**Southwest Virginia Health Authority**
**DRAFT - Minutes of Meeting**
**September 27, 2017 at 3:00 PM**
**Southwest Virginia Higher Education Center, Class Rooms 103 and 104**
**Abingdon, Virginia**

**I. Call to Order.**

Chairman Kilgore called the meeting to order at 3:10 PM.

**II. Roll Call.**

Ms. McFadden called roll. Ms. Brillhart, Dr. Cantrell, Senator Carrico, Senator Chafin, Mr. Clark, Ms. Copeland, Mr. Eaton, Mr. Givens, Chairman Kilgore, Mr. Leonard, Dr. Mayhew, Dr. Means, Mr. Neese, Mr. Vanover, and Ms. Ward were present.

Dr. Henry, Dr. Rheuban, and Dr. Tooke-Rawlins were present by telephone.

Several guests were available in person and by telephone.

Ms. Baker, Delegate Morefield, Mr. Mosley, Ms. Murray, Ms. Odell, Mr. Perdue, Mr. Prewitt, Dr. Weiting, Mr. Mulkey, Mr. Perdue, Dr. Sarrett and Mr. Horn were absent.

**III. Declaration of Quorum.**

Chairman Kilgore declared that a quorum did not exist, but that Mr. Eaton was on his way and we would need to wait until he was present to conduct business. He was on his way to the meeting and should be at the meeting soon. Mr. Eaton arrived at the meeting at approximately 3:50 p.m. A quorum was declared.

**IV. Old Business**

**A. Review of Final Report – Mr. Mitchell**

Mr. Mitchell began,

> "As I mentioned to Mr. Chairman, I was not at the April meeting, and I apologize, but I was able to call into the meeting. You all did get your report submitted on time on the 22nd, and it is probably a good time to bring everyone back to where we were last fall to get ready for now to get the ball back and start moving forward. I was just going to take a minute or two and remind you all of what you did as sort of a set up for the Applicants to give us an update from this point on. If you remember, when you originally got the application and went through that whole process of determining completeness; you had those various working group meetings that we set up to look through this material, and you guys negotiated those commitments and you made your completeness determination. You decided to go out and engage staff that provided you the expertise

that would be helpful in reviewing the application; and some of those staff members are on the phone today, and I think you all will agree they were an integral part of that process.

In the report we summarized the written and public comment for you all for the record. Ultimately, you all had to make that determination if you remember on whether the likely benefits of the proposed COPA outweighed the likely disadvantages from the reduction in competition. You all weighed each individual benefit and each individual disadvantage, and if you remember correctly, made that determination. We are not in a position at this point to revisit that; you have done that. Ultimately, you voted to recommend the Cooperative Agreement to the Commissioner with the revised commitments that were negotiated with your staff.

I think the approach that you all took, and we tried to reflect this in the report, was that you very much engaged anybody that came to the table. We had multiple meetings with the FTC, significant public comment, and we tried to capture all of that in the report; and hopefully at the end of the day, you all were pleased with the report that got submitted and that it was nothing less than comprehensive, I hope."

Chairman Kilgore agreed and said,

"We did have a very deliberate process and we had a lot of commitment from the health care providers and a lot of experts from Southwest Virginia as it relates to those commitments and to our healthcare needs and challenges. I know we have relied a lot on the Blueprint that this health authority adopted in 2009 and updated again in 2015. A lot of our recommendations and commitments came from that Blueprint as to our needs and what our challenges would be moving forward. Some of those results were presented to the Commissioner and whether our commitments would be getting results in providing better health care for our region and things of that nature. That was one thing Delegate Kilgore stated that he was proud of the group for working through and holding the Applicants accountable as to what our healthcare outcomes are going to be. I think we can really be proud of what we did at that time."

Chairman Kilgore said, "So, Jeff, where are we now?"

Mr. Mitchell stated,

"Mr. Chairman, at your request, we asked the Applicants to come back and give us an update. I think they have two presentations; one presentation is to discuss the updates and the other one is regarding the certification. So maybe do the update presentation first and then Jeff has some questions before they go into the TN application presentation."

**B. Update from Applicants:**

**Review of Tennessee Certification of COPA**

Chairman Kilgore announced that Mr. Keck would address the terms of certification.

Mr. Mitchell stated that he could do that first, but said,

> "I would say that the terms of certification, and Dennis may want to jump in now or at the end, obviously that was an incredibly large document that we got a few days ago and have tried to plow through. I think it is appropriate for you all to ask them to explain provisions and to ask them to better help you better understand provisions. I am not sure we should be asking for them to opine on what Tennessee did. It has been suggested to me by the Chairman that we should focus on Virginia so when we are through, just keep that in mind."

Mr. Keck asked, "how much time do you want me to spend on Tennessee anyways".

Mr. Mitchell said, "I think it is important for them to have a clear grasp of what Tennessee did, but Dennis please speak up, I don't think we need to go down to the one-foot level."

Mr. Barry replied, "After having read the Tennessee document, I would love to have a better understanding of it."

Mr. Keck stated,

> "Obviously, this is a robust document for those of you who have it in front of you. For those of you who don't have it, it is posted on the Tennessee Department of Health Website; so, you can get access of it there and review it. There are about 60 slides in this presentation, and it is not completely comprehensive, but in terms of coming here today and generating questions or clarifications back from you, we think it is appropriate. I can move thru this as fast or as slow as you need me to. Just in terms of process, both boards of MSHA and Wellmont have accepted the terms and conditions that TN had put together last Monday or Tuesday (18th or 19th), and then the Commissioner of Health in Tennessee, Dr. Dreyzehner, gave his approval to the terms of certification on the 19th. So, what you have in front of you is what the State and both Boards have agreed to.
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> The terms are 116 pages in length and about half of that is addendums. We will talk about some of that today as we talk about the seven sections to include: definitions, statutory requirements/factual findings, monetary obligations and commitments, non-monetary commitments. How we will deal with managed care contracting and pricing limitations, active supervision from the State and miscellaneous provisions. We will talk about everything today at probably not the 100 ft. level but a little higher. Except for the statutory requirements and factual findings that is more for the COPA in TN."
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> **Definitions:**

Mr. Keck explained that there were a few key definitions that pertain to state supervision. He said that the first is **active supervision** and that a lot of this document is designed around the requirement that the state actively supervises the Cooperative Agreement; both in terms of granting the agreement and in supervising it going forward for ongoing benefits. He said,

> "So, the ongoing process of the department, the AG's office, appointed agents and independent contractors will be involved in evaluating and enforcing the COPA in terms of certification."

He explained that the,

> "New Health System Entities – means collectively that as the contract requires that the COPA parties (Wellmont and Mountain States); all of the hospitals and any other entity that has been majority owned or controlled by the COPA parties (so that is essentially everything we do where we have decision making majority and ownership.
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> Geographic Service Area – In the TN definitions means the service area covered by the COPA. That essentially includes all of the TN and VA areas served by MSHA and Wellmont. It goes further to say any additional counties or municipalities in any state which the new health system would provide services or operate facilities.
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> Rural Hospital – This means any COPA hospital not located in either Sullivan County Tennessee, Washington County Tennessee or Washington County Virginia. So, there is a list of hospitals currently operating outside of those areas, and that will become important later on."

Mr. Mitchell asked, "so that means the hospitals in Virginia have been wrapped into this definition, and therefore have been wrapped into the agreement?"

Per Mr. Keck, "that is correct."

Mr. Keck continued on to define terms covered in the agreement.

> "Service Lines – means the following service lines of a COPA hospital and that includes orthopedics, pediatrics, surgery, OB/GYN, cardiovascular and heart, cancer, emergency medicine, neurology, neurosurgical, psychiatric and behavioral health, neonatal and trauma. These are not hard and fast definitions that exist somewhere in the literature necessarily; they are more of a market and operations concept, but there is general acceptance of the terms between the State and the COPA parties.
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> Underinsured – an important definition because typically a definition of underinsured doesn't exist anywhere, and there is a lot of debate about it. But in the context of this agreement, it means essentially any health plan that does not meet ACA minimal essential coverage as of July 1, 2017; so, anyone that has one of these health plans is considered underinsured regardless of their income level.

> Article 3: Monetary Obligations – These are what gets a lot of attention obviously in the press, and I think all of you know these. Monetary obligations are expanding access, and we will go a little bit into these, 140 million, health research and graduate medical education 85 million, population health and improvement 75 million, a region wide HIE (health information exchange) 8 million which was not explicitly spelled out in our original proposal in terms of the dollar amount, and this is over a ten-year period. What you don't see there is the electronic medical record commitment. Tennessee felt that it was not necessary to include that in the calculations related to the benefits so that was $150 million dollars that no longer shows up there, but it is still a planned expense that will go through; it just isn't in this document. So, very quickly about the $140 million, you will see a lot of similarities from our discussions with Virginia, $85 million dedicated to behavioral health services out of that $140 million."

The terms of certification require that staff develop a three-year behavioral health plan and submit to the Department of Health for approval within six months of the issue date. Mr. Keck said,

> "So, the approval date was last Tuesday; the issue date is the date that will be 90 to 120 days past the approval date which is when the new health system formally closes; so that becomes an important deadline in terms of starting the clock. There actually are some things that as of the approval date which was last Tuesday that has started the clock and I will mention a couple of these as I go forward.
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> Children Services commitment of over $27 million over a ten-year period. Same thing, we have to develop a children's health plan within the next six months and submit for approval. With children's services, we are facilitating recruitment and retention of pediatric sub specialists according to a needs assessment, we will complete. We will develop a comprehensive pediatric center at Nicewonger, which has a formal definition and keep pediatric emergency room in Kingsport and Bristol and that will expand pediatric telemedicine rotating specialty clinics out into the rural hospitals.
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> Rural Health Services has a commitment of 28 million dollars; same thing with a plan within six months submitted for approval and will be based on a needs assessment of physicians, nurse practitioners and PA requirements primarily in underserved areas where independent physicians cannot or will not address this need.
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> Health Research and Graduate Medical Education – $85 million dollars. This is a three-year plan that we have to submit within 12 months after the issue date. Again, focused on health research; spending our investments within the entire geographic service area to attract additional research funding from national sources. Graduate Medical Education, a couple of key points here…. we shall reduce or eliminate any medical residency programs or available resident positions presently operating. This has a couple caveats…we are allowed to move residency if a program warrants it. There obviously are some natural fluctuations and you don't always fill all of your slots and if there is a decrease in federal or state funding, which is a considerable amount for these

positions, we are allowed to make some reductions. The idea for spending under GME is we are going to develop an academic infrastructure at Ballad Health to provide effective training and to support fellowship training on a regional basis of sub specialties.

Population Health Improvement – we have had a lot of conversation about this. There is a three-year plan that we need to deliver within six months. Important under this commitment is the creation of a department of population health improvement that will report to either the executive chairman of the board who is Alan Levine or to the CEO who is Bart Hove. It will be the efforts in implementing the population health plan and it will also be the efforts of the population health department to establish one or more accountable care communities. Part of the conversation that we need to have in the region is how do we set up our accountable care communities. Will there be one for the region? Or will there be a TN accountable care community and a VA accountable care community? That is a conversation that we still need to have.

Region wide HIE – in our original proposal, we didn't have a dollar amount attached to it. The upshot to it is that we need to develop a three year HIE plan for submission and approval within 12 months of the issue date, and the idea here is that we need to coordinate with independent physicians and other health care providers in the region, and all relevant third parties to determine the optimal technology solution for expanding the scope and effectiveness of providing access to electronic health information; in particular, to independent physicians located throughout the region. So, some people use health information exchange as a noun, and some people use it as a verb. I think the most important thing in this document is that we put together a plan to get the necessary patient information in the hands of people who need it to treat the patient."

Mr. Keck explained that there are several requirements related to facility maintenance and capital expenditures. He said that staff has to develop a Capital Plan for submission to the Department of Health within six months of the issue date that does not need the departments approval but does need to list Capital projects for the first three years along with estimated timing of items, plans for funding and an estimated capital expense. He said that what is required is that staff spend over that three-year period at least 90 percent of what we have committed in terms of capital expenditures. He explained,

"If we don't, there is a process that is spelled out in this section where there could be a third party assessment of capital requirements at Ballad and there could potentially be modifications of the capital plan recommended by the COPA monitor; which we will talk about a little later on, the external evaluation party, and potentially could be modified by the Commissioner of Health. So, we don't need initial approval for the plan when we submit it, but we do need to stick with the plan. We need to be within that 90 percent expenditure rule.

He continued to define topics covered in the application. He said,

> "Employee Benefit and Protection – I think most of these will look familiar. We need to create an implement an equalization plan to spend at least a minimum of $70 million over a 10-year period to eliminate differences in salaries, pay rates and employee structures. I think in the original document for Virginia, we estimated it would be about $70 million. Here, we required that it would be that we spend at least $70 million. That process needs to begin no later than our next fiscal year. We have committed to combining the career development programs of MSHA and Wellmont. This is probably the biggest edition since you last seen these commitments; is that we shall not terminate any employee without cause of any rural hospital depending on the approval date which was last Tuesday and continuing for 24 months after the terms of certification issue date. We shall not require any employee of a rural hospital to transfer their principal place of employment to a location more than 30 miles from where they work during the period from last Tuesday through 24 months after certificate issue date. There are some exceptions to this, but this is the general rule. This is why the rural hospital definition is so important because it specifically ties this back to rural hospitals. Even after that 24 months expires, any without cause terminations require notice and any reduction in 50 or more employees in a 90 period trigger a 60-day notice period where we not only have to notify the department of health, but we have to spell out what our severance policy will be for that particular action. So, these have changed quite a bit since we last talked; at least in TN."

Mr. Keck explained that continuing with benefit protection and going specifically into the service lines is why the service line definition is important. He said if the new health system intends to pursue a facility closure or the deletion or repurposing of any service line; which is spelled out specifically; or any material reduction workforce during the COPA term, and such action is permitted under the terms of certification, the new health system should notify the department at least 60 days in advance and again. He said the notice should include a severance policy addressing how employees will be compensated in connection with the action that is occurring as well as what support we will provide. Mr. Keck said that this has a significant reporting action attached to it, and obviously significant protections for employees in rural areas.

Article 4: Non-Monetary Obligations

Mr. Keck suggested that,

> "There is a number of conduct commitments as we have referred to them in the past; quality of care is related to our adherence to all joint commission accrediting agencies, state, federal compliance and auditing agencies, prompt reporting, etc. There is a requirement that we establish a system wide physician led clinical council that will be responsible for establishing common standards of care, credentials standards, peer review and performance standards, and best practice requirements. It spells out the process for putting that Council together and how it will operate. There is a significant amount of new data collection which is reported to the department and is spelled out later in the document. These include equality index, satisfaction surveys, report of our staffing ratios and any commitments that we made previously also quality enhanced reporting to the public to get information that we generally produce for the government

in terms of our performance out to the public sooner than it is available to the federal government in an easy to digest/understand manner so people can make better decisions about the quality.

In terms of access to health care services, so, we have proposed maintaining the three tertiary referral hospitals that continues in Kingsport, Bristol and Johnson City. Will it be different from what was in the original submission both here and in Tennesee? We will maintain in operation as a hospital all COPA hospitals at the approval date for five full fiscal years. Originally, that read as health care facilities. So, that has become more stringent. There are some exceptions to it and we will talk about them in just a second. With approval, we may repurpose any COPA hospital provided in the geographic service area as long as it meets the goal of providing access to affordable health care services during the first five years repurposing only alters the physical plant of the repurposed COPA hospital to the degree required to repurpose as long as it maintains essential services (and I will show you those in a second). The notable exceptions have been there are pre-approvals in Wise in Norton, Virginia and Greene County where they have significant overlap in rural areas.

Mr. Keck continued,

"We still need to put in our plans our objectives for Wise, Norton and Greene Counties and those plans have to be preapproved, but these particular counties are considered pre-approved in terms of repurposing any COPA hospitals. So, there is kind of a back-door approval may be a better way to put it, but it is acknowledged that there is significant overlap in these areas in both Tennessee and Virginia. The leasing or repurposing of other service lines or facilities, there is notice and consent required for leasing or repurposing any existing or future service line including a zero component or procedure of a service line. That language we will continue to analyze and try to understand what component or procedure; how glandular that is, preapproved for repurposing or consolidation is level 1 trauma. We have two level one trauma centers one in Kingsport and one in Johnson City. Areas where there is urgent care center duplication; most of that is in Tennessee, there may be two urgent cares in Abingdon; surgery services at Indian Path Medical Center and Holston Valley Medical Center; that doesn't mean we would consolidate surgery in one hospital or the other. What it means is that we may move one aspect of the surgical services to one hospital and another aspect of surgical services just as a way to improve flow and as a way to improve quality and the consolidation of non-medical support service; to include a lot of administrative services and so on.

All of this needs to go through our consolidation policy that we have talked about in this group at lengths, and all though it is preapproved, there is a fairly robust process that has to happen within the new health system to actually do this and no decision have been made about where we would combine services for instance, what critical services might move to where in Kingsport.

Continuing with Assets and Underinsured Patients, as we talked about underinsured means any health care plan or individual that has a plan that does not meet the minimal essential coverage defined under the Affordable Care Act (ACA). We are required going forward to offer to the underinsured discounts on their care regardless of their income level, and that has changed. We have previously offered discounts to individuals where their bill exceeded a certain percentage of their income. This particular definition requires that we ignore that income level. In terms of charity care, probably the most important thing here is that there is a general expectation that our charity care; the care that we deliver to the uninsured; the cost of that care will grow over time, and if it doesn't grow over a period of time, we need to provide an explanation to the COPA monitor as to why it doesn't grow over time. With charity care, we don't have a pot of money that we put in place and then dole it out as charity care.

Mr. Keck explained that,

"Charity care is who comes to us and whether or not they have insurance and the cost of their care is; we both have policies that govern that and so charity care can go up and down quite a bit year to year depending on who is visiting the facility, and it is influenced by things such as unemployment, and it is influenced obviously by the affordable care act which drove down the amount of charity care. This allows us to explain to the COPA monitor why our charity care is not going up or maybe up as fast as would be anticipated with normal health care inflation."

He continued,

"Finally access to healthcare services requires that we provide access to Tennessee licensed facilities. That is if hospitals or other types of facilities need to transfer patients into us. Typically, if they are underinsured because they don't have the capability to deliver those services. This essentially says that we will provide access to those patients without restrictions. I talked about essential services and this list is the list that you all put together. I think there are a couple of additions that were made in Tennessee and I think that includes lab services, physical therapy, rehab services and care coordination. So, the list that you have asked that we include has been somewhat enhanced in Tennessee. Any questions on any of this? I have been rushing trying to get through all of this, but I want to make sure you have a chance to stop me to ask questions.

Board Governance is in our original master affiliation agreement, which is the agreement between the two boards before they are merged, the original board had 16 members with ETSU being a non-facility exfictio member, and in our conversation with you required three Virginia members. The agreement reached with Tennessee that the Board will be smaller and will have 11 voting members that would include three ex officio members, the executive chair president, the chief executive officer, the president of ETSU who is now a voting member and would have two (2) members from Virginia. I have the percentages to show that the percentages are very close in terms of

representation of Virginia on the Board.

Following up on governance, a lot of conversation we had with this group was the population health and social responsibility committee. That committee is responsible for oversight and compliance with commitments in reporting listed in the terms of certification. It has governance oversight with population health. The leadership of the accountable care committee that we put together will include members of this committee, and there is a 30 percent minimum membership requirement on this committee from Virginia."

Mr. Keck continued,

"Article 5: Addendum 1: I am only going to include a few slides from this. If you have the terms and conditions, you will see that addendum 1 is approximately 20 pages of very detailed calculations regarding pricing limitations that are put on the organization to manage cost below what would be expected under general health care inflation, and it also includes a number of items which I haven't completely listed here, but you all will be familiar with related to how we will interact with payers and how we will interact with competitors and that is addendum 1 which is all the pricing information and then in article 5, are these conduct commitments about how we will interact in a competitive environment. So, probably the biggest change; except from going to two paragraphs to 20 pages for the pricing, it can probably be summed up here. We originally used as our basis for the payout, the hospital and medical consumer price index as the cap ceiling, but it has been changed in addendum 1; the Tennessee formula to the Medicare market basket which is a cost index prepared by Medicare. So, the Medicare market basket plus .25 percent and 1.25 percent if a payer contract that we have doesn't have a quality component. So, our original proposal had a hospital consumer index minus .25 percent as the cap. This changed that around significantly. It also removed the 50 percent decrease in the first full year principal fiscal year for all the payer contracts where we had some payers.

The state of Tennessee wanted to treat all payers equally, so the concept of large payers, small payers and principal payers does not run through this document. Although some of the terms might affect some of the small and large payers differently, there is no consideration that we are going to treat them differently. We are prepared to honor all of our current agreements and it includes a mediation/arbitration and a list of all required or prohibited activities in Section 5.02. So, mediation and arbitration are significant changes where if there are disagreements between us and the health plans in terms of getting to reasonable terms, we will go to mediation. If we still can't get to an agreement, we will go to arbitration and there are some very specific requirements around how that arbitration will work.

Instead of listing the 20 or so conduct commitments, again which were very similar to what we did in Virginia, I have just referred you to section 5.02. In this same section, dealing with competing services; a competing service might be where we own our own

> DME company (durable medical equipment company), and there are obviously lots of competitors in the market so if each COPA hospital will compile a list of ancillary services, and post-acute services offered by providers competitive to Ballad Health, including at least three competitors; for each category of service, and we need to provide that list to patients if we are going to engage in allowable guiding or directing of patients and that is a very technical term about what you are permitted to refer to in terms of services; always understanding the patients much retain choice. We have to provide this list of competitors to every individual regardless of payer class and a lot of these requirements around Medicare regardless of payer class, we have to provide this list before we can engage in allowable guidance and directing of patients."

Mr. Keck explained that another difference between Virginia and Tennessee is Ballad Health will not oppose awards of certificate of need unless the Applicant for the CON does not consistently accept in-patient Medicaid patients or uninsured patients. He said that the staff's opposition would be provided through the COPA monitor, and through the preparation of relevant material opposing such application and then the COPA monitor would deliver the relevant material to the Department of Health to be included in the administrative record. Mr. Keck said that this does not allow the Authority to go through the extensive appeal process; either administrative appeals or court appeals that exists and only allows them to enter information into the record under extenuating circumstances.

He explained,

> "Related to physician services, there are a few more than I listed here, but I think some important ones are that we cannot restrict physicians or other health care providers from performing services outside the new health system and we can't prohibit them from participating in any networks, health plans or payer contracts that they choose to participate in. We shall provide an open medical staff offering equal access to all qualified physicians. Qualified is essentially defined by the medical staff at each hospital and there are some other licensing and credentialing requirements, and I think importantly, is this rural hospital definition comes up again that no more than 35 percent of the physicians practicing in any specialty at any COPA hospital that is not a rural hospital may be employed. In rural hospitals, we are able to employee as many physicians as we need to meet the needs, and often we do; in many cases, we are the only provider of specialty services in that market, but in the non-rural areas, such as Washington Counties Virginia and Tennessee (Abingdon and Sullivan County), we had a cap. Now, grandfathered in are places where we already exceed that cap, and there are a number of instances where we do, and we can't apply for acceptance here which essentially if there is need, and that need is not being met, we can petition the Department of Health.
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> There is some language here regarding vendor contracts. There is some general language regarding the purchase of equipment and supplies shall be made with the goal of effectuating the lowest cost consistent with necessary quality in the category of efficiency. Importantly, the new health system shall not bargain for and insist upon restrictions upon it supplies with vendor group purchasing organizations preventing or impairing such person doing business or entities that compete with the new health

system and that is a common practice throughout the United States; so, this is a new restriction."

Mr. Keck said that the new health system shall not also require the vendor to include most favored nation clause in the contract. He said these,

"Require that we get the best price in the market with the caveat that we participate in a group purchasing organization that has those clauses; that would not be included in these restrictions."

Mr. Keck continued to review commitments along with his presentation. He said,

"Communications with payers – prior to initiating negotiations, the new health system shall provide a complete copy of terms of certification to the payers. All of the payers have it in hand and are getting familiar with it right now. But there are many small payers that we do very little business with who we would have to provide these terms of certification to. In the Department, part of the supervision will investigate complaints regarding our compliance with this contracting process. So, all of the commitments that we have in the terms of certification, we have to make sure the payers know what those are or at least have access to those, then if they believe that we are not meeting those requirements, they have an avenue to make complaints.

Finally, everything that is in Section 5 and Addendum 1 is put into an economic index that is essentially pass/fail. So, we have to comply with all of these conduct commitments and our pricing commitments and you either comply with them all or you don't comply, and that is an important consideration because if you fail these particular set of commitments, the COPA slips into a non-compliant phase, and so it is very important that we meet all of these.

Active supervision – so the structure of active supervision consists of a COPA compliance officer which is employed by the new health system but can only be fired by the Commissioner of Health and they report directly to the Audit and Compliance Committee Board. The COPA monitor is an individual or a firm outside of state government, outside of the health system who is responsible for independently verifying that we are complying with COPA. There is a local advisory council that is made up of health care stakeholders in TN which has a set of duties among them are receiving annual COPA comment and giving recommendations on the spending of any penalties that the systems might incur in terms of their noncompliance with a number of these items. Then obviously, the Tennessee COH, the AG and the Division of Health Planning within the Department of Health. This is exhibit F if you want to look at what these duties and responsibilities lays them out. Also, part of active supervision – access and audits; we have to grant reasonable access to all non-privilege documents, staff and to the Board. Regular audits will be performed and any other deemed reasonably necessary by the Commissioner, the AG or the COPA monitor and all of these will be

paid for by the new health system.

There is an extensive list of annual and quarterly reports that are included, and you can access, and also describe in this section active supervision is the population health initiatives fund that references the local advisory council. Funds are paid into this fund for non-compliance of a non-monetary obligation. There is a list of all the types of fines that could be levied and the amounts. The local advisory council then recommends how any monies that go into this fund should be spent within the geographic service area or otherwise for the direct benefit of the population, but ultimately, the Commissioner may veto, approve or modify these recommendations.

Mr. Keck further explained,

"Now, to the index and sub-indices, there are four indices to measure our compliance with the COPA, and to measure the continuing benefits or disadvantages. Those are the Access Sub- Index, the Population sub-index, the other sub-index, and I have already talked about the economic sub-index which is based on pass/fail. So, all of those indices are added up into a final score. The first thing that we do is take a look at the economic index of pass/fail, and if you fail, then you don't get past go; right there, you essentially get a final score of zero. But, if you do pass, you then take the three indices and weight them. Population Index has the greatest weight of 50 percent; access is 30 percent, and then the other sub index is 20 percent. You weigh those individual scores, and you get a final score. You add all of that up and if your score is 85 or greater, there is clear and convincing evidence of continuing public advantage. If you are below 60, there is clear evidence that there is not continuing public advantage, and the COPA can be revoked under compelling circumstances.

Then, there is a grey area that is 60 to below 85 which is unclear and so all of the facts and circumstances in addition to the index need to be considered in determining whether or not there is continuing public advantage, and it may constitute non-compliance and it may result in some type of COPA modification from the Secretary. So, this is very important to us ,and we have talked a lot about the score mechanisms and these indices. Just to give you an idea of measurements, we have 69 individual measures that we will be scored on; 25 are in the population health sub index. For many of these, they relate to the entire population of the geographic service area; some of them relate just to the population that is managed by the new health system, but in general it is to the entire population, and I won't read all of these, but there are a number of them that we obviously have talked a lot about in this group and in the subgroup that was looking at population health.

There is sort of a graduated approach to achieving outcomes on the population health index over a ten-year period. Year one, it is primarily process related…did you make the million-dollar investment that we promised in our sources and uses document. Did you submit the population health plan, the six-month plan we talked about, and did you achieve planning measures set out in the population health plan? In year two, 25% did

you make the 2-million-dollar population health investment and then 75% for achieving the implementation measures set out in the plan; now you can see why these plans are so important. Year three, 25% for making the five-million-dollar population health index and population health investment. Sixty to seventy-five percent for achieving the implementation measures and zero to ten percent for improvement in the 25 priority measures compared to the geographic service area baseline. That zero to ten percent is left up to the secretary depending on the results of the plans that we submit; there is a little bit of range there.

Years four through seven is again if we have any implementation measures that the Commissioner believes we should be scored on in years four through seven, but potentially moves us to 100 percent evaluation on our ability to improve the 25 priority measures compared to the geographic service area baseline. So, in this time period, we are being evaluated against ourselves. Our prior performance in the geographic service area and it is the rate of change. So, for instance, if the four years before the COPA was granted, smoking was going down a half of a percent, and in the four years after the COPA was implemented, smoking was going down one percent, we would be considered successful in achieving that goal."

He continued to explain,

"In years eight through ten, there are still some components of that comparison against ourselves, but then compares us to a set of ten peer counties that are in Tennessee, and these are the peer counties that they have chosen; which have similar demographics to what we have in our Tennessee service area. The access to care sub index has twenty-eight measures that we have to either maintain or improve; they are weighted differently. I failed to mention that there are weights on the population health index also, they were not listed, but here, we have listed them. In our access plans, we have to identify what the baselines are for all of these measures. Our job during the first year is just to maintain for every measure. For years past that, we have to improve. We have to set the targets and that has to be approved by the Dept. of Health and our access plan group.

Finally, the other sub index can include a wide variety of metrics in terms of performance. It is sort of a kitchen sink category, but in this case, it is focused on all payer target quality metrics particularly focused on safety. I say all payer because there is a very large set of CMS quality metrics that we currently measure and report, and here, we have to measure and report for all payers. This particular index is made up of a performance requirement and a reporting requirement so here, we have to improve on 16 safety related measures, and we have to report on 83 other quality related measures, and again this is for all payers not just CMS, and the weighting is 25% for achieving the priority quality measures and 75% for reporting all payer quality measures."

Mr. Keck concluded,

> "So, that is the document. Todd is going to talk to you about Virginia. I pointed out some of the areas where there may be differences between the Virginia document that we originally agreed on, but Todd may have some additional information. I will take questions.

Chairman Kilgore, "before we do that, let me note that we do have a quorum now. We have had a quorum since about half way through your presentation, and Dennis are you still on the phone?"

Mr. Barry responded, "yes, I am Terry".

Chairman Kilgore, "after listening to the presentation, I know that you had a suggestion. Not just you, but you and your staff. What was your all's suggestion as it relates to moving forward?"

Mr. Barry replied,

> "That was an excellent presentation, and I very much appreciate it. Although I am really interested in hearing the differences between the Tennessee COPA and the original Virginia commitments and the revised Virginia commitments, which the Commissioner made available to Dr. Cantrell and has since been made available to everyone there, but to be candid with you, Delegate Kilgore, I, nor the rest of the staff, are comfortable with our understanding of the Tennessee document because we have not had a lot of time to read it, and we also have, I believe, some questions for the Applicants and we would like to meet with them and in light of the significant differences between Tennessee and Virginia in how Tennessee has approached this. I am not saying it is bad. I am not saying it is good. I am saying that the staff does not completely understand it right now and we would like more time to study this, talk to the Applicants about it; and therefore, our suggestion to the members of the Authority is that they direct the staff to meet with the Applicants ASAP, absolutely as quick as possible, and to analyze the differences, to assess the materiality, and to report back to the members of the Authority so that they can be fully informed in making a recommendation to the Commissioner on what the Commonwealth of Virginia should be doing with the still pending application in the Commonwealth."

Chairman Kilgore responded,

> "I think that from what I hear from the Commissioner and others, that this doesn't need to be a long period of time, Dennis. I think the word is that we just need to move and do what we are going to do, just get on it for a lack of a better way of putting it. Do you think that you could have your meeting by Thursday? Could you have your meeting with the Applicants and allow this board to come back and meet on Thursday, October 12, 2017? Do you think you could do that? Of course, we have to get a quorum by then."

Mr. Barry replied,

> "I am virtually certain the staff could do that. I don't want to speak for all of us. We may have to do some of this by telephone. Also, it would be dependent on the Applicants to find time in their schedule to able to meet not sure of their schedule. From our side, we will make that happen."

Chairman Kilgore asked Mr. Keck if they thought they could meet with our staff and they will be able to meet. Chairman Kilgore stated,

> "That sounds like a good plan. It will mean another meeting ,but I think that the deliberate process we have been taking as a Board; we need some guidance here because after looking at just the slides, I had some questions, and I know some of these questions are why we have our staff to address some of these questions regarding population health and some of those metrics you are going to be working on. I have decided I would need a math degree to figure out some of those pass/fail grades."

Mr. Mitchell said he had a recommendation. Chairman Kilgore asked what his recommendation would be.

Mr. Mitchell stated,

> "The next presentation was going to go through the changes in the Virginia commitments and where we are in the process. I would suggest that we ask the Applicants to save that comparison of the difference in the Virginia commitments to the next meeting if that is what you are going to discuss and maybe give just a quick set on where we are in the process so everyone can understand that really what I think the Authority needs to focus on is getting a response back to the Commissioner to keep the ball moving and that there will be a meeting on the 12th."

Chairman Kilgore asked, "could you help us with that Todd?" Mr. Norris responded, "thanks Tony for doing a great job with that presentation.

Chairman Kilgore agreed the presentation was very detailed and appreciated the information. Chairman Kilgore asked if the presentation was going to be available.

Mr. Mitchell stated that it would be on the website.

**C. Review of Revised Virginia Commitments**

Mr. Norris stated that he was not going through all of the slides. He said,

> "Just the first couple slides and you will see when you look at this and you may already have looked at this if you have studied the Virginia commitments that you worked so diligently on last year, there are a lot of similarities between the Tennessee and Virginia commitments, but the level of detail is different. But keeping that in mind, I think the main difference in our updated commitments are the payer pricing commitments, and as we reviewed them significantly, we saw a lot of similarities between the two. I think

> what we want to focus on here primarily is what is left to be done? So as Tony mentioned, we got the approval from Tennessee on August 19th, 2017. We anticipate because we have submitted some additional information to the Commonwealth, that they may need to up to the end of October to approve or deny the application. Then we have committed to the FTC post approvals from both Tennessee and Virginia a 30-day review period by them. That will take us through November 30, 2017 or so. Remembering that we had 90 days in the Tennessee document to close post approval with the potential of another 30 day or so extension and that takes us through 12/18/17 or so without the consent and through January 31st, 2018 with a possible extension. So, there is a lot to be done in this time frame. So, you can see that it is very important because of that 90-day period in Tennessee that we move forward as carefully and expeditiously as possible in the Commonwealth."

Chairman Kilgore, stated "that is what I understood that is a set time period in which we need to act."

Mr. Norris stated, "and we are committed to do whatever we need to do to make it happen working with your all's schedule. I think this is far as you wanted me to go with the presentation?"

Chairman Kilgore agreed,

> "I think with our staff, they are going to want to meet with you all on the commitments and that may change a little bit as we move forward. So, I think that is probably the best way to go today."

Mr. Mitchell said, "Mr. Chairman, as Dr. Cantrell pointed out, we will circulate both presentations if that is ok for people that want to see the differences can pick those out and they can see the highlights."

Chairman Kilgore stated that would be fine. He said,

> "So, unless there is any discussion on this. Is there any discussion on this? Does everybody think this is the right approach. I just don't want us to rush into something today and not feel comfortable about it. I think it is good and that is why we have our staff to make some recommendations; of course, we relied on them a lot during the process of weighing the benefits of the advantages and looking at the disadvantages. I think we should rely on them to help us work through the TN COPA and what we need to look like in VA. Does anyone on the phone have any other comments?"

Ms. Henry stated, "So it sounds like we are going to reconvene the entire Health Authority on October 12th, 2017. Did I understand that correctly?"

Chairman Kilgore stated, "yes, I don't know any other way to do it Chancellor Henry and meet some of the requirements and deadlines."

Dr. Henry stated, "No, I agree. I just wanted to confirm that I had the right date."

Dr. Tooke-Rawlins said, “after hearing the talk, I just feel like we really do need to have time to study this and to get answers to questions we may have”.

Chairman Kilgore stated, “that was my thoughts too. So that is what we will do. What I would suggest we do is have a recess to reconvene meeting on October 12th, 2017 at 3:00 p.m. at the Higher Education Center.”

Dr. Cantrell had a question about the presentation. She said,

> “Did I understand when you were talking about the population health metrics and how you were going to look at those and I think I remember if we saw a ¼ decrease in smoking cessation that went to a full one percent decrease by year four, that we are looking at a rate of change and not the absolute number?”

Mr. Keck responded,

> “Yes, in years four through seven in each comparison, it is by rate of change. A good example on any asp erg? Since our region is so much higher than any other comparison we could find, if it was sort of a raw comparison, it would essentially fail from the start. We want to see that the COPA intervention is reasonably, the reason that certain numbers improve and so they are using a rate of change. So, a rate of change is better to measure against ourselves than it was in previous years when we were being compared against Tennessee comparison counties. It is the same rate change.”

Dr. Cantrell asked,

> “So, are you looking at an acceleration in rate of change? Because if you have a quarter percent decrease before anything was done that went to a full percent? So, I guess the final question is being they going to (normally those are reported out as absolute metrics and not as percent’s rate of change). It is going to be a little bit different to interpret that, and are you looking at the COPA accelerating a rate of change or just maintaining a baseline rate of change that might have been there to start with?”

Mr. Keck responded,

> “It needs to accelerate it beyond the comparison, so the Tennessee Department of Epidemiology spent a fair amount of time surfing over what they are going to have to do in terms of over sampling, so I am sure there are some methodology issues that they will need to work through. If you look at the document it is very specific about where the sources are, and they have indicated where some new sources might have to be developed.”

Dr. Cantrell thanked Mr. Keck.

Chairman Kilgore asked, “are there any other questions?”

**V. New Business**

No new business.

**VI. Announcements**

The Health Authority reconvened session and will meet again on October 12th, 2017 at 3:00 p.m. at the Southwest Virginia Higher Education Center – Rooms 103 and 104.

**VII. Public Comment**

There was no public comment.

**VIII. Next Meeting of Authority**

Chairman Kilgore asked for a motion to recess until October 12th, 2017 at 3:00 p.m.

Senator Chafin made a motion and Dr. Cantrell seconded the motion. The motion passed unanimously.

Chairman Kilgore asked that the Authority thank Mr. Norris and Mr. Keck for preparation for the presentations. He knows it took a long time to prepare all of their slides and to go through the document, but the Authority appreciates their hard work. He thanked everyone on the phone and his staff, members from the FTC and AG's office and members for attending.

**IX. Adjournment**

Meeting was recessed and will reconvene on October 12th, 2017 at 3:00 p.m.

_____,
Chairman, Terry Kilgore