

Meeting Between Mountain States Health Alliance, Wellmont Health System,
and Virginia Department of Health Staff
Cooperative Agreement Application – Commonwealth of Virginia
August 8, 2017

Attendees:

Virginia Department of Health (VDH)

Dr. Marissa Levine – State Health Commissioner
Erik Bodin – Director, Office of Licensure and Certification
Peter Boswell – Director, Certificate of Public Need Program
Heather Anderson – Director, Division of Primary Care and Rural Health
Richard Corrigan – Deputy Commissioner for Administration
Catherine West – Administrative Assistant

Virginia Department of Medical Assistance Services (DMAS)

John Stanwix – Formal Appeals and Final Agency Decision Supervisor

Virginia Office of the Attorney General (OAG)

Allyson Tysinger – Senior Assistant Attorney General/Chief
Sarah Allen – Senior Assistant Attorney General/Unit Manager
Ty Henry – Assistant Attorney General
Amanda Lavin – Assistant Attorney General

Mountain States Health Alliance (MSHA)

Alan Levine – President and CEO
Marvin Eichorn – Executive Vice President and Chief Operating Officer (by phone)
Tony Keck – Senior Vice President, Chief Development Officer
Lynn Krutak – ~~Senior~~Executive Vice President, Chief Financial Officer
Tim Belisle – ~~Senior~~Executive Vice President of Corporate Compliance and General Counsel

Wellmont Health System (WHS)

Bart Hove – President and CEO
Todd Norris – Senior Vice President, System Advancement
Todd Dougan – Chief Financial Officer
Gary Miller – Executive Vice President and General Counsel

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

Claire Haltom – Counsel to Wellmont Health System (by phone)
Ashby Burks – Counsel to Wellmont Health System

Hancock, Daniel, Johnson & Nagle, PC

Jim Daniel – Counsel to Mountain States Health Alliance
Jenny McGrath – Counsel to Mountain States Health Alliance

The meeting convened 1:55 p.m.

Dr. Levine welcomed and thanked the attendees. All of the attendees introduced themselves. Dr. Levine then reviewed the meeting agenda.

Dr. Levine said that there has been a lot of activity associated with Virginia's review of the application since the last meeting with the applicants on May 17. Dr. Levine then reviewed some statutory provisions that are relevant to Virginia's review of the application. Section 15.2-5384.1(A) of the Code of Virginia states "The policy of the Commonwealth related to each participating locality is to encourage cooperative, collaborative, and integrative arrangements . . . and to invest in the Commissioner the authority to approve cooperative agreements recommended by the Authority and the duty of active supervision to ensure compliance with the provisions of the cooperative agreements that have been approved." Section 15.2-5384.1(B) states "A hospital may negotiate and enter into proposed cooperative agreements with other hospitals in the Commonwealth if the likely benefits resulting from the proposed cooperative agreements outweigh any disadvantages attributable to a reduction in competition that may result from the proposed cooperative agreements." Section 15.2-5384.1(C) states ". . . the applicants shall state in detail the nature of the proposed arrangement between them, including without limitation the parties' goals for, and methods for achieving, population health improvement, improved access to health care services, improved quality, cost efficiencies, ensuring affordability of care, and, as applicable, supporting the Authority's goals and strategic mission."

Dr. Levine told the applicants that several members of Virginia's application review team recently travelled to the Remote Area Medical Clinic (RAM) in Wise County in order to solicit additional public comment concerning the proposed merger between MSHA and WHS. This was done in lieu of holding an additional public hearing. Dr. Levine told the applicants that the RAM participants were eager to provide feedback. VDH received comments from 189 individuals. Among the 189 comments, 70 expressed support for the merger and 95 expressed opposition with the remainder providing other types of comments. Dr. Levine observed that there are strong feelings; with those opposed to the merger expressing strong concerns. On the other hand, there were a lot of comments that the merger could be a good thing, although many of the positive comments were conditional, such as, the merger would be a good thing if costs are kept in check or if quality improved. Dr. Levine noted that most individuals who go to RAM seeking care or treatment are seeking dental and/or vision services, although many of those individuals also have co-morbid conditions.

Dr. Levine then asked the applicants if they wished to provide any opening comments.

Mr. Hove expressed his appreciation to have another opportunity to talk to the Virginia team. He also applauded the Virginia team for going to the RAM clinic in Wise in order to talk to the people there, and to see the good and the bad. Mr. Hove said that the presence of the Virginia team at RAM was very meaningful to the applicants, as the people seeking care at RAM are the people they hope to help. He said that people who criticize the application [are typically outsiders and](#) do not understand the problems in Southwest Virginia or the opportunities that are there [to meet the needs](#) in that region. Mr. Hove said that WHS wants to keep its head above water and its feet on the ground to provide services. WHS wants to improve the quality of services, the

amount of services, [keep costs at a reasonable level \(a level at or better than would occur with the status quo or with an outside acquisition\)](#), and to provide services and opportunities that are not currently available. He said that many organizations would have fallen aside but WHS has remained committed.

Mr. Levine thanked Dr. Levine for the additional opportunity to meet and talk. He said that about a year ago, MSHA made the decision to apply for an accountable health community grant. The application had to be supported by the state. [Mr. Levine noted that Virginia DMAS approved of the application, which was required to receive the CMS grant.](#) DMAS signed the application but the Tennessee Medicaid agency did not sign. [He said that there were only 32 ACOs selected in the country.](#) Utilizing the CMS Accountable Health Communities grant, MSHA began in a limited way to connect people that have social needs and try to bridge connections for them in the community. Mr. Levine said that the five-year grant does not provide a lot of money over five years but it represents a start. [Mr. Levine also stated that by endorsing the grant application, he believes Virginia understands the needs of the region and that the status quo will not work.](#)

Mr. Levine said that mortality in rural Appalachia is increasing. He said that if a way can be found to obtain additional resources, they can move the needle to affect positive change. MSHA believes if it can eliminate unnecessary costs, and maintain synergies within the market, fundamental change can happen. [He said it is important to identify resources and dedicate the resources in a focused way.](#) Mr. Levine said that currently, one-third of all health care spending is wasted. He said that MSHA is not trying to do something here for themselves. If they were, they could have simply sold the business. Mr. Levine said that MSHA could not be more grateful for the time and effort that Virginia has put into review of the application. The conversation with Virginia has been meaningful.

Mr. Levine expressed some frustration with the Federal Trade Commission (FTC). He said that throughout this process, every consultant that the FTC engaged submitted opinions without first speaking to [MSHA the parties](#). Mr. Levine mentioned, in particular, a letter stating that there was no benefit associated with a common IT platform.

Dr. Levine then requested that the applicants clearly identify any time during the meeting when they start to discuss information that is considered to be proprietary in nature.

Ms. Tysinger explained some of the key differences between Virginia and Tennessee law concerning proposed cooperative agreements. She explained that according to Tennessee law, prior to granting a COPA, the parties and the Tennessee Department of Health will agree upon terms of certification and specific conditions that assure public advantage. Tennessee uses more of a contractual approach. In Virginia, the law states that the Commissioner may reasonably condition the approval of the proposed cooperative agreement upon the parties' commitments. She explained that if the Commissioner approved the cooperative agreement, it would be done in an order with conditions imposed within the order.

Dr. Levine then said that she would review the commitments as recommended by the Southwest Virginia Health Authority, with a focus on what her advisors had identified as possible gaps.

She also told the applicants that she wanted to hear about the retreat of the envisioned Ballard Board of Directors, which had been mentioned by the applicants at the May 17th meeting, as it pertained to a discussion of the social determinants of health.

Mr. Levine responded by saying that the [Ballad](#) Board retreat had taken place over an entire weekend, with a focus on population health. He said that the [retreat was staffed by the Robert Wood Johnson Foundation and the Public Health Institute, and the Board](#) spent the weekend talking about social determinants and where the problems are. The [discussion message that they received](#) included the following:

- Don't spread yourself too thin. [\[Applicants' Note: In other words, limit the number of focus areas in which to direct resources.\]](#)
- Don't try to do too much—go for areas that can have the most return. [\[Applicants' Note: In other words, focus on key determinants of health and identify the measures that data indicates will have the greatest benefit to population health for our population.\]](#)
- Focus on where [and what](#) you want [your health system](#) to be at the end of five years.

Mr. Levine stated that the Board believed they could do more than has been done by other health systems they reviewed.

Mr. Levine said that the Board's discussion was very useful, and that the board wants to be a health improvement entity.

Move into proprietary discussion

Return to non-proprietary discussion.

Mr. Hove added that healthy lifestyles have a lot to do with social determinants. [Mr. Hove noted the WHS Board has educated themselves on healthy lifestyle components and the opioid crisis. WHS has emphasized hearing from providers to understand the challenges.](#)

Dr. Levine then asked how the proposed merger would help the uninsured and underinsured. Mr. Levine responded by saying that not all planning can be done pre-merger, but also that MSHA already serves the uninsured in the region. He said further that there are things we can do as a system to help the uninsured become active participants. For example, cell phone technology can be used to help with targeting the uninsured in order to organize a system of care, by actually having them enroll in the system—which could be followed with a risk assessment and identification of a treatment plan. Mr. Levine also explained that, for their own employees who have diabetes, [for example,](#) if they enroll they could be provided with free medication and a 0 co-pay.

Mr. Norris said that WHS has been involved with Healthy Kingsport, which has represented thinking outside of the traditional health care model. [He noted that the model offered by Healthy Kingsport just scratched the surface and represents a microcosm of the needs.](#) Dr. Levine responded that she was surprised that the applicants didn't feature the Healthy Kingsport initiative more prominently in the application. Mr. Norris said that it was used as a model for the accountable care community.

Mr. Levine commented that there is great opportunity within the region, [for example](#), for improvement of children's health and wellbeing, which over time would begin to influence adult health and wellbeing. He said that if you focus on one thing and move the needle on one thing, overall health rankings will improve. Mr. Levine said that everyone needs to remain passionate on what affects child health. Dr. Levine agreed that improvement in childhood wellbeing is critical. She added that doing so requires intentionality and aligned efforts. Mr. Hove said that [he wants we want](#) to rely on existing community agencies to help drive home the message that health is important [and to improve health, and Ballard can be a facilitator for these existing resources](#).

Dr. Levine said that it is clear that, at least in terms of charity care, the uninsured will receive treatment under the proposed merger. However, the extent to which care will be coordinated and risk-based is not clear. Dr. Levine then asked if any additional pre-merger planning had been done by the applicants.

Mr. Levine responded by saying that the applicants have established 17 functional teams for pre-merger planning purposes, as permissible under anti-trust law. He said that pre-planning documents from those teams will be provided to Virginia. He also commented concerning governance planning, which he said has followed national best practices for policy development.

Initially, two members of the Ballard board will be Virginia residents. [\[Applicants' Note: Ballard has committed that a third Virginia Board member will be in place within 5 years after closing.\]](#)

Move into proprietary discussion

Return to non-proprietary discussion.

Mr. Levine said that Ballard wants to close on the first of the month.

Dr. Levine asked Mr. Levine if there were any outstanding data or information requests from Virginia to which the applicants had not yet responded. Mr. Levine responded that he was not aware of any outstanding requests.

Dr. Levine said that she now wanted to walk through Virginia's review of some of the specific commitments made by the applicants. She said that Virginia has taken a team approach to reviewing the application, and that her advisors had done a lot of good work in terms of reviewing advantages and disadvantages, and of reviewing gaps in the various commitments. Dr. Levine said that she is hearing concern from her advisors on the issue of advantages versus disadvantages. She told the applicants that she needs to hear from them regarding why something that Virginia has identified as a gap really is not, or how such a gap could be closed through a revision to a commitment. She also told the applicants that if the application is approved, it would be approved with conditions.

Dr. Levine said she views the commitments in terms of several categories—competition; price; access, including charity care; quality; population health; governance; and other. She said that, as far as she is concerned, competition is a disadvantage. In terms of pricing, she is concerned about the distinction drawn between principal payers and other payers. Any pricing

commitments should apply to all payers. She also commented on the lack of assurance that any savings realized by health insurers will be passed on to the consumer. An assurance that that would happen would be important. She identified a gap in commitment 3 pertaining to a lack of specificity concerning the method of dispute resolution. In addition, Dr. Levine said that her advisors have noted that Commitment 3—as currently written—could be interpreted as suggesting that the applicants are not currently negotiating in good faith with payers. Therefore, Dr. Levine requested clarification as to why Commitment 3 is an advantage.

Mr. Stanwix commented concerning commitments 1 and 2, dealing with pricing. He said that the parties have indicated that contracts with Medicaid Managed Care Organizations in Virginia are based off a percent of the rates DMAS pays providers and that the current commitments do not protect such a rate structure. Mr. Stanwix also stated that the commitment language concerning value-based payments would need something more firm for DMAS. [\[Applicants' Note: Mr. Stanwix suggested a commitment to “partner” with DMAS on value-based purchasing.\]](#) Mr. Levine requested clarification regarding DMAS' concern. Mr. Stanwix responded with an illustrative example that if a contract stated that the hospital would be paid at 105% of the Medicaid rate, there is nothing in the commitments stopping the New Health System from seeking to increase that rate to 125% or higher. Dr. Levine added that, according to the application, the parties will endeavor to transition to value-based contracting. She stated that her advisors don't see this as an advantage unless there is a firm commitment from the parties that they will do so.

Dr. Levine then commented that issues pertaining to access to care, including charity care, have a significant impact on population health and wellbeing. She said that Ballad would be working with independent physicians, and primary care issues are critical with a need for a commitment, [for example](#), to meet relevant national standards pertaining to medical home and same-day access to primary care.

Mr. Levine asked if Dr. Levine would consider the use of technology to address primary care issues. Dr. Levine [said](#) that she would absolutely consider the use of technology. She also said that, recognizing that Ballad wants to expand specialty care services, there is a growing recognition of a standard of 5-day access to specialty care. Currently there is no commitment regarding access to specialty care.

Dr. Levine commented concerning the applicants' commitment concerning charity care, which she said mainly committed the applicants to develop charity care policies post-approval that are consistent with charity care policies that WHS and MSHA already have. She also noted that the commitment only extends to hospital services, not to other products or services that may be costly, including medications. Dr. Levine added, as a general rule, that any plan or policy submitted to Virginia by the applicants' post-merger would make it difficult to identify any advantage prior to the merger. Several commitments indicate that different types of plans will be submitted to VDH subsequent to approval of the merger, but Dr. Levine said that she needs to see such plans prior to any approval. She said further that her advisors have told her that such plans need to contain definitive information.

In commitment 10, which involves discounts to uninsured or underinsured individuals who do not qualify for charity care, Dr. Levine said that it is hard to identify a merger-specific advantage without understanding whether or not this simply represents a continuation of current policy and practice. Dr. Levine then again mentioned the RAM clinic, and how none of the applicants' commitments pertain to addressing the need for dental and vision services in the region. Dr. Levine said that her advisors saw that as a significant gap.

Commitment 20 (all hospitals in operation at the effective date of the merger to remain operational as clinical and health care institutions for at least five years) pertains to hospital and tertiary services. However, Dr. Levine requested clarification whether the definition of hospital includes everything in the hospital system. Her advisors also questioned whether the list of essential services contained in Commitment 20 is adequate if a hospital were repurposed. Commitment 21 (maintain three full service tertiary referral hospitals) relates to larger services. However, Dr. Levine said that her advisors noted that the revised commitment is narrower than the original, and does not require maintenance of the level of services currently provided or maintenance of staffing. Dr. Levine said that, according to her advisors, Commitment 22 (maintain an open medical staff at all facilities) provides little advantage given that providers will likely stay close to their home base.

Mr. Stanwix commented that the applicants have not responded to a request for a written policy that assures no restrictions to Medicare and/or Medicaid patients, including Virginia Medicaid patients receiving services in Tennessee. Additionally, Mr. Stanwix stated that although the applicants have made written statements about contracting with all of the Medicaid Managed Care Organizations, the current commitments do not contain this information. He said further that the commitments do not address participation in Virginia Medicaid's Addiction Recovery Treatment Services (ARTS) program. Mr. Levine responded by saying that Ballad would continue to see Medicaid patients in the hospital. [\[Applicants' Note: Section V.K. of the VDH Request dated December 22, 2016 contained questions specific to Virginia Medicaid patients plans and asked what commitments the parties would be willing to make on several Medicaid issues and concerns. The Applicants made definitive statements in their responses to these questions about the inclusion of Virginia Medicaid patients and plans in all Ballad services and facilities, which statements we believed addressed and satisfied the desire for Virginia Medicaid assurances. Our understanding of Mr. Stanwix' comment is that he is seeking formal "commitments" about Virginia Medicaid patients and plans in these areas.\]](#)

Dr. Levine then said, in terms of commitments pertaining to quality, while the focus on reporting measures is appreciated, that would not necessarily be considered a merger-specific advantage. She then asked the applicants, in terms of population health improvement, what they are doing or planning to do for their own employees? Dr. Levine observed that approaches with respect to employees would be consistent with approaches to improve the health of the larger population. It could also be an example of what could be done via an accountable care community.

Dr. Levine told the applicants that Commitments 17, 18, 25, 26 and 27 all call for the development of plans that would not be submitted to VDH until after approval of the Cooperative Agreement. She said further that VDH needs to see those plans prior to a decision in order to help assess the advantages of the Cooperative Agreement.

Dr. Levine said further that Commitment 13 (honoring of prior service credit) does not specify whether or not full credit will be granted and may not actually be a benefit of the merger since employees already have this benefit today. Commitment 15 (employee severance policies) requires development of severance policies that would not be submitted to VDH until after approval of the Cooperative Agreement. Commitment 17 about residency slots requires a plan but not an implementation. Commitment 19 concerning a common IT platform does not specify whether or not there will be any cost to independent providers in order to gain access to the platform. Commitment 25, concerning a physician/physician extender needs assessment and recruitment plan, requires further clarification as to why it should be considered a merger-specific benefit. Dr. Levine told the applicants that commitment 27 (population health plan) is not definitive as to the establishment of an accountable care community. In addition, Dr. Levine said that the applicants do not address participation in the Connect Virginia Emergency Department Care Coordination program.

Dr. Levine then provided some additional comments concerning Ballard employees. One of the concerns that Virginia heard expressed early in the review process was that the merger should “do no harm”. At the RAM clinic in Wise, participants provided many comments to VDH staff in which they expressed concern about losing jobs, and concern that cost savings for Ballard resulting from employee layoffs would do more harm. Dr. Levine said that without an assurance that lay-offs would not happen, it will be a disadvantage.

Dr. Levine told the applicants that many of the commitments were dependent (conditional) upon available funding. She also said those commitments, which include the commitments to improve population health, should be unconditional, as the Cooperative Agreement would not be advantageous if population health commitments were not met.

Dr. Levine identified the following additional gaps with respect to certain commitments:

- There is no commitment for screening for long term care services, which is a growing issue. [\[Applicants' Note: The Commissioner did not provide any further detail on her comment and what is intended by "screening for long term care services."\]](#)
- Commitment 11 (furnishing notice of default to VDH) does not require the development and submission of a corrective action plan.
- Commitment 29 (Governance/Board of Directors) – Virginians are very concerned about the low number of board directors who would be Virginia residents. Adequate Virginia representation on the Board is required.
- The application contains an entire section concerning a physician council but there is not a specific commitment regarding such a council.
- There is no commitment to connecting to the Virginia Immunization Registry through Connect Virginia, or to the Connect Virginia Health Information Exchange in general.

Dr. Levine also said that, while the application speaks to Ballad evolving to become a health improvement system, Virginia needs more information to understand how the system will evolve. In addition, Dr. Levine said that her advisors believe that, since the applicants' focus has traditionally been on inpatient hospital services, more information is needed concerning how Ballad plans to change its service delivery model, and how the new system will evolve from its current focus on hospitals and health care to a new focus on primary and preventive care. She also told the applicants that Virginia law requires the Commissioner to appoint a technical advisory group to identify specific metrics to be utilized during the active, ongoing monitoring and supervision of a cooperative agreement. This is an area that will require a lot of attention. Dr. Levine said that such monitoring and supervision would probably require reporting more frequently than just annually. Dr. Levine also mentioned that, as stated within one of the recommendations of the Southwest Virginia Health Authority, the commitments were negotiated and drafted with the intent of remaining in effect for ten years, but under the statute the requirement for active monitoring and oversight by Virginia is ongoing. Dr. Levine asked the applicants if the commitments are time-limited.

Mr. Levine responded to Dr. Levine's discussion of the gaps by saying that he thinks a lot of the described gaps will be easy to address. He did wish to clarify, however, that many of the commitments were not intended to be advantages of the merger, but rather to mitigate potential disadvantages of the merger. He said further that, knowing that the population in the region is declining, that the people who are staying are not necessarily people that are working, and that people who are staying have addictions, mental health issues, and other health care issues, coupled with a reduction in inpatient utilization rates, it is unlikely that some of the WHS and MSHA hospitals will still be open in five years. Given these trends, he asked what would happen if the proposed merger doesn't happen. He said that, without the commitment to keep hospitals open for five years as health care facilities, closures are likely.

Mr. Levine said that Southwest Virginia has some unique challenges. He said that the idea of keeping facilities open and repurposing them is an advantage because there is no commitment

that the hospital will stay open without a cooperative agreement. He said that MSHA sees a huge financial advantage in population health. Mr. Levine said that if they don't succeed as an enterprise, nothing gets done. He stated that the Southwest Virginia Health Authority's [attorneys advisors](#) recognized that and suggested making the commitments conditional upon achieving financial savings. Mr. Levine also said that MSHA agrees with the importance of health insurers passing any cost savings along to consumers. He explained that is why Commitment 1 calls for a 50% reduction to fixed rate increases, which savings would flow directly to self-insured employers. However, Mr. Levine said that MSHA cannot control whether health insurers actually pass savings on to their own insureds. He also said that another way to get the savings back to consumers is through spending the savings to improve population health.

Mr. Hove said that he appreciates the thoughts of VDH and the thought behind them. He said that many of the points are clarifications that can be made to the commitments going forward.

Mr. Levine requested that the applicants be given the opportunity to review the terms and conditions of any draft order prior to it being issued. Dr. Levine responded by saying that that is part of the reason why VDH is meeting with the applicants today, so that such a discussion of potential conditions can occur. Dr. Levine also said, in response to comments from Mr. Belisle and Mr. Daniel, that a decision on the application has not yet been made and therefore she is not ready to issue an order.

Mr. Levine asked if the applicants can provide written feedback to VDH on the gaps that have been identified, either in terms of redline edits or as comments concerning what the applicants are trying to accomplish. Dr. Levine said that would be a good start.

Mr. Keck requested some clarification concerning the issue of same day access to primary care. He asked if that referred to physicians employed by Ballard, or all physicians. Dr. Levine responded by saying that, if Ballard is monitoring what is going on in the community, it would know if there were issues of people being able to see physicians the same day they requested the care and then adjust the capacity of Ballard-employed physicians to meet the needs of the community. Mr. Levine said that he envisions technology as a solution.

Mr. Levine asked for some clarification on the issue of five-day access to specialty care. Dr. Levine said that what is important is that Ballard assures that the community's need for timely access to specialty care is met. Mr. Levine said that technology opens so many doors for them.

Mr. Keck said that the applicants believe one of the biggest advantages of the proposed merger is the redirection of synergy to improve health. He said that what they've tried to do is to recognize that all the community building that will need to be done is one of the biggest commitments and will take a couple of years. Mr. Keck said that the applicants have committed to a financial outlay of funds, and have proposed outcomes tied to that funding. However, he said that a true plan cannot be developed until Ballard has had the opportunity to work with community partners to develop strategies. He then requested some further guidance from Dr. Levine.

Dr. Levine responded by saying that MSHA has a population—its own employees—that is already within its control. This population could serve as a place to start for purposes of population health improvement. She said that it could be very powerful and impactful to utilize your own employees as the focus of your initial efforts. This requires, in part, identification of critical drivers of health status that Ballard can do something about. Dr. Levine said that her advisors are telling her that there is “not enough meat on the bone” concerning Ballard’s population health improvement plans. The job of the applicants is to provide sufficient detail concerning what you are going to do and how you are going to do it. That’s the kind of detail that she will need to compare advantages vs. disadvantages in order to make a decision.

Mr. Levine said that he was embarrassed for not thinking to start their population health improvement planning efforts with their own employees. [\[Applicants' Note: The parties wish to clarify that they have previously contemplated population health improvement planning efforts with their own employees. However, these efforts have not been previously described in the Application or subsequent information provided to the VDH. We agree that this could be a viable approach.\]](#) He recognized the value of implementing a strategy with MSHA’s own employees that can ~~be~~ subsequently be presented to other groups. He said further that every cooperative agreement they have found has focused on mitigating disadvantages. There is no roadmap for doing what they are trying to do. He said that the applicants’ discussions with Virginia have been incredibly productive, as a lot of the questions have helped to inform what they do. He said that whatever is approved, the Commissioner can have certainty that they are not going to do harm. He said further that they need to better understand the community before making commitments regarding things like specialists. Should the application be approved, they will probably have to sit back down with the Commissioner to discuss aspects of the cooperative agreement that are not working properly. He also said that while Virginia is the regulator, it also needs to be a collaborator.

Move into proprietary discussion

Return to non-proprietary discussion.

Mr. Keck asked how many of the Plan for Well-Being metrics that the applicants would need to meet. Mr. Keck said that the applicants are not talking about things that are new to public health. We are trying to make sure that the advantages of the cooperative agreement are realized. He asked Dr. Levine what she thought were an appropriate number of population health measures.

Dr. Levine responded by saying that Virginia could have included hundreds of measures in the Plan for Well-Being but instead utilized a relatively small number of measures. The measures were selected were because they represented items/topics/issues that had a big impact on community health and wellbeing. She explained further that currently in Southwest Virginia there is a lack of community infrastructure for people to practice preventive health and to get the proper treatment at the proper time. The building of community infrastructure (not just physical infrastructure but also coalitions/collaborations) is required to make improvements in population health. What really needs to be done is to create systems to promote health and contribute to improved outcomes. She reiterated her suggestion that the applicants focus on infrastructure, which can be data-informed.

Mr. Norris raised the issue of post-approval monitoring. He asked if Dr. Levine would like for the applicants to propose or suggest what an ongoing monitoring of the cooperative agreement would look like. Dr. Levine responded by saying yes, she would.

Move into proprietary discussion

Return to non-proprietary discussion.

Mr. Hove commented that currently WHS has a lot of hospital facilities. In his opinion, that will change over time. One possibility is to repurpose some hospitals with specialty facilities—which could result in new jobs.

Dr. Levine mentioned the continued uncertainty in the federal arena, and that there could be new developments. There was a brief discussion concerning the need for another face-to-face meeting between Virginia and the applicants.

Move into proprietary discussion

Return to non-proprietary discussion.

Dr. Levine asked how much time the applicants would need to review and respond to the gaps that were identified during the meeting. Mr. Levine said that the applicants would respond back to Virginia within a week.