

Meeting Between Mountain States Health Alliance, Wellmont Health System,
and Staff from the Virginia Department of Medical Assistance Services
and the Virginia Department of Health
Cooperative Agreement Application – Commonwealth of Virginia
October 4, 2017

Attendees:

Virginia Department of Health (VDH)

Dr. Marissa Levine – State Health Commissioner
Erik Bodin – Director, Office of Licensure and Certification
Joe Hilbert – Director of Governmental and Regulatory Affairs

Virginia Department of Medical Assistance Services (DMAS)

John Stanwix – Formal Appeals and Final Agency Decision Supervisor

Virginia Office of Attorney General (OAG)

Allyson Tysinger – Senior Assistant Attorney General/Chief

Mountain States Health Alliance (MSHA)

Alan Levine – President and CEO
Marvin Eichorn – Executive Vice President and Chief Operating Officer
Tony Keck – Senior Vice President, Chief Development Officer
Tim Belisle – Executive Vice President of Corporate Compliance and General Counsel

Wellmont Health System (WHS)

Bart Hove – President and CEO
Gary Miller – Executive Vice President and General Counsel

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

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

Hancock, Daniel, Johnson & Nagle, PC

Jenny McGrath – Counsel to Mountain States Health Alliance (by phone)

The meeting convened at 10:00 a.m.

Mr. Levine welcomed and thanked the attendees. Commissioner Levine said that she would like to learn more about the meeting held on October 3, 2017 in Charlottesville between the Applicants, Delegate Terry Kilgore, and other representatives of the Southwest Virginia Health Authority (the Authority). She also said that, because of the unique nature of the issues underlying the Application, a different type of solution is required—such that the people of Southwest Virginia and their health are better off. The type of solution that is required cannot simply involve the provision of health care services. Dr. Levine told the Applicants that absence of detailed planning information remains a concern. She also said that employee severance

issues in Norton, as contained in the Terms of Certification Governing the Certificate of Public Advantage Issued to Ballad Health, as approved by the State of Tennessee (Tennessee Terms), is a “red flag” to her. She added that the Applicants’ current commitment to have only two Virginia residents on the New Health System Board is inadequate. Mr. Levine stated that there are conditions in the Tennessee Terms pertaining to Virginia and he would expect Virginia to exercise its sovereignty.

Mr. Levine and Mr. Hove briefed the attendees on the substance of their meeting/conference call on October 3, 2017 with Delegate Terry Kilgore and other representatives of the Authority. The meeting concerned the provisions of the Tennessee Terms as well as the Revised Commitments sent by the Applicants to VDH on September 22, 2017. The following topics were discussed during the October 3 meeting:

- Governance of the new health system;
- Rate structure
- Number of population health measures required to be monitored;
- Cost of compliance with the Tennessee Terms, specifically the Pricing Limitations contained in Article V and Addendum 1;
- Conflicts between the Tennessee Terms and the Revised Commitments;
- Closure of facilities and staff layoffs;
- Locations of planned investments in research and faculty;
- Graduate medical education, training of health care professionals, and interaction with institutions of higher education; and
- Access to specialty care via mobile clinics and telemedicine.

Mr. Levine said that the New Health System had originally budgeted \$1 million per year for compliance with the terms of the Certificate of Public Advantage in Tennessee. However, with the change in the pricing limitation provisions, from what the Applicants’ originally proposed to what is now contained in the Tennessee Terms, the Applicants estimate that the annual cost of compliance will be \$5 million. Mr. Levine said that every additional dollar that needs to be spent on compliance represents less funding available for health care services. He added that the Applicants told the Authority representatives during the October 3 meeting that there could be ways to ensure that the additional costs to comply with the Tennessee Terms would only be allocated to facilities located in Tennessee and not to any facilities located in Virginia.

Mr. Levine said that there are provisions in the Tennessee Terms (i.e. Establishment of Payment Indices, Excess Payment Testing, and Refund of Excess Payments) that are not reflected in the Revised Commitments, and those differences are intentional because they reflect provisions that the Authority did not want. Mr. Levine also said that the Cooperative Agreement needs to be about the geographic service area as a whole, and not about what is in it specifically for the benefit of either Tennessee or Virginia. He said that the Applicants “do not see a state line” and he intends to push back whenever the conversation turns to identification of specific benefits for either Virginia or Tennessee. Mr. Levine said that about half of Mountain States’ debt is tied to investments made in Virginia.

Concerning the composition of the New Health System Board of Directors, Mr. Levine said that Commissioner Levine's point that the Board should have more than two Virginia residents was well-made, but that including more Virginia residents on the Board at the outset would make it harder for the New Health System to seat a Board that meets various requirements, including those pertaining to competency. He stated that the composition of the Board should be based on competencies and not on residency. He also said that the Applicants had told Del. Kilgore and the other representatives of the Authority that they were committed to bringing a third Virginia resident onto the Board within three or four years. Commissioner Levine responded by saying that she would have a hard time with that proposed timeline and that it was important to have at least three Virginia residents on the Board as early as possible because many decisions will have to be made during the first three years of the New Health System's existence.

Mr. Levine said that no health system merger anywhere in the country has sought to do what the Applicants are proposing. He also stated that out of market acquisitions increase pricing but reduce the ability to eliminate duplicative services.

Concerning population health, Mr. Levine said improvement efforts need to be focused. A "shotgun approach" should not be used or else funding will be wasted.

Mr. Keck then discussed the provision in the Tennessee Terms (Section 4.03(b)(ii)), which allows the immediate repurposing of up to two of the three hospitals in the City of Norton/Wise County without prior approval of the Tennessee Department of Health (the Department). Mr. Keck explained that, while the provision allows for the termination, without cause, of non-clinical employees of such hospitals, the Tennessee Department of Health must receive notice at least 60 days in advance of such layoffs and the notice must include a severance policy addressing how such employees will be compensated. Mr. Levine noted that if the merger is approved, redundant services would be eliminated but new services needed in the community would be created. He stated that the New Health System needs flexibility so it can create new services. Mr. Levine noted that these new services would create job opportunities. Commissioner Levine stated that the merger must focus on people, both patients and members of the workforce, and that she would like to see something in the commitments that showed an investment in their employees and helping them make transitions. Commissioner Levine stated that it was unclear how the severance policy and career development program contained in the Tennessee Terms would benefit employees in Norton/Wise who might be subject to termination. She requested that the Applicants clarify Commitment 15, pertaining to a severance policy, given the provisions in the Tennessee Terms. The Applicants agreed to do so.

Mr. Eichorn provided an overview of the pricing limitations in the Tennessee Terms, particularly in terms of how the maximum ceiling on fixed rate percentage increases for hospitals under the Applicant's CPI-based initial proposal compared to the Medicare Market Basket-based provision contained in the Tennessee Terms. According to Mr. Eichorn, for a Large Network Payer with a quality rate adjustment, the ceiling would be 2.95% compared to 4.14% under the Applicants' original proposal. On the other hand, for small payers without a quality rate adjustment, the ceiling would be 4.2% under the Tennessee Terms as compared to 4.14% in the Applicants' original proposal. Mr. Eichorn also said that the Tennessee Terms also include provisions

allowing the Tennessee Department of Health to review and potentially adjust prices contained in the New Health System's chargemaster.

Mr. Eichhorn explained the Tennessee Terms require that, once the New Health System has completed the first year of a payer contract, they must look back – with the use of payment indices – and conduct excess payment testing to make sure that they did not exceed the pricing limitations. If they do exceed the limitations, they are required to refund the excess payments. He said that, under the Tennessee Terms, a Large Network Payer can opt out of the prescribed methodology for excess payment testing if it and the New Health System agree on an alternative methodology for measuring compliance with the pricing limits. Mr. Levine said that several of the large payers have already told the Applicants that they may not be interested in using the methodology prescribed in the Tennessee Terms. He said further that the possibility of an excess payment is small, given the processes and procedures that health plans have in place for paying claims. Mr. Levine questioned how the New Health System would know to whom a refund of an excess payment should be paid. He said that the Applicants had proposed that any excess payments be refunded into a population health fund, but that was rejected.

Mr. Stanwix expressed a concern that the most recent commitments provided by the applicants on September 2nd do not appear to protect Virginia Medicaid Managed Care Organizations (MMCO) who have contracts with the New Health System that tie payment to a percentage of Virginia Medicaid's payment rate. Mr. Levine stated that one proposal is to freeze the existing MMCO contracts at the current negotiated percent and if new contracts come in to play, then place a cap on the new contract being no greater than the current highest negotiated percentage of the Medicaid rate.

Mr. Stanwix also mentioned that there are specific exceptions made by the applicants for skilled nursing, home health, hospice, and durable medical equipment. The applicants responded that the rates for these were typically already set and that these areas have a high degree of competition in the geographic service area. The applicants stated that to the extent that these services fall under MMCO contracts, they would modify the commitments to clarify that Medicaid is not a part of the exception.

Commissioner Levine discussed her interest in seeing the New Health System quickly transform into a population health improvement organization, reflected in part by having at least 30% of its health insurance contracts be value-based, risk-based, or shared savings contracts. Mr. Eichhorn and Mr. Levine said that they would utilize other documents describing their planned transition to value-based contracting in order to prepare some revised commitment language. Mr. Levine said that Virginia Medicaid "funding silos" need to be merged. If the Medicaid funding silos were merged, and Virginia was willing to create a stop-loss mechanism, then the New Health System would be in a position to enter into a capitated, shared savings arrangement with DMAS in Southwest Virginia.

Commissioner Levine discussed some ongoing issues and concerns with respect to several of the Applicants' revised commitments:

With respect to Commitment 3 (negotiation in good faith with payers to include the NHS in health plans), this commitment still includes a reference to "Principal Payers". Commissioner Levine said this commitment needs to apply to all payers. The Applicants responded that they would make that change.

With respect to the financial commitments to invest \$140 million to recruit health care providers and enhance access to care (commitments 25 and 26), \$85 million on academics and research (commitments 17 and 18), and \$75 million on population health (commitment 27), Commissioner Levine said that she is seeking assurance that there will be significant benefit to the Virginia portion of the geographic service area. Mr. Levine said that the money needs to go where the need is. Mr. Keck stated that if you evaluate public benefit by the outcomes that are achieved, then it should not matter if \$10 is spent versus \$1 million as long as the outcome is achieved. Commissioner Levine said that she is looking for commitment language that articulates those concepts and milestones that get the New Health System to the desired outcomes, which could include both process and financial milestones. Commissioner Levine stated that she wanted a clear commitment to methodology and involvement in Virginia and noted that such a commitment could take the form of a floor of a percentage of dollars that would be spent in Virginia. The Applicants responded further, with respect to commitments 17 and 18, that they would commit to collaboration with Virginia institutions of higher education whenever possible and practicable to compete for research funding.

Commissioner Levine stated that a commitment regarding access to primary care was needed. Mr. Levine stated that they could commit to same day access to primary care within 24 months as long as it included the use of technology.

Commissioner Levine said she would look for the Applicants' assistance in developing a commitment that is tied to eliminating the continued need for the Remote Area Medical and Mission of Mercy Clinics in Southwest Virginia. Commissioner Levine explained that most people come to these clinics in search of dental and vision service, although there are typically co-morbidities, and that she is not necessarily looking for the Applicants to provide all of the necessary health care services themselves. Rather, she is looking for them to play a leadership, facilitation, and assurance role in the region. Mr. Levine noted that Mountain States had recently made an investment in the Southwest Virginia Food Bank and that they now can do health screenings for clients of the Food Bank, which is a population that they did not have access to prior to this investment. Mr. Levine also stated that a workforce assessment could include an assessment of access to dental services.

There was a discussion concerning active monitoring and oversight should the application be approved. Bart Hove asked about how the Technical Advisory Panel (TAP) would function, and if they could see Virginia's proposed metrics before any Order approving the Cooperative Agreement is issued. Commissioner Levine explained that the work of the TAP would only begin subsequent to issuance of an order. Mr. Levine said that the New Health System Board needs to vote in order to approve the closing of the merger, and they cannot vote unless they

know what metrics the New Health System will be held to. He also said that the Board and the Applicants would need to see the proposed VDH metrics in order to determine if they can meet them. Commissioner Levine explained the actual metrics would not be contained in an order approving the cooperative agreement, if such an order is issued. Mr. Levine said that the Applicants have to close by January 31 or the Tennessee Terms will be no longer be valid. Commissioner Levine acknowledged the Applicant's concern and expects that VDH would complete its metrics by the time needed for the Applicants' boards to vote to close. Mr. Levine was satisfied with that proposal.

With respect to Revised Commitments 11 and 12, Commissioner Levine stated that in addition to notice, the Applicants should submit a plan to address any material default or material adverse event and that typically such plans should be submitted within a 30 to 45 day time frame. Mr. Levine stated that would not be a problem.

Commissioner Levine stated that repurposing of hospitals could affect EMS transport and requested that the Southwest Virginia EMS Council be part of any planning process regarding repurposing of a facility. It was noted that ED utilization in Norton is high.

Commissioner Levine stated that essential services should include routine obstetrical services. Mr. Levine said that it would be hard to make such a commitment. Commissioner Levine said that if a commitment was made to reduce infant mortality and make such a reduction a priority, services would be addressed.

Commissioner Levine noted that a merger could result in consolidation of level 1 trauma services. She asked that Level 1 trauma services be maintained in Kingsport. Mr. Levine stated that no conversations had been had regarding location. Commissioner Levine requested that the Southwest Virginia EMS Council be included in planning.

Mr. Stanwix explained that DMAS' Chief Medical Officer sees a critical need for increased participation the DMAS Addiction and Recovery Treatment Services (ARTS) program in the region, to include: developing at least one Substance Use Partial Hospitalization Program (ASAM Level 2.5), at least two Medically Managed Withdrawal Management Programs (ASAM Level 3.7) providing detox in inpatient psychiatric units, and at least two Preferred Office-Based Opioid Treatment Providers at health system outpatient clinics. The applicants stated that they would work with DMAS to establish priorities for mental health and substance use treatment. Additionally, they noted that there will be an increase in mental health treatment capacity with repurposing of facilities.

Additionally, Mr. Stanwix stated that the Applicants had asked for more information about what was meant by pre-admission screening when it was discussed at the August 8th meeting. Mr. Stanwix stated that DMAS would like to see a written commitment that the applicants will continue to perform hospital-based pre-admission screening assessments to determine if the screened individual meets the functional criteria to receive Medicaid-funded long term services or supports. The applicants agreed to add this as a commitment.

Dr. Levine said that VDH would be the regulator of any approved Cooperative Agreement. The overall objective of Virginia's regulatory approach would be to achieve better outcomes for the people of Southwest Virginia.

Mr. Levine and Mr. Hove agreed that they would submit revised commitments to the Commissioner reflecting the discussion within a matter of days.