Southwest Virginia Health Authority
Minutes of Meeting
August 26, 2016 at 2:00 PM
Southwest Virginia Higher Education Center, Room 240
Abingdon, Virginia

I. Call to Order.

Chairman Kilgore called the meeting to order at 2:05 PM.

II. Roll Call.

Ms. McFadden called roll. Mr. Mosley, Dr. Cantrell, Ms. Welch, Mr. Leonard, Mr. Givens, Ms. O'Dell, Ms. Murray, Mr. Kilgore, Dr. Mayhew, Mr. Morefield, Mr. Horn, Mr. Chaffin, Dr. Tooke-Rawlins, Ms. Ward, Mr. Vanover, Dr. Wieting, Dr. Counts, Dr. Means, Mr. Neese and Ms. Billhart were present. A quorum was confirmed. Mr. Prewitt arrived at 2:30 p.m.

Dr. Henry, Mr. Mulkey, Ms. Baker and Dr. Rheuban, were present by phone. Note: Guests experienced some issues with calling into the meeting, however, the Authority worked through these technical issues. The Polycom did not work therefore the telephone's speaker was used.

Ms. Copeland, Mr. Carrico, Mr. Clark, Mr. Perdue, and Dr. Sarrett were absent.

III. Declaration of Quorum.

Chairman Kilgore declared that a quorum existed and the meeting was called to order.

IV. Approval of the Minutes of the April 13, 2016 Meeting.

Dr. Tooke-Rawlins called for a motion to approve the minutes of the May 25, 2016 meeting as distributed.

Dr. Wieting seconded the motion and the motion was unanimously approved, except Ms. Brillhart abstained stating that she was not a member at the May meeting.

V. Officer Report

Chairman Kilgore introduced the staff, Dennis Brownlee and Tom Massaro, and he welcomed and thanked them for driving down to the meeting. Chairman Kilgore reported that he and Mr. Mitchell had a meeting in Washington, D.C. on August 24, 2016 with the staff of the Federal Trade Commission.

The Chairman also stated:

> "Also, I met with Ms. Allen and the Attorney General and there were multiple sections of the FTC present. There were over 20 people with expertise ranging in economics, policy, legal and analytics and they were all involved and talking. We had a good discussion about procedures. We did find out this is probably the biggest merger that has ever been before the FTC to date as a cooperative agreement. We had a good discussion about our

procedures and we walked them through our process. We had questions about accountability and remedies and how we would hold the parties accountable. We discussed total cost of care and they have offered to meet with us and we are going to try and take them up on that. We either want to meet with them on poly com or in person. They are going to try to come down and meet with us and they are waiting on approval from the Trade Commissioners on whether or not they are filing public written comments during the public comment period."

Dr. Cantrell asked for a clarifying question, "Can people on the phone vote and will their vote count?"

Mr. Mitchell said,

> "According to your policy, the answer is yes unless someone challenges it, but we need to make sure that they can hear since there are phone issues and also that they have identified themselves which they have."

Mr. Mitchell clarified that the telephone lines had been resolved.

Dr. Henry gave a financial report. She reported that the current balance was $22,300.14. She said,

> "We have paid consulting project through July as well as our rent which is $300 per month. So, we are right at $22,000."

Dr. Henry reported that the staff had been paid through July and rent had been paid.

The Chairman noted that,

> "Last night the Authority received a letter filed from the Virginia Associations of Health Plans and the letter was delivered to us and Kyle Shreve is here. Kyle, if you would like to come forward and give us the highlights?"

Mr. Shreve thanked Chairman Kilgore for allowing him to present this early in the agenda. Mr. Shreve, who is the Director of Policy for the Virginia Association of Health Plans, stated:

> "We represent ten insurance carriers that operate in the Commonwealth of Virginia to include commercial payers as well as Medicare and Medicaid. If you recall at the May meeting our Deputy Director, Doug Gray, addressed the Authority and laid out some trends in industry as well as a series of questions that you all should consider when trying to deem this application complete. Since that time, the Authority has sent 68 questions to the Applicants and have received response. We just want to take this opportunity to lay out our concerns. Doug could not be here today and asked that I come down and express our concerns regarding those responses.
>
> Our position is that the application continues to lack the specificity and more time should be taken to ensure the information is adequate so that the public as well as the

Commissioner of Health will have adequate information. The Cooperative Agreement between Wellmont and Mountain States essentially allows them to combine and effectively eliminate competition in seven counties in Southwest Virginia in ways that would otherwise violate the anti-trust laws at both federal and state levels.

The Authority has a critical initial task of reviewing this information and deeming it complete so that the regulatory process and the 75 days regulatory review process will begin after the application is deemed complete. We want to express our concerns before the application is deemed complete. The Authority's goal in this is not merely to move the process along while trying to ensure that all the necessary information has been submitted, but the goals should be to ensure that the parties have submitted an application that meets all the statutory requirements and provides adequate information for the public, the Authority and for the Commissioner to make a recommendation of whether to grant the Cooperative Agreement."

Mr. Shreve explained that the parties submitted over a thousand pages in application materials; much of which has been submitted at a very high level, very competitive, very general and in certain ways very vague. He explained that the Authority needs to continue the dialogue with the parties in order to make sure that they fully respond to the Authority's questions that were direct and "laid-out" questions Mr. Gray discussed at the May meeting.

Mr. Shreve explained the approved merger would not only affect Virginia, but would also affect Tennessee. He said that Tennessee is going through a similar process that the Authority is going through right now. The Tennessee Authority has not found the application complete so far, and they are scheduling more hearings and have made several requests to the parties to submit regarding their application. He proclaimed,

"At this time, both Virginia and Tennessee need to move forward at the same time in order for this Cooperative Agreement to go into effect. So, we would caution you to just slow down and take your time just like Tennessee. If you start the regulatory process now and Tennessee does not, you may cause issues for them. So, what is the hurry in trying to get through? Try to get through and take your time and provide due diligence. Make sure that there is enough information to allow for public scrutiny.

I just want to walk through a few of the ways in which the information that was requested does not honor the review request. First; and the largest as far as we are concerned, is the potential to harm competition is not adequately addressed in the application from Mountain States. The Authority's recommendation and the Commissioner's ultimate decision on whether to grant the Cooperative Agreement hinges on weighing the potential benefits of the Cooperative Agreement against the disadvantages. There has got to be a balancing act between the benefits and the disadvantages of what is going on and it is up to the parties to prove that the benefits outweigh the disadvantages. That cannot happen if there is not adequate information and that the disadvantages are not acknowledged. In their response, the Parties fail to explain why one of the potential disadvantages – harm to competition --- will not result from the transaction. The Parties significantly understate the competitive risks from the combination, stating that they did

not foresee any adverse impacts on population health, quality, access, availability or cost of health care to patients and payers as a result of the Cooperative Agreement. Making such a cursory claim completely ignores the reality that this merger will result in a dramatic loss of competition in the region. The Parties are the only in-patient hospital service providers in seven counties in Southwest Virginia. The Authority asked the Parties to explain why their market share analysis included two counties closer to other metropolitan areas in Virginia and Tennessee – Roanoke and Knoxville. Upon revising their market share calculations in response to this question, the Parties' combined market share is higher than 90% in most cases. Under any standard, such shares are extremely high and will result in very likely anticompetitive harm. We ask that you would ask for more information and have them address the loss of competition so the public and the Commissioner of Health can weigh that disadvantage when the application is ultimately submitted."

Mr. Shreve continued,

> "The other point that Mr. Gray discussed in May was what does active supervision look like from the Commonwealth? In the next few points, we want to flesh out what the Commonwealth is going to be responsible for when asking for this Cooperative Agreement. So, they are vague benefits that they have laid out in their application and unsubstantiated in some instances. For some, the goal the Parties have set themselves is no greater than what they are already achieving now, without a merger. The Authority specifically asked the Parties what metrics they were committing to report beyond those already report on. The Parties' response continues to be vague and appears to not commit to report on any additional metrics nor do the parties propose what additional metrics should be used, other than agreeing to participate in the Commonwealth's effort to create a common system performance scorecard. Improving quality and access is crucial claimed benefits of the Cooperative Agreement and without the proper resources to evaluate such a claim is not in the best effort of the cooperative agreement.

Mr. Shreve explained that Commitments to report rather than achieve outcomes – In Supplemental Question 56, the Authority noted that the Parties were only committing to "report" on a number of metrics rather than committing to outcomes, and that merely reporting was not enough for the state to exercise active supervision. *Note: Commitments are attached.*

He noted that the Authority asked the Parties to explain how the Commonwealth should respond if the "reporting" is insufficient and metrics were not met. He said that the Parties have provided no such response – instead stating now that reporting obligations of the New Health System and the Department of Health's oversight of these commitments will be agreed upon by the Commonwealth and the Parties prospectively in sufficient detail. Details on these commitments and how this oversight needs to happen before the regulatory process starts to deem if they are adequate or not. Mr. Shreve explained,

> "It is very hard to have public comment for the Commissioner to evaluate this process if it is uncertain what that regulatory structure is going to be and what that evaluation is going to be if it has not actually happened yet. So, we urge you to develop a system prior to granting completeness of the Cooperative Agreement so that it can be improved upon

during the regulatory process.

There is insufficient information on the proposed scoring system. As the Authority's advisors noted, the Parties suggest that supervision and oversight by the Commonwealth will greatly minimize the impact of reduced competition. They do not, however, explain how the oversight should work or describe the elaborate resources that will be necessary to actively supervise the Cooperative Agreement."

He continued on with more Supplemental Questions. He said,

"Question 5 asked for more detail on the proposed Alignment Policy and Scoring System. In their response, the Parties simply repeated information already provided in their Application; they did not provide any additional input. Not only that, but their system would allow them to pick and choose which commitments they will actually meet. So the Parties would weigh their commitments equally; despite the fact that their categories are not the same and needs are not the same. This does not account for the vast differences in the impact on patients and the community from non-compliance with various commitments. The commitment to maintain three full-service tertiary hospitals does not have the same importance to patients and the community as the commitment to combine the "best of both organizations' career development programs" – yet both carry equal weight under the proposed scoring system. Mr. Shreve explained that this sets up a scoring system in which they may fail to reach a commitment here and there in the same category yet still achieve a "passing" grade from the Commonwealth."

Mr. Shreve said,

"The failure to identify specific efficiencies: the parties claim one of the most significant benefits of the merger is to generate savings through consolidation of duplicate support services as well as duplicate patient services. However, they fail to provide any specifics on which services or programs will be reduced, claiming that:

(1) the antitrust laws prohibit them from discussing the information to formulate such detailed plans; and

(2) the Parties expect the Commonwealth will contribute to this determination.
They should provide more information regarding specific efficiency benefits. We understand that some information is going to be proprietary, but that proprietary information is based on how they operate now; not on future plans once they are merged, and they should be able to provide this information when asked by this Authority."

Mr. Shreve thanked the Chairman for allowing him the opportunity to express the VAHP's concerns and was sorry that Mr. Gray was not available to continue the dialogue himself. In closing, Mr. Shreve urged the Authority to closely consider whether all the information is available to properly evaluate the Application. Mr. Shreve stated,

"The public comment period begins the minute that the Application is deemed complete.

> In order for the public and the Commissioner's office to fully vet this Application, the Application needs more specifics to know what we are talking about and that is all the VAHP is asking. If there are still outstanding commitments the Parties need to address or there is more detail required about the proposed benefits against the disadvantages, that information should be submitted prior to deeming the Application complete. It is essential that the Authority perform all due diligence before the regulatory clock begins."

Chairman Kilgore thanked Mr. Shreve for presenting and asked if there were any questions for him.

Dr. Brownlee stated that the parties have stated that they cannot give more detail on elimination or duplication of services without violating the anti-trust laws. Dr. Brownlee asked Mr. Shreve, "Do you believe that is incorrect as a legal statement?"

Mr. Shreve stated that he is not sure if it is legal or not. He said,

> "The supplemental question asked, 'Can you provide more specifics on what your future plans will be if they were merged?' That speaks more as a hypothetical if the merger takes place then what they would do. There should not be any reason why they cannot disclose this information as a hypothetical response if they are granted this merger. It is hard to weigh the benefits versus the disadvantages and they need to be as specific as possible before the Application is deemed as complete or so that an adequate public review can occur."

VI. New Business:

A. Presentation from Applicants

The Chairman introduced Bart Hove, CEO of Wellmont and Alan Levine, CEO of MSHA.

Mr. Hove began by thanking the group for allowing them to be there, to share information, and to answer questions that may be asked by the Authority. He said,

> "I appreciate the opportunity to address the Cooperative Agreement application in this forum. We are thankful that the Commonwealth had the wisdom to set up the Southwest Virginia Health Authority to work with our organization on this transformational matter. Collectively, our seven Virginia hospitals and facilities represent around 18 percent of our combined total in-patient census for our organization. There are four competitive facilities in Southwest Virginia beyond those seven. But as you know, in-patient business is not reflective of the path health care is being driven to follow. With our increasing legislation, out of control costs as evidence by recent news coverage of some of the drug companies for example, the recent exurbanite price increases on the Affordable Care Act of Health Care Exchanges; not to mention new technology, our entire industry is in a state of flux. Not inappropriately, however, the provision of health care is being driven out of hospitals and into less expensive settings in all of our communities.

Physicians are also facing the biggest challenges in raising their reimbursement particularly in the implementation of Medicare and Medicaid. All of these and many other factors have led us to apply to the Commonwealth of Virginia for this Cooperative Agreement. For we believe as I pray that you do that this transformational approach will lead us to greater improvements in population health, access, quality, efficiency and portability of health care for our region. Without this Cooperative Agreement approval, we will be forced to follow traditional business model which is strictly following revenues versus expenses and it does not address any of the specific goals as laid out in the legislation. This alternative would likely be an out of market acquisition of our health systems by another system. If that were to occur, we would fully expect that system to leverage their size and seek higher pricing from payers and to eliminate local corporate and administrative jobs and to close unprofitable services and facilities and the newer synergy mergers to their own interests rather than investing in our region as we proposed."

Mr. Hove explained that the new Health Care System developed under the merger will be based on a business model designed specifically to benefit the communities through enforceable commitments and active supervision by the Commonwealth and the on-going partnership with the Authority. He said,

"With the merger, we will have the means and the resources to add to a presently existing marketplace and to work with the Authority to build upon the template community healthcare improvement plan that has already been developed. To prioritize and address the key public health issues with reliable funding, and to develop a concrete plan along with a focused set of plans with a successful set of success measures. Legally, the merger of our two health systems is by far the best solution to advance the Authority's vision to achieve continuous improvement in health and prosperity of the region.

In spite of the challenge the region faces, there is an alternative vision which offers opportunity for the region and sustainability for needed health care resources. We see the Southwest Virginia Health Authority working with the New Health System at the center of that vision. You have heard about and read about the commitments in our application which include almost 450 million ten-year investment plan that includes spending on rural sustainability development, academics and research, community health improvement, health IT and a clear mechanism to bend the curve of health care cost improvement and limit cost increases moving forward."

Mr. Levine talked more about the benefits of the proposal and thanked the Board for their work on this project. He said,

"The Board members are individuals that care deeply about this region and would be adversely affected by a lot of policies outside of our region that impact our economy and our ability to grow. Our hospitals are not immune to this and are affected by it. Mr. Levine stated that he appreciated the work that Kyle and his organization does and are grateful for the relationship that they have with their payers. The payers are essential partners and we have a great relationship with them. We just happen to disagree on this issue. We do agree on one thing though and that is bringing organizations together brings

synergies can improve health and improve outcomes and I know we agree on that because your own members are pursuing their own mergers as we speak. So, we agree that bringing organizations together that are like minded, consistent in what their goals and objectives are, can net measurable improvements.

It is up to each of us to make that case, so I would like to talk a little bit about that. One comment that was made was that we are eliminating competition in seven counties and that simply is not true. If you go to Russell County, almost 13% of the patients that live in Russell County go to Clinch Valley Medical Center; that is a competitor. If you go to Wise County, you know that Pikeville is all over Wise County advertising, competing for staff; it is a major competitor, a multi hundred bed facility that competes with our three hospitals there that have a combined census of maybe 30. Our seven hospitals have a combined census in Southwest Virginia of 250; that is the size of an average mid-size hospital, but we are spread over seven counties and seven facilities; five of which have negative operating margins – they are losing money. Today, the Commonwealth of Virginia announced they are facing a 1.5-billion-dollar budget deficit; everything but teacher's salaries are on the table and that affects us."

Mr. Levine said that thirty percent of rural hospitals are projected to close in the next two years per the Governing Magazine. He further explained,

"Just today, Tennessee had the second highest number of rural hospital closings since 2010 with eight hospitals closing. We had one hospital close just in this region. We understand, this is not just something we are making up. It is happening right before our eyes. Now, let me tell you what we are facing, and I will come back to some of Kyle's comments in just a minute. I will tell you what we are facing in this region, we combined numbers and provided in our last cover letter that we sent, but let's assume MSHA and Wellmont has about a hundred discharges today between the two systems. Now, if you look at the population of this region, throughout the 29-county service area, we have a negative one percent population growth. If you go to some of the counties in Southwest Virginia, we have seen populations decline as much as nine percent. We have seen the population decline among children 0-17 by as much as 17 percent. This is a region that is not growing; organically it is shrinking. Now, the second part of this equation is the hospital use rates to Bart's point. Our average in-patient hospital use rates in this region are 127 per 1,000; some of VA counties are as high as 140-150 per 1,000. We know that the national use rates are somewhere between 90 – 110 per 1,000. If we get to as low as 90, which is the direction we are going in in terms of use rates. If we get to as low as 90, you are talking about a decline in admissions of 30,000 in this region. If you get to 110, you are talking about a decline by as much as 15,000. So, somewhere between 15,000 and 30,000 decline in this region. If we were in Nashville, Charlotte, Atlanta or Richmond or other areas where we have population growth, our hospitals could sustain a decline in use rate and declining admissions because actually you would not have a decline in admissions.

As use rates decline as population grows, you can deal with this decline and in fact most

of those cities are already somewhere around 90-110 in their in-patient use rates. My point is we have no population growth and in some communities a decline, and we have significantly declining use rates. We are well above what the national norms for what the use rates are. So, if you sit back and think about this, if we don't do anything as Kyle suggested, then as in-patient use rates decline, and admissions decline somewhere between 13,000 and 30,000, more of the health care dollars are used to sustain the corporate structures of two independent systems locally. An increasing percentage of the health care dollars locally will go to sustain administration and overhead and less of the percentage will go to the bedside. Others might want to advocate this model with more administration and more costs and more fixed costs with less money going to patient care. We believe that it should be the opposite.

We believe that we should decrease the administrative costs of delivering health care in this region and, therefore, sustain investment where it matters; that is where these synergies come from. Most of them are going to come from TN and not necessarily from VA because that is where most of our larger facilities are located and where all the corporate and administrative functions are located, but VA will be a beneficiary from all of this."

Mr. Levine continued,

"Now, the other option, if not this is what? I can tell you if we do nothing; which is not an option. If we do nothing, we are facing a substantial decline in patient utilization with hospitals that have 30-40 percent occupancy. I think we all know where that leads. That is where you get 30-40 percent of rural hospitals in the United States closing in the next two years. I don't think we want that because my concern is that if that is the track we go down, five of the seven hospitals that we operate in Southwest Virginia have negative operating margins today.

One of the questions that you have asked, which is a very important question, is our commitment to training of physicians. That is clearly important to us. At Norton, we have a great residency program and we just started one in Abingdon. Because of the movement and the merger happening between the American Osteopathic Association and the ACGME, they are merging their operations. We are moving to ACGME standards. Our costs for sustaining these residency programs is going to go from currently $200,000 per year that we subsidize to close to a million dollars to sustain current programs. If there is no merger and no commitment to sustain these programs, then there is no commitment to sustaining the residency programs. Either we are going to have to find another million dollars or they are going to get cut. In fact, when we announced this merger, both Wellmont and Mountain States were in the process of cutting residency slots. Mountain States had a plan to cut eighty. I don't know the numbers for Wellmont. The reality is that if you do nothing, there are consequences and that is why we put forth a plan that we think is unique for our region. We don't think this is the solution for every community in the country, but we think because of the uniqueness of what we are dealing with in our region, we put forth something that creates sustainability; a rational approach to what

we see as a declining in-patient use rate and investment where it matters.

Now, the VAHP might think that building a residential addiction treatment center isn't a specific commitment, but addiction is a major problem in our community and our region. We think that is a pretty significant commitment. We think that outweighs the cost of elimination of competition and by the way, one of the comments Kyle made was that we are picking and choosing which commitments we will address and two, he said that we don't address the adverse effects of the Cooperative Agreement in our application. You got to go back and read the law, because the law kind of matters here. The law doesn't ask us to tell you the negative consequences of the Cooperative Agreement. The law asks you to consider the negative consequences of elimination of competition; and our application directly addresses that. One of the negative consequences of the elimination of competition is that pricing goes up, and we know that. That is why we put an affirmative commitment that all existing rate increases that health plans have already agreed to will decrease by 50 percent and then we cap our pricing at the CP guidelines (hospital guidelines) 425 going forward. So, we do put affirmative limits so that you won't have pricing increases resulting from the merger. So, in reality, the price increase would go up more without the merger than it would with the merger. So, we did address what are the negative consequences of the elimination of competition. Although, we will argue that competition remains. There are more than in-patient services here; there are out-patient that we are not anywhere near being the ultimate provider of out-patient services in our region, and in-patient services are continuing to decline."

Mr. Levine continued,

"So, one of the things that I know and we received some additional questions that might be asked related to some of the things that continue to be important and we look forward to answering these questions and I am happy to answer them here today. I will address a few things that I think apply and are very important. The Authority is in a very strong position as it relates to things like population health. For instance, if we have made a commitment to invest $85 million dollars over ten years to do research, one of the questions that I noticed has come up is how much of this will be in Virginia? Well, you are in a great position here because the resources were are prepared to throw on the table to do research whether it is housed at East TN State University or the University of VA, Virginia Commonwealth University or wherever the host organization is to do research they are certainly going to want to see partnerships with these universities as we do major research, and if we put money on the table, you all can also put money on the table to provide local matching dollars to go get NIH and other federally sponsored grants. If you put money on the table, those dollars are going to stay here."

Mr. Levine explained that,

"Any research that we do as a system, our hospitals in Virginia are going to cooperate with that research that is why a common IT platform is so important and part of the commitment we made in our application. Having a common IT platform gives you the

ability to have data and all of our scientists and physicians would participate in the research and use that data to conduct research. We think that makes us very attractive to physicians and you all know how difficult it is to recruit physicians in this region.

As it relates to the residency programs, I told you about some of the challenges we are facing before. We are committed to continuing this program and frankly, we need to diversify. These programs are a huge part of our pipeline for new physicians in our region; where they do their residency is more than likely where they will stay to practice. We do a great job with Primary Care, but we need to look at some of these specialties as well and what better way to do it. If we come together it gives us the ability MSHA and Wellmont to collaborate on rotations so that residents that are here can get rotations. This has been a problem with our health systems with two health systems. Having one health system will eliminate some of these issues whether it is Orthopedics or some other sub specialty; so, we think there are some opportunities to enrich the opportunities for our students and residents.

As it relates to governance, I know what has come up is Virginia and its role in governance. A couple of things I want to say about this. First of all, Mountain States and Wellmont reached an agreement early on to have quality governance between MSHA and Wellmont moving forward and it is very important. The results for this merger to get the synergy and to get the execution you need in order to be successful, we need the kind of governance that is committed to the system and has a history of knowledge of why things are done the way they are within the system and that is important from a governance standpoint. We do have a gentleman from VA that is on this board, Gary Peacock who is very active. One thing that I can say of the committees that we have on the Board; where most of our decisions are made at a community level, our vice chair is Gary Peacock. He will be our vice chair of the finance committee of the Board; so somebody from Virginia will be in that position and we are committed and we can talk about this during the phase of developing the agreement; we are committed to making sure that Virginia is extremely well represented on all these committees; particularly the population health committee; that is really important."

Mr. Levine said that,

"One thing that I would really like to point out that is unique in Virginia and that you don't have in Tennessee is that four of our seven hospitals currently operate under governance made up by Virginians. These are joint venture hospitals (50% of governance in Abingdon is made up of people that live in Virginia; 50% of the governance of Smyth County is made up of people that live in Virginia; 50% of the governance of Norton Community Hospital is made up of people that live in Virginia), those are Virginia corporations; those are real Boards, and they share fiduciary responsibility for those hospitals. So, there is a tremendous amount of control from Virginians of these Virginia hospitals and I know that is very important to you and it should be.

A lot of these things that we are talking about and that Kyle mentioned that we don't

have specifics on; I think the word he used was hypotheticals, while we are talking about people's livelihoods, we are not going to talk hypothetically. We have made a commitment in the merger document (application), we need a commitment to collaborate with our local communities. That is not a small commitment for us. These are their hospitals, so if we are going to make a decision about consolidating services or anything like that, we want the commitment of working with the local community and that is what the people want and that is what we have said, but more importantly, it is a legal one because these are joint venture hospitals with real governance, we can't close a hospital (say in Norton) without the consent of that Board. It is a Virginia corporation so there is enormous oversight of Virginians over these hospitals and the Authority and the goal of the Authority moving forward.

I agree with Kyle when he said that we need to look at our priorities going forward. This is where the role of the Authority is going to be important. We can certainly say that third grade literacy is important; we believe that it is and that is why we put it as one of the items we need to focus on. We believe that every third grader should be able to read at grade level by the end of third grade. Why would a health care system care about that? We know that there is a high correlation between third grade reading literacy and graduation and reading literacy and health literacy; so we know that is a priority for this region. Now, while we think it is a priority, you may not think it is a priority, and while we think it is a priority today, it might not be a priority two years from now; or three years from now; that is why what we want is a living, breathing relationship with the Authority where we meet with you and you tell us here are the things collaboratively that we want to focus on in this region. That way when we put our resources into it and the Authority puts its resources into it, we can actually move the needle. That is where the public/private partnership is very important. It would be inappropriate for us to dictate to you as to what are the priorities; that should be the other way around. We see ourselves as a tool of the Authority."

Mr. Levine concluded,

"So, I will close with a couple of other comments that are more general. From our perspective, this is not just about whether to merger or not and if we are allowed to merge great and if not allowed to merge, then we will just keep going on our merry way. The other alternative is this…each, both or one of these systems MSHA or Wellmont at some point might have to make the decision to merge with a larger system based elsewhere that is what is going on throughout the country. The two things that have resulted from mergers of that nature (this is not my opinion but based on studies funded by the health insurance industries)…large mergers that are unregulated; creating a large footprint allow hospitals to go back to the payers and leverage their hospitals in certain markets to get more money.

A large number of our employers here are self-insured. If we were to merge with an outside party, you would still have two systems separately with this capital arms race and spending money locally to do all these things that are redundant and still sustain all this

capacity. The system that acquires us can't get the synergies from elimination of costs. The only way to sustain the margins is to bill increase the rates and if we join a larger system; that has a large footprint; that is what will happen and in fact one study out of Clemson and University of Alabama was very clear in the results. Out of a 100 mergers they analyzed, the average price increase was 17 percent.

The second thing that happens is the elimination of local infrastructure. The first thing a system based elsewhere does is they eliminate your corporate infrastructure and they get all the incremental synergies they can. By our calculations, that would result in the elimination of 600-1000 jobs for this region. Again, we are not making this up; these are real numbers, and this is the real evidence as to what happens when systems like ours merger with larger enterprises. So we think this cooperative agreement and COPA is a reasonable way of protecting the public from runaway pricing; that is ultimately the issue here. Will this merger lead to higher pricing and reduce quality? I will tell you that I have look at every single cooperative agreement that I am aware of and COPA that has been approved and none of them go as far as ours does in terms of providing additional public benefits. I have not found one that has committed to spending 85 million dollars on research and to help survival of the local economy. Again, that is a unique issue for our region. That is a way to diversify our economy away from what has gotten us to where we are now. We have committed to build a residential addiction treatment facility in an area of the country is cited as the number two area in the country for prescription and opioid addiction epidemic. We propose to do that. Neither of us individually proposed to build it nor could we have paid for it and sustained it individually would be questionable. We are in an environment where our revenue is shrinking. These are real commitments that have a real public benefit and I hate to hear people minimize those things. Perhaps they don't understand the real problems in our region; we do."

Mr. Levine said,

"We think we are best positioned to solve them in partnership with you, and under the supervision of the state and Commonwealth to make sure that we don't do the things that people are worried about from the merger. So, I want to thank you for the time you guys have taken. It is above and beyond. We are deeply committed to the people here. We have seen the results of what is happening in this economy. We have struggled with people that come to our urgent care centers or ERs that are seeking drugs and/or medications; not because they decided they want to become an addict, but because they have lost hope. They have lost hope. We are either going to be a part of that solution or we are not going to be. Mountain States and Wellmont and our Boards have chosen to be and we invite you and the Commonwealth and the State of Tennessee to be our partners in this, and help us do this. We are committed. We might not get this all right, and we are likely to make mistakes along the way, but we are committed to doing this the right way, and to making our region proud of the capability of what we can become. With that, I will just say, Thank you."

Mr. Levine emphasized the importance of the role of the Authority. Mr. Levine thanked the

Authority for their time.

Chairman Kilgore expressed his thanks to Alan for presenting to the Board. Chairman Kilgore asked if there are any questions and acknowledged Delegate Todd Pillion's arrival and thanked him for attending the meeting. Delegate Morefield asked the Chairman whether he could ask a question. Delegate Morefield stated that he represented three hospitals that do not fall under this merger (Tazewell Community, Buchanan General, and Clinch Valley Medical Center). He stated that he understood the benefits of patients affected and access to health care but asked if those hospitals or groups made any input on this particular merger.

Mr. Levine responded that he has not had any conversation with these facilities and these markets will remain competitive from his perspective. Mr. Levine stated that,

> "Although they are competitors in a business sense, we do have great relationships with those communities and with those hospitals and we do support each other with services we offer."

Dr. Cantrell asked Mr. Levine about the questions that were submitted for follow-up at the beginning of August, and whether he could address any of those questions.

Mr. Levine stated that he was happy to address these questions. He asked,

> "Which of the following services would be considered by the new facility essential for patients if they repurpose rural or small community hospitals; if the hospital is 20 to 24 miles or greater from an acute care hospital?"

> "Generally speaking, emergency care is critical; emergency obstetric care; emergency specialty care is obviously critical; diagnostics everything from CT to x-ray to basic diagnostic; including screenings are obviously critical and important because a big part of this is access. Our plans to spend up to 75 million dollars over ten years on population health and a critical element of that and might be an argument for this particularly for the uninsured is to sign up for our programs that will be later established and then what we will do is provide them with the access to our services and track their progress with screenings to make sure they are getting their screenings, and this is a major challenge in our region."

Mr. Levine discussed how rotating major medical specialty care throughout the region is something that is in the COPA itself and will expand access to specialties. He further explained,

> "So rotating specialties such as helicopter and air transport to tertiary centers and trauma centers and these are things that we are already investing in and telemedicine is also a critical service. That was the first element. All of these are high priority no matter what you do."

Mr. Levine said,

- "Will there be a minimum number of hospitals with acute beds in Virginia that will not be repurposed and ambulatory only?"

The answer is there are no guarantees that any of these hospitals will not be repurposed. I think there really is one more if in Virginia (particular SWVA), Wise County has three acute care hospitals with a combined census of 30. So, in a community like that, you start having dialogue with the people about what are the services that we are not providing in the community that we might be able to provide; whether it is psyc, long term acute, rehab, skilled nursing; that is how the conversation starts. What is needed that is not being provided because we are all focused on keeping acute care services and working collaboratively with the physicians in the local community how do you assure you have the right service mix in that community? That is the process that we have committed to in the application and I would remind you that each of these margins (Smyth County, Washington County and Wise County) certainly as it relates to MSHA has local Boards that have to agree on anything that we do, and they are 50 percent of people that live in those communities. So, nothing can be imposed in these communities that we have not had the dialogue that we need to have without input.

- "Will Johnston Memorial Hospital continue to provide graduate medical rotations?"

Per Alan, we just started that program and we have made a major investment in it. As I just shared with you, some of the challenges that are being thrusted upon us now, because of the change in dynamics with the AOA and the American ACGME. As the AOA and the ACGME merge, they are moving towards the ACGME standards which will tend to be more difficult to meet in terms of how to run the program and it is going to cost around $100,000 million dollars. Right now, we do not have funding for that. So, without the merger, I can tell you that we are going to have to look at this. With the merger, we have made a commitment that we are going to sustain these programs. So, that to me is an affirmative benefit as it would not exist without the merger.

He stated,

- "Will Norton continue to be an acute care facility?"

I believe I have answered this question. Will GME and health care programs be maintained? Again, same answer I have already provided. Nothing can happen without the consent of the local community and without the consent of the governing board. Also, the first two years of this merger requires a single majority vote by the Board members; so, there is a pretty high standard established as we look at some of these questions.

- "The next question was how many total hospitals in Virginia will be maintained as a teaching hospital in years two through five?"

We have said that all of the facilities that are there will be sustained as health care facilities. Again, it is hard to predict what happens after year five. You only asked about years 2-5. It is very hard to predict as some of it depends on inpatient use rates and what happens with it. It is not necessarily good for patient payers if you have a hospital that has an average census of two or three. As volumes decline hospitals can't sustain financially the hospital can't sustain quality and a lot of hospitals are closing. A lot of that depends on what happens with our use rates and the overall admissions. Our friends in the insurance industry which we partner with are pushing this hard to move business out of the hospitals and into other settings. That is something that we have publicly said is a goal and part of the value-based purchasing initiatives that are out there. So, it is the stated goal of the federal government and the insurance companies is to move patient's out of hospitals. So, there are a lot of questions about whether brick and mortar facilities can continue to sustain themselves.

Mr. Levine explained that tobacco abuse and substance abuse are two leading causes that are preventable and treatable causes of mortality and morbidity in Southwest Virginia. He said the application targets programs for children and other prevention programs. These programs will provide targeted intervention for individuals with substance abuse disorders. While screening programs are mentioned here, where will these patients be referred and where will any patient service be provided to those requiring high levels of care on detox, etc. He said,

"As we invest in a residential treatment facility, and some of the current programs that go along with that and are community based, we expect that patients will go to the closest place that is appropriate for their needs and that is what we try to do. You want to keep patients closest to where their home is and where their family is. If someone has a deep-seated addiction, you have to get them out of that environment in order to get them on the right path. So, I suspect there will be a clear role for the residential treatment facility.

These other things as I mention, we all agree that those are all priorities, but what we want to know from the Authority is if we work together to collaborate what are the areas and what are the community resources that are there and that we can commit community resources to. Then, I think we will have a better outcome and I can tell you now before getting your input that what we say is a priority may not be your priority. The Southwest Virginia Health Authority can argue needs to be the leader; to determine the priorities in this region. We the private sector should not be determining the priorities. The government does have a role here in telling us where we should put those resources and so that is why that conversation is so important, and we certainly don't want to be pretentious about us determining what the priorities are. We think we agree on them, but we want to be sure. To me, it shouldn't be hypothetical. It should be really and truly what do we want to tackle and what resources do we want to put into it and how are we going to measure our progress along the way. Some of the things, we can measure on process along the way. Some of them, you can measure over time or result. Are we doing the things that would be good to reduce obesity…that we can measure the process of these things. We can't measure results on obesity real time; that is something that has

to happen over time. So, it has to be a combination of those factors."

Mr. Levine asked,

- "Will high risk maternal fetal services occur in Abingdon. Bristol and Kingsport for high risk patients being referred from Wise or Russell counties? Will this be one of the improvements from the merger and improve access to resources as well?"

It is a highly regulated service and it is done that way deliberately to protect newborns and I don't see that changing. What we would be willing to change is how we push forward in these committees to address prenatal care and that is where there are a lot of resources and opportunities for us to try and reduce the high number of high-risk pregnancies. So, this problem is upstream as to whether you live in Bristol or Kingsport, but what can you do to prevent high risk pregnancies to begin with and that is where we can put resources. Let me pause to do a commercial editorial…I just saw a 60-minute story that we ran and it was about Wise County; it was about the Health Wagon. There was a young man there that was a diabetic. In the first 60-minute story, he told about how he couldn't get access to preventive services in detail and how it was affecting his health. By the second time 60 minutes told the story, they reported that the young man had died. Folks, there are three hospitals in Wise County, and yet there was a 60-minute story on lack of access in Wise County. There is a mismatch of where we are putting the money and where it needs to be. It is embarrassing but the way the payment system is structured today, it isn't going to change unless we change it, and that is what we are trying to do here.

- "The last question is recognizing that rural hospitals are top three or four employers, what are the estimates for loss of employment for healthcare jobs by repurposing rural hospitals? "

If we don't merge and we don't repurpose, hospital closings will result in a 100 percent loss of health care jobs. I can tell you that with certainty. If we merge and repurpose, we think there will be loss of jobs relating to inpatient services, but we also think that if we invest in some of the community-based services which is repurposing of the funding there will be new jobs created from those opportunities. I can't tell you today what those numbers are because we have to go through a process of analyzing what is needed and that is where we need input from the Authority."

Mr. Levine said,

"So, I ask you to look at this incrementally. What is the state of affairs in Southwest Virginia if there is no merger and what are the possible consequences of that decision and what are the consequences if there is a regulated merger with a clear partnership with the Southwest Virginia Health Authority and a regulatory structure in place with the Commonwealth of Virginia to make sure that we are not hiking prices up because of the merger, and aren't not quality compliant because of the merger. Those are the fundamental issues that any anti-trust authority is concerned about. All the other stuff is

just pure benefits on top of it. I think that answers all of the questions that we received and certainly these answers are on the record and we are happy to answer any other questions you may have."

Chairman Kilgore asked if anyone else had any more questions.

Mr. Prewitt stated that he missed the last meeting, but asked if a question regarding scoring the success rate would be appropriate. He said,

"As a layman, we read your proposal and evaluate the pros and cons and the money that is going to be put back into certain initiatives, but the scoring itself identifies 50 percent as a passing rate which means that a lot of those items there will be nothing done to them and some of them may receive 50 percent. So, how do we as laymen representing communities; how do you weigh the pros and the cons when 50 percent of the monetary pros are commitment piece?"

Mr. Levine said,

"First, the Authority is to deem whether the application is complete and then the next step is to discuss and negotiate those items and there is flexibility to talk about how we would be willing to do the scoring. One, are we delivering on the things that we are promising? Some of the things are more important in our view.

We measure the effects of the elimination of competition and that is an important piece of this. In an anti-trust environment, we want to respect that. Making sure that we are doing what we say on pricing and making sure that we are doing what we say on quality in terms of increasing transparency and setting goals to be the top health care system we think are important because these are the two things that are the consequences of competition. All the other things to me and to us are true added benefits on top of addressing the negative benefits of elimination of competition, and so there are also other variables out there that we have no control over."

Mr. Prewitt said,

"We are very concerned because once we merge, we are going to be very committed to executing on this thing and the idea that lets say we are going to spend $85 million dollars on research and academic enhancement over 10 years that is easy to measure, but if we set out to achieve improvements in obesity, and we do all the things that evidence shows that we need to do, but obesity rates do not decline, or you have major problems with poverty or a major economic event that shuts down an entire industry, that leads to addiction, we would argue that establishing a residential addiction treatment center and doing the things that we are supposed to do to make sure individuals have access to that facility, I think we should get credit for that even if other factors drive the number of people that are identified as addicts up.

We want to be very careful that we can measure things that we can control and that to me is important. Starts with eliminating the negative effective of elimination of competition which we have addressed and then what are we affirmatively agreeing to are easy to measure for example, how much money are we spend on research or to put a quality system in place. Those are very easy to measure. We can measure those with very critical points. Then there are other things that are softer that use more money but are a lot of different parts and we think there needs to be a little bit more flexibility back and forth with the Authority and the Commonwealth about what the priorities are and which are going to be measured by process and which will be measured by results. So, for instance, third grade reading we think this is a result of the metric over time. We can get an inventory of children first and second grade that are six months or more behind the reading proficiency, there are things that we can do in partnership with local groups and organizations that are focused on education. We think we can provide resources that can help identify those children and close that gap and over a five-year period, we can see a reduction in the rate of children who are not reading at grade level by third grade."

Mr. Prewitt explained,

"Each of those things has to be addressed very carefully. So, at the end of the day, it is a pretty serious thing when you guys or the Commonwealth can terminate the COPA. So, we think termination of the COPA could happen when issues that lead to decision to terminate arise to a level that termination is appropriate. If we do all of the things that we are supposed to do to reduce obesity and yet we have not been able to move the needle as much as we should, but we have followed all of the metrics does that mean that the COPA should be terminated? The public benefit is not that we are guaranteeing results in improving obesity. We have never said that. What we have said is that we are going to provide resources that have never been put on the table before to help improve those issues. So, that is why we want to be careful about what we commit to and how it is measured to make sure that the punishment is not anything that matches anything that we may not have met."

Dr. Tooke-Rawlins stated that most of the questions that were asked were addressing issues across two states. She said,

"You have a really well-educated guest here that understands the changes in health care and sees what is happening to rural hospitals and the danger that all of our hospitals are in. However, under the application, describes what would happen in Tennessee and very little of it describes Virginia. That is why we asked for more specifics in questions not as much about commitment as more about the plans in Virginia; because that is who we answer to. Those are the things that we have to look at when we are sitting and looking at the application. We have to ask, how will this impact quality, how will this impact access in Virginia and some of those questions have not been answered that well. Certainly, that is why we got very specific on the questions; realizing some of things you may not be comfortable when you are talking merger but some of them can and should

be addressed. One hospital that closed came and talked to us about not having any community notification.

So, the fact that 50 percent of the Board will be made up of local individuals is a comfort to us if we know that is the process. So, that is not really in the application. So, this is the reason we are bringing the questions to you and need for you to recognize that Norton and hopefully now MSHA are our source of primary care; so, it is important to us that those physicians produce primary care physicians in Southwest Virginia. When we ask these questions, it helps your application if we know those answers and are somewhat reassured and we can answer if asked. We know about what is happening to health care today, but what is happening to health care in Southwest Virginia is our concern and we recognize that hospitals are at risk here. We are all about employment and still providing services in the community, so when we ask in general what services will be offered and about repurposing, we are really all about a plan and what services will be provided in a community. So, when we ask in general you say that you can't answer, but in those five years, are there going to be acute care hospitals closing in Southwest Virginia?"

The response was yes.

Dr. Tooke-Rawlins asked if the Board would make that decision about what services will be provided for each of those.

Mr. Levine responded,

"The process they have outlined illustrate an established a policy that says the services that are going to be eliminated or consolidated and if by doing so it leaves that community without the service, it would require a 2/3rd vote of Board of the new health systems, and before it even gets to that point it requires collaboration with the local community to determine what are the options for that local community. So, we put a very important process in place to make sure that we consider all of the variables for that community before a decision like that is made. It is hard to say today which services will be eliminated and it is a matter of public record which hospitals have the worst financial situation today and it is hard to say what they will look like in three to five years. What I am telling you with the answer is it depends on what happens with those use rates and how fast they continue to come down.

What happens to the population in that community and I will tell you the difference between not having this cooperative agreement and us going on our way vs having the cooperative agreement in place… without the cooperative agreement, none of the process that I have just outlined is required. We can make the decision today if we wanted to close a service at a local hospital. What we are saying is that we are willing to sacrifice our unilateral ability to make that decision with a process in place first?"

Dr. Tooke-Rawlins commented that it takes 2/3rd of the Board to eliminate service and asked how much of the local Board is that. She said,

"So, in Abingdon, Smyth, Norton, and Dickenson, it requires both the local members of the Board as a block and Mountain States Board agreeing. In those hospitals that are joint ventures, you have to have agreement from Virginia residents that live in that community. It is a 50/50 Board, but you have to have agreement from both sides. Let me also just articulate something. I think it is important to note that we constantly have services being added and deleted today. If a doctor retires and we don't have another physician to replace that physician, that service is closed; that happens every day. It happens all the time. So, services are added and subtracted on an on-going basis and that is just the nature of what we do. With a lot of the services that we are going to provide, it depends on what is the availability of the physician count."

Mr. Levine responded,

"One of the things that we have committed to in the COPA in the Cooperative Agreement that is not a commitment today is that every three years, we are going to do a comprehensive physician estimate for each community to determine what are the needs based on the population and demographics of that community. From that needs assessment that will inform our physician recruitment plan. So, the commitment that we have made is to have an on-going assessment of the needs are so that we are always planning ahead. We have a very aging medical staff and the residencies are not guaranteed today with us facing a million dollar increase in our costs investing in those residency programs, and without the COPA there is no agreement, and that is a fact. There is nothing in writing other than the agreement we have with the University to permit our hospital to be the site for residents. As the cost for residency programs continues to go up and there is no reimbursement for that, at some point…we either cut patient care or we do something else. That is the present state… that is the environment we are in today.

The commitments that we are making in the Cooperative Agreement are designed to put a firewall against that. If we can generate synergies from other parts of the system, the $85 million we talked about over ten years, it gets us more resources to sub-plant these residencies, but it is getting increasingly difficult. Part of the problem too, I didn't say this earlier, the reason we have been able to sustain the Virginia hospitals in a large part, and I will exempt JMH from the comment as they are very successful in SWVA, is because of our Tennessee hospitals and our ability to cross subsidize. As our TN hospitals are seeing this reduction in use rates, and a decrease in volumes, our ability to continue to cross subsidize VA hospitals becomes more difficult, and that is why reducing duplication overhead between MSHA and Wellmont and getting the synergies from there and eliminating duplicate services where it is not necessary generates the synergies that enables us to continue to do business. That is why we make the commitment to continuing sustaining these enterprises until at least five years as health care enterprises."

Chairman Kilgore commented that he is sure there are going to be other opportunities as the process goes along to other commitment (i.e. Lee County) and others and he thought that is something that we can talk about as we move forward. Mr. Hove and Mr. Levine thanked the chairman and Board for their time.

VII. Old Business

A. Working Group Reports

No working group reports. Chairman Kilgore stated that everybody has already reported. He said that that this was put on the agenda in case someone had something new.

B. Discussion of Cooperative Agreement Application

i. Staff Report

Chairman Kilgore indicated that the Board would now hear from its staff, Dr. Massaro and Dr. Brownlee.

Dr. Brownlee did not have any comments or questions.

Dr. Massaro commented that in terms of background, staff sees what is happening nationally everything that they see is consistent with the provision that has been presented and the underbidding of this application. Factually, the interpretation of what is going on in the United States with health care systems is probably pretty accurate. He added,

> "So, the real question is in terms of timing whether one wants to try to negotiate and deal with issues prior to deeming the application complete or to move forward and to deem it complete and then do the negotiation."

Dr. Massaro stated that he understood both sides of the argument. He said that speaking from his perspective and from the staff's perspective, this is a very unique situation. He explained,

> "You have got two states involved; you have a regional Authority; you have got two department of health's and the sooner that you can get to a position where everyone that deserves to be at the table is at the table and begin discussing what is going on, the better off we will be. We have all been very impressed by the way this has all been handled, but at the basis of a merger of this type can be and, in some ways, has to be adversarial at some level. We see possibly that one way to minimize the adversarial nature of this is to say, 'Ok, the application is not perfect, but it is complete enough to move forward.'
>
> So, I think basically, the three of us feel that in an imperfect world, we would say that trying to move a collaborative model as opposed to an adversarial model which is at the basis of the nuclear when it is merged makes sense, and the question then is how do you move to that collaboration? Do you wait until issues that are outstanding (there will always be issues outstanding because of the uncertainties of the marketplace), but certainly, I think that it is fair and that is the way the three of your researchers have come down in terms of timing. It doesn't speak in terms of whether the merger should be

approved because you clearly do not have enough data to know at this point whether it should be approved. The question is whether you can get closer to that information moving toward a collaborative and interactive model once the application is deemed as complete. I would argue that at least the possibility that the Authority speaks for the people of this region better than any other stakeholder, and therefore it is not inappropriate for the Authority to take the lead. People who play tennis, I believe, like to serve first.

If the regional Authority with the representatives in this community can come together and then take a leadership role and try to bring Tennessee; try to bring Virginia Department of Health; try to bring the providers and the insurers all together and work for these priority establishing goals, then I think the people in the region, which you know better than anyone else, will be better served. I think that is where we are. Dr. Brownlee agreed with everything Dr. Massaro said and mentioned that we are going to go into executive session shortly and that he and Dr. Massaro will be available to expand upon that if there are any questions from anyone."

ii. Executive Session

Chairman Kilgore announced that the meeting will go into Executive Session. He said the purpose for going into Executive Session is to review the proprietary information.

Mr. Mitchell advised Chairman Kilgore that it would be appropriate for the staff to stay. He noted that the conflicted board members could not stay during the Executive Session.

The Chairman and Delegate Morefield stated that the Board has concluded its closed session and is hereby in open session.

Upon returning from closed session Delegate Morefield said,

"We will now take a roll call vote that will be included in the minutes certifying to the best of each members knowledge: 1) only public business matters lawfully exempted from open meeting requirements under the Freedom of Information Act, and 2) only such public business matters as were identified in the motion by which the closed meeting was convened were heard, discussed or considered in the meeting of the public body. To fulfill the requirements of section 2.12-3712, commissioners shall respond, "'I so certify.' if they intended to vote yes."

Mr. Mitchell stated specifically section, he said:
"MR. CHAIRMAN, IN ACCORDANCE WITH SECTION 2.2 – 3711(A) OF CODE OF VIRGINIA, I MOVE THAT THE COMMISSIONERS CONVENE IN CLOSED SESSION TO DISCUSS OR CONSIDER THE INVESTMENT OF PUBLIC FUNDS WHERE COMPETITION OR BARGAINING IS INVOLVED, WHERE IF MADE PUBLIC INITIALLY, THE FINANCIAL INTEREST OF THE GOVERNMENTEAL UNIT WOULD BE ADVERSELY AFFECTED, IS THERE A SECOND?"

Chairman Kilgore noted this is just for those individuals that were in the closed session meeting.

Chairman Kilgore began by stating that he is certified. Each of the following members responded, "I so certify," Senator Chafin, Mr. Mosley, Mr. Neese, Ms. O'Dell, Dr. Welch, Dr. Cantrell, Dr. Tooke-Rawlins, Mr. Brillhart, Mr. Prewitt, Delegate Morefield, Mr. Horn, Dr. Wieting, Dr. Mayhew, and Mr. Horn.

Chairman Kilgore noted that we are back in open session.

iii. Consideration for Completeness:

Mr. Mitchell stated that when the Authority started this process, one of the things that we talked about that caused some chuckles was the difference between the submitted application and the received application. Mr. Mitchell said that last night the Board members should have received a memorandum giving. He said,

> "You have not yet received the application that you have before you because you have not deemed it complete. So, when you decide to make a completeness determination, you actually receive the application and as you know by the statute, things start to happen to move this process forward. Last night, you should have received a memo that we have been working on to give you some guidance on whether or not you are in a position to determine that the application is complete."

Mr. Mitchell stated that Chairman Kilgore wanted to make sure at the onset that the Board ran a process that would help make that determination. Mr. Mitchell stated that he believed that the creation of the working groups and the several meetings that took place, the nearly sixty questions that were asked, and the employment of staff with unique expertise to help the Authority review the application certainly has aided this endeavor.

Mr. Mitchell continued,

> "Obviously earlier during this meeting, you were asked to consider whether or not you are actually at a point where you can make an appropriate determination about completeness. I would remind you that the process itself enables additional input and that it would be impossible for you to receive all of the input that you need before you could determine that it would be complete; else why would there be a public hearing. So, there is a public hearing, there is public written comment. The Applicants have the opportunity to respond to that written comment, and you will have the opportunity I believe to actively engage with the Applicants to address any additional information that you might need to determine your recommendation; not to determine completeness. I think you will have additional opportunities to meet with the Applicants to discuss the commitments. I think that you are asked today to determine if a motion should be made and you should decide to do so, you are asked today to determine whether or not the application is complete such that it has been received so that the process can begin. That is the issue that is before you. It is not the end of the process; it is merely the beginning.

Everything that you have done thus far is leading up to that moment. I am happy to answer any questions. We really felt like you all would at least benefit from our perspective as to whether or not you were in a position to deem the application complete and I know that Tom and Dennis might have some comments as well to add and I am happy to answer any questions that you might have."

Dr. Brownlee said that the recommendation from the three staff members, including himself, of the Authority is that the application be deemed as complete. He said,

"Obviously, the decision has to be made by each member individually, but the questions that I asked myself was do we need more information on the effect on competition? There are going to be effects in different markets as Mr. Levine pointed out earlier. But I think that while there will be less competition and there may be additional questions on redefining that, but that is a reasonable conclusion here. If you really need much more information on that, and I didn't feel like I did. I think the questions turn not on less competition, but what are the mitigating strategies: what is the investment back into the community that improves health care? How do we control quality? How do we control cost particularly cost to the consumer? And that gets to the commitments and I will talk about those in a minute.

A second question is: how does the authority believe competition is working in communities so far and there are probably very few folks if anyone that is in a better position to make that determination than the members of the Authority? There is information on that in the application but I didn't feel like we needed additional information there. There is information in the application that are not unique, but they are unusual aspects in this market including the market area is sparsely populated. There is poverty, there is substance abuse, there is a high level of uninsured or under insured, there are redundancies in services, there are population health indicators that indicate that there are population health problems worse than many other parts of the Country. So, this is an unusual market, and could there be additional information? There is always additional information that can be given on anything, but you have enough information to start the process and move it forward on the timeframe within the Statute. As I resolved that question in my mind, I said yes there would permitting. Now on the commitments and scoring business, I think there is a definite need to firm that up and get more clarity on what those commitments are, and to have mutually acceptable measurable metrics for evaluating how these commitments have been satisfied or not, and how the monitoring and supervision is going to work in practice. That is something that you heard in the comments earlier suggesting they should be improved and more specific commitments and it was acknowledged that the commitments could be improved upon during the regulatory process; which indicates an acceptance that it will be appropriate to deal with them during the regulatory process; if we choose to deem the application complete."

Dr. Brownlee concluded,

> "Finally, there was a suggestion that there is no urgency here because the State of Tennessee is dragging its feet in this process. We are not the State of Tennessee and we don't control the State of Tennessee. My view of that is that the members of the Authority should do their job as they see fit. Certainly, they may not agree with me, but I think as Dr. Massaro said there may be advantages to this region if move forward and negotiate commitments before Tennessee begins negotiating commitments. I think there is a lot of merit to that and finally I think that moving forward in Virginia will be a catalyst for Tennessee, those are my comments per Dr. Brownlee."

Chairman Kilgore thanked Dr. Brownlee.

Dr. Massaro stated that one thing that he agreed with Mr. Shreve is the importance of regulation. He said,

> "We heard in the application and other comments about the Asheville experience. Even now, the State of North Carolina went back and looked at it and publicly admitted that it probably had not regulated that process enough. So, it is a much more complicated world out there and with this process, there are two states involved with other things. So, the regulation for this merger is going to be more complexed. I think the Authority again has the opportunity to somehow shape the way that the regulatory process takes place. The Authority could be the linchpin between Tennessee and Virginia, between the department of health's and between the insurers and the providers and it is good to have five years. We wish the CEO's all the best, but healthcare management is not necessarily a long-term process. You want to put in place a regulatory structure that regardless of who is in Richmond, regardless of who the CEO of the new firm, everyone knows what the State expects. I think there is a lot of work to be done and will be better done in a collaborative way that might come about during the review process."

Delegate Kilgore asked if there were any comments from the Board, "While we are on the Consideration of Completeness are there any comments from anybody?"

Dr. Cantrell noted that she had an observation. She said,

> "We have spent a lot of time talking about the Authority's role in this process an acknowledgement that in addition to our other obligations and our lack of resources to do the job that is required for this process is a concern."

Chairman Kilgore noted that,

> "We are really going to have to look at the Authority's role and how we are able to address that and fund it and things like that moving forward if we are going to be one of the checks and balances on the COPA moving forward.

Dr. Cantrell noted that there are a lot of people here with ties to the area and Richmond is over 300 miles away.

Chairman Kilgore stated that it is 355 miles from his house.

Mr. Mosley stated that at their last working group meeting one of the things that was mentioned was the make-up of the Board that we felt like the Authority should have representation on that Board, and that they refused that.

Chairman Kilgore stated that he thinks the Authority is in an entirely different light as we move forward. He said, "Once we deem the application complete, the collaboration begins. Then we can begin to address some of Virginia's concerns."

Mr. Mosley stated that he thought it was more for information for the board so that we would know what is going on here after this happens.

Ms. O'Dell stated that,

> "She chaired the 'Access Working Group' and one issue that consistently came up and I feel like it has not been addressed and I know we can do that in the future, but I wanted to go ahead and put that on the table, is the issue of Lee County. The closure of that facility; what services might be on the table for that community? Just a heads up, I think we will get a lot of public comment related to what is this going to do for that community."

The Chairman asked for further discussion. There was none.

Mr. Mitchell noted that it would be appropriate for a director to make a motion to deem the application complete. The stated that the motion should direct the Chairman to deliver a copy of the received application to the Commissioner of Health and the Attorney General, and it should direct the Chairman to publish proper notice of receipt of the application and initiate public comment period and fulfill the other statutory requirements set forth in the Code.

Delegate Morefield made a motion to deem the application complete and direct the Chairman to deliver a copy of the received application to the Commissioner of Health and Attorney General's office, to publish proper notice of receipt of the application, and to initiate public comment period and fulfill other statutory requirements set forth in the Code.

Senator Chafin seconded the motion.

Chairman Kilgore asked for a discussion on the motion.

Dr. Cantrell asked a question about what the next four to six weeks will look like in terms of negotiation as she feels there is going to be a lot of work to be done and curious if the Board has a visual on what that is going to look like.

Mr. Mitchell responded,

> "Now that you have acted, Ashley has been attempting to draft a notice of the publication

so on Monday you will get that. Given the nature of the publications that you all determined six months ago, it is not possible to publish in one newspaper and fulfill the requirements that is set out in the statute. So, it is her recommendation and I agree that we pick a date and publish in all three newspapers on the same date so that it is clear when the 20-day period starts for written public comment, and we will get that to you over the weekend. Then you will have 20 days of written public comment which is going to be limited to what is in writing and sent to the office because I don't think you decided to do web based public comment. You can discuss that if you want, but I would encourage you to keep it simple."

He concluded,

"I think that the working group leaders should take the lead in representing their constituents and groups and we will probably be meeting with the Applicants and I anticipate that you all will be having more public meetings to discuss those commitments and receive any additional responses. You are going to get responses back from written public comment. You are required to share public comment immediately with the Applicant when it is received. Now that you have an office set up in Abingdon, we will be doing that."

Chairman Kilgore noted, "These are working days. Twenty working days and seventy-five working days; which is a big difference from just 20 or 75 days."

Mr. Mitchell stated,

"They have been trying to diligently keep issues that you all have raised so that we can raise those with the Applicants, and they have made it very clear that they are going to devote the time and resources necessary to getting this done, but I think you are going to be meeting and I think you are going to be hearing from Delilah and Ashley a lot on meeting dates over the next period of time.

Your next big scheduled meeting outside the regular meeting will be the public hearing which has to be 45 working days from today. So, this process will begin in earnest. Mr. Chairman, my hope is that everyone will have an understanding of the issues that have percolated to the top. I think it is important for you to remember that the Commissioner of Health is the Officer that is entrusted with finally approving this. You are simply making a recommendation and I think you need to be able to decide that you put yourself at the end of the review you are in a position to make that recommendation and react to the public comments that you receive and the responses."

Dr. Tooke-Rawlins mentioned that as the working groups meet they bring items to the table, and Chairman Kilgore agreed there are so many overlaps in the committees. He recommended two meetings a day for potential overlap of meetings and meetings in a timely basis. He noted that the meetings would require a significant amount of time.

Chairman Kilgore stated,

> "We have a motion and a second is there any more discussion? All members that can vote on this prepare to vote. The members that are conflicted and not eligible to vote include: Mr. Leonard, Mr. Givens, Ms. Ward, Mr. Vanover, Ms. Baker, Dr. Counts, Dr. Means and Mr. Mulkey.[1]"

Dr. Tooke-Rawlins mentioned the 75 days and asked if there a response time. Mr. Mitchell responded and said in 10 days business days.

Chairman Kilgore asked if we were prepared to vote.

The motion carried unanimously.

VIII. Next Meeting:

Chairman Kilgore told the group to just keep an eye out. He said that Delilah is going to be working hard to get that done.

IX. Public Comment:

Chairman Kilgore asked for public comment. No public comment was made.

X. Adjournment:

The meeting was adjourned by Senator Chafin and seconded by Mr. Mosley. The meeting was adjourned at 5:27 pm.

_____, Chairman
Terry Kilgore

[1] Note: Mr. Clark was absent from the meeting.

Attachment
List of Commitments (New Health System)

1. For all Principal Payers,* the New Health System will reduce existing commercial contracting to fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation 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.

2. For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, 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%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. 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. 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. If following such approval, the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health System agrees to mediation as a process to resolve any disputes.

3. 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.

4. The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. 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.

5. 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.

6. With academic partners in Virginia and Tennessee, the New Health System will develop and implement a 10-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.

7. The New Health System will work closely with ETSU and other academic institutions in Virginia and Tennessee to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.

8. The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. 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.

9. The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the Geographic Service Area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.

10. The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.

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

12. The New Health System will maintain 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 hospitals-based physicians, as determined by the New Health System's Board of Directors.

13. The New Health System will commit to not engage in exclusive contracting for physician services, except for hospital-based physicians, as determined by the New Health Systems Board of Directors.

14. The New Health System will not require independent physicians to practice exclusively at the New Health System's hospitals and other facilities.

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

16. All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. After this time, the New

Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scoped of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.

17. The New Health System will maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher-level services are available in close proximity to where the population lives

18. The New Health System will commit to the development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference. The Parties expect the combined system to facilitate this goal by employing physicians 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.

19. The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. 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.

20. The New Health System will participate meaningfully in a health information exchange open to community providers.

21. 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.

22. The New Health System will collaborate 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 the overall health of the region.

23. The New Health System will create a new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.

24. 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.

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

26. 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.

27. The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than $75 million over ten years in population health improvement.

28. The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the Virginia State Agreement.

29. The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.

30. The New Health System commits to spending at least $140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.

31. The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.