Southwest Virginia Health Authority
851 French Moore Jr. Boulevard, Suite 178
Abingdon, Virginia 24210

October 16, 2017

Via Electronic Mail
Marissa J. Levine, M.D., M.P.H., F.A.A.F.P.
Commissioner
Virginia Department of Health
109 Governor Street
Richmond, Virginia 23219

Dear Commissioner Levine:

On September 19, 2017, the Commissioner of Health of the State of Tennessee approved the *Terms of Certification Governing The Certificate of Public Advantage Issued to Ballad Health Pursuant to the Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System and Mountain States Health Alliance* that will be issued upon completion of the proposed merger (the "Tennessee COPA Certification"). I write to report the results of the review by the Southwest Virginia Health Authority (the "Authority") on the impact of the Tennessee COPA Certification on our earlier recommendation and proposed commitments.

First, as you know, the Authority received the "*Commonwealth of Virginia Application for a Letter Authorizing Cooperative Agreement*" between Mountain States Health Alliance and Wellmont Health System (collectively, the "Applicants")[1] on February 16, 2016 and deemed the filing complete on August 26, 2016 (the "Application"). The Authority acted pursuant to Section 15.2-5384.1 of the Code of Virginia (the "Code") and on November 7, 2016 considered the statutory requirements prescribed for our review and then voted to recommend to you that you approve the Application as amended by our proposed commitments. We transmitted our final report to you on December 22, 2016 (the "Authority Report"). We have now concluded our review of Tennessee COPA Certification to determine what, if any, further recommendations we might make to you as you conclude your deliberation of the pending Application.

To review the Tennessee COPA Certification the Authority convened on September 27, 2017, recessed and reconvened on October 12, 2017. During the September 27th meeting, the Authority received an extensive briefing from the Applicants. The Board requested that the staff

[1] The Applicants are also referred to as the "New Health System" (which was the name they utilized in the Application and "Ballad," which is their selected post-merger name.

of the Authority immediately meet with the Applicants to review the Tennessee COPA Certification in detail and return to the Board with recommendations for the Authority to consider. The Authority staff, myself, Dr. Sue Cantrell, and our attorney met with the Applicants on October 3, 2017 for several hours to review the Tennessee COPA Certification in detail. Following this meeting, the staff and the Applicants had several follow-up conversations and, during our October 12th meeting, the staff presented an extensive review of the Tennessee COPA Certification, including a thorough review of the very complicated proposed Tennessee rate formula and other economic related issues.

Following their review and the Authority's consideration of the Tennessee COPA Certification, the Board of Directors unanimously adopted a resolution (a) recommending to you the revised Virginia commitments attached hereto as Exhibit A (which shows newly revised language), (b) adopting the recommendations of the staff, as amended, and set forth below and (c) directing the Chairman of the Authority to work with our staff to transmit as quickly as possible the Authority's comments and recommendations to you for your consideration.

First, our staff focused on the impact of the Tennessee COPA Certification on our previously recommended commitments and the impact, if any, of the Tennessee COPA Certification on Virginia. Our Board of Directors and the staff immediately noted that the Tennessee COPA Certification created a more restrictive and bureaucratic framework than the Authority had recommended in November. The Tennessee requirements, for example, encompassed 119 pages of text, while our recommended Virginia commitments were contained in 19 pages. We recognize that ultimately this dramatic increase in oversight, perhaps because the two Applicants are Tennessee-based entities, will produce ancillary oversight and monitoring benefits for the Commonwealth; however, the Authority is deeply concerned about the impact of these requirements on both the ultimate success of the proposed merger and the implementation of the New Health System's investments in Southwest Virginia. We also understand that the impact of the cost of the compliance by the New Health System to both state's requirements, given the Tennessee COPA Certification requirements, could create an administrative cost of approximately $5,000,000 per year versus the estimated cost of compliance to the recommended Virginia framework of $1,000,000 per year for compliance with the requirements of both states. We are very concerned about the impact of financial cost of compliance with the Tennessee COPA Certification requirements on the ultimate success the New Health System.

In the end, we did not, however, conclude that any instance exists where compliance by the New Health System with the Tennessee COPA Certification requirements will require the Applicants to violate the commitments the Applicants made to the Commonwealth in the Authority's recommended commitments. As the staff reported to the Authority's Board of Directors, the State of Tennessee chose a different approach, which does not mean that the approach the Authority chose was incorrect. Tennessee has required the Applicants to produce

more data, draft more plans, and submit more reports, and the Commonwealth may benefit from a review of this material. The Authority's earlier review was comprehensive and our suggested commitments the result of a very deliberative process focused on the statutory requirements governing the process. In concluding our review of the Tennessee COPA Certification, the Authority decided to harmonize, where appropriate, the Tennessee COPA Certification requirements with our earlier recommendations to you, but to recommend, where we believe essential to health care in our region, that you require in Virginia adherence to our Virginia-focused commitments.

During our recent meeting, the Authority's Board of Directors adopted the following recommendations for your consideration:

- **<u>Recommendation 1: Additional Monitoring of Financial Information</u>. The Authority recommends that the Commissioner require Ballad to send to the Commissioner the 5-year financial projections that it will develop after closing of the merger and which it submits to rating agencies.**

  Tennessee requires the Applicants to produce certain post-merger financial projections. We recommend that you require the New Health System to provide such reports to Virginia for your review.

- **<u>Recommendation 2: Caps on Rate Increases</u>. The Authority recommends that the final Virginia commitments accede to Tennessee formula capping rate increases as reflected in the draft revised Virginia commitments posted to the Authority's web site as of October 12, 2017 (Revised Commitments).**

  The proposed payor rate structure developed by the State of Tennessee involves a complicated set of calculations. Also, the State of Tennessee based the new formulae upon the Medicare Market Basket rather than the Consumer Price Index used in the original Virginia commitments. The Applicants reported that the Tennessee formula (which applies to the calculations for hospital inpatient services, hospital outpatient services, and services furnished in physician office settings) could reduce the revenue of the New Health System in the range of $53,000,000 to $115,000,000 compared to our original proposed framework that would potentially reduce the revenue of the New Health System by approximately $80,000,000. Our staff did not conduct an independent analysis but reviewed the Applicants' worksheets and believes that they are a reasonable estimate of the dollar impact of the Tennessee formula.

We believe that for the sake of efficiency the Virginia commitments should conform to the Tennessee calculation, even though it is not the calculation we proposed. We believe it is impractical to have different rate cap formulas in the two states.

- **<u>Recommendation 3: Population Health</u>. The Authority recommends that the Virginia Commissioner should require adherence to the Authority's plan to measure and develop priorities to gain targeted results in Virginia as reflected in the Revised Commitments.**

  For nearly a decade the Authority has worked to implement the Authority's vision "to achieve continuous improvement in the health and prosperity of the region." As we conducted our initial review of the Application, we did so with significant consideration to our existing blueprint for improving health care in the region. The commitments we recommended in the Authority's Report reflect our unique knowledge of the region and proposed a strategy for a focused and targeted implementation of the population health goals of the New Health System.

  The Tennessee COPA Certification contains a total of 69 different goals and criteria. We recommended a much more focused approach based on our evidence-based, results-oriented outcomes developed in collaboration with the New Health System. We strongly recommend that you require adherence to our approach to the implementation of the population health goals of the New Health System in Virginia.

  During our discussions, the Authority carefully considered requiring the New Health System to create a Virginia-focused division within the Department of Health Population required by the State of Tennessee to be created within the New Health System. The Authority also considered whether it should consider recommending that a fixed ratio of funds be required to be expended within the Commonwealth. In both instances, the Authority ultimately concluded that with the development of the appropriate measuring metrics and adherence to the proposed Virginia plan for developing and implementing the proposed commitments, the Authority would not recommend these contemplated changes.

  The Board of Directors of the Authority did alter the staff's initial recommendation to insert "measure" into the recommendation.

- **<u>Recommendation 4: Closing Hospitals</u>. The Authority recommends that the Virginia Revised Commitments be left as is. In addition, the Authority recommends that that Virginia Commissioner communicate with the Tennessee Commissioner and negotiate a Memorandum of Understanding whereby each state agrees to seek the input of the other state on issues arising under the merger, and also state the obvious proposition that Virginia is not giving up any sovereignty or regulatory authority over Virginia health care facilities or services.**

  Our review of the Tennessee COPA Certification requirements regarding the decision to close existing rural facilities does not supersede our proposed Virginia commitment. The Tennessee requirements specifically include Virginia rural hospitals within its purview and require the Applicants to submit a rural hospital plan prior to taking any action. In addition, the Tennessee COPA Certification recognizes that the three hospitals in the City of Norton and the County of Wise may be impacted by closing and repurposing. Prior to the Applicants taking any action on one of these hospitals, the Applicants must incorporate such actions in the rural plan required to be submitted to the State of Tennessee. Given the engagement of the State of Tennessee in decisions that will affect health care in Southwest Virginia, we recommend that your office and the Office of the Commissioner of Health of the State of Tennessee formerly develop a written process of resolving issues impacting Virginia, especially since the State of Tennessee has already stated that it intends to seek the input of the Commonwealth of Virginia on such decisions.

- **<u>Recommendation 5: Lay-Offs</u>. The Authority recommends that the Virginia Commissioner take no action on this issue and that the language in the Revised Commitments stand as is.**

  Our initial recommendation balanced strong protections for employees of potentially closed facilities with the desire to enable the New Health System to be successful in any plans it develops for re-purposing hospitals in Southwest Virginia.

  The Tennessee provisions mainly apply to non-clinical employees, and as a result, we believe the combination of our proposed Virginia commitment and the new Tennessee requirement provide strong protections for the Virginia-based employees. We also believe the commitments and the Tennessee COPA Certification requirements are not mutually exclusive and can be simultaneously enforced.

- **<u>Recommendation 6: Board Positions</u>. The Authority recommends that the Virginia Commissioner require 3 Board seats for Virginia.**

  The Authority again considered the appropriate number of members of the Board of Directors of the New Health System who are residents of the Commonwealth of Virginia. The Tennessee COPA Certification reduced the overall size of the Board of Directors of the New Health System from 16 members to 11 members and moved the President of East Tennessee State University from a non-voting member of the Board of Directors to a voting member of the Board of Directors.

  After extensive discussion by the members of the Authority's Board of Directors, led by State Senator Ben Chafin, the Board of Directors amended slightly the staff recommendation and made clear the Authority's position that the proposed minimum three board seats should be permanent.[2]

- **<u>Recommendation 7: Research</u>. The Authority recommends that the Virginia Commissioner require the Applicants to adhere to the research and development plan currently under development by the academic institutions in the region, which includes input from Virginia's institutions.**

  The Tennessee COPA Certification requirements will require the New Health System to prepare and subsequently update a plan for both graduate medical education and research and development. Last year Virginia institutions participated in the initial meetings on these areas and, when these committees are reactivated, the Virginia academic institutions should remain active and engaged participants in these areas of implementation by the New Health System. The implementation plans in these two important areas should adhere to a plan developed by the academic institutions through a process where each institution has a single representative and collaborates on the development and implementation of the plans.

- **<u>Recommendation 8: Overhead Allocation of Compliance Costs</u>. Because compliance under the Tennessee Terms of Certification will likely result in substantially higher costs than the Virginia Cooperative Agreement**

[2] The proposed wording in Commitment #30 does not reflect the Authority's final action as the Authority chose not to engage in further editing of the recommended commitments and the language of this recommendation overrides the suggested language.

supervision structure, it is the Authority's view that the costs of compliance with the Tennessee Terms of Certification should be borne by facilities located in Tennessee and the costs of compliance with the terms of the Virginia Cooperative Agreement should be borne by facilities located in Virginia. Accordingly, the Authority recommends that the Virginia Commissioner add the following commitment: In order to ensure that the Virginia operations are allocated an appropriate, fair and reasonable amount of the New Health System's ongoing and annual compliance costs, the New Health System agrees to adopt an allocation methodology that specifically takes into account and separately tracks the differences in ongoing and annual compliance requirements between the State of Tennessee and the Commonwealth of Virginia.

We project a substantial potential cost to the New Health System for compliance with the Tennessee COPA Certification requirements. The Authority is concerned that a simple, unsophisticated allocation of the overhead related to this compliance could significantly and adversely impact the financial performance of the Virginia rural hospitals, some of which are already losing money on an annual basis. The Authority recommends that you require the New Health System to adopt an allocation methodology that allocates the cost of the compliance to the Tennessee COPA Certification to the hospitals located within the State of Tennessee.

- **<u>Recommendation 9: Transparency</u>. The Authority recommends to the Virginia Commissioner that the Applicants submit to the Virginia Commissioner and the Authority all plans, reports, notices, and other substantive communications that the New Health System submits to Tennessee pursuant to the Tennessee Terms of Certification, and the Virginia Commissioner protect any information that is privileged or confidential under applicable law.**

  As earlier mentioned, the State of Tennessee now requires the production by the New Health System of many additional documents. We recommend that you require that those reports be shared with the Commonwealth of Virginia.

We hope these additional recommendations assist you in your final review and action. In short, we have recommended that the integrity of the Virginia structure and process remains intact notwithstanding the many references to Virginia in the Tennessee COPA Certification. Finally, consistent with our earlier effort to conduct a very transparent review, we have added to

the Authority's website several documents relevant to our recent review of the Tennessee COPA Certification. These documents may be found at our website, which is located at https://swvahealthauthority.net/cooperative-agreement/.

Thank you for the opportunity to provide additional comments on the proposed merger and cooperative agreement. Please contact me if you require additional information.

Very Truly Yours,

SOUTHWEST VIRGINIA HEALTH AUTHORITY

Terry G. Kilgore

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Terry G. Kilgore, Chairman

Attachments

cc: Members of the Board of Directors of the Southwest Virginia Health Authority
Ms. Barbara Allen
Mr. Roger Leonard
Mr. Alan Levine
Mr. Bart Hove
Tim Belisle, Esq.
Gary Miller, Esq.
Jim Daniel, Esq.
Richard G. Cowart, Esq.
Dennis M. Barry, Esq.
E. Richard Brownlee, II, PhD, CPA
Thomas A. Massaro, M.D., PhD

Attachments

Revised Virginia Commitments (clean copy)
Revised Virginia Commitments (compare)
Exhibit A
Exhibit B

Revised New Health System Virginia Commitments
Dated October 9, 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, the New Health System shall honor all existing Payer contract terms and not unilaterally terminate without cause any such existing contract prior to its stated expiration date. In addition, 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 (defined below). 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.

If either the New Health System or any Payer terminates a Payer contract, the New Health System will be subject to the pricing limitations of this Commitment. That is, this Commitment will apply, with the increased pricing limitation listed below, even if the New Health System goes out-of-network with a Payer. In this event, there will be no balance billing of patients over and above the following amount:

- The provisions of this Commitment shall apply to any Payer which has a managed care contract with NHS, MSHA or WHS and subsequently goes out-of-network; provided, however, that the Hospital Inflation Adjustment and Physician Inflation Adjustment with respect to such Payer shall be multiplied by two (2x) in the first two (2) years the Payer is out of network and multiplied by one (1x) each year thereafter.

The following definitions will apply to this combined Commitment 1 and 2, and when used in other Commitments:

"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%

"Physician Inflation Adjustment" means the Hospital Inflation Adjustment without the Quality Adjustment Factor. Medicare's annual physician market basket update factor is currently limited by law to 0.50. When and if Medicare begins using an inflation-based update to the physician fee schedule, the Physician Inflation Adjustment used herein will be the Medicare physician market basket rate of increase plus 0.25 percent.

"Payer" means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any New Health System hospital or other medical providers' medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payers which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payers and health plans which negotiate the payment or rate of payment for hospital or medical services, supplies and/or items. Payer includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare payers or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of

Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the term of the Cooperative Agreement.

"Large Network Payer" means a Payer which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges ("Gross Revenue") for the New Health System. The same Payer may have several networks, each of which utilize different fee schedules, and each of which could constitute 2% or more of the Gross Revenue; each network attaining the 2% threshold would constitute a separate Large Network Payer. Conversely, several Payers may only constitute one network, because they use a common fee schedule. An example would be PHCS Multiplan.

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 Large Network 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 $8 million over 10 years, consistent with the regional annual incremental spending amounts in Exhibit B.

   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, reduce unnecessary utilization of hospital services, and more fully align the New Health System, Payers, the business community, patients and the public, the New Health System, subject to the agreement of Payers as defined herein, will establish payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers as follows:

    1. All risk-based model components of existing WHS and MSHA contracts would continue from the date of closing into the future upon their terms.
    2. One new risk-based model contract would commence no later than January 1, 2020.
    3. A second new risk-based model contract would commence no later than January 1, 2021.
    4. The New Health System would initiate risk-based model contracts for any remaining Large Network Payers that do not already have at least one risk-based model component in their contracts by no later than January 1, 2022.

    By January of 2022, all of the Large Network Payers are expected to have a risk-based model/population health/partnership relationship with the New Health System that includes aligned incentives. The risk-based components in each contract will be based on the unique priorities and timelines agreed upon by each Large Network Payer and the New Health System.

    For purposes of this section, "risk-based model" shall be defined as contracts which contain elements of reimbursement tied to incentives for quality, value-based care, shared savings or alignment of financial incentives between Payers, the New Health System, employers and patients.

    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 continuing through January 1, 2022.

    Amount: No cost.

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

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.

    For purposes of these commitments, a "Material Adverse Event" means any fact, event, change, development or occurrence that, individually or together with any other event, change, development or occurrence, is or is reasonably likely to be, materially adverse to the business,

condition (financial or otherwise), assets, operations or results of operations of the New Health System, taken as a whole, or on the ongoing ability of the New Health System to comply in all material respects with the commitments.

13. **Commitment:** With respect to any potential non-compliance with these Commitments, the New Health System shall endeavor to cure any such non-compliance in accordance with the process outlined herein.

    In connection with any noncompliance reported by the New Health System or identified and noticed by the Commissioner generally, the New Health System shall have sixty (60) days from the date of notice to Cure, or, if not curable within sixty (60) days, to demonstrate substantial progress toward a complete Cure of, the noncompliance, unless (i) the Noncompliance is not Curable, or (ii) the Noncompliance is due to a Force Majeure Event, in which case the New Health System shall have sixty (60) days from the end of the Force Majeure Event to cure the Noncompliance. The Commissioner (and his/her designees/agents) shall be provided full access, at reasonable times and upon reasonable notice, to all non-privileged documents and information of the New Health System and its personnel necessary to make a determination concerning the noncompliance, any Cure thereof, and, if applicable, any Force Majeure Event.

    For purposes of these commitments, "Cure" means (1) if the noncompliance arose due to failure to spend and pay, in full, the amount specified by a monetary commitment, to pay the amount that remains to be spent and paid, in immediately available funds, either toward the initiative or plan that was the subject of the monetary commitment and/or, as applicable and as agreed by the Commissioner, to enter into a Cooperative Agreement modification as proposed by either the New Health System or the Commissioner, and (2) if the Noncompliance arose due to a nonfulfillment of a non-monetary commitment, to fully perform such non-monetary commitment and/or, as applicable and as agreed by the Commissioner, to enter into a Cooperative Agreement modification as proposed by the New Health System or the Commissioner.

    With respect to any noncompliance that is not Cured or is not Curable, the Commissioner shall have the right to invoke one or more corrective actions, which may include, without limitation, the following: (1) a Cooperative Agreement modification; (2) equitable relief, including a temporary restraining order, an injunction, specific performance and any other relief that may be available from a court of competent jurisdiction; and (3) if public advantage is not evident, termination of the Cooperative Agreement.

    For purposes of these commitments, “Force Majeure Event” means any failure or delay by the New Health System to fulfill or perform any of the commitments when and to the extent such failure or delay is caused by or results from an act beyond the New Health System's reasonable control, including, without limitation, (a) acts of God; (b) flood, fire, earthquake, or explosion; (c) war, invasion, hostilities (whether war is declared or not), terrorist threats or acts, riot, or other civil unrest; (d) change in applicable law (other than Virginia Code § 15.2-5384.1 et seq. or

governmental order pursuant to Virginia Code § 15.2-5384.1 et seq.), including a major structural change to the federal payment system such that it materially changes the needs of the region and the New Health System's ability to meet those needs, and a substantial and material reduction in federal reimbursement; (e) actions, embargoes, or blockades in effect after the issuance of the Cooperative Agreement; (f) action by any governmental authority, other than the Virginia Department of Health or any other Virginia entity (with legal standing) acting to enforce the Cooperative Agreement; and (g) any national or regional emergency. If the New Health System suffers or believes it is reasonably likely to suffer a Force Majeure Event, the New Health System shall (y) give notice to the Commissioner within ten (10) days after knowledge of the existence or reasonable likelihood thereof by the New Health System, stating the period of time the failure or delay is expected to continue, and (z) use diligent efforts to end the failure or delay and minimize the effects of such Force Majeure Event.

Timing: Ongoing.

Amount: No cost.

Metric: Credible report and easy to determine.

14. **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.

15. **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.

16. **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, including any repurposing of facilities in Wise County, Virginia and the independent city of Norton, Virginia, 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.

17. **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.

18. **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 and implement, in collaboration 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 and in Virginia and Tennessee. The plan will be delivered within

12 months of the closing date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan will also include, but not be limited to, how it will address the Authority's Blueprint access, quality and population health goals, the structure of an ongoing academic collaborative, and how training will be deployed in Virginia and Tennessee based on an evidence based assessment of needs, clinical capacity and availability of programs. Within 45 days of the closing of the merger, the New Health System will have convened the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. Furthermore, and contingent on continued funding for existing programs from federal and state sources, the New Health System 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 18 and 19 total $85 million.

Metric: Completed convening of the collaborative within 45 days and delivery of 10 year plan within 12 months of merger closing. 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. In addition, on an annual basis 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. The 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. 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 set forth on Exhibit B under commitments number 18 and 19 is appropriately shared in by Virginia. The Commissioner will review expenditures made pursuant to this commitment for adherence to the 10-year plan and the appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

19. **Commitment:** In order to create opportunities for investment in research at Virginia's academic institutions, the New Health System will develop and implement, in collaboration with at least its current academic partners, a 10-year plan for investment in the research enterprise in the Virginia and Tennessee service area. The plan will be delivered within 12 months of the closing

date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan will also include, but not be limited to, how it will address the Authority's Blueprint goals, the structure of an ongoing research collaborative, and the criteria according to which research funding available as a result of the Virginia Cooperative Agreement and Tennessee COPA will be deployed in Virginia and Tennessee based on community needs, matching opportunities, economic return to the region, and overall competitiveness of the research proposals. Within 45 days of the closing of the merger, the New Health System will have convened the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee.

Timing: 10 years.

Amount: Combination of commitments 18 and 19 total $85 million.

Metric: Completed convening of a research collaborative within 45 days and delivery of 10-year plan within 12 months of merger closing. In this plan the New Health System will present a plan for research expenditures for the second and third full fiscal years after the closing of the merger. Thereafter, the New Health System must annually update its plan to address subsequent fiscal years. An 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 two through ten should report on the outcome of previously reported research projects including references to any published results. The Commissioner will annually review expenditures made pursuant to this commitment for adherence to the most recently updated plan and the appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

20. **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.

21. **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 an acute care hospital is opened in Lee County, and subsequently fails or ceases to operate, the New Health System will provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System. Such terms must include the appropriate access to space, located within the existing

hospital facility, based upon reasonable terms. If an acute care hospital is not open and operational under a partnership with the Lee County Hospital Authority by December 31, 2018, the New Health System will provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System until such time as a hospital is open and fully operational.

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.

22. **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.

23. **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.

24. **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.

25. **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.

26. **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. These elements will become components of the Rural Health Services Plan for the Geographic Service Area, including aspects of focus in Virginia. The Plan will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The Plan will be focused, along with the Population Health Plan, on managing the burden of disease and breaking the cycle of disease according to the priorities set forth by the Southwest Virginia Health Authority and the Virginia Department of Health. The Plan shall, at a minimum, include the New Health System's approach to the following:
    - Primary Care Services, with a plan for same day access, which may include telemedicine and other technology based access
    - Services to support maternal and prenatal health
    - Pediatrics and regional pediatric specialty access
    - Specialty care and regional specialty care access
    - Access to essential services (as defined under Commitment 21)
    - Improved access to preventive and restorative dental and corrective vision services

- Emergency service access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia EMS Council

The Rural Health Services Plan will account for needed workforce development strategies in consultation with the Southwest Area Health Education Center (AHEC) and regional educational institutions. It will also support the development of health professions education needed to help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops.

Timing: The Rural Health Services Plan will be developed in the first six months after closing and the physician and provider needs assessment will be conducted 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 27. 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 the Rural Health Services Plan, which identifies needs, priorities and recruitment strategies and timelines. The first community needs assessment and physician/physician extender recruitment plan results shall be presented to the Commissioner as part of the Rural Health Services Plan 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 Rural Health Services Plan goals including the number of recruited physicians by specialty, and related data such as recruitment efforts, interviews conducted, the number of offers extended, and the elements of the Rural Health Services Plan set forth in the commitment above. To the extent that rural service plans identified 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.

27. **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: A Behavioral Health Plan, encompassing items a. and b. above, will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The Behavioral Health Plan will also consider the goals set forth in the Virginia DMAS Addiction and Recovery Treatment Services program and the Community Service Boards in the Virginia Geographic Service Area. A Children's Health Plan, encompassing item c. above, will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. Some elements of the Children's Health Plan may also be included in the Rural Health Services Plan.

Amount: $140 million over 10 years including physician recruitment referenced in number 26 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 plans and expenditures made.

28. 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, consistent with the regional annual incremental spending amounts in Exhibit B. The distribution of the funding across the total population of the GSA shall consider the relative population of the counties and communities within the GSA, the relative per-capita cost of interventions within each community and the relative value of the intervention towards improving overall population health. Of this amount, the New Health System will commit to spending an amount necessary to support the creation of at least one regional Accountable Care Community organization. The New Health System will take the lead to formally establish this ACC. The ACC's membership will include members of the New Health System, the Authority, and other local, state or federal agencies, payers, service providers and community groups who wish to participate. Within 90 days of the closing of the merger, the New Health System will recruit and convene the ACC's initial leadership team to help develop the Population Health Plan. After consultation with the ACC and within 6 months of closing, the New Health System will submit to the Commissioner a Population Health Plan to improve the scores of the Southwest Virginia population on these measures. The Plan will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The submission of the Plan, the process measures associated with the implementation of each component, 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. A draft set of Quantitative Measures and associated scoring is submitted as Exhibit A.

No later than six (6) months after the merger closing, the New Health System will establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing the Population Health Plan and improving the overall health of the GSA population. This department shall be shall be staffed with leaders charged with financial compliance, physician relations and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the NHS Board of Directors.

The New Health System is committed to pursuing an approach in Southwest Virginia which focuses on a limited number of interventions that will have a disproportionate impact on breaking the cycle of poor health and reducing the future burden of disease. These interventions will be consistent with priorities set forth in the Authority's Blueprint for Health Improvement and Health-Enabled Prosperity and Virginia's Plan for Well-Being. Quantitative Measures will be established for each intervention as informed by the Technical Advisory Panel process with final approval by the Commissioner of Health.

Timing: 10 years.

Amount: $75 million.

Metric: The submission of the Population Health Plan, the process measures associated with the implementation of each component, 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. A draft set of Quantitative Measures and associated scoring is submitted as Exhibit A.

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.

29. **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.

30. **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, three members of the 11-member Board of Directors will be Virginia residents. After the second anniversary of the closing of the merger creating the New Health System, not less than two members of the Board shall 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.

31. **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.

32. **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.

33. **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.

34. **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.

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

36. **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.

37. **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

38. 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

39. 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 CCC Plus. In addition, for Virginia DMAS beneficiaries, the New Health System will continue pre-admission screening at the New Health System hospitals for long-term care.

Timing: Immediately upon closing of the merger.

Amount: No cost.

Metric: Easily verifiable.

40. 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.*

41. In order to ensure that the Virginia operations are allocated an appropriate amount of the New Health System's ongoing and annual compliance costs, the New Health System agrees to adopt an allocation methodology that takes into account the differences in ongoing and annual compliance requirements between the State of Tennessee and the Commonwealth of Virginia.

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, including but not limited to, a Material Adverse Event, 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 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

[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.

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

These commitments have been created with the intent of them remaining in place for ten (10) years. 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 B

**Regional Monetary Commitments Under
the Virginia Cooperative Agreement and Tennessee COPA**

~~New Health System~~ Revised New Health System Virginia Commitments
Dated October 9, 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. ~~**Commitment:** In order to ensure pricing is not increased as a result of the elimination of inpatient competition for the majority of consumers covered by third party commercial insurance, pricing will increase by less with the merger than if the merger were not to occur. For all Principal Payers[1], the New Health System will reduce existing commercial contracting for fixed rate increases by 50% for the second full fiscal year commencing after the closing date of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next which include annual inflators tied to external indices or contractually specified rates of increase in reimbursement. Applicants represent that the fiscal year for the New Health System will end on June 30, and that the fiscal year will not change until after the second full year commencing after the closing date of the New Health System.[2]~~**Combined Commitment 1 and 2**

   ~~**Timing:** First full fiscal year following the first contract year after the formation of the New Health System.~~

~~[1] For purposes of this Application, "Principal Payers" are defined as those commercial payers and governmental payers with negotiated rates who provide more than two percent (2%) of the New Health System's total net revenue. (All of a payer's revenue shall be considered in calculating the revenue percentage even if the payer has more than one contract with the New Health System.) .) The proposed commitments would not apply to traditional Medicare or any other payers that provide two percent (2%) or less of the New Health System's net revenue. Notwithstanding any provision to the contrary, the limitation on rate increases applicable to insurers providing coverage on behalf of governmental payers (i.e., Medicare Advantage Plans or Medicaid Plans) does not apply if the adjustments are tied to actions made by government entities, including but not limited to, market basket adjustments, adjustments tied to area wage index, or other governmentally imposed rate adjustments. The limitations on pricing committed to by the parties are intended to ensure price increases beyond the limits imposed by the Cooperative Agreement (COPA) do not occur as a result of increased market concentration resulting from the merger transaction. The price limits imposed by the Cooperative Agreement (COPA) are not intended to interfere with government-imposed pricing which would occur with or without the creation of the New Health System. To the degree pricing for insurers providing coverage on behalf of governmental payers is tied contractually to Medicare rates (i.e., a percent of Medicare), the Cooperative Agreement (COPA) is not intended to interfere with such pricing relationships. The intent is to ensure future pricing is not increased as a result of the merger transaction.~~

~~[2] For purposes of these commitments, the Commissioner shall not appoint an individual as his or her delegate if such person has a conflict of interest. If the Commissioner appoints an entity as his or her delegate, such as the Southwest Virginia Healthcare Authority, the entity must take steps to assure that no person involved with the entity in its role as the Commissioner's delegate has a conflict of interest. Notwithstanding anything herein 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.~~

~~**Amount:** The estimated annual savings to consumers for the combination of Commitments 1 and 2 are $10 million in lower health care costs annually.[3]~~

2. **Commitment:** To ensure the Cooperative Agreement protects consumers from pricing increases that could otherwise result from the elimination of competition, the New Health System shall honor all existing Payer contract terms and not unilaterally terminate without cause any such existing contract prior to its stated expiration date. In addition, a limit on pricing growth is applied for each year ~~to restrain pricing growth to below the national hospital consumer price index~~. 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 ~~hospital Consumer Price Index for the previous year minus 0.25%~~Cumulative Hospital Inflation Adjustment, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the ~~medical care Consumer Price Index minus 0.25%.~~ Cumulative Hospital Inflation Adjustment without the Quality Adjustment Factor (defined below). 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. ~~To the extent, if any, that the Applicants negotiate contracts with Principal Payers between October 10, 2016 and the closing date of the merger and such contracts include fixed rate increases in excess of the hospital Consumer Price Index for hospital inpatient and outpatient services and the medical care Consumer Price Index for physician and non-hospital outpatient services compared with previous contracts with the same payer, no later than one month following the closing date, New Health System will rollback its rates to what they would have been if the negotiated rates of increase had been no more than the above-referenced Consumer Price Index changes. Applicants represent that their current contracts with Anthem for nongovernmental patients will not expire prior to the now-expected date of the rate increase commitment becoming effective, i.e., July 1, 2018.~~

   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.~~ 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

~~[3] This estimate is nonbinding. To the extent, however, that there is a dispute on the New Health Systems compliance with these rate of increase commitments, the estimate may be used as a tool to interpret what the commitment means.~~

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. ~~For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes.~~

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 ~~current applicable consumer price index.~~Hospital Inflation Adjustment. If following such approval, the New Health System and a ~~Principal~~ Payer are unable to reach agreement on a negotiated rate~~,~~ or other contract terms, the New Health System agrees to mediation[4] as a process to resolve any disputes. The New Health System shall timely notify the

[4] ~~Nothing herein is intended to override dispute resolution provisions that may be parts of binding contracts between New Health System (in its own name or as a successor to the Applicants) and any payer.~~

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.

If either the New Health System or any Payer terminates a Payer contract, the New Health System will be subject to the pricing limitations of this Commitment. That is, this Commitment will apply, with the increased pricing limitation listed below, even if the New Health System goes out-of-network with a Payer. In this event, there will be no balance billing of patients over and above the following amount:

- The provisions of this Commitment shall apply to any Payer which has a managed care contract with NHS, MSHA or WHS and subsequently goes out-of-network; provided, however, that the Hospital Inflation Adjustment and Physician Inflation Adjustment with respect to such Payer shall be multiplied by two (2x) in the first two (2) years the Payer is out of network and multiplied by one (1x) each year thereafter.

The following definitions will apply to this combined Commitment 1 and 2, and when used in other Commitments:

"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%

"Physician Inflation Adjustment" means the Hospital Inflation Adjustment without the Quality Adjustment Factor. Medicare's annual physician market basket update factor is currently

limited by law to 0.50. When and if Medicare begins using an inflation-based update to the physician fee schedule, the Physician Inflation Adjustment used herein will be the Medicare physician market basket rate of increase plus 0.25 percent.

"Payer" means any person, corporation, or entity that pays, or arranges for payment, for all or any part of any New Health System hospital or other medical providers' medical services or supplies and items for itself or for any other person, corporation or entity, and which negotiates the payment or rate of payment for such Hospital or medical services, supplies and/or items. This includes Payers which are third party administrators, health insurers, self-insured health plans, employer health plans, managed care organizations, health maintenance organizations, administrative service organizations and other similar Payers and health plans which negotiate the payment or rate of payment for hospital or medical services, supplies and/or items. Payer includes any person, corporation, or entity that develops, leases, or sells access to networks of hospitals. The term does not include Medicare or other governmental healthcare payers or programs which do not negotiate contracts or payment rates with the New Health System, nor does it include Medicare Advantage Plans that pay based on a predetermined percentage of Medicare rates, for example, 105% of Medicare, so long as the percentage does not change during the term of the Cooperative Agreement.

"Large Network Payer" means a Payer which has a network, with a fee schedule specific to that network, which comprises 2% or more of the total charges ("Gross Revenue") for the New Health System. The same Payer may have several networks, each of which utilize different fee schedules, and each of which could constitute 2% or more of the Gross Revenue; each network attaining the 2% threshold would constitute a separate Large Network Payer. Conversely, several Payers may only constitute one network, because they use a common fee schedule. An example would be PHCS Multiplan.

Timing: Subsequent contract years.

Amount: The estimated annual savings to consumers for the ~~combination of Commitments~~combined Commitment 1 and 2 are $~~10~~80 million in lower health care costs ~~annually~~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~~Large Network 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 ~~insurers that do not meet the definition of "Principal~~any Payer~~",~~ as long as the ~~payer~~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~~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~~Payers coming into area, and ongoing.

Amount: No cost.

Metric: Complaints from ~~payers~~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~~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~~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~~8 million over 10 years~~.~~, consistent with the regional annual incremental spending amounts in Exhibit B.

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 endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.~~ , reduce unnecessary utilization of hospital services, and more fully align the New Health System, Payers, the business community, patients and the public, the New Health System, subject to the agreement of Payers as defined herein, will establish payment models designed to incentivize quality, value, and shared financial alignment in contracts with Large Network Payers as follows:

   1. All risk-based model components of existing WHS and MSHA contracts would continue from the date of closing into the future upon their terms.
   2. One new risk-based model contract would commence no later than January 1, 2020.
   3. A second new risk-based model contract would commence no later than January 1, 2021.
   4. The New Health System would initiate risk-based model contracts for any remaining Large Network Payers that do not already have at least one risk-based model component in their contracts by no later than January 1, 2022.

   By January of 2022, all of the Large Network Payers are expected to have a risk-based model/population health/partnership relationship with the New Health System that includes aligned incentives. The risk-based components in each contract will be based on the unique priorities and timelines agreed upon by each Large Network Payer and the New Health System.

   For purposes of this section, "risk-based model" shall be defined as contracts which contain elements of reimbursement tied to incentives for quality, value-based care, shared savings or alignment of financial incentives between Payers, the New Health System, employers and patients.

   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.~~ continuing through January 1, 2022.

Amount: No ~~incremental~~ cost.

Metric: ~~Annual report and complaints, if any, from payers.~~The New Health System shall report annually to the Commissioner on the mileposts toward meeting this Commitment.

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 ~~ensure~~prevent low income patients who are uninsured ~~are not~~from being adversely impacted ~~due to pricing~~, the ~~New Health System will~~NHS shall adopt a charity care policy ~~that is substantially similar to~~for the hospitals that is compliant with applicable law, that is more charitable than the existing policies of both ~~Parties~~Applicants, and that is consistent with the ~~Internal Revenue Service's final~~ 501 (r) rule. The ~~New Health System~~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, ~~the~~ New Health System shall furnish to the Commissioner a copy of any revisions to such policies immediately upon the effective date of such revisions. These policies shall provide for the full write-off of amounts owed for services by patients with incomes at or below two hundred twenty-five percent (~~200~~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: ~~Immediately upon closing of the merger~~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 ~~that number can come from the Medicare cost report S-10 schedule~~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 ~~affected~~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 ~~are those with some level of insurance or third-party assistance but with out-of-pocket expenses that exceed financial abilities.~~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~~, technical or otherwise~~, 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 ~~which may impair the~~ ability of the New Health System to fulfill ~~the commitments~~, the New Health System will notify the Commissioner and the Authority within 30 days of making such a determination.

    For purposes of these commitments, a "Material Adverse Event" means any fact, event, change, development or occurrence that, individually or together with any other event, change, development or occurrence, is or is reasonably likely to be, materially adverse to the business, condition (financial or otherwise), assets, operations or results of operations of the New Health System, taken as a whole, or on the ongoing ability of the New Health System to comply in all material respects with the commitments.

13. **Commitment:** With respect to any potential non-compliance with these Commitments, the New Health System shall endeavor to cure any such non-compliance in accordance with the process outlined herein.

    In connection with any noncompliance reported by the New Health System or identified and noticed by the Commissioner generally, the New Health System shall have sixty (60) days from the date of notice to Cure, or, if not curable within sixty (60) days, to demonstrate substantial progress toward a complete Cure of, the noncompliance, unless (i) the Noncompliance is not Curable, or (ii) the Noncompliance is due to a Force Majeure Event, in which case the New Health System shall have sixty (60) days from the end of the Force Majeure Event to cure the Noncompliance. The Commissioner (and his/her designees/agents) shall be provided full access, at reasonable times and upon reasonable notice, to all non-privileged documents and information of the New Health System and its personnel necessary to make a determination concerning the noncompliance, any Cure thereof, and, if applicable, any Force Majeure Event.

    For purposes of these commitments, "Cure" means (1) if the noncompliance arose due to failure to spend and pay, in full, the amount specified by a monetary commitment, to pay the amount

that remains to be spent and paid, in immediately available funds, either toward the initiative or plan that was the subject of the monetary commitment and/or, as applicable and as agreed by the Commissioner, to enter into a Cooperative Agreement modification as proposed by either the New Health System or the Commissioner, and (2) if the Noncompliance arose due to a nonfulfillment of a non-monetary commitment, to fully perform such non-monetary commitment and/or, as applicable and as agreed by the Commissioner, to enter into a Cooperative Agreement modification as proposed by the New Health System or the Commissioner.

With respect to any noncompliance that is not Cured or is not Curable, the Commissioner shall have the right to invoke one or more corrective actions, which may include, without limitation, the following: (1) a Cooperative Agreement modification; (2) equitable relief, including a temporary restraining order, an injunction, specific performance and any other relief that may be available from a court of competent jurisdiction; and (3) if public advantage is not evident, termination of the Cooperative Agreement.

For purposes of these commitments, "Force Majeure Event" means any failure or delay by the New Health System to fulfill or perform any of the commitments when and to the extent such failure or delay is caused by or results from an act beyond the New Health System's reasonable control, including, without limitation, (a) acts of God; (b) flood, fire, earthquake, or explosion; (c) war, invasion, hostilities (whether war is declared or not), terrorist threats or acts, riot, or other civil unrest; (d) change in applicable law (other than Virginia Code § 15.2-5384.1 et seq. or governmental order pursuant to Virginia Code § 15.2-5384.1 et seq.), including a major structural change to the federal payment system such that it materially changes the needs of the region and the New Health System's ability to meet those needs, and a substantial and material reduction in federal reimbursement; (e) actions, embargoes, or blockades in effect after the issuance of the Cooperative Agreement; (f) action by any governmental authority, other than the Virginia Department of Health or any other Virginia entity (with legal standing) acting to enforce the Cooperative Agreement; and (g) any national or regional emergency. If the New Health System suffers or believes it is reasonably likely to suffer a Force Majeure Event, the New Health System shall (y) give notice to the Commissioner within ten (10) days after knowledge of the existence or reasonable likelihood thereof by the New Health System, stating the period of time the failure or delay is expected to continue, and (z) use diligent efforts to end the failure or delay and minimize the effects of such Force Majeure Event.

Timing: Ongoing.

Amount: No cost.

Metric: Credible report and easy to determine.

14. ~~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.

15. ~~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.

16. ~~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, including any repurposing of facilities in Wise County, Virginia and the independent city of Norton, Virginia, 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.

17. ~~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.

18. ~~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 and implement, in ~~partnership~~collaboration 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 and in Virginia and Tennessee. The plan will be delivered within 12 months of the closing date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan will also include, but not be limited to, how it will address the Authority's ~~goals,~~Blueprint access, quality and population health goals, the structure of an ongoing academic collaborative, and how training will be deployed in Virginia and Tennessee based on ~~the assessed~~an evidence based assessment of needs, clinical capacity and availability of programs. ~~Contingent~~ Within 45 days of the closing of the merger, the New Health System will have convened the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee. Furthermore, and contingent on continued funding for existing programs from federal and state sources, the New Health System 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~~18 and ~~18~~19 total $85 million.

Metric: ~~Annually,~~Completed convening of the collaborative within 45 days and delivery of 10 year plan within 12 months of merger closing. 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. In addition, on an annual basis 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~~The 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 set forth on Exhibit B under commitments number ~~17 and~~ 18 and 19 is appropriately shared in by Virginia. ~~On the other hand, the~~The Commissioner will review expenditures made pursuant to this commitment for adherence to the 10-year plan and the appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

19. ~~18.~~ **Commitment:** In order to ~~help~~ create opportunities for investment in research ~~in partnership with~~at 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~~will develop and implement, in collaboration with at least its current academic partners ~~to develop and implement~~, a 10-year plan for investment in ~~research and growth in~~ the research enterprise in the Virginia and Tennessee service area. The plan will be delivered within 12 months of the closing date of the merger and will include a time schedule for implementing the plan and expenditures under the plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The plan will also include, but not be limited to, how it will address the Authority's ~~goals, how research~~Blueprint goals, the structure of an ongoing research collaborative, and the criteria according to which research funding available as a result of the Virginia Cooperative Agreement and Tennessee COPA will be deployed in Virginia and Tennessee based on ~~the~~community needs ~~and~~, matching opportunities, ~~capacity and competitiveness of the proposals.~~ economic return to the region, and overall competitiveness of the research proposals. Within 45 days of the closing of the merger, the New Health System will have convened the first meeting of the collaborative which shall be co-chaired by one academic representative from Virginia and one from Tennessee.

Timing: 10 years.

Amount: Combination of commitments ~~17~~18 and ~~18~~19 total $85 million.

Metric: ~~Report in year one and dollars spent thereafter. The~~Completed convening of a research collaborative within 45 days and delivery of 10-year plan within 12 months of merger closing. In this plan the New Health System will present a plan for research expenditures for the second and third 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 annually 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~~. An 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~~two through ten should report on the outcome of previously reported research projects including references to any published results. The Commissioner will annually review expenditures made pursuant to this commitment for adherence to the most recently updated plan and the appropriate inclusion of Virginia sites and/or demonstrable benefit to Virginia residents and businesses.

20. ~~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.

21. ~~20.~~ **Commitment:** In order to preserve traditionally hospital-based services in geographical proximity to the communities ~~traditionally~~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. ~~After this time~~"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 ~~continued~~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 ~~community.~~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.~~an acute care hospital is opened in Lee County, and subsequently fails or ceases to operate, the New Health System will provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System. Such terms must include the appropriate access to space, located within the existing hospital facility, based upon reasonable terms. If an acute care hospital is not open and operational under a partnership with the Lee County Hospital Authority by December 31, 2018, the New Health System will provide essential services for Lee County based upon reasonable terms established by agreement between the Lee County Hospital Authority and the New Health System until such time as a hospital is open and fully operational.

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.

22. ~~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.

23. ~~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.

24. ~~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.

25. ~~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.

26. ~~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. These elements will become components of the Rural Health Services Plan for the Geographic Service Area, including aspects of focus in Virginia. The Plan will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The Plan will be focused, along with the Population Health Plan, on managing the burden of disease and breaking the cycle of disease according to the priorities set forth by the Southwest Virginia Health Authority and the Virginia Department of Health. The Plan shall, at a minimum, include the New Health System's approach to the following:

- Primary Care Services, with a plan for same day access, which may include telemedicine and other technology based access
- Services to support maternal and prenatal health
- Pediatrics and regional pediatric specialty access
- Specialty care and regional specialty care access
- Access to essential services (as defined under Commitment 21)
- Improved access to preventive and restorative dental and corrective vision services
- Emergency service access, transport, and transfer strategies formulated in concert with regional agencies including the Southwest Virginia EMS Council

The Rural Health Services Plan will account for needed workforce development strategies in consultation with the Southwest Area Health Education Center (AHEC) and regional educational institutions. It will also support the development of health professions education needed to

help the New Health System's workforce and the regional pipeline of allied health professionals adapt to new opportunities created as the New Health System evolves and develops.

Timing: ~~Every~~The Rural Health Services Plan will be developed in the first six months after closing and the physician and provider needs assessment will be conducted 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.~~27. 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~~the Rural Health Services Plan, which identifies needs ~~and~~, priorities and recruitment strategies and timelines. The first community needs assessment and physician/physician extender recruitment plan results shall be presented to the Commissioner as part of the Rural Health Services Plan 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~~Rural Health Services Plan goals including the number of recruited physicians by specialty, and related data such as recruitment efforts, interviews conducted, ~~and~~ the number of offers extended, and the elements of the Rural Health Services Plan set forth in the commitment above. To the extent that ~~physician needs~~rural service plans 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.

27. ~~**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~~ A Behavioral Health Plan, encompassing items a. and b. above, will be developed in the first six months after closing and will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The Behavioral Health Plan will also consider the goals set forth in the Virginia DMAS Addiction and Recovery Treatment Services program and the Community Service Boards in the Virginia Geographic Service Area. A Children's Health Plan, encompassing item c. above, will be developed in the first six months after closing and will include a time schedule for implementing the ~~plan~~Plan and expenditures under the ~~plan.~~ Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. Some elements of the Children's Health Plan may also be included in the Rural Health Services Plan.

Amount: $140 million over 10 years including physician recruitment referenced in number ~~25~~26 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~~plans and expenditures made.

28. ~~27.~~ **Commitment:** ~~In an effort to~~ 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 ~~service area. The New Health System will establish a plan, to be updated annually in collaboration with the Authority, the Commonwealth, and possibly the State of Tennessee, to make investments that are consistent with the plan and to complement resources already being expended. The New Health System also commits to pursuing opportunities to establish Accountable Care Communities in partnership with various local, state and~~Geographic Service Area, consistent with the regional annual incremental spending amounts in Exhibit B. The distribution of the funding across the total population of the GSA shall consider the relative population of the counties and communities within the GSA, the relative per-capita cost of interventions within each community and the relative value of the intervention towards improving overall population health. Of this amount, the New Health System will commit to spending an amount necessary to support the creation of at least one regional Accountable Care Community organization. The New Health System will take the lead to formally establish this ACC. The ACC's membership will include members of the New Health System, the Authority, and other local, state or federal agencies, payers, service providers and community groups who wish to ~~partner in such efforts. It is the desire of the New Health System for the Commonwealth and Tennessee to collaborate with the New Health System to establish a regional plan that disregards state boundaries~~participate. Within 90 days of the closing of the merger, the New Health System will recruit and convene the ACC's initial leadership team to help develop the Population Health Plan. After consultation with the ACC and within 6 months of closing, the New Health System will submit to the Commissioner a Population Health Plan to improve the scores of the Southwest Virginia population on these measures. The Plan will include a time schedule for implementing the Plan and expenditures under the Plan that are consistent with the regional annual incremental spending amounts in Exhibit B. The submission of the Plan, the

process measures associated with the implementation of each component, 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. A draft set of Quantitative Measures and associated scoring is submitted as Exhibit A.

No later than six (6) months after the merger closing, the New Health System will establish a Department of Population Health Improvement to lead the New Health System's efforts in implementing the Population Health Plan and improving the overall health of the GSA population. This department shall be shall be staffed with leaders charged with financial compliance, physician relations and community relations and led by a senior executive that reports directly to the Executive Chair/President or the Chief Executive Officer of the New Health System and serves as the administration liaison to the Population Health and Social Responsibility Committee of the NHS Board of Directors.

The New Health System is committed to pursuing an approach in Southwest Virginia which focuses on a limited number of interventions that will have a disproportionate impact on breaking the cycle of poor health and reducing the future burden of disease. These interventions will be consistent with priorities set forth in the Authority's Blueprint for Health Improvement and Health-Enabled Prosperity and Virginia's Plan for Well-Being. Quantitative Measures will be established for each intervention as informed by the Technical Advisory Panel process with final approval by the Commissioner of Health.

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.~~submission of the Population Health Plan, the process measures associated with the implementation of each component, 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. A draft set of Quantitative Measures and associated scoring is submitted as Exhibit A.

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.

29. ~~**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.

30. ~~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:

- ~~Currently, one member~~At closing, three members of the 11-member Board of Directors ~~resides in Virginia. No later than 3 months after closing, an additional resident of Virginia will be appointed to serve on the Board of Directors of the New Health System. Such resident shall be appointed through the governance selection process outlined in the bylaws of the New Health System;~~will be Virginia residents. After the second anniversary of the closing of the merger creating the New Health System, not less than two members of the Board shall 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)~~; and• Within 5 years, not less than 3 members of the Board of Directors will reside in the Commonwealth of Virginia, and such composition shall be sustained~~.

Timing: Ongoing.

Amount: No dollar cost.

Metric: Easily verifiable.

31. ~~30.~~ **Commitment:** The New Health System expects that the conditions under which the Cooperative Agreement is granted will be ~~enumerated in a formal enforceable agreement between the New Health System and~~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.

32. ~~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.

33. ~~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.

34. ~~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.

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

36. 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.

37. 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

38. 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

39. 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 CCC Plus. In addition, for Virginia DMAS beneficiaries, the New Health System will continue pre-admission screening at the New Health System hospitals for long-term care.

Timing: Immediately upon closing of the merger.

Amount: No cost.

Metric: Easily verifiable.

40. 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.*

41. In order to ensure that the Virginia operations are allocated an appropriate amount of the New Health System's ongoing and annual compliance costs, the New Health System agrees to adopt an allocation methodology that takes into account the differences in ongoing and annual compliance requirements between the State of Tennessee and the Commonwealth of Virginia.

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, including but not limited to, a Material Adverse Event, which affect the feasibility or the meaningfulness of the commitments and which are not possible to foresee presently. For example,[51] 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

[51] 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.

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 ~~clear and convincing~~ evidence that changes in circumstances have materially affected its ability to meet the commitments and that 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

These commitments have been created with the intent of them remaining in place for ten (10) years. 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 ~~the New Health System is generating excessive profits and~~ 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 B

Regional Monetary Commitments Under the Virginia Cooperative Agreement and Tennessee COPA

Document comparison by Workshare Compare on Monday, October 9, 2017 1:34:01 PM

Input:	
Document 1 ID	PowerDocs://DM_LIBRARY/843418/3A
Description	DM_LIBRARY-#843418-v3A-Virginia_Commitments
Document 2 ID	PowerDocs://DM_LIBRARY/843418/17
Description	DM_LIBRARY-#843418-v17-Virginia_Commitments
Rendering set	Standard

Legend:	
Insertion	
~~Deletion~~	
~~Moved from~~	
Moved to	
Style change	
Format change	
~~Moved deletion~~	
Inserted cell	
Deleted cell	
Moved cell	
Split/Merged cell	
Padding cell	

Statistics:	
	Count
Insertions	261
Deletions	138
Moved from	6
Moved to	6
Style change	0
Format changed	0
Total changes	411

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.

EXHIBIT B
REGIONAL MONETARY COMMITMENTS UNDER THE VIRGINIA COOPERATIVE AGREEMENT AND TENNESSEE COPA

		Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Total
Expanded Access to HealthCare Services	Behavioral Health Services	$1,000,000	$4,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	$10,000,000	**$85,000,000**
	Children's Services	1,000,000	2,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**27,000,000**
	Rural Health Services	1,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	**28,000,000**
Health Research & Graduate Medical Education		3,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**85,000,000**
Population Health Improvement		1,000,000	2,000,000	5,000,000	7,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	10,000,000	**75,000,000**
Region-wide Health Information Exchange		1,000,000	1,000,000	750,000	750,000	750,000	750,000	750,000	750,000	750,000	750,000	**8,000,000**
Totals		$8,000,000	$17,000,000	$28,750,000	$33,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	$36,750,000	**$308,000,000**