Revised New Health System Virginia Commitments
Dated September 22, 2017

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

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

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

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

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

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

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

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

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

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

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

The following definitions will apply to this combined Commitment 1 and 2:

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

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

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

Contract Year Beginning	Adjustment for Absence of Quality
2018	1.25%

Timing: Subsequent contract years.

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

Metric: Easily verifiable.

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

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

   Amount: No cost.

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

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

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

   Amount: No cost.

   Metric: Easily verifiable.

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

   Timing: No later than 36 months after closing.

   Amount: Up to $6 million over 10 years.

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

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

   Timing: No later than 36 months after closing.

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

7. **Commitment:** In order to enhance quality, improve cost-efficiency and reduce unnecessary utilization of hospital services, for all Principal Payers, the New Health System will include

provisions for improved quality and other value-based incentives based on the unique priorities and timelines agreed upon by each payer and the New Health System. The New Health System will partner with the Virginia DMAS to develop, pilot, or implement value-based payment programs in the region as appropriate, including programs allowing the New Health System to accept direct capitation from DMAS for the Medicaid enrollees in the Geographic Service Area.

Timing: Immediately upon closing of the merger and ongoing.

Amount: No incremental cost.

Metric: Annual report and complaints, if any, from payers.

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

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

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

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

policies in accordance with all applicable laws and shall post such policies on its publicly accessible web site and on the separate web sites for all provider components that are part of the New Health System.

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

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

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

10. **Commitment:** In order to ensure low income patients are not adversely impacted due to pricing, uninsured or underinsured individuals who do not qualify under the charity care policy will receive a discount off hospital charges based on their ability to pay. This discount will comply with Section 501(r) of the Internal Revenue Code, and the rules and regulations relating to that Section governing not for-profit organizations, and payment provisions will be based on the specific circumstances of each individual/family. The New Health System will seek to connect individuals to coverage when possible.

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

    Timing: Immediately upon closing and ongoing.

    Metric: Credible report.

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

    Timing: Ongoing.

    Amount: No cost.

    Metric: Credible report.

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

    Timing: Ongoing.

    Amount: No cost.

    Metric: Credible report and easy to determine.

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

    Timing: First year.

    Metric: Easily verifiable.

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

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

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

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

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

    Timing: 5 years.

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

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

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

    Timing: No later than 24 months after closing.

    Metric: Credible report.

17. **Commitment:** In order to ensure training of physicians and allied health professionals meets the goals and objectives of the health system and the Authority, the New Health System will develop, 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 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.

18. **Commitment:** In order to help create opportunities for investment in research in partnership with Virginia's academic institutions, the New Health System is committed to collaborating with the academic institutions to compete for research opportunities. The New Health System will work closely with current academic partners to develop and implement a 10-year plan for investment in research and growth in the research enterprise in Virginia and Tennessee service area. The plan will include, but not be limited to, how it will address the Authority's goals, how

research will be deployed in Virginia and Tennessee based on the needs and opportunities, capacity and competitiveness of the proposals.

Timing: 10 years.

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

Metric: Report in year one and dollars spent thereafter. The New Health System will present a plan for research expenditures for full fiscal years two and three starting after the closing of the merger no later than the end of the first fiscal year after the merger. Thereafter, the New Health System must update its plan to address subsequent fiscal years no later than the end of the period for which the prior plan ends up to the end of the ninth full fiscal year after the closing of the merger. The annual report should include a description of research topics, the entities engaged in the research, the principal researcher(s) who is/are responsible for each project, any grant money applied for or expected, and the anticipated expenditures. Annual reports for full fiscal years three and through ten should report on the outcome of previously reported research projects including references to any published results. 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.

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

    Timing: Implementation No later than 48 months after closing.

    Amount: Up to $150 million.

    Metric: Implementation of promised system with mileposts along the way. The mileposts shall be proposed by New Health System no later than three months after the closing of the merger or June 30, 2017, whichever is later. The New Health System will report in each annual report its progress toward implementing the Common Clinical IT Platform, and after implementation, any material enhancements or changes. The New Health System will also include in the annual report the researchers (by individual or by group for those working together) who have entered into Business Associate Agreements for purposes of conducting research.

20. **Commitment:** In order to preserve traditionally hospital-based services in geographical proximity to the communities in the Geographic Service Area served by such facilities, to ensure

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

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

If 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.

Timing: Ongoing.

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

Metric: Each year, the operating results for the Virginia hospitals and sites furnishing "essential services" as defined above will be reported to the Commissioner. The annual report to the

Commonwealth will also outline services provided in each community by the hospitals or other sites furnishing "essential services" as specified in this commitment.

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

    Timing: Immediately upon closing of the merger and ongoing.

    Amount: Not applicable.

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

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

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

    Amount: No cost.

    Metric: Easily verifiable.

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

    Timing: Immediate upon closing of the merger and ongoing.

    Amount: No cost.

    Metric: Easily verifiable.

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

Timing: Immediate upon closing of the merger and ongoing.

Amount: No cost.

Metric: Easily verifiable.

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

    Timing: Every 3 years, starting within the first full fiscal year.

    Amount: Costs of recruitment related to implementation of the recruitment plan shall be part of the $140 million commitment referenced below in number 26. Expenditures incurred in the development of the community needs assessment and the recruitment plan shall not be credited toward that $140 million commitment.

    Metric: Credible evidence of 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.

26. **Commitment:** Enhancing healthcare services:
    a. In an effort to enhance treatment of substance abuse in the region, the New Health System will create new capacity for residential addiction recovery services serving the people of Southwest Virginia and Tennessee.
    b. Because improved mental health services is a priority of the Authority and the law, the New Health System will develop community-based mental health resources, such as

mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements throughout the Virginia and Tennessee service area.

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

Timing: The plan will be developed no later than 24 months after closing and will include a time schedule for implementing the plan and expenditures under the plan.

Amount: $140 million over 10 years including physician recruitment referenced in number 25 above.

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

27. Commitment: To enhance population health status consistent with the regional health goals established by the Authority and the Virginia Department of Health, the New Health System will invest not less than $75 million over ten years in population health improvement for the Geographic Service Area. Of this amount, the New Health System will commit to spending an amount necessary to support the creation of a new, regional Accountable Care Community. The New Health System will take the lead to formally establish this ACC within 12 months of the close of the merger, and its membership will include members of the New Health System, the Authority, and other local, state or federal agencies, payers, service providers and community groups from Virginia and Tennessee who wish to participate. Within 12 months after the Commissioner has approved the priority population health measures to be included in the Quantitative Measures, and after consultation with the ACC, the New Health System will submit to the Commissioner plans to improve the scores of the regional population on these measures. The submission of these plans, the process measures associated with the implementation of each plan, and the achievement of population health improvement for each measure, will be evaluated according to the index scoring methodology described in the New Health System's Quantitative Measures and Scoring Mechanism.

Timing: 10 years.

Amount: $75 million.

Metric: The New Health System will establish and track long-term outcome goals similar to those developed in Healthy People 2020 and consistent with the health plans of Virginia and Tennessee, and will be evaluated based on whether expenditures made are consistent with the

plan established by the collaborative between the states, including the Authority, and the New Health System.

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

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

    Timing: Annual.

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

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

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

    Timing: Ongoing.

    Amount: No dollar cost.

    Metric: Easily verifiable.

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

    Timing: Annual.

    Amount: No material cost.

    Metric: Receipt of compliant report.

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

    Timing: Annual and quarterly.

    Amount: No material cost.

    Metric: Easily verified.

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

    Timing: If closing a facility is considered.

    Amount:

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

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

    Timing: Immediate upon closing of the merger.

    Amount: No cost.

    Metric: Creation of a Joint Task Force.

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

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

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

    Timing: As soon as practicable

    Metric: Easily verifiable

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

    Timing: Within six months after closing

    Amount: Minimal cost

Metric: Annual reporting of activities and progress

38. In order to ensure that Virginia Medicaid patients will continue to be served by the New Health System, (a) the New Health System will continue to treat VA Medicaid beneficiaries in Tennessee hospitals and other NHS facilities, and (b) the New Health System will accept and participate in all Medicaid managed care plans such as Medallion Three, CCC, and Medicaid Plus.

Timing: Immediately upon closing of the merger.

Amount: No cost.

Metric: Easily verifiable.

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

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

These commitments have been negotiated and drafted with the intent of them remaining in place for ten (10) years. Nevertheless, there may be changes in circumstances that arise which affect the feasibility or the meaningfulness of the commitments and which are not possible to foresee presently. For example,[1] a major structural change to the federal payment system could, depending on how it is implemented, materially change both the needs of the region and the New Health System's ability to meet those needs. Other events which may have a material effect include, but are not limited to, substantial and material reductions in federal reimbursement, repeal of Certificate of Public Need, labor shortages causing significant and material increases in labor expense, significant reductions in inpatient hospital use rates which cause a material decrease in revenue (and which may be demonstrated to reduce the total cost of care), or an act of God. It is the interest of the Commonwealth that the region's hospitals maintain their financial viability, that they are of sound credit worthiness and that they are capable of reinvesting capital. Accordingly, if the New Health System produces evidence that changes in circumstances have materially affected its ability to meet the commitments and that

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

its inability is not affected by deficiencies in management, either the Commissioner or the New Health System may petition the other to amend the commitments to reduce the burden or cost of the commitments to a level that may be more sustainable. In the event that the New Health System petitions the Commissioner for amendment of the Cooperative Agreement, the Commissioner may require the New Health System to engage an independent consultant to prepare a report validating that the changes in circumstances have adversely affected the New Health System, the extent to which this has occurred, and validating that the changes in circumstances are not related to the effectiveness of management. The cost of such an independent consultant engagement shall not exceed $250,000 (as adjusted by the CPI from the date of the closing of the merger). The amendment process should not be used to increase the overall level of burden or cost on the New Health System, although the parties acknowledge that depending on the change in circumstance, measuring the change in the level of burden or cost may be subject to reasonable ranges and disagreement of the impact within a range. If either party petitions for amending the commitments and the parties cannot come to agreement, the parties shall agree on a dispute resolution process in order to reach agreement.

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

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

Exhibit A

Virginia Quantitative Measures

Exhibit A
Virginia Quantitative Measures

Quantitative Measures Categories

1. Population Health
2. Access to Health Services
3. Economic
4. Patient Safety/Quality
5. Patient Satisfaction
6. Other Cognizable Benefits

Category Scoring

1. POPULATION HEALTH CATEGORY

Commitment/Outcome	Percentage Weight
Population Health Priority Measures Achieved	50
Population Health Monitoring Measures Reported	50
Total	**100**

2. ACCESS TO HEALTH SERVICES CATEGORY

Commitment/Outcome	Percentage Weight
Essential Services Achieved	50
Access to Health Services Monitoring Measures Reported	50
Total	**100**

3. ECONOMIC CATEGORY

[PASS/FAIL]

4. PATIENT SAFETY/QUALITY CATEGORY

Commitment/Outcome	Percentage Weight
Patient Safety/Quality Target Measures Achieved	50
Patient Safety/Quality Monitoring Measures Reported	50
Total	**100**

5. PATIENT SATISFACTION CATEGORY

Commitment/Outcome	Percentage Weight
Patient Satisfaction Monitoring Measures Reported	50
Patient Satisfaction Report documenting plan to address opportunities for improvement	50
Total	**100**

6. OTHER COGNIZABLE BENEFITS CATEGORY

Commitment/Outcome	Percentage Weight
Commitments Achieved	100
Total	**100**

GRADING; FINAL SCORE

1. Determine grade (Pass or Fail) for Economic Category.

2. If applicable, determine impact of a failing grade on the Economic Category on the weighing of benefits against disadvantages of the Cooperative Agreement.[1]

3. If the result of Item 2 indicates that benefits continue, then determine numerical grade for each Category (excluding the Economic Category):

Grade	Results of Commissioner's Evaluation ("Achievement Percentage")
91-100	≥90% Targets Achieved
80-90	80-<90% Targets Achieved
70-79	70-<80% Targets Achieved
60-69	60-<70% Targets Achieved
0-59	Less than 60% Targets Achieved

4. Multiply the applicable Achievement Percentage in 3 above for each Sub-Category by its assigned weighting:

Category	Year I Percentage Weight
Population Health	20
Access to Care	20
Patient Safety/Quality	20
Patient Satisfaction	20
Other	20
Total	**100**

5. Add results of Item 4 for Final Score.

6. Application of Final Score to Determine that Benefits Continue to Outweigh the Disadvantages Attributable to a Reduction in Competition:

Final Score	Benefits Outweigh Disadvantages Attributable to Reduction in Competition?
(≥60)	Yes
(<60)	No; Cooperative Agreement is revoked absent compelling circumstances, including without limitation additional Cooperative Agreement modifications proposed by the Commissioner

[1] 12VAC5-221-110.F of Virginia's Rules and Regulations Governing Cooperative Agreements states: The commissioner shall issue a written decision and the basis for the decision on an annual basis as to whether the benefits of the cooperative agreement continue to outweigh the disadvantages attributable to a reduction in competition that have resulted from the cooperative agreement.

SCORING PROCESS FOR EACH CATEGORY

1. Population Health Category

Definitions

"Baseline" means the value of each individual measure available as of the year the Cooperative Agreement was granted.

"Population Health Priority Measures" means the list of 10 measures defined in Table 1 below, as further defined in Table 2.

"Population Health Monitoring Measures" means measures defined by the Commissioner for monitoring and reporting only.

"Year 1" means the period of time that begins with the first full Fiscal Year after the Commissioner approves the plans of the New Health System pursuant to Commitment 27.

Data reported in the Population Health Report, as deemed appropriate by the Commissioner, will be used to calculate the Quantitative Measures Score. The overall Population Health Category will be comprised of the Population Health Priority Measures and the Population Health Monitoring Measures calculated and weighted annually as follows:

Population Health Priority Measures

The Population Health Priority Measures are closely related to Virginia Plan for Well-Being goals and are the measures on which the New Health System will be evaluated to show improvement in population health outcomes. Each measure will be evaluated on a specific population which include either the entire population of the Geographic Service area or the patients served by the New Health System.

Table 1: Population Health Priority Measures

1. Youth Tobacco Use
2. Physically Active Children
3. Adult Obesity Counseling & Education
4. Vaccinations - HPV Females
5. Vaccinations - HPV Males
6. Vaccinations - Flu Vaccine, Older Adults
7. Teen Pregnancy Rate
8. Third Grade Reading Level
9. Children Receiving Dental Sealants
10. Infant Mortality

Scores for the Population Health Priority Measures will be calculated by the Commissioner on an annual basis according to the following schedule:

Commitment/Outcome	**Year 1 Percentage Weight**
Investment - Population Health	25
Approved population Health Plan	35
Achievement of Process Measures Identified in Population Health Plan	40
Total	**100**

Process / Investment Phase - Years 2 and 3

For year 2 in the Process / Investment Phase, the Population Health Category will be calculated as follows:

Commitment/Outcome	**Years 2 and 3 Percentage Weight**
Investment - Population Health	25
Achievement of Process Measures Identified in Population Health Plan and augmentation of Population Health Plan	75
Total	**100**

Progress / Improvement Phase - Years 4 through 10

For each year in the Progress / Improvement Phase, the Population Health Category will be calculated as follows:

Commitment/Outcome	**Years 4 through 10 Percentage Weight**
Achievement of Process Measures Identified in the Population Health Plan for new	25

initiatives, if any

Improvement in Population Health Priority Measures as compared to Geographic Service Area Baseline — 75

Total — 100

Extra Credit: A credit of between 0-2.5% may be given in the Population Health Priority Measures improvement section, at the discretion of the Commissioner, for an improvement in the proportion of preschool children aged 5 years and under who receive vision screening compared to the Geographic Service Area Baseline.

Table 2: Population Health Priority Measures Descriptions and Sources

	Measure	Description	Source
1	Youth Tobacco Use	Percentage of High School Students who self-reported currently using tobacco (current cigarette, smokeless tobacco, cigar, or electronic vapor products use on at least 1 day during the 30 days before the survey)	Virginia Youth Risk Behavior Survey
2	Physically Active Students	Percentage of High School Students who were not physically active 60+ minutes per day for 5 or more days in last 7 days	Virginia Youth Risk Behavior Survey
3	Obesity - Counseling & Education	Increase the proportion of physician office visits that include counseling or education related to weight and physical activity	New Health System Patient Records
4	Vaccinations – HPV Females	Percentage of females aged 13 to 17 years who received 2:3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent	New Health System Patient Records
5	Vaccinations – HPV Males	Percentage of males aged 13 to 17 years who received 2':3 doses of human papillomavirus (HPV) vaccine, either quadrivalent or bivalent	New Health System Patient Records
6	Vaccinations – Flu Vaccine, Older Adults	Percent of adults aged 65 and over who self reported receiving a flu shot or flu vaccine sprayed in nose in the past 12 months	New Health System Patient Records
7	Teen Pregnancy Rate	Rate of pregnancies per 1,000 females aged 15-19 years	Birth Statistics, Virginia Department of Health
8	Third Grade Reading Level	3rd graders scoring "proficient" or "advanced" on TCAP grading assessment (%)	Virginia Standards of Learning Results. Virginia Department of Education
9	Children receiving dental sealants	Children receiving dental sealants on permanent first molar teeth (%, 6-9 years)	*TBD*

	Measure	Description	Source
10	Infant Mortality	Number of infant deaths (before age 1) per l,000 live births	Birth Statistics, Virginia Department of Health

Population Health Monitoring Measures

The Population Health Monitoring Measures will provide a broad overview of the population's health. The goal of these measures is to continually monitor performance of the New Health System with regard to population health.

Population Health Monitoring Measures will be determined by the Commissioner and will reflect performance against identified Virginia's Plan for Well-Being and the Southwest Virginia Health Authority goals not scored as Population Health Priority Measures.

Population Health Monitoring Measures will be reported for the specific populations specified for each measure. These will include either the entire population of the Virginia Geographic Service area, the patients served by the New Health System, or the patients served by the New Health Systems primary care physicians.

2. Access to Health Services Category

Essential Services Measures for New Health System

Essential Services Measures will be evaluated to ensure that the New Health System continues to provide access to health care services in the community. During the first Ten-Year Period, the New Health System will be required to maintain the following essential services in each specified county.

The Essential Services Measures are identified in Table 3. The counties in which the Essential Services must be maintained during the first Ten-Year Period and the weight to be applied for compliance are specified in Table 4.

Table 3: Essential Services Measures

	Essential Service
1	Emergency room stabilization for patients
2	Emergent obstetrical care
3	Outpatient diagnostics needed to support emergency stabilization of patients
4	Rotating clinic or telemedicine access to specialty care consultants as needed in the community and based on physician availability
5	Helicopter or high acuity transport to tertiary care centers
6	Mobile health services for preventive screenings, such as mammography, cardiovascular and other screenings
7	Primary care services, including lab services
8	Physical therapy rehabilitation services
9	Care coordination service
10	Access to a behavioral health network of services through a coordinated system of care
11	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

Table 4: Counties and Weights for Access Measures

	County	Weight
1	Wise County, Virginia	10%
2	Dickinson County, Virginia	10%
3	Washington, County, Virginia	10%
4	Russell County, Virginia	10%
5	Smyth County, Virginia	10%

Access to Health Services Monitoring Measures for New Health System

The Access Monitoring Measures provide a broad overview of access to care. The goal of these measures is to continually monitor performance of the New Health System with regard to access to services.

Access Monitoring Measures will be reported for the specific populations specified for each measure. These will include either the entire population of the Geographic Service area or the patients served by the New Health System. Access Monitoring Measures are identified below in Table 5.

Table 5: Access Monitoring Measures

1	Population within 15 miles of an acute care hospital (%)	Population within 15 miles of any acute care hospital; acute care hospital may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Virginia U.S. Census Population Data 2010; Facility Addresses
2	Population within 15 miles of an emergency department (%)	Population within 15 miles of any emergency room; emergency rooms may be owned by the New Health System or a competitor and may or may not be located in the geographic service area	Virginia U.S. Census Population Data 2010; Facility Addresses
3	Personal Care Provider	Percentage of adults who reported having one person they think of as a personal doctor or health care provider	Virginia Behavioral Risk Factor Surveillance System
4	Preventable Hospitalizations - Adults	Number of discharges for ambulatory care-sensitive conditions per 1,000 adults aged 18 years and older	Virginia Health Information
5	Screening - Colorectal Cancer	Percentage of adults who meet U.S. Preventive Services Task Force recommendations for colorectal cancer screening	New Health System Patient Records
6	Screening - Diabetes	Percentage of diabetes screenings performed by the New Health System for residents aged 40 to 70 who are overweight or obese; Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	New Health System Patient Records
7	Screening – Hypertension	Percentage of hypertension screenings performed by the New Health System for residents aged 18 or older	New Health System Patient Records
8	Follow-Up After Hospitalization for Mental Illness	Percentage of adults and children aged 6 years and older who are hospitalized for treatment of selected mental health disorders and scheduled an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner within seven (7) days post-discharge	New Health System Patient Records
9	Antidepressant Medication Management – Effective Acute Phase Treatment	Percentage of adults aged 18 years and older with a diagnosis of major depression, who were newly treated with antidepressant medication and remained on an antidepressant medication for at least 84 days (12 weeks)	New Health System Patient Records
	Engagement of Alcohol or Drug Treatment	Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of alcohol or other drug dependence within 30 days of the initiation visit.	New Health System Patient Records

3. <u>Economic Category</u>

Pass/Fail Determination based on whether the New Health System has satisfied its rate cap commitments.

4. Patient Safety/Quality Category

Target Patient Safety/Quality Measures for New Health System

The Target Patient Safety/Quality Measures identify areas in which the New Health System should show maintenance of or improvement in quality outcomes. The Clinical Council may suggest revisions to this list based on quality improvement priorities of the New Health System. Revisions may be made to this list of Target Quality Measures depending on baseline data, annual performance improvements, and other factors.

Target Quality Measures will be evaluated for the entire patient population and will not be restricted based on the patient's payer status. Specifically, these measures will not be limited to the Medicare population.

For the first year of the Ten-Year Period, the New Health System will be required to maintain performance on the Target Quality Measures. For each subsequent year, the New Health System will be required to maintain or improve performance on Target Quality Measures.

Target Quality Measures

1. Pressure Rate
2. Iatrogenic Pneumothorax Rate
3. Central Venous Catheter-Related Blood Stream Infection Rate
4 Postoperative Hip Fracture Rate
5. PSI 09 Perioperative Hemorrhage or Hematoma Rate
6. PSI 10 Postoperative Physiologic and Metabolic Derangement Rate
7. PSI 11 Postoperative Respiratory Failure Rate
8. PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate
9 PSI 13 Postoperative Sepsis Rate ·
10. PSI 14 Postoperative Wound Dehiscence Rate
11. PSI 15 Accidental Puncture or Laceration Rate
12. Central Line-Associated Bloodstream Infection (CLABSI) Rate
13. Catheter-Associated Urinary Tract Infection (CAUTI) Rate
14. Surgical Site Infection (SSI) Rate
15. Methicillin-Resistant Staphylococcus Aureus (MRSA) Rate
16. Clostridium Difficile Infection (CDI) Rate

Quality Monitoring Measures for New Health System

The Quality Monitoring Measures provide a broad overview of system quality. The goal of these measures is to continually monitor performance of the New Health System with regard to quality.

For hospital quality performance, Quality Monitoring Measures will include CMS Hospital Compare measures. Hospital Compare measures that are identified as Target Quality Measures and measures of payment and value of care will be excluded from Quality Monitoring Measures. Quality Monitoring Measures will be evaluated for the entire patient population and will not be restricted based on the patient's payer status. Specifically, these measures will not be limited to

the Medicare population. The New Health System will be evaluated on Quality Monitoring Measures for each applicable New Health System Entity.

Quality Monitoring Measures are identified in Table 6.

Table 6: Quality Monitoring Measures

	Measure identifier	Technical measure title	Measure as posted on Hospital Compare
	General information - Structural measures		
1	SM-PART-NURSE	Participation in a systematic database for nursing sensitive care	Nursing Care Registry
2		Participation in a multispecialty surgical registry	Multispecialty Surgical Registry
3	ACS-REGISTRY	Participation in general surgery registry	General Surgery Registry
4	SM-PART-GEN-SURG	The Ability for Providers with HIT to Receive Laboratory Data Electronically Directly into their ONC-Certified EHR System as Discrete Searchable Data	Able to receive lab results electronically
5	OP-12	Tracking Clinical Results between Visits	Able to track patients' lab results, tests, and referrals electronically between visits
6	OP-17	Safe surgery checklist use (outpatient)	Uses outpatient safe surgery checklist
7	OP-25	Safe surgery checklist use (inpatient)	Uses inpatient safe surgery checklist
	Timely & effective care-Cataract surgery outcome		
8	OP-31	Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	Percentage of patients who had cataract surgery and had improvement in visual function within 90 days following the surgery
	Timely & effective care-Colonoscopy follow-up		
9	OP-29	Endoscopy/polyp surveillance: appropriate follow-up interval for normal colonoscopy in average risk patients	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy
10	OP-30	Endoscopy/polyp surveillance: colonoscopy interval for patients with a history of adenomatous	Percentage of patients with history of polyps receiving follow-up

		polyps - avoidance of inappropriate use	colonoscopy in the appropriate timeframe
	Timely & effective care-Heart attack		
11	OP-3b	Median time to transfer to another facility for acute coronary intervention	Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital
12	OP-5	Median time to ECG	Average (median) number of minutes before outpatients with chest pain or possible heart attack got an ECG
13	OP-2	Fibrinolytic therapy received within 30 minutes of emergency department arrival	Outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival
14	OP-4	Aspirin at arrival	Outpatients with chest pain or possible heart attack who received aspirin within 24 hours of arrival or before transferring from the emergency department
	Timely & effective care-Emergency department (ED) throughput		
15	EDV	Emergency department volume	Emergency department volume
16	ED-lb	Median time from emergency department arrival to emergency department departure for admitted emergency department patients	Average (median) time patients spent in the emergency department, before they were admitted to the hospital as an inpatient
17	ED-2b	Admit decision time to emergency department departure time for admitted patient	Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room

18	OP-18b	Median time-from emergency department arrival to emergency department departure for discharged emergency department patients	Average (median) time patients spent in the emergency department before leaving from the visit
19	OP-20	Door to diagnostic evaluation by a qualified medical professional	Average (median) time patients spent in the emergency department before they were seen by a healthcare professional
20	OP-21	Median time to pain medication for long bone fractures	Average (median) time patients who came to the emergency department with broken bones had to wait before getting pain medication
21	OP-22	Patient left without being seen	Percentage of patients who left the emergency department before being seen
22	OF-23	Head CT scan results for acute ischemic stroke or hemorrhagic stroke who received head CT scan interpretation within 45 minutes of arrival	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival
	Timely & effective care-Preventive care		
23	IMM-2	Immunization for influenza	Patients assessed and given influenza vaccination
24	IMM-3-OP-27-FAC-ADHPCT	Influenza Vaccination Coverage among Healthcare Personnel .	Healthcare workers given influenza vaccination
	Timely & effective care-Stroke care		
25	STK-4	Thrombolytic Therapy	Ischemic stroke patients who got medicine to break up a blood clot within 3 hours after symptoms started
	Timely & effective care-Blood clot prevention & treatment		
26	VTE-6	Hospital acquired potentially preventable venous thromboembolism	Patients who developed a blood clot while in the hospital who did not get treatment that could have prevented it

27	VTE-5	Warfarin therapy discharge instructions	Patients with blood clots who were discharged on a blood thinner medicine and received written instructions about that medicine
	Timely & effective care-Pregnancy & delivery care		
28	PC-01	Elective delivery	Percent of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary
	Complications-Surgical complications		
29	COMP-RIP-KNEE	Hospital level risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and total knee arthroplasty (TKA)	Rate of complications for hip/knee replacement patients
30	PSI-90-SAFETY	Complication/patient safety for selected indicators (composite)	Serious complications
31	PSI-4-SURG-COMP	Death rate among surgical inpatients with serious treatable complications	Deaths among patients with serious treatable complications after surgery
	Complications-Healthcare-associated infections (HA)		
	Readmissions & deaths-30 day raid of readmission		
32	READM-30-COPD	Chronic obstructive pulmonary disease (COPD) 30-day readmission rate	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients
33	READM-30- AMI	Acute myocardial infarction (AMI) 30-day readmission rate	Rate of readmission for heart attack patients
34	READM-30-HF	Heart failure (HF) 30-day readmission rate	Rate of readmission for heart failure patients
35	READM-30-PN	Pneumonia (PN) 30-day readmission rate	Rate of readmission for pneumonia patients
36	READM-30- STK	Stroke 30-day readmission rate	Rate of readmission for stroke patients
37	READM-30- CABG	Coronary artery bypass graft (CABG) surgery 30-day readmission rate	Rate of readmission for coronary artery bypass graft (CABG) surgery patients
38	READM-30- HIP-	30-day readmission rate following	Rate of readmission after

	KNEE	elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)	hip/knee replacement
39	READM-30-HOSP-WIDE	30-day hospital-wide all- cause unplanned readmission (HWR)	Rate of readmission after discharge from hospital (hospital-wide)
	Readmissions & deaths-30-day death (mortality) rates		
40	MORT-30-COPD	COPD 30-day mortality rate	Death rate for COPD patients
41	MORT-30-AM1	Acute myocardial infarction (AMI) 30-day mortality rate	Death rate for heart attack patients
42	MORT-30-HE	Heart failure (HF) 30-day mortality rate	Death rate for heart failure patients
43	MORT-30-PN	Pneumonia (PN) 30-day mortality rate	Death rate for pneumonia patients
44	MORT-30-STK	Stroke 30-day mortality rate	Death rate for stroke patients
45	MORT-3 0- CABG	Coronary artery bypass graft (CABG) surgery 30-day mortality rate	Death rate for CABG surgery patients
	Use of medical imaging-Outpatient imaging efficiency		
46	OP-8	MRI Lumbar Spine for Low Back Pain	Outpatients with low-back pain who had an MRI without trying recommended treatments (such as physical therapy) first If a number is high, it may mean the facility is doing too many unnecessary MRIs for low-back pain.
47	OP-9	Mammography Follow-Up Rates	Outpatients who had a follow-up mammogram, ultrasound, or MU within the 45 days after a screening mammogram
48	OP-10	Abdomen CT - Use of Contrast Material	Outpatient CT scans of the abdomen that were “combination” (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is

			all they need).
49	OP-11	Thorax CT - Use of Contrast Material	Outpatient CT scans of the chest that were "combination" (double) scans (if a number is high, it may mean that too many patients have a double scan when a single scan is all they need).
50	OP-13	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery (if a number is high, it may mean that too many cardiac scans were done prior to low-risk surgeries).
51	OP-14	Simultaneous Use of Brain Computed Tomography (CT) and Sinus CT	Outpatients with brain CT scans who got a sinus CT scan at the same time (if a number is high, it may mean that too many patients have both a brain and sinus scan, when a single scan is all they need)

5. Patient Satisfaction Category

Patient Satisfaction Monitoring Measures for New Health System

The Patient Satisfaction Monitoring Measures provide a broad overview of patient satisfaction. The goal of these measures is to continually monitor performance of the New Health System with regard to patient satisfaction.

For patient satisfaction performance, the New Health System will use those metrics included in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey required by CMS. The New Health System will be evaluated on Patient Satisfaction Monitoring Measures for each applicable New Health System Entity.

Patient Satisfaction Monitoring Measures are identified in Table 7.

Table 7: Patient Satisfaction Monitoring Measures

	Survey of patient's experiences Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)		
1	H-COMP-1-A-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Always" communicated well
2	H-COMP-1-U-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Usually" communicated well
3	H-COMP-1-SN-P	Communication with nurses (composite measure)	Patients who reported that their nurses "Sometimes" or "Never" communicated well
4	H-COMP-2-A-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Always" communicated well
5	H-COMP-2-U-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Usually" communicated well
6	H-COMP-2-SN-P	Communication with doctors (composite measure)	Patients who reported that their doctors "Sometimes" or "Never" communicated well
7	H-COMP-3-A-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Always" received help as soon as they wanted
8	H-COMP-3-U-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Usually" received help as soon as they wanted
9	H-COMP-3- N-P	Responsiveness of hospital staff (composite measure)	Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted

10	H-COMP-4-A-P	Pain management (composite measure)	Patients who reported that their pain was “Always” well controlled
11	H-COMP-4-U-P	Pain management (composite measure)	Patients who reported that their pain was “Usually” well controlled
12	H-COMP-4-SN-P	Pain management (composite measure)	Patients who reported that their pain was “Sometimes” or, “Never” well controlled
13	H-COMP-5-A-P	Communication about medicines (composite measure)	Patients who reported that staff “Always” explained about medicines before giving it to them
14	H-COMP-5-U-P	Communication about medicines (composite measure)	Patients who reported that staff “Usually” explained about medicines before giving it to them
15	H-COMP-5-SN-P	Communication about medicines (composite measure)	Patients who reported that staff “Sometimes” or “Never” explained about medicines before giving it to them
16	H-CLEAN-HSP-A-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Always” clean
17	H-CLEAN-HSP-U-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Usually” clean
18	H-CLEAN- HSP-SN-P	Cleanliness of hospital environment (individual measure)	Patients who reported that their room and bathroom were “Sometimes” or “Never” clean
19	H-QUJET-HSP-A-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their MOM was “Always” quiet at night
20	H-QUIET-HSP-U-P	Quietness of hospital environment (individual measure)	Patients who reported that the area around their room was “Usually” quiet at night
21	H-QUIET-HSP-SN-P	Quietness of hospital environment (individual measure) .	Patients who reported that the area around their room was “Sometimes” or “Never” quiet at night
22	H-COMP-6-Y-P	Discharge information (composite measure)	Patients who reported that YES, they were given information about what to do during their recovery at home
23	H-COMP-6-N-P	Discharge information (composite measure)	Patients who reported that NO they were not given

			information about what to do during their recovery at home
24	H-COMP-7-SA	Care Transition (composite measure)	Patients who “Strongly Agree” they understood their care when they left the hospital
25	H-COMP-7-A	Care Transition (composite measure) .	Patients who “Agree” they understood their care when they left the hospital
26	H-COMP-7-D-SD	Care Transition (composite measure)	Patients who “Disagree” or “Strongly Disagree” they understood their care when they left the hospital
27	H-HSP-RATING-9-10	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)
28	H-HSP-RATING-7-8	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)
29	H-HSP-RATING-0-6	Overall rating of hospital (global measure)	Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)
30	H-RECMND-DY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would definitely recommend the hospital
31	H-RECMND-PY	Willingness to recommend the hospital (global measure)	Patients who reported YES, they would probably recommend the hospital
32	H-RECMND-DN	Willingness to recommend the hospital (global measure)	Patients who reported NO, they would probably not or definitely not recommend the hospital

Patient Satisfaction Report

The Report will document a satisfactory plan for the New Health System to address deficiencies and opportunities for improvement related to patient satisfaction with health care services and document satisfactory progress towards the plan.

6. Other Category
New Health System Compliance with Cooperative Agreement Commitments

The New Health System shall receive credit under the Quantitative Measures for compliance with each of the commitments set forth in the Letter Authorizing a Cooperative Agreement.

The Cooperative Agreement commitments and each commitment's weight are identified in Table 8.

Table 8: Cooperative Agreement Commitments

	Commitment	Weight
1.		
2.		
3.		
4.		
5.		
6.		
7.		

NOTE: TABLE 8 TO BE FINALIZED ONCE COMMITMENTS ARE FULLY AGREED UPON. WE PROPOSE THAT EACH COMMITMENT BE GIVEN EQUAL WEIGHT FOR A TOTAL SCORE OF 100.