Southwest Virginia Health Authority
Minutes of Meeting
April 13, 2016 at 3:00 PM
Southwest Virginia Higher Education Center, Room 222
Abingdon, Virginia

I. Call to Order.

Chairman Kilgore called the meeting to order at 3:04 PM.

II. Roll Call.

Ms. McFadden called roll. Ms. Copeland, Mr. Mosley, Dr. Cantrell, Mr. Carrico, Ms. Welch, Mr. Leonard, Ms. O'Dell, Dr. Henry, Mr. Kilgore, Mr. Horn, Mr. Chafin, Dr. Tooke-Rawlins, Ms. Ward, Mr. Vanover, Dr. Counts, Mr. Prewitt, Mr. Neese, Mr. Mulkey and Ms. Crowder were present.

Dr. Rheuban and Dr. Sarrett were present by phone.

Mr. Givens, Mr. Perdue, Mr. Mosley, Dr. Mayhew, Dr. Wieting, Ms. Baker and Dr. Means were absent.

III. Declaration of Quorum.

Chairman Kilgore declared that a quorum did not exist at the beginning of the meeting and no business was conducted until a quorum was established. Mr. Chaffin was on his way and voting on business items were postponed until a quorum could be established. Mr. Chafin arrived at 3:10 p.m. Chairman Kilgore declared a quorum.

IV. Approval of the Minutes of the January 7, 2016 Meeting.

The Chairman noted that the minutes had been distributed.

Senator Carrico made a motion to approve the minutes of the March 15, 2016 meeting as distributed. Mr. Neese seconded the motion and the motion was unanimously approved.

V. Presentation of Application.

Mr. Tony Keck the Senior Vice President and Chief Development Officer of Mountain States Health Alliance ("**MSHA**") and Mr. Todd Norris Senior Vice President for System Advancement of Wellmont Health Systems ("**Wellmont**") presented a presentation on the application to the Board.

Mr. Keck started the presentation, asking Chairman Kilgore how much time they had to present the application to which the Chairman responded "to take as much time as needed to review the application." Mr. Keck announced that Ms. Jennifer McGrath was also present and would do a live search of the application if Board members have any questions.

Mr. Keck stated that "if we do not know the answer, we will go back and try to find the answer but there are a lot of things that we are unable to answer." He noted that there were a number of things that the applicants could not answer. He reminded the Board that the Applicants are still competitors and there were certain things they could not talk about yet. Also, he noted that some issues had not been decided yet. He stated "this is usual because we are asking to merge two health systems. Mr. Keck stated that we will actually be making an investment in the future in public health and making commitments in the future, meaning everything will not be answered. Mr. Keck stated the process indicating that more would probably be heard from Mr. Norris as it will be a change in how the entities do business. Mr. Keck stated that all of the Authority members have been involved in making changes in health care and sometimes they are decade long processes. As we go through the presentation, we will talk more."

Mr. Keck started his presentation by noting in April 2014, MSHA began a strategic options process to look at its alternatives to fulfill its mission indicating they sent out 22 requests for proposal to organizations that might be interested in merging or partnering with the health system in which they received nine proposals back. One of those responses was Wellmont. Mr. Keck continued, stating that a year later, Wellmont and MSHA entered into a process to extensively explore a merger. Mr. Keck noted that the health systems recently announced that they had signed a definitive agreement to move forward with a merger.

Mr. Keck noted the parties decided to move forward to merge for a number of reasons. He stated that the continued local governance of the system as opposed to margining with an outside system was important. Local leadership would allow the system to keep regional focus and integrate our health system in the region. The merger process will create an enforceable set of commitments to work on public health issues that were critical in the areas and to keep hundreds of millions of dollars in this region as opposed to a corporate office in another state.

Mr. Keck noted that the proposed merger is not the traditional merger approach, he said "there is a history of competition." He reported that the merger is contingent upon granting a letter authorizing a Cooperative Agreement from the Commonwealth of Virginia and in the state of Tennessee a Certificate of Public Advantage. Mr. Keck stated that this merger would not be possible without the Certificate of Public Advantage and COPA would provide us. He reported in February 2016, the Applicants submitted a 150 page application to the Commonwealth of Virginia and the Exhibits are about 4681 pages exactly. About 1500 pages longer than what was submitted in the Commonwealth of Virginia because the State of Tennessee laws are a little different. State of Tennessee asked for additional information.

Mr. Keck stated that the geographic service area of the proposed system was in section five of the application and includes 21 counties in the Commonwealth of Virginia and State of Tennessee. He said there was very little market share in Kentucky and North Carolina because they have no facilities there. The 21 county areas is the Commonwealth of Virginia and Sate of Tennessee and everybody in the 21 counties in the new system would be subjected to the agreement which is an overwhelming majority of the population.

Mr. Keck stated that the application was assembled according to how the legislation and regulations were written. Mr. Keck said his presentation would follow the five working groups of the Authority but there was a lot of overlap in these five areas and topics may show up in several locations.

Mr. Keck started with reducing the cost burden. He stated that they took the charge of the working group to make sure they understood. The charge includes but is not limited to reducing health cost, accountability of cost of care, and reviewing cost efficiency in the application. Mr. Keck stated that there is a high cost of health care in general and in our region. The integrated care increases cost and increases overall effectiveness of care.

Mr. Keck stated that the merger offers the opportunity to create a regional delivery model that de-duplicates some of those resources and increases the use of other sources that will increase utilization of inpatient care. Mr. Keck stated how they plan to do it which were exhibited by bullet points from the application that try to point to specific areas in application or to certain exhibits. He requested that the Board, call or write if you have specific questions in a working group.

Next, Mr. Keck addressed how they plan to reduce cost. He stated the first thing is to reduce duplication.

Chairman Kilgore asked if they would be able to get a copy of the presentation to which Mr. Keck responded yes.

Mr. Keck proceeded by stating that a few ways in reducing duplication is that MSHA and Wellmont have services across the road from each other, reducing duplication in facilities and staff are just ways to reduce the duplication. Mr. Keck stated that good example is if your competitor buys a shiny machine, you have to buy one. He stated they are in an arms race in terms of capital purchases, we have places where we have the same services across the street from each other stating that we can combine those services into one and same in overtime costs.

Mr. Keck stated that reducing duplication, having services in the community, a protection we put in place as an alignment policy is on exhibit 12.1 pages 35-36 of the application. He stated that it is a policy that was agreed upon by both organizations and is referred to in the bylaws as the "new organization," which is a rigorous method that the system has to go through in consolidating services where the community may be without certain services. He stated that during the first two years of the merger, a super majority vote of the new health system Board would be required to make those decisions. Mr. Keck indicated that if you read the policy in exhibit 12.1 it requires a special committee made up of physicians and other members of the new health system analyze every consolidation opportunity and recommend to the Board whether or not that is in the best interest of the community and the new health system. He stated that it is a process way above anything that exists now. Mr. Keck stated that we do not have anything like this in place now and that the Authority is aware of times before where services have been removed from the community.

Mr. Keck proceeded by stating that we are going to focus on hospital use services, equipment and inpatient services from enabling a combined-based care to a value-based care. For example, MSHA would participate in a Medicare shared savings program and Wellmont would not participate. As a Medicare recipient, it does not allow good care management of that patient. It allows hospitals to better manage, right now we have our hands tied behind our back. He stated that patients will still have the choice of which doctor or hospital, but will be in a directed shared management system to better manage their care. Wellmont will be able to share in these savings. Everyone will be able to share in the savings without fear of competition.

Mr. Keck stated that we made pretty specific commitments about how we will control cost, these are enforceable commitments. He stated the mechanism the state will chose to use, MSHA and Wellmont will have enforceable commitments. Mr. Keck indicated that MSHA and Wellmont are allowing the Commissioner of Health to monitor what we are doing what we say we will do while having recourse if we do not do what we say in the application. He stated that he can go through it in more detail if you want, but we take this serious and we think the Department takes it serious. Mr. Keck stated that we have to give our separation plan to the department and if we don't live up to the application, they can revoke our Cooperative Agreement then we would be subject to the FCC's review and dissolution.

Chairman Kilgore asked if questions were allowed at this point.

Mr. Mitchell asked whether there would be consequences if commitments were not met. Mr. Mitchell asked if there was anything about how this accountability would be enforced.

Mr. Keck stated, in response to Mr. Mitchell, that the plan of separation is in place where systems have come together and worked out some agreements, then not lived up to those agreements. Other authorities have such parties that are not living up to those agreements and the parties have said, "Oh we have already merged and there is nothing we can do about it now."

Mr. Keck stated that in both Tennessee and Virginia, the states have been very focused on having a plan of separation so that if the applicants are not honoring those agreements, there is a plan of how the systems can separate. He stated that short of this option there is all of the public reporting that has to be done. "We have to publically report on how we are performing. We have a lot of interaction with legislatures, business and community leaders. We will report to the public how we are living up to our agreements. More strongly, he indicated in Virginia, the Commissioner has the authority to require a corrective action plan, so as we give our annual updates on how we are performing on our commitments, if the Commissioner determines that the benefits are no longer in line with the advantages or certain commitments are not being met the Commissioner has the ability to require us to submit a corrective action plan. If that corrective action plan is not to the satisfaction of the Commissioner, then they can remind us of the next steps needed to move on."

Mr. Mitchell asked if there are any sanctions.

Mr. Keck stated that there are not any sanctions, there is no financial punishment.

Senator Carrico asked so how do you measure that performance? You are starting out new so how do you measure performance?

Mr. Keck stated that there are two types of commitments. One is a conduct commitment that says the Applicants will engage or not engage in this type of behavior and it is simply a yes or no response. Another type of commitment that says, we will spend a certain amount of money. The third performance says that the community perceives certain results. Mr. Keck stated this process would show how the process works. Mr. Keck noted that when Mr. Norris speaks about the community health improvement, we will give you a very detailed proposal about how we think we should do that. "It is very detailed proposal on how we think we should do that. There will be a lot of conversations about whether this all makes sense in both states as to whether it is strong enough and detailed enough, but this is our first shot" he said.

Dr. Tooke-Rawlins asked that if the Applicants meet 60 % or 30 % of the commitments is that overall the whole commitment or is the range for just one individual commitment that is 60 %?

Mr. Keck answered by stating that we suggested there is a range that is weighed that tips off certain actions and if we are above a certain percentage, we are in a passing range. If we are below a certain percentage, it immediately kicks us into a nuclear option and in between, it kicks us into the correction action.

Dr. Rawlins asked, If the current standard for passing is fifty percent?

Mr. Keck asked MSHA legal counsel to answer.

Mr. Mitchell asked, do you know what the grade is for passing?

Ms. McGrath responded, "There will be conversations about this."

Mr. Neese stated, on page 126 of the application, the current plan is that as long as you are meeting 50-70% then there is definitive evidence that you are meeting benefits. As long as you do half of what you say you are going to do, then you are in compliance.

Mr. Keck said that is the proposal. Mr. Keck stated "we can set it up throughout this entire process in both states that there will be a negotiation that occurs on all these things not just this. What programs we decide to work on and what prices levels we set, etc. and we both have to mutually agree whether we can live with that. So, that is our current proposal."

Mr. Neese asked about the 50%, is there a breakdown as to your compliance as it affects SWVA or the rest of the system, or is just a compilation where you could be meeting everything in Tennessee side but not coming close in Virginia?

Mr. Keck stated that Applicants assumed that the two different states will be independently evaluating the performance, so, Virginia will obviously be concerned about Virginia and Tennessee about Tennessee. "We hope that there will be conversation between the two states because we have a lot of border issues where we share resources. I think it will be state by state" he said.

Mr. Neese asked about the twenty five million dollars annually. Do you know what percent of that will be in Virginia and what percent will be in Tennessee?

Mr. Keck stated that they did not know. "We took our data and put against national averages and that is why it is shown as conservative. If you look at the breakdown of who is there, most all of the top positions are in Johnson City, Tennessee and Kingsport, Tennessee. There is a lot of folks that have the same job. It requires sitting down together to get a lot done. That is about as definitive as I can be."

Mr. Norris stated that if the Board just focuses on that, it misses the investments. He added "we are going to be reinvesting in the region over a given period of time. This reinvesting will allow us to strengthen certain areas and grow. The other side of that is the economic development opportunities is strong and much stronger to do that than other options that would cause shrinkage without the reinvestment. Mr. Norris asked that the Authority keep the reinvestment in mind as you review the

application, the reinvestment will create jobs, opportunities and will shift positions. It is very important that you keep that in mind."

Chairman Kilgore asked that people asking questions to identify themselves for those folks on the telephone.

Mr. Keck stated that the money will be staying in the region and being invested in the region.

Ms. O'Dell stated a concern that the twenty five million dollars savings would be on the Tennessee side and the application doesn't address those concerns.

Mr. Keck stated that right now, there is no guarantee as to how anything is going to go forward in either Tennessee or Virginia. "We know what services are in communities and there are no guarantees as to how this will happen." Mr. Keck stated in South Carolina, a hospital in the small town where the Governor was from closed.

> He stated that "there are other hospitals getting ready to go under. So this change is happening and it is happening now. We are not immune to it. Mr. Keck indicated they do not exactly know from the state because of the legal processes that we want to go through to actually make the best decisions on where the programs should start. We don't know the answers to all of that now. He stated that want to commit to processes that give enough of the global view of the region that the disadvantages of the merger will far outweigh the advantages, but also the processes that are in place far better than today that can make you comfortable that the community is going to be involved in making these decisions. Mr. Keck indicated that it is going to be based on our region and won't be based on the old ways of doing things or politics. That is about the best answer I can give you. MSHA and Wellmont understand the task ahead."

Dr. Tooke-Rawlins stated that the Applicants mention on page 73 that there are hospitals the Applicants use for training: Bristol Regional Medical Center ("**BRMC**"), Holston Valley Medical Center ("**HVMC**") and Johnson City Medical Center ("**JCMC**").

Mr. Keck stated that these are the three largest hospitals. None of these are physically located in Virginia, but at least 50% of the volume that goes to BRMC are from Virginia. Mr. Keck stated HVMC also has a very high percentage of Virginia folks. He stated that right now Johnston Memorial Hospital sends folks to JCMC and bypasses BRMC because they are competitors, so this would help with this type of merger. It would improve patient care as patients would be going to a closer hospital.

Dr. Tooke-Rawlins noted that the Authority represents Virginia. "You are putting the boxes here that this is what you are committed to. When I look at the boxes, I do not feel Virginia. I don't see Virginia hospitals and I don't see Virginia education institutions and those are things that I think when we are looking at the application as being complete, there may need to be answers. It may not be that we are keeping these hospitals and not this one, but I think if you could commit to keeping at least so many acute care hospitals open in Southwest Virginia, I think that kind of statement would at least provide some assurance to the commitment to Southwest Virginia as well as Tennessee" she said.

Mr. Norris stated that they are committed to keeping all the hospitals open for at least five years and then to keep access available to communities past the five year period not focus on the old patient model, we need to find primary medical homes, improve mental health, access long term care needs and specialty care needs. He said that all that is difficult to envision five years down the road. He said this does speak to Virginia even though it is not specifically stated as Virginia commitment.

Dr. Tooke-Rawlins stated that knowing where the acute care facilities will be located and having that knowledge though not exactly, but just that they will exist as we are looking at the other sections of the application. There is a lot of information that is lacking in all of this.

Mr. Keck discussed the commitments to access to care. He noted that all but two of the rural hospitals are located in Virginia. Rural hospitals are bringing in money and will keep them open for five years.

> "We are trying to reassure you that there will be access in the community. The whole point of this is to expand services. It is not to keep hospitals open, but to keep the right health care at the right place. The world is shifting to an out- patient environment. MSHA and Wellmont have a billion dollars' worth of bonds to pay. If we are not making smart decisions about our hospitals, folks will not have the access that they need. It is not about hospitals but about health care services. The right services at the right place and at the right time through out-patient services and telemedicine. There are a lot of different ways to make that happen."

Mr. Norris noted that the Authority asked about academic institutional relationships and stated we have had a lot of discussion about that and decided not to because there are so many of them. Mr. Keck stated that East Tennessee State University is mentioned a lot in the application because it is located in the Tri-Cities and MSHA and Wellmont has a relationship with them. He stated they also have relationships with many other institutions in Virginia as well but they are not reflected in the application, but because they are not mentioned in the application does not mean they do not exist. Community health improvements efforts and our ten year plan reflect our Virginia relationship with the academic institution that we are partnered with.

Mr. Mitchell asked how many academic relationships do you have running through Johnston Memorial Hospital.

Mr. Keck replied that there are 18 based in Virginia. The twenty five million dollars could expand academic research and we are very clear that we need to do that for the benefit of Virginia and Tennessee.

Chairman Kilgore stated that a listing of those academic partners would make the Authority more comfortable.

Mr. Keck stated that in the application, there is not a specific reference to retaining a certain number of jobs, but there is reference to reinvestments. The twenty five million dollars in the next decade will make a substantial investment in the communities. So the programs will increase pediatric services. He stated the money is being reinvested into new programs where the market has never had these programs. He stated that research and academics is so important.

Mr. Neese stated that most if not all hospitals have their local board of directors. Some are owned by the system and some are operated by the system. He asked, "If a hospital or facility or service is looking at being discontinued or repurposed, how much influence or authority is made in that decision will the local board have vs the system board?"

Mr. Keck said each hospital is different so some are wholly owned and some have partnerships either sides have certain rights in regard to certain actions. It depends by hospital. He offered to get a list of the hospitals and their rights. He said "certain rights are reserved to MSHA and certain rights are reserved to the trust of the hospital, but it is different hospital to hospital. I don't know exactly what those are, but we can provide that."

Mr. Neese asked, "whether the local board would make a decision or whether the decision be forced down upon them? Basically, will the board have input?"

Mr. Keck stated that the board has certain rights, but I don't know hospital to hospital. Some might have more say than others.

Mr. Tim Baliles, an attorney with MSHA, stated that when MSHA and Wellmont make a decision without listening to local boards, they are often not the best decisions. He stated "hopefully, the Applicants have learned from that and would not repeat the bad experiences that would happen." "It needs to be best for the hospital and the community. We are talking more about moving more towards a system that is geared to what is in the best interest of the community and less to what is in the financial interest of a corporation," Mr. Baliles said. Mr. Keck noted that Mr. Baliles was referring to the alignment policy in Exhibit 12.

Mr. Keck stated that some of these checkboxes can fit in other categories. In reducing cost, we look at how we can get certain commitments as it relates to checking the box. Did we do it or did we not do it? Some of these can fit in multiple categories.

> He stated in terms of reducing cost, one of the most important commitments we make is to the payers, the employers and the insurance companies and what we have done here is we have suggested that for all principal payers, and that is any payer that has more than two percent of our revenue, the new health system will reduce existing commercial contracts their fix rate increases by 50 % the first year of the contract following the first full year of the merger. Within the first year, it puts in a rate reduction on a negotiated rate. So it automatically lowers the cost to more than it is now. He further stated that talking about bending the cost curve for subsequent contract years, we will commit to not increase our hospital negotiated rates by more than the hospital consumer price index which takes into account inflation rates for hospitals of 2.5 percent and we will always stay below that. Same thing for physicians and out-patient services. So these are two important components when combined give us a clear rate reduction because we have negotiated those rates already. Mr. Keck indicated that they know what we are going to get in two years from now. The third is for all principal payers will endeavor to include provisions for improved quality and other value based incentives. He stated that they

cannot force payers to start to pay us based on quality performance, but we will actively seek out finding payers that will pay based on that. The next is that we will negotiate in good faith principal payers to include the new health system, health plans that are offered in our service area on commercially reasonable terms and rates and that we will agree to go to mediation if we get any disputes in the health care contract. So that is something that is new. He stated they do not say that when we have a disagreement with a payer that we will go to mediation now. Most of the time, we just go our separate ways. So that is a new additional bar for us to reach a reasonable agreement with the payers. Mr. Keck indicated they will agree not to be the exclusive network provider to any commercial Medicare managed Medicare plan. Meaning that we will not just agree to work with one payer or another. Thereby, pushing out other payers in the system. So this is how the conduct commitments will work, but we will discuss in more detail later. In terms of improving health care quality, a lot of what we have suggested will ultimately improve quality including some of the things we just talked about in cost containment. He stated they believe if you get paid based on the quality you achieve, then your quality will improve. Mr. Keck indicated that they actually have very high quality health care in the region, it is not always evenly distributed, but we think to enhance the quality of services, we are willing to commit significant investments of time and money to improve patient outcomes faster than we believe they would improve without the merger. The three that we think are important are promoting collaboration and utilization of technology specifically adopting a common clinical IT platform. Mr. Keck continued by stating that a lot of bad care is delivered because we don't have the right information at the right time and we either make decisions that are not fully informed and duplicate services. For instance a lot of duplicate imaging happens because somebody shows up in the ER and an imaging is done when they have had one someplace else maybe at another ER or at an outpatient diagnostic center and if we just had access to that imaging then we would not have had to give them exposure to additional radiation, just a very common example."

Mr. Keck stated that the next is to establish a physician led clinical counsel. This was actually approved last night at the Joint Board Task Force. The general structure of this counsel. Essentially, it is based on what best practices from high quality systems around the country that will take a more active lead. Mr. Keck stated the third item is to implement a system wide quality reporting that goes beyond just the traditional reporting that we have to do for the government, but is much more transparent and much timelier than the government system that we currently have. He stated they would commit to reporting a broader range of statistics in a timelier manner than you can currently get if you go to healthcare.gov. Public reporting is a pretty powerful tool for improving quality.

Mr. Keck stated that our commitment is that we will adopt a new IT platform as soon as reasonably practical after the formation of the new health system. He state they will collaborate with independent physician groups to develop a local region-wide approach to clinical networks to share data, share best practices and improve outcomes for patients overall health in the region.

Ms. Welch asked how a public reporting system is holding you accountable other than pitch forks and torches. What can the public do in a rural based community?

Mr. Keck replied that even more so in a rural based community the hospitals are closer and more responsive in many cases to rural communities because the community is more involved and more tightly knit.

> He stated "if you think about public reporting in terms of the type of people you attract to the organization, if you think about the fact that we will have a more prominent market share of the hospital business and that around a third of the people that leave the region for inpatient care is important. More and more hospitals are competing with doctors. They are competing with diagnostic centers; there is a lot more competition to the hospital than just other hospitals. Mr. Keck indicated they certainly compete with other hospitals in other states, more and more there are facilities, physicians and apps that compete with us. If people don't believe that we have high quality, they will go other places. Now that is not the only way you improve quality. It is just one way and that is why we have got a series of things. Mr. Keck stated that he spent a lot of time in South Carolina publically posting financial performance and quality performance of our hospitals and nursing homes and federally qualified health systems and it made a difference. I knew it made a difference based on how much the people that run those organizations would scream that I was doing that because it made a difference in their bottom line."

Mr. Norris stated that it makes a difference within the health system organization because people are judged and/or rewarded based on quality too. "Right now, people have to go looking for this information because it is kind of hidden. We know where to find it, but does the average consumer know where to find it?" Mr. Norris said that the Applicants are telling the hospital presidents and other leaders that quality metrics will be posted on the internet ahead of current reporting to CMS. The public will have the opportunity to find the information faster. Mr. Norris stated that the motivation would be to drive quality within the organization, but I think in and of itself, the transparency doesn't necessary result in improved quality, but the ramifications to the transparency absolutely drives change.

Dr. Tooke-Rawlins asked, "Is your quality improvement circle for lack of a better word, and is it closed at the hospital level? Or will it be closed at the system level when referring to methods to improve. Just wondering how that is driven?"

Mr. Keck said that collaboration with independent physician groups will develop a local region-wide clinical service network and share data and best practices. He said there is a lot of working going on nationally where physicians, hospitals and other organizations are banding together to form clinically integrated networks that are designed almost solely around improving outcomes.

> He stated that as the system, they would commit to help develop one of those and to get the participation that we would want, we have a lot of physicians including a lot that of large physician practices that don't have to participate in a network like this so we would have to make it attractive to them. This would be one of our contract commitments of yes or no, did

you pull it off? It is a much broader view than just the hospital. The clinical counsel also takes a much broader view than just the hospital.

Ms. McGrath directed Mr. Keck to page 75 where the Applicants will be reporting a lot of the quality measures by facility; so not just the system. He said "these clinically integrated networks are really producing some compelling results and so we think it is important to connect to that.

Mr. Keck stated that he was just in Greenville looking at their health systems last week with a few folks from the region, they had a clinical care coordination institute so people were coming from all over and we spent some time with their system and they have formed a clinically integrated network that has 1,500 employee physicians, 800 independent physicians belong to it and nine hospitals half of them owned by Greenville and half of them owned by an affiliate to Greenville. It is powerful so that is one of the things we commit to in our proposal."

Someone on the telephone asked about the investment of one and half billion dollars and what are the two electronic medical records currently being used by the hospitals. "Do you anticipate a new EMR for the new health system?"

Mr. Keck responded that one hospital just went to EPIC and all scripts shop. "We do anticipate that we would put out a RFP for some type of common clinical platform. What that would look like and what the technology solution is, there are different ways that could happen. We could all go to something completely new. Mr. Keck indicated they could switch from Serner to all EPIC or from all EPIC to all Serner. There is a lot of new technology that allows you to lay new technology over different systems and actually create useful clinical information. We have a functional team that is looking at that right now and part of that includes putting together the RFP for once we would close we would send that out and see which technology best fits our needs" he said.

Dr. Rheuban stated that UVA has spent a lot of money on EPIC as has a lot of health systems as well as the additional phases of EPIC which we like very much. "I would ask that you consider inoperability when you are evaluating platforms" she said.

Mr. Keck stated that advice is very much appreciated. He said there has been a lot of conversation on this particular item as it is not inexpensive. We will participate in health information exchange ("**HIE**") with community providers. We do have information exchange that is not fully operational, but is operating in the region right now with one partner. There are other ways of doing this, but we will participate in a HIE so we can communicate in and out of the system. Then each year, we will establish priorities related to quality improvement and publically report these. We will set annual goals.

Mr. Keck stated that "when you set annual goals and you don't meet them, guys like Jeff Keeling call us up and ask why you didn't meet your goals. So, it becomes more of a reason to perform. Nobody that works for us wants to be identified as providing poor quality. So, we think those four things are important contributions to health care quality. Like I said, there are others in other areas, but these are the four that we have agreed on."

Mr. Keck reported that:

> "one of our biggest commitments is spending over a billion dollars over ten years pursuing new specialty services that otherwise wouldn't be attainable in the region or currently not in the region. That breaks down to about nine hundred and fifty million dollars in behavioral health and forty five million which are the first two on that list and forty five million dollars on specialty services with outpatient services. We have some needs for pediatric services and pediatric subspecialties in the region. People still need to go outside the region to get these services. We have problems with prenatal care and we have pockets where we do not have prenatal care being delivered effectively and certainly with addiction recovery in community based health services and this is a nationwide problem and that is why we think it is so exciting because we think we can actually leap frog from what a lot of other communities are doing and increase the access points for these services. In all of this, we intend to do as much as possible with providers that currently exist in the market. Mr. Keck stated that we are not interested in inventing services and running or owning a lot of services, we are much more interested in finding the organizations that are doing these things well but don't have enough funding to reach all the folks that we need to reach and invest in their services. A lot of what we are talking about here and in some other sections is about partnerships. It is truly about reinvesting in the community, not building a new massive behavioral health section and getting into the mental health business. We don't need to do that. There are folks in the market that do that very well, but for whatever reason (maybe because we are not medicare expansion state), we are not able to reach as many people with these services."

Mr. Keck continued by indicating the work that is being done with telemedicine is really impressive. We have a team at MSHA that spent a lot of time in North Dakota who is one of the countries' leading telemedicine innovators because they are so spread out and they have an incredibly active robust telemedicine service there. They are reaching people that are 100 and 100's of miles away for all sorts of different specialties. We currently do have some telemedicine capacity, but they are located in pockets. Mr. Norris can speak to Wellmont's telemedicine which I am sure is the same, but telemedicine does hold a very big promise for a region like ours where the distances aren't so great, but the time to get to those distances are very long.

Dr. Rheuban, who is over the telemedicine at UVA, stated they would welcome the opportunity to continue our collaboration by providing access to services to specialized services. They have over 400 participants in their telemedicine program from nine states. The telemedicine program is licensed in Virginia. We welcome all collaborations and the opportunity to provide resources. We have connection to thirty sites in Virginia.

Mr. Keck stated that he appreciated that and it goes back to partnerships and collaborations. There is a lot of specialties that our region just can't support because of the volume and we have to either heavily subsidize to the tune of several hundred thousand dollars per physician or we can tap into places like UVA and other organizations that exist in our region to buy the amount of time that we need for specific specialties and that might be a better use of resources than trying to bring someone here and them not be busy enough. So the full continuum of these services is important.

Dr. Sarrett asked what the vision is for academic partners and are you currently hosting GME supported residency programs. "Do you have a chief academic officer or are you thinking about hiring a chief academic research officer?" Just that whole arena of training and how that is addressed.

Mr. Keck stated that the Applicants both do have a fairly robust residency program some which they fund above and beyond the cap. It varies widely largely by facility. We have considerable other training programs outside of graduate medical physician training. We don't have a MSHA a chief academic officer, the programs report to our chief medical officer.

Mr. Norris stated that there is an opportunity to draw research opportunities to the area where we do not have them right now. "I think we are going to see a new kind of model develop. We will be partnering with a lot of different institutions in a very collaborative model and that is going to be very attractive to national grant agencies and government research organizations and others. So, I think as we start focusing on some of the really tough community issues that are worse in our region than in any other part of the country that we will be able to develop research that converts to very practical applications and will be attractive to a lot of people. The idea is to develop a very cohesive model, but we haven't identified what that model will look like" he said.

Dr. Sarrett said that he was looking at the oral health/dental health mission and noticed there are eight dentists that are independent so it looks like you don't currently have on staff any dentists or oral surgeons. I assume that the ER visits for dental can't be solved in the ER and they need dental care. I think the blueprint for the SWVA Health Authority includes a focus on oral health and I didn't see a lot of that there. Also, I would add that medical residencies are capped, but dental residencies are not capped federally. He encouraged the Applicants to examine the situation.

Mr. Norris stated that dental care, was being discussed. "We know we have folks showing up in the ER because of oral care issues that are beyond what the ER can take care of and they become emergent. We believe that we can affect some good collaborative models with FQHC and health departments and other partners although we don't deliver those services directly ourselves. It does relate to the overall health of the community and is important" he said.

Mr. Keck stated that one of the work groups of the merger discussion process is research and academics and it included a wide swath of folks from different institutions in the immediate geographic region and I think ETSU has finished this community work group project and they have finished their first draft of all the community work group reports and there will be a report coming out about what one possible model of this research/academic enterprise could look like in the future if we work collaboratively and have the dollars that we are proposing putting into the system to expand those programs.

Dr. Tooke-Rawlins stated that she wanted to point out that the access to care committee that the access and quality are closely tied. She stated that a question that does still come back to us is the access in Virginia to acute care, because it is a long distance if you go into labor from Lebanon to get to Bristol and those kind of thought processes" she said. "I am sure those are in your thoughts and plans, but they are not in the commitment that there would be some type of acute care. I think that would go a long way in answering questions that there would be some type of acute care in those facilities in Southwest Virginia."

Mr. Keck asked, "are you specifically referring to ob/gyn and just general?" "I think Ob is an example of something you can't deliver by telemedicine. I think acute care facilities on this side of the state is of interest to us from the standpoint of economy, jobs, from academics and patient care; that whole realm. I think it is something that we don't have an answer to."

Mr. Keck stated that the Applicants needed to bring people together and it may take two years to figure out. He said that is why the Applicants have these timelines of two years and five years.

Dr. Rawlins stated that she thinks the Authority are just wants something general that there will be acute care facilities.

Mr. Keck stated, "I hear you."

Dr. Cantrell mentioned with the Ob/Gyn, when the Authority looks at hospitals that closed and the Ob/Gyn doctors that left, you can watch the early entry into prenatal care and the individuals receiving prenatal care numbers just go down and that is tied to that.

Mr. Keck said that the problem encountered is not enough deliveries which leads to poor quality. "So how do you deliver good prenatal care that is not necessarily tied to delivery capacity" he asked.

Dr. Rawlins said I can guarantee that there are a lot of babies being born in Southwest Virginia. It is a specific region question not a specific facility question."

Mr. Keck stated that the Applicants need to look at inventive ways particularly related to prenatal care to make sure that patients are not showing up in the ER having never received prenatal care.

Mr. Keck stated that the Applicants will do a needs assessment of where the three tertiary hospitals are now and for five years from now for keeping hospitals open. He stated the Applicants will review charitable care and complying with the IRS and they will not go backwards on that. He said Medicare and Medicaid, we will continue to serve those individuals without barriers. "At MSHA, we are engaged with some medicare HMOs that manage those populations and we think that is a terrific service to offer and will continue moving that forward" he said.

Mr. Keck stated that Mr. Norris would talk about this issue in one of our four proposed focus areas. "We think there is a lot of opportunity there for us to better case manage those individuals; not just their medical care but connecting them into social services and again we are not an [Medicaid] expansion state, so folks that might otherwise be eligible for Medicaid, we think we can set up a delivery system where individuals that fall into this category to help get them into care managed and hopefully reinvest those savings into serving more folks and all of this is in partnership with organizations that already exist. This is our accountability commitment that will go in our contract. So we have committed to spending 140 million, pursuing specialty services, creating new capacity for residency programs; addiction and recovery services; expanding patient treatment services in the service area; to ensure retention of pediatric sub specialties in accordance with Nicewonder Children's Hospital physician needs assessment" he said.

Mr. Keck stated that the plan is to deploy these resources throughout the region, not just simply have people go to Norton Community Hospital and further expanding pediatrics via telemedicine.

> He added "that the system would conduct a comprehensive physician needs assessment every three years and work with a community physician to help meet that need. There is fear by some community physicians that our intent would be to buy up all the physician practices in this region and that is not the case at all. What we prefer to do is help improve and support community physicians in established practices and bring new physicians into the community. If you look at how many physicians we hire, it is substantially less than most health systems. Again, these are access to care we have talked about keeping the hospitals open and maintaining open medical staff so that all facilities are subjected to the same rules. Right now, there are a number of physicians that can't work in a particular facility. For example one of Wellmont's best cardiologist can't admit to JCMC although his office is in Johnson City. That makes no sense and with the new health system, a lot of that would be eliminated. Now there are certain exemptions for pathologists."

He further added that:

> "We would also commit to not engaging exclusive contracts for physician services except in certain hospital based services that won't require that independent physicians practice exclusively at a particular hospital and they won't take any steps to prevent independent physicians from participating in certain managed health care plans. It will be their choice so we are not interested in restricting the ability of independent physicians in the market place. In making these commitments, we have met with independent physician groups to talk through these so they feel comfortable about them and we are continuing to get feedback."

During the presentation, the Chairman declared a five minute recess.

Chairman Kilgore called the meeting back to order and asked that the presentation be interrupted so that several agenda items could be addressed while a quorum was present. Before continued the presentation, the Chairman moved to the agenda items following the presentation.

VI. <u>Cooperative Application</u>.

No discussion.

VII. <u>New Business</u>.

Chairman Kilgore called Mr. Mitchell to present to the Board on a confidentiality policy and resolution. Mr. Mitchell discussed the confidentiality policy and resolution in detail.

Chairman Kilgore presented the following resolution:

WHEREAS, Mountain States Health Alliance and Wellmont Health System (collectively, the **"Applicants**") on February 16, 2016 delivered to the Authority an Application for a Letter Authorizing Cooperative Agreement (the "**Application**"); and,

WHEREAS, pursuant to Section 15.2-5384.1.C.2 of the Code of Virginia, the Applicants delivered with, and as part of, the Application certain clearly identified materials that each believes to be proprietary information that are required to remain confidential (the "**Proprietary Information**"); and,

WHEREAS, the Authority by may be subject to the Freedom of Information Act of Virginia ("**FOIA**") unless an exemption to the FOIA is identified; and,

WHEREAS, under FOIA there are qualifying exceptions for the Authority (i) to hold information as confidential and (ii) to convene in closed session to discuss proprietary information received by the Authority from the Applicants; and,

WHEREAS, Section 2.2-3711(A)(40) of the Code states that public bodies may hold closed meetings only for certain purposes, which include, the "discussion or consideration of records excluded from this chapter pursuant to subdivision 3 of § 2.2-3705.6 of the Code";
and,

WHEREAS, Section 2.2-3711(A)(6) of the FOIA permits a closed session for the "discussion or consideration of the investment of public funds where competition or bargaining is involved, where, if made public initially, the financial interest of the governmental unit would be adversely affected" which would also be a valid exception for the Authority to use in relation to the proprietary records received; and,

WHEREAS, the Virginia Department of Health ("**VDH**") has noted in the VDH Final Virginia Rules and Regulations Governing Cooperative Agreements in Section 12VAC5-221-40(D) that it shall rely upon 2.2- 3706(3) of the Code as the FOIA exception regarding the treatment of the Proprietary Information; and,

WHEREAS, the Authority desires to adopt a confidential information policy to document the Authority's treatment of appropriately designated confidential information; and,

WHEREAS, the Authority received a request to confirm the confidential treatment of the Proprietary Information by the Authority;

NOW, THEREFORE, BE IT RESOLVED that, with respect to Proprietary Information provided to the Authority by the Applicants, the Authority shall rely upon all available applicable exemptions to FOIA, including Section 2.2-3711(A)(6) and Section 2.2-3711(40) of the Code; and, be it,

FURTHER RESOLVED, that the Board of Directors of the Authority hereby adopts the "*Policy for Confidential Information*", attached hereto as Exhibit A; and be it,

BE IT, FURTHER RESOLVED, that the Board of Directors confirms to the Applicants, as requested, that the Proprietary Information will be treated by the Authority as confidential information as contemplated by Section 2.2-3705.6(3) of the Code.

Additionally, Mr. Mitchell describe in detail the confidentiality policy. Chairman Kilgore stated that there is a confidentiality page that needs to be signed and returned.

Senator Carrico called for a motion to adopt the resolution.

A motion was made. Mr. Neese seconded the motion and the motion was unanimously approved.

Chairman Kilgore called Mr. Mitchell to discuss the conflict of interest memorandum distributed to members of the Board. Mr. Mitchell reviewed the document with the Board. Mr. Mitchell indicated there was a form that needed to be signed by all conflicted Board members.

The Application presentation by Mr. Keck and Mr. Norris continued after agenda items were discussed. Many Board members asked questions during the presentation.

VIII. ANNOUNCEMENTS:

The Chairman noted that meetings and minutes from the Tennessee cooperative application review are posted on the Tennessee Department of Health website.

Chairman Kilgore requested that the working groups have two meetings between the meeting and mid-May. The Chairman requested working group questions directed to the Applicants be submitted to him or Mr. Mitchell.

IX. NEXT MEETING OF THE AUTHORITY:

The next meeting will be May 25, 2016 at 3:00 p.m.

X. PUBLIC COMMENT:

No public comment.

XI. ADJOURNMENT:

Meeting adjourned at 5:35 pm. Senator Carrico made a motion to adjourn and Mr. Neese seconded the motion. Motion carried.

_____, Chairman
Terry Kilgore

Mr. Norris with Wellmont thanked the Board for the time they are investing today as well as the time they have already invested in reviewing the application. The questions are probably more important than what we are saying.

Mr. Norris discussed Section 4 which was Improving Population Health and our commitment to do that in the community as well as in the region. Mr. Norris identified the charge of the working group stating that this section is charged with not only population health issues in their normal consideration, but regional health issues, academic engagement, health related workforce issues. The region served by MSHA and Wellmont faces significant and wide ranging health care challenges. This group is well aware of this than most as you all created the Blueprint for Improving Health and Prosperity and just revised the Blueprint. We have spent a lot of time looking at the Blueprint to make sure we are in tune with the regional plan that is outlined in the blueprint as well as the State Health Improvement Plans. To accomplish Population Health Improvement, the new health system is committing to pursing goals outlined in these documents. Just as a background, many of you particularly those involved in public health are familiar with NACCHO's MAPP model. This is the model we are looking at using moving forward in a ten year plus plan.

Mr. Norris indicated that we use ten years a lot, but it is a timeframe we can wrap our heads around. We want to make health care sustainable and cost controlled moving well into the future. Dr. Cantrell stated that this group should be very familiar with the MAPP process because this is what we used when we did our Community Health Assessment to revise the Blueprint.

Mr. Norris went on to say that what we are proposing in the application is initially two phase process. In phase 1, we set forth what we hope to do is gain agreement during the process of determining the completeness of the application that the new health system will agree with the Virginia Department of Health and the SWVA Health Authority on key focus areas of the commitment to improve community health. So, big picture, what are the things we need to focus on? We took into consideration all the things you have done over the years initially. I call these four plus one categories. Mr. Norris proceeded to the fifth category, stating that is not represented here is behavioral health and mental health. We didn't list it separately in the process because it crosses over all four of these other categories. The categories are as follows: (1) strong start for children; (2) creating drug free communities; (3) living well in the community; (4) connecting high need, high cost for uninsured individuals to care. We want to create a more proactive system of care where individuals can access care. We think these things will have a strong impact on improving population health and will be necessary for deeming the application complete.

Mr. Norris further stated that Phase 2, gets us into this on-going active relationship. Right now, we are accountable to the community broadly, but we are not held directly. We are accountable to our Boards. We will have a new accountability system moving forward and that accountability system includes active supervision by the Commonwealth of Virginia and the Tennessee Department of Health

and it is a very important aspect of this. We believe that as we look at a dynamic plan on improving population health over time, making a generalization change in the health status of the community, and the trend of community health moving forward. What we need to do is work together in a process to develop annually plan goals that align with the needs of the community and so, somewhere between deeming the application as complete and having an agreement on those raw goals, and getting a Cooperative Agreement from the Commonwealth, we would like to solidify that first step in the annual plan in identifying and aligning those goals. Where you don't see specificity now, what our goal is to establish that specificity before the Cooperative Agreement is granted.

Mr. Norris stated that Community Health Improvement measures process for development involves looking at what we invest, what we do, who we reach and what are the results in a logic model process. So, this is what needs to be build out in more specificity as we move towards the granting of the Cooperative Agreement.

Mr. Norris stated we have attempted to set forth some of the inputs from the investments that we are planning to make and accountability mechanisms associated with those investments. In the Accountability of the Health Improvement Plan, will get more into the actual prioritized activities that we need to pursue and who we are planning to reach in the priority reach area focus. Over time, we want to track not only the short and medium outcomes that are closest to the work we are actually doing. The issues that we are looking at are generational issues, multigenerational issues and the work that is required to break those trends or to reshape the trend curve is also going to take a lot of time and a lot of effort. It will be important not to focus on the long-term outcomes because that could undermine our ability to achieve the path towards getting to that generational improvement.

Mr. Norris stated that we set forth in the application just a framework that we hope will be beneficial in showing how we would like to think about this improvement that we are working on. The community health improvement measures looks at health concerns and the example used is low birth weight babies which is certainly a priority at the state level and the authority's plan, and look at a tracking measure that is a validated measure that will show us if we are making improvements or not with low birth weight per 100,000. Looking at a representative investment (meaning not a complete list; this will need to be built out in collaboration with experts at the state level and local advisory groups like the SWVA Health Authority to be sure we are getting the plan right) we have the resources to invest and that is what we want to aim to do. A representative accountability measure that tracks to a shorter term progress measure might be something like establishing an agreed upon number of center pregnancy programs in specific counties by a set date.

Mr. Norris stated that center pregnancy programs might be an evidence based approach to having improvement in this area that we want to make investment in and we might want to say Tazewell, Buchanan and Smyth are examples of Virginia counties where there is a gap or disproportionate evidence of low birth weight babies and we might want to focus our efforts in that region. A representative progress measure might be the number of women in high risk communities with five plus visits to a pregnancy center program which is a measure that was developed over time by an evidence based process measure that shows that if you have that level of participation, then you will have improved outcomes moving forward. This is just a framework that was set forth envisioned to represent a plan that we can work on together at some point between now and when the Cooperative Agreement is hopefully granted.

Ms. McGrath directed everyone to page 106 that addresses this item.

Mr. Norris posed the question of how do we plan to address this moving forward? Mr. Norris stated that we want to identify the most pressing health needs in the region for focus in the next ten years that are aligned with the goals that we talked about and then development an assessment mechanism over that ten year plan. What is set forth in our commitments is the investment and also the plan evaluation every year and that is a check point. We talk about active supervision; having that on-going dialogue and relationship with the VDH, that really gives us an opportunity not only every year, but throughout the year to test our thinking and to define our plans and strategies and to have a very active approach to addressing these issues.

Mr. Norris stated that assessment on mental health and addiction services comprehensive regional approaches to the well-being of children; coordinated public and private resources to improve health; to develop research and academic partnership strategies. We really believe this research and academic will include all the Virginia institutions that we mentioned will create a national model here in our region for population health and community health improvement. This will be a great opportunity for our region to show even though we have very dire health issues that we have a way of addressing especially in the rural communities in the region will benefit from this. We want to address regional health issues.

Mr. Norris stated that the next section is related to Healthcare Workforce. Our goal is to become one of the best health system employers in the nation. To have frequent employee satisfaction surveys for benchmarking to achieve at least top quartile performance; to establish new partnerships with regional colleges and universities to train physicians, nurses and allied health professionals. This would include elevating everyone to a higher pay raise. We would provide competitive compensation to maximize career enhancement training. We want to be a health system that draws the best and brightest from our regional institutions and from the nation here to our region to practice medicine as physicians and to become model nurses. We believe that with the ability we will have to align resources, that we will be able to do that effectively.

Mr. Norris further stated that it is Inherent this is a very strong commitment to workforce development and to improving the work life of the people that already work in our health systems. The new health system will offer all Wellmont and MSHA employee's comparable positions within the new health system. We are not anticipating layoff and reductions in workforce just because of the merger. Want to be careful here, because the environment that we are operating under is tough environment, but we are absolutely not anticipating any of this associated with the merger. In fact, we believe that the merger reduces the chance of any of that happening. There is a significant amount of annual turnover now to go to work at various places (approximately 100 per year). We believe that we have a great opportunity in an orderly way to realign the workforce effectively and to find new positions for people who want to stay engaged and stay involved and who are high performers that we want to keep working for the new health system.

Mr. Norris indicated that we want to attract medical professionals. This is very important because as separate organizations, it is really difficult for us to sustain certain positions that are in high demand that we are competing on a broad regional or national level for. This will position us to sustain those positions and to be attractive to top talent across the country and to retain those people. This will also give them the opportunity to practice in a more complex medical environment that physicians in the room can appreciate. Physicians want to practice where they can stretch their skills; where they can grow professionally and where they can connect to academic opportunities; and that is a very important

part of this. The research component of this will allow competition for grant funding through research/academics. We believe a lot of this will play out in SWVA. On residency slots, we have a lot of those between the two health systems now, but they are threatened. In fact, both health systems have had to cut back on residency slots over the past couple of years. There are limits to the number of residency slots that are covered under the federal arrangement and it is very expensive for health systems to invest in those slots beyond the caps that they have to work with.

Mr. Norris stated that our goals really is to expand this. It is unfortunately short sighted as we need physicians in the pipeline moving forward; yet we have this catch 22 with the financial dynamics associated with it. We will be in a much better position to address this as a single organization moving forward and we believe that benefit will allow the region to have top notch physicians in the region. Our accountability relates to the commitments that we are making. These three areas on commitment (75 million dollar investment and the annual report associated with that); the investment in the key focus areas we want to keep moving forward as you seek to deem the application complete. The new health system will agree to reporting on a timely basis and we have discussed this before. The new health system will work with academic partners in VA and TN to commit not less than $85 million over ten years to build academic research. To work with academic partners to develop a ten year plan for post graduate training for physician, nurses and allied professionals and will work closely with academic institutions to implement a ten year plan in advancement and research and growth in the research enterprise within the region. This will have a dramatic impact on the region that we really can't anticipate.

Mr. Norris stated that we are planning on honoring prior service credit so our employees that are valued and have been with us for a long time won't lose that tenure moving forward or vacation and sick leave. The new health system will work as quickly as practical after the completion of the merger to address differences in salary and pay rates and employee benefits structures and all of our employees will benefit from that. The new system will take the best practices from both health systems to ensure maximum opportunity for career enhancement.

Mr. Norris indicated that the final area is competition. Mr. Norris stated that you do have a competition work group and the charge of that group is to determine whether the benefits of the Cooperative Agreement outweigh the disadvantages likely to result from reduction in competition from the Cooperative Agreement by considering issues related to ensuring accountability and cost; improving health entity regional integration; gains and cost efficiency on services provided by the application and improvements in the utilization of resources and avoidance of duplications. So the issue in that the benefits of the application should outweigh any disadvantages that might be created.

Mr. Norris stated the approach that the new health system is proposing is to be actively supervised by Virginia and Tennessee officials. This supervision will ensure that the new health system will act accordingly to public policies that are outlined in the Cooperative Agreement. This is not a situation where you will have to take our word for it. It is something that will be actively supervised by Department of Health in two states. There will be a mechanism for enforcing the commitments that we are making and Mr. Keck called it the nuclear option earlier. There will be a way of unwinding this if for some reason these commitments are not fulfilled to the satisfaction of the Commonwealth of Virginia or Tennessee. This is a very important dynamic in all of this.

Mr. Norris proposed the question of how do we plan to address this issue of competition and benefits? Mr. Norris stated the benefits outlined in the application simply wouldn't be possible without

the merger. A lot of things we talk about relate to a reinvestment and resources; defining an efficiency that we can't define today because we are competing with one another and unnecessarily duplicating scarce resources in some cases especially in rural areas; so the benefits need to outweigh that. The funding would not be possible without the merger. Federal anti-trust laws prohibit coordination necessary to achieve significant savings without the merger under a cooperative agreement. You will see in the application that there are some things that we have done to cooperate with one another where we were able to do that over the years. There are some things in community health improvement, we have scratched the edges. We have worked together several years ago to bring Susan G. Coleman affiliate to the region. These have been significant efforts but they really don't even begin to scratch the surface of what we can do under the cooperative agreement; things that are prohibited such as the clinical integration especially that is needed to truly provide an integrated care delivery model across the region that we serve and to truly improve the community health across the region that we serve.

Mr. Norris stated that clinical standardization wouldn't be possible without the merger because we have to be able to work together in a very integrated fashion. We have to share IT resources to be able to do that. The integration of the common IT platform would not be possible without the merger. Imagine the inefficiency that results from not having patients seen in both systems be privy to this electronic medical records. Mr. Norris stated all have experienced the disconnect that we have when we see providers in different health systems and we are just not able to connect those resources in an integrated fashion. We can develop a health information exchange without that, but it is not the same things as clinical integration that could be achieved through the development of a unified electronic health record where physicians can see everything and share a set of protocols and approach things from a common clinical background. Active state oversight is absolutely essential to this. He stated that you do not have to rely on us to keep our promises but you know this will be done because the states will supervise it.

Mr. Norris stated that the quantitative measures will serve as a scorecard to ensure that the new health system is in compliance with the terms authorized in the cooperative agreement. It is important to realize as we move forward that there continue to be competition in the region and that competition will be substantial. Approximately 70 percent of all physicians in the geographic service area are and are expected to remain independent. The majority of the out-patient facilities are not controlled and will not be controlled in the future by the new health system. There are nine acute care hospitals in the geographic service area that are not operated or owned by MSHA or Wellmont. That helps to provide a picture of the competition that still exists if the merger is approved.

Mr. Norris stated that our commitments related to competition are that the new health system will negotiate a good faith agreement with all principal payers to include the new health system health plans offering reasonable terms and rates, and the new health system would agree to resolve through mediation disputes, Mr. Norris indicated that Mr. Keck had previous talked about this. Mediation is not necessarily something we would do separately. The new health system will not agree to be the exclusive provider to any commercial medicare managed or medicare insured companies, but rather keeping open working with the insurance companies. The new health system will not engage in new favored pricing with any health plans.

Mr. Norris stated that we will maintain the three tertiary referral hospitals in Johnson City, Tennessee, Bristol, Tennessee and Kingsport, Tennessee that will ensure high level services continue to be available in proximity to the markets where they are available now. We will maintain open medical

stats and will commit to not engaging in exclusive contract with physician services. Independent physicians will not be required to practice exclusively at the new health systems hospitals and other facilities and that is a more open system than exists today. The new health system will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice. We are not going to exercise anything that decreases the competitive environment for the independent physicians or impedes their ability to compete.

Mr. Norris stated that Tennessee has a process going on now and I am sure you are watching that now as closely as they are watching your process closely.

Chairman Kilgore asked, when is that public hearing going to be?

Mr. Norris stated the public hearing will be June 7, 2016 at NETN State. There is actually a listening session coming up next Tuesday at NETN State. The way they have done this, they have had a couple meetings that are open listening sessions that are open to the general public and have formed an advisory group that is a temporary group that is listening to public perceptions on how the new health system will be measured and what are the outcomes that should be focused on.

Mr. Norris stated that the last meeting is on whether the COPA should be granted or not. They have already had one internal listening session of employees and internal stakeholders. They are having another session for external stakeholders such as payers and self insured employers, etc. Tennessee is placing their correspondence to us and from us on their website so you can go there and look at those exchanges of that information. We are working really hard to make sure if we share anything with Tennessee, we share it with you and the VDH and vice versa.

Ms. Welch asked about the training in the three tertiary hospitals. She also mentioned Norton, JMH and Smyth County Hospitals provide training. There is concern that these are not listed only the hospitals in Tennessee. Is this realistic?

Mr. Norris responded by stating that we want the Virginia hospitals to have the approved residency slots. It is our intention to continue these programs.

Chairman Kilgore asked, Can you write that down?

Mr. Norris stated that they would take it back to their boss.

Dr. Rawlins mentioned that there is a difference in residency slots that can be moved around in an institution and where the residency exists. Just maintaining residency slots just doesn't quite do it.

Mr. Norris stated that you are going to get the comparison that will help you find things in the application. We having working groups that have met and you have questions that need to be answered. Now, you will have proprietary information and can compare it with the other information you have reviewed.

Chairman Kilgore stated that the intention is the next time we meet in May will be when we will make a decision on whether the application is complete and the time starts running. If you have questions, you need to get those to Chairman Kilgore to get those questions answered. Does anyone think that mid-

May is too optimistic. Just about every working group will have questions. We need to get questions, but we don't know the turnaround time for questions.

Mr. Norris stated they are highly motivated. Some of the questions may involve their legal team.

Chairman Kilgore stated that in mid-May we would want to take a vote.