.1I – MSHA Forms 990 for the Last Five Years 7.2F – WHS Forms 990 for the Last Five Years
Expansion of Services	L-5 – Revenues and Expenses O-5 – NHS plans for Investments T-14 – $140 million investment in expanded services	L-5A – MSHA Behavioral Health Revenues and Expenses L-5B – WHS Behavioral Health Revenues and Expenses

Academics and Research	B-7 – GME financial information C-2 – Research Revenues and Expenses T-14 – $85 million investment in research and academics	B-7A – MSHA GME Programs [financial data] B-7B – WHS GME Programs [financial data] C-2A – MSHA Research Revenues and Expenses C-2B – WHS Research Revenues and Expenses
IT Investment	Q-11 – NHS IT systems consolidation plan Q-14 – NHS timeline for implementation IT systems Q-15 – NHS timeline for $150 million investment	Q-2A- High-Level Timeline for Common Clinical IT Platform Q-2B – Summary Description of Parties Current Electronic Health Records Systems and Plans for Common Clinical IT Platform Q-2C Ballad Health Alignment Overview IT Strategy

LIST OF EXHIBITS

SECTION V

Exhibit Number	**Description**
K-7A	MSHA GME Qualifications ***This information will be submitted separately to the Virginia State Health Commissioner and the Attorney General for the Commonwealth of Virginia as proprietary information required to remain confidential under Virginia Code Section 15.2-5384.1.C.1, and Virginia's Rules and Regulations Governing Cooperative Agreements (12VAC5-221-40.D).**
O-4	COPN Needs Analysis