EXECUTION COPY

First Amendment to
Master Affiliation Agreement
and
Plan of Integration

By and Between

Wellmont Health System

and

Mountain States Health Alliance

Dated as of September 8, 2016

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EXECUTION COPY

THIS FIRST AMENDMENT TO MASTER AFFILIATION AGREEMENT AND PLAN OF INTEGRATION (this "First Amendment") is dated as of September 8, 2016, by and between Wellmont Health System, a Tennessee nonprofit public benefit corporation with a principal place of business in Kingsport, Tennessee ("Wellmont") and Mountain States Health Alliance, a Tennessee nonprofit public benefit corporation with a principal place of business in Johnson City, Tennessee ("MSHA"). Wellmont and MSHA are each a "Party" and collectively the "Parties."

WHEREAS, the Parties have entered into the Master Affiliation Agreement and Plan of Integration dated as of February 15, 2016 (the "Agreement"); and

WHEREAS, the Parties have agreed to amend certain provisions of the Agreement as set forth herein.

NOW, THEREFORE, in consideration of the representations, warranties, premises and the mutual covenants and agreements hereinafter contained, each of the parties hereto, intending to be legally bound, hereby agree as follows:

Article I. Amendments.

Section 1.01 Exhibits C-2 and F. Exhibit C-2 (Interim Officers) and Exhibit F (Integration Council) are deleted in their entirety and replaced with the correspondingly labeled Exhibits attached hereto.

Section 1.02 Cooperative Agreement. Section 5.06(a) of the Agreement is amended to read in its entirety as follows:

> (a) The Parties deem this Agreement to be their "cooperative agreement" as defined in the Tennessee Hospital Cooperation Act of 1993, as amended (the "Tennessee COPA Act") and § 15.2-5369 of the Code of Virginia (the "Virginia COPA Act" and together with Tennessee COPA Act, the "COPA Acts"). Pursuant to the Tennessee and Virginia regulations promulgated under the authority of the Tennessee COPA Act and the Virginia COPA Act, the Parties hereby agree upon and incorporate the terms contained in Exhibit H as part of this "cooperative agreement."

Section 1.03 Exhibit H. The Agreement is amended by adding a new Exhibit H as labeled and attached hereto.

Section 1.04 Amendment, No Further Modification. The Parties agree that this First Amendment is an effective and binding amendment of the Agreement pursuant to Section 10.07 of the Agreement. Except as otherwise expressly stated in this First Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect, without amendment or modification.

Section 1.05 Capitalized Terms. Capitalized terms used but not otherwise defined herein shall have the same meaning ascribed to such terms in the Agreement.

Section 1.06 Execution in Counterparts. This First Amendment may be executed in more than one counterpart, each of which shall be deemed to be an original, but all of which shall be deemed to constitute one instrument. It shall not be necessary for all parties to have signed the same counterpart provided that all parties have signed at least one counterpart.

[Signature page follows]

IN WITNESS WHEREOF, the parties hereto have executed or caused to be executed this First Amendment on the day and year first above written.

WELLMONT HEALTH SYSTEM

By: _____
Roger Leonard
Chairman of the Board of Directors

_____
Bart Hove
President and Chief Executive Officer

MOUNTAIN STATES HEALTH ALLIANCE

By: _____
Barbara Allen
Chairman of the Board of Directors

_____
Alan Levine
President and Chief Executive Officer

EXHIBITS

Exhibit C-2. **Interim Directors and Interim Officers.**

Exhibit F. **Integration Council**

Exhibit H. **Cooperative Agreement Terms**

EXHIBIT C-2
Interim Directors and Interim Officers

Directors:

Barbara Allen

Roger Leonard

Roger Mowen

Gary Peacock

Officers:

President: Alan Levine

Secretary/Treasurer: Bart Hove

EXHIBIT F
Integration Council

MSHA
Marvin Eichorn (Co-Chair)
Dr. Morris Seligman
Lynn Krutak
Tony Keck
Dr. Sandra Brooks
Tim Belisle

WHS
Eric Deaton (Co-Chair)
Todd Dougan
Dr. Robert Funke
Dr. Dale Sargent
Todd Norris
Gary Miller

EXHIBIT H

Cooperative Agreement Terms

Pursuant to the Tennessee and Virginia regulations promulgated under the authority of the Tennessee COPA Act and the Virginia COPA Act, the Parties do hereby agree upon and incorporate the following terms as part of this Cooperative Agreement:

(e) **REQUEST**: A description of the competitive environment in the parties' geographic service area, including:

(i) Identification of all services and products likely to be affected by the Cooperative Agreement and the locations of the affected services and products;

RESPONSE: The Parties intend for the Cooperative Agreement to include all services, products, and service locations under the control of Mountain States and Wellmont at the time of execution of the Cooperative Agreement and for so long as those entities remain under the control of the New Health System.

(ii) The parties' estimate of their current market shares for services and products and the projected market shares if the COPA is granted;

RESPONSE: The Parties estimate their current share in the Geographic Service Area for general acute care inpatient services based on Calendar Year 2014 ("CY2014") discharge data[1] as follows:

Table 11.1 – Share of CY2014 Discharges, Current Systems[2]

System	Total	Share of Total Discharges
Mountain States	58,441	45.6%
Wellmont	35,075	27.4%
Other	34,584	27.0%

Table 11.1 identifies the percentage of total discharges in the Geographic Service Area (exclusive of DRG 795) that are accounted for by Mountain States, Wellmont, or other health care systems. Share analyses demonstrate that three hospitals (Bristol Regional Medical Center, Holston Valley Medical Center, and Johnson City Medical Center) make up fifty-eight percent (58%) of the combined

[1] Shares of the Geographic Service Area and for general acute care inpatient services were calculated using CY2014 discharge data for all Tennessee and Virginia hospitals. Shares were calculated defining general acute care services excluding normal newborns (DRG 795) and including (excluding) MDC 19 (Mental Diseases) and MDC 20 (Alcohol/Drug Use or Induced Mental Disorders). Tables detailing discharges by hospitals serving the Geographic Service Area, and hospitals in the Geographic Service Area, are in **Exhibit 5.2**.

[2] Shares for this table were calculated defining general acute care services excluding normal newborns (DRG 795).

system's discharges.[3] Other Mountain States and Wellmont hospitals individually contribute less than one to two percent (1-2%) to the total discharge volume accounted for by their respective parent system.

If the COPA is granted and volumes in the Geographic Service Area remain consistent with CY2014 trends, then the Parties estimate the projected shares for general acute care inpatient services would be as follows in **Table 11.2**:

Table 11.2 – Share of CY 2014 Discharges, New Health System

System	Total	Share of Total Discharges
New Health System	93,516	73.0%
Independent Competitors	34,584	27.0%

Due to the large independent physician community in the Geographic Service Area, the Parties do not expect a material change in the shares for physician services. Approximately seventy percent (70%) of all practitioners in the Geographic Service Area are independent. Even in overlap specialties, there are substantial competitive alternatives as reflected in the number of independent physicians in the specialty. **Table 11.3**[4] provides share estimates for independent physicians, Wellmont, and Mountain States in the specialties in which there is an overlap. **Table 11.4** reports shares for specialties in which there is not an overlap – that is, where Mountain States and Wellmont do not each employ physicians.

[3] These three hospitals account for 42.3% of discharges by all hospitals in the Geographic Service Area.

[4] **Tables 11.3** and **11.4** are based on data and information provided by the Parties regarding physicians with admitting privileges at their hospitals and employed or affiliated physicians and the specialty of physicians.

Table 11.3 – Shares of Physicians in Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate[5]
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Emergency Medicine	X	141	95%	1%	1%	3%
Neurology	X	75	91%	3%	4%	3%
Otolaryngology	X	21	90%	5%	5%	0%
Pediatrics	X	87	87%	3%	9%	0%
General Surgery	X	57	70%	7%	19%	4%
Internal Medicine	X	178	67%	19%	13%	1%
OB/GYN	X	81	67%	10%	23%	0%
Neurosurgery	X	20	65%	5%	25%	5%
Family Medicine	X	183	63%	16%	20%	1%
Orthopedic Surgery	X	68	63%	3%	32%	1%
Psychology	X	5	60%	20%	20%	0%
Psychiatry	X	30	57%	10%	33%	0%
Pain Management	X	6	50%	17%	17%	17%
Cardiothoracic Surgery	X	21	43%	38%	19%	0%
Pulmonology	X	37	38%	38%	19%	5%
Occupational Medicine	X	5	20%	40%	40%	0%
Hematology/Oncology	X	34	15%	44%	35%	6%
Cardiology	X	70	14%	49%	36%	1%
Hospital Medicine	X	123	14%	10%	58%	15%

[5] Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate[6]
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Allergy and Immunology	-	5	100%	0%	0%	0%
Child Development	-	1	100%	0%	0%	0%
Colorectal Surgery	-	2	100%	0%	0%	0%
Dentistry	-	8	100%	0%	0%	0%
Hand Surgery	-	2	100%	0%	0%	0%
Maternal and Fetal Medicine	-	2	100%	0%	0%	0%
Neonatology	-	8	100%	0%	0%	0%
Ophthalmology	-	35	100%	0%	0%	0%
Optometry	-	1	100%	0%	0%	0%
Oral Surgery	-	11	100%	0%	0%	0%
Pathology	-	24	100%	0%	0%	0%
Pediatric Dentistry	-	7	100%	0%	0%	0%
Pediatric Emergency Medicine	-	3	100%	0%	0%	0%
Pediatric Gastroenterology	-	2	100%	0%	0%	0%
Pediatric Hematology Oncology	-	2	100%	0%	0%	0%
Pediatric Nephrology	-	1	100%	0%	0%	0%
Pediatric Pulmonology	-	1	100%	0%	0%	0%
Pediatric Surgery	-	1	100%	0%	0%	0%
Perfusionist	-	1	100%	0%	0%	0%
Physician Assistant	-	55	100%	0%	0%	0%
Plastic Surgery	-	13	100%	0%	0%	0%
Podiatry	-	20	100%	0%	0%	0%
Radiology	-	186	100%	0%	0%	0%
Rheumatology	-	6	100%	0%	0%	0%
Sports Medicine	-	3	100%	0%	0%	0%
Telemedicine	-	2	100%	0%	0%	0%
Teleradiology	-	10	100%	0%	0%	0%

[6] Mountain States Affiliate physicians are those physicians who are not employed by Mountain States but who do provide services to Mountain States through a contractual arrangement. To be conservative, these physicians are counted along with the Mountain States employed physicians in assessing the "overlap" between Mountain States and Wellmont.

Table 11.4 – Shares of Physicians in Non-Overlapping Specialties, by System (Continued)

Specialty	Overlap Flag	Total	Independent	Wellmont	Mountain States	Mountain States Affiliate
Grand Total (Overlap/Non-Overlap)		**2,142**	**70%**	**9%**	**17%**	**4%**
Nurse Practitioner	-	89	98%	0%	2%	0%
CRNA	-	75	97%	0%	0%	3%
Anesthesiology	-	65	97%	0%	0%	3%
Nephrology	-	16	94%	0%	6%	0%
Gastroenterology	-	30	90%	0%	10%	0%
Unknown	-	9	89%	0%	11%	0%
Urology	-	23	87%	0%	13%	0%
Physical Medicine and Rehabilitation	-	11	82%	18%	0%	0%
Infectious Disease	-	10	80%	20%	0%	0%
Dermatology	-	6	67%	0%	33%	0%
Pediatric Critical Care	-	3	67%	0%	0%	33%
Palliative Care	-	2	50%	50%	0%	0%
Pediatric Cardiology	-	4	50%	50%	0%	0%
Pediatric Neurology	-	2	50%	0%	0%	50%
Surgical Oncology	-	2	50%	50%	0%	0%
Radiation Oncology	-	11	36%	64%	0%	0%
Oncology	-	7	29%	43%	0%	29%
Trauma Surgery	-	29	21%	0%	38%	41%
Critical Care	-	15	7%	0%	80%	13%
Behavioral Health	-	8	0%	0%	50%	50%
Endocrinology	-	4	0%	0%	50%	25%
Pediatric Endocrinology	-	1	0%	0%	0%	100%
Pediatric Hospital Medicine	-	6	0%	0%	0%	100%
Sleep Medicine	-	2	0%	0%	50%	50%
Urgent Care	-	58	0%	0%	86%	14%

A large number of independent providers of outpatient services compete in the Geographic Service Area. In many outpatient services, including imaging, surgery and urgent care, independent providers account for at least a fifty percent (50%) share. **Table 11.5**[7] depicts counts and share numbers for categories of outpatient services based on the affiliation of the providers:

[7] **Table 11.5** depicts the counts and shares for categories of outpatient services and is based on a listing provided by the Parties of outpatient facilities by type including names, locations, and affiliations.

Table 11.5 - Shares of Outpatient Facilities by System

Service Type	WHS & MSHS Combined %	Mountain States	Mountain States-NsCH Affiliate	Wellmont	Non-Managed Joint Venture	All Other*	Total
Pharmacy	1.4%	5	0	0	0	349	**354**
Fitness Center	0.0%	0	0	0	0	98	**98**
XRAY	28.3%	14	0	12	0	66	**92**
Nursing Home	7.6%	3	0	2	0	61	**66**
Physical Therapy	6.6%	1	0	3	0	57	**61**
Home Health	16.7%	8	0	2	0	50	**60**
Rehabilitation	39.5%	9	0	8	0	26	**43**
CT	51.2%	12	0	10	0	21	**43**
MRI	43.9%	11	0	7	0	23	**41**
Surgery - Endoscopy	45.2%	9	0	5	0	17	**31**
Urgent Care	50.0%	8	0	8	0	16	**32**
Surgery - Hospital-based	46.7%	9	0	5	0	16	**30**
Dialysis Services	0.0%	0	0	0	0	25	**25**
Wellness Center	14.3%	2	0	1	0	18	**21**
Surgery - ASC	60.0%	2	0	3	4	6	**15**
Chemotherapy	55.6%	4	1	5	0	8	**18**
Rehabilitation & Physical Therapy	31.3%	0	0	5	0	11	**16**
Radiation Therapy	54.5%	3	0	3	0	5	**11**
Cancer Center	54.5%	3	0	3	0	5	**11**
Weight Loss Center	14.3%	0	0	1	0	6	**7**
Community Center	0.0%	0	0	0	0	6	**6**
Cancer Support Services	0.0%	0	0	0	0	1	**1**
Women's Cancer Services	100.0%	0	0	1	0	0	**1**

Note: Wellmont and Mountain States provide cancer support services at their cancer centers.

(iii) A statement of how competition among health care providers or health care facilities will be reduced for the services and products included in the Cooperative Agreement; and

RESPONSE: The Parties acknowledge that the merger will eliminate competition between Wellmont and Mountain States in certain areas. The benefits of the merger will far outweigh this loss of competition, due to the cost-savings, quality enhancement and improved access the merger will generate. In addition, significant benefits will result from the Parties' commitments outlined herein, all of which will be actively supervised by the States. Moreover, the New Health System will face significant competition from the independent hospitals and other health care providers located in its service area, and, increasingly, from more distantly located health systems. With enhanced access to cost and quality information, patients utilize their mobility and often leave the immediate service area for health care services in locations including Nashville, Asheville, Knoxville and Winston Salem. The parties expect this pattern to increase.

(iv) A statement regarding the requirement(s) for any Certificate(s) of Need resulting from the Cooperative Agreement.

RESPONSE: No Certificate of Need will be required under the proposed Cooperative Agreement.

(f) **REQUEST**: Impact on the service area's health care industry workforce, including long-term employment and wage levels and recruitment and retention of health professionals.

RESPONSE: It is the objective of the New Health System to become one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. In order to achieve this objective, the Parties will conduct frequent employee and physician satisfaction and engagement assessments benchmarking with national organizations to achieve at least top quartile performance. The Parties will also build substantial partnerships beyond what currently exist with regional colleges and universities in Tennessee and Virginia that train physicians, nurses, and allied health professionals to ensure there is a strong pipeline of regional health professionals.

The Parties recognize that their workforce is mobile, and there are many opportunities both within the region and in nearby metropolitan areas for their team members. Thus, competitiveness of pay and benefits is critical to the New Health System's success. The New Health System is committed to its existing workforce. Therefore, when the New Health System is formed:

COMMITMENTS

- The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States, and will provide all employees credit for accrued vacation and sick leave.

- The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures. The New Health System will offer competitive compensation and benefits for its employees to support its vision of becoming one of the strongest health systems in the country and one of the best health system employers in the country.

- The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.

The New Health System will achieve substantial efficiencies and reduce unnecessary duplication of services, but it is not anticipated that the overall clinical workforce in the region will decrease significantly. Demand for health professionals is generally driven by volume and varies across the market from time to time. Health care workers are in great demand in the region, and retaining and developing excellent health professionals in the region will be of utmost importance to ensure the highest clinical quality. Wages must remain competitive to attract top regional and national talent.

Further, significant investments must be made in the development of infrastructures and human resources for community health improvement, population health management, academics and research, and new high-level services. In addition to the significant ongoing base of clinical personnel, support staff, and physicians, all of these initiatives will serve to further develop the region's health care workforce and support the regional economy.

A hallmark initiative enabled by the proposed merger is the development of an enhanced academic medical center aligned in important ways with the New Health System in its efforts to transform health care delivery and to address health care needs, access, experience, and economic well-being of the local community in the near term as well as long term. The proposed merger provides funds generated through merger efficiencies, some of which the Parties will invest in the development of an enhanced academic medical center to bring specific health care and economic benefits to the community. For example, the Parties, with their academic partners, plan to create new specialty fellowship training opportunities, build an expanded research infrastructure, add new medical and related faculty, and attract research funding, especially translational research, to address regional health improvement objectives. These efforts will benefit the community directly and indirectly, with expanded efforts to develop research specific to the local communities' health care needs and issues. The Parties intend for the enhanced academic medical center to be a focal point for health care and population health research specific to the issues and needs of the communities served by the New Health System in Tennessee and Virginia to focus strategies for interventions and improvements in health and health care delivery. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, expanded services and training can also contribute to the economic vitality of the area as well as the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities with overall health and economic well-being.

In the current environment, Wellmont and Mountain States have been reducing the number of residency slots due to financial constraints. It is a goal of the New Health System to reverse this trend. Using savings obtained from merger-derived efficiencies, the New Health System will work with its academic partners and commit not less than $85 million over ten years to increase residency and training slots, create new specialty fellowship training opportunities, build and sustain research infrastructure, and add faculty. These are all critical to sustaining an

active and competitive training program. New local investment in this research and training infrastructure will attract additional outside investments. State and federal government research dollars often require local matching funds, and grant-making organizations such as the National Institutes of Health and private organizations such as pharmaceutical companies want to know that their research dollars are being appropriated to the highest quality and resourced labs and scientists. Specifically, the Parties commit to the following:

COMMITMENTS

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

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

(g) **REQUEST**: Description of financial performance, including:

(i) A description and summary of all aspects of the financial performance of each party to the transaction for the preceding five years including debt, bond rating and debt service and copies of external certified public accountants annual reports;

RESPONSE: See attached **Exhibit 11.4** for a description and summary of all aspects of the financial performance of Mountain States for the preceding five fiscal years. See attached **Exhibit 11.5** for a description and summary of all aspects of the financial performance of Wellmont for the preceding five fiscal years. The Mountain States Covenant Compliance Certificates (**Exhibit 11.4D**), the Mountain States Officer's Certificates accompanying Independent Auditor's Reports (**Exhibit 11.4E**), and the Wellmont External Auditor Management Letters (**Exhibit 11.5D**) are considered confidential information and will be subsequently filed.

(ii) A copy of the current annual budget for each party to the Cooperative Agreement and a three year projected budget for all parties after the initiation of the Cooperative Agreement. The budgets must be in sufficient detail so as to determine the fiscal impact of the Cooperative Agreement on each party. The budgets must be prepared in conformity with generally accepted accounting principles (GAAP) and all assumptions used must be documented;

RESPONSE: The current annual budgets for Mountain States (**Exhibit 11.6**) and Wellmont (**Exhibit 11.7**) are considered competitively sensitive information under federal antitrust laws and will be subsequently filed. A five-year projected budget for the New Health System is attached as **Exhibit 11.8**.

(iii) A detailed explanation of the projected effects including expected change in volume, price and revenue as a result of the Cooperative Agreement, including;

I. Identification of all insurance contracts and payer agreements in place at the time of the Application and a description of pending or anticipated changes that would require or enable the parties to amend their current insurance and payer agreements;

RESPONSE: Please see attached **Exhibit 11.9** identifying all insurance contracts and payer agreements in place at the time of the Application for Mountain States. Please see attached **Exhibit 11.10** identifying all insurance contracts and payer agreements in place at the time of the Application for Wellmont.

While some of the payer agreements held by both Parties permit the termination of the agreement by the payer upon a change of control, the Parties do not intend to amend their current insurance and payer agreements in connection with completing the affiliation except as set forth herein. Going forward, the Parties intend the New Health System will negotiate with the payers in the ordinary course of business as each managed care contract comes up for renewal after the Closing.

II. A description of how pricing for provider insurance contracts are calculated and the financial advantages accruing to insurers, insured consumers and the parties of the Cooperative Agreement, if the COPA is granted including changes in percentage of risk-bearing contracts;

RESPONSE: Like other health systems across Tennessee and the nation, the Parties negotiate with commercial health insurance providers for inclusion in the health insurance plans they offer to employers and individuals. Wellmont and Mountain States each approach these negotiations with the basic goal of agreeing on rates and terms that will enable the health systems to cover the cost of providing high quality health care while earning a reasonable margin to invest in maintaining and improving their facilities and expand their service offerings.

Any pricing limitations agreed to by the New Health System are intended to benefit employers and those who are shouldering the burden of what is projected to be increased overall health care costs in the coming years. This burden has increasingly fallen on consumers who have seen dramatic increases in the deductibles they are required to pay. Unregulated merged systems do not provide for limitations on commercial payment increases,

which can negatively impact self-insured employers, employees and insurers who are managing risk. Conversely, the New Health System has committed to a reduction in price increases and set a new, lower cost trend for many third party payers. These pricing commitments are proposed so as to pass savings on to consumers through their chosen insurers resulting from the efficiencies the New Health System expects to achieve.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

In addition, as a result of the merger, the Parties project that the merger will result in improved quality of care and enhanced clinical coordination. This capability will enable the system to participate meaningfully in various federal and commercial efforts to share risk and take advantage of the scalable ability of the New Health System to better manage the care for high cost, high utilization patients. Through this effort, these changes will result in fewer hospitalizations and reduced lengths of stay when patients are hospitalized. Insurers and insured consumers will benefit through lower expenditures for inpatient care when patients spend less time in the hospital or are able to avoid hospitalizations altogether.

The Parties' intend to manage population health through the deployment of a research-based ten year plan that is focused on reducing the variables leading to chronic disease, improved clinical coordination, higher quality facilitated by the consolidation of services, and a shared information technology platform, among other things. All of these benefits strengthen the ability of the Parties to engage in risk-based contracting to a far greater extent than is currently the practice in the region. It is, therefore, the intent of the New Health System that future contractual arrangements with payers will be more focused on identification of the drivers of cost, with a shared objective of reducing unnecessary cost, and sharing the benefit of such successful initiatives.

III. The following policies:

A. Policy that assures no restrictions to Medicare and/or Medicaid patients,
B. Policies for free or reduced fee care for the uninsured and indigent,
C. Policies for bad debt write-off; and
D. Policies that assure parties to the Cooperative Agreement will maintain or exceed the existing level of charitable programs and services.

RESPONSE: Wellmont and Mountain States are the primary providers for Medicare and Medicaid in the region, and operate the primary system of access for children. Additionally, the primary location for inpatient mental health services for the uninsured and Medicaid are housed within Mountain States. The New Health System will continue to remain committed to these populations, a commitment neither system can make without the proposed merger. The current charity and other related policies for both Mountain States and Wellmont are attached as **Exhibits 8.3 and 8.4**. If the COPA is granted, the Parties intend for the New Health System to adopt policies that are substantially similar to the existing policies of both Parties and consistent with the IRS's final 501(r) rules. As evidence of this commitment, the Parties have committed in the Cooperative Agreement that the New Health System will adopt policies that are substantially similar to the existing policies of both Parties.[8] Specifically, the Parties intend to address each category of patients as follows:

[8] *See* **Exhibit 11.1**, Master Affiliation Agreement and Plan of Integration By and Between Wellmont Health System

Medicare. Many of the "Helping Adults Live Well" strategies discussed in this Application will be designed specifically for the Medicare senior population and dual eligible population. Medicare hospital and physician pricing is determined by government regulation and is not a product of competition or the marketplace. As a result, the merger is not expected to impact the cost of care to Medicare beneficiaries, but access to and quality of services are expected to improve. Additionally, through care coordination models implemented as part of value based arrangements, it is expected that use rates will be favorably affected, and savings to the Medicare program will result. The many strategies contained within this Application, including implementation of a Common Clinical IT Platform, will be key factors in succeeding within the value-based Medicare environment.

Medicaid. Many of the population health strategies detailed in this Application, such as child maternal health, will directly benefit the Medicaid population, and thus, the program. Also, the New Health System will seek innovative value-based models with the commercial payers that serve as intermediaries to the state Medicaid programs. Such models may include care management/shared savings, integrated mental health services and development of access points of care for the Medicaid and uninsured populations. It is widely known that simply having a Medicaid card does not equate to access. The intent of the New Health System is to ensure an organized care delivery model which optimizes the opportunity for access in the lowest cost, most appropriate setting. Importantly, these opportunities become more likely when the New Health System has the scale in terms of the number of lives it is managing. This should be an attractive feature for the states and to those payers acting as intermediaries with the states.

Uninsured Population. As described in **Section 8.G** of this Application, both Parties currently provide significant amounts of charity care to the vulnerable populations in the Geographic Service Area and will continue to do so in the future. If the COPA is granted, the Parties intend that the New Health System will adopt a charity care policy that is substantially similar to the existing policies of both Parties. The uninsured population will also be the target of several inter-related health strategies outlined in this Application. For example, the Parties intend to encourage all uninsured individuals to seek coverage from the federal health marketplaces from plans offered in the service area. The Parties intend to work with charitable clinics in the area to improve access for the uninsured population to patient-centered medical homes, federally qualified health centers, and other physician services. These efforts will help ensure that the uninsured population has a front door for non-emergent care and seeks care at the appropriate locations. The New Health System intends to create an organized delivery model for the uninsured which relies upon the medical home as the key entry point, and which also encourages individual responsibility for determinants of poor health.

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and Mountain States Health Alliance, Section 1.02 “Community Benefit."

All categories of payers and the uninsured. Additionally, for all patients covered by all categories of payers and the uninsured, the New Health System will:

- Develop effective strategies to reduce the over-utilization and unnecessary utilization of services, particularly high-cost services such as emergency department care. This better-managed, more proactive approach will be developed in collaboration with a host of community-based resources and will be consistent with the CMS Accountable Health Communities model. Under this model, both traditional health care resources and societal resources are considered in tandem. Recognizing that factors such as transportation, educational attainment, food availability, housing, social support and other factors play a key role in health care access and outcomes, effective program development will include opportunities to help high-utilizers of care gain awareness of available resources, provide navigational access to those resources, and ensure systems of contact and collaboration exist and are effective.

- Develop with the State and community stakeholders Key Focus Areas for population health investment and intervention. These index categories will apply regardless of payer and the priorities for programming and intervention will be based on the communities where the need/impact will be greatest. The Parties intend to account for geographic gaps and disparities by aiming resources or strategies at specific populations, which will be outlined in the long-term community health improvement plan. Where payers have existing care management programs in place, the New Health System will work with payers to increase compliance for effective prevention and disease management programs. The Parties strongly believe that the New Health System must provide opportunities for prevention, navigation, and disease management, and must connect individuals, regardless of their coverage status, to community-based resources if the regional population health management initiative is to be successful.

IV. Identification of existing or future business plans, reports, studies or other documents of each party that:

A. Discuss each party's projected performance in the market, business strategies, capital investment plans, competitive analyses and financial projections including any documents prepared in anticipation of the Cooperative Agreement; and
B. Identification of plans that will be altered, eliminated or combined under the Cooperative Agreement or subsequent COPA.

RESPONSE: Information regarding existing and future business plans of Mountain States (**Exhibit 11.11**) and Wellmont (**Exhibit 11.12**) is considered competitively sensitive information under federal antitrust laws and will be subsequently filed.

(h) **REQUEST:** A description of the plan to systematically integrate health care and preventive services among the parties to the Cooperative Agreement, in the proposed geographic service area, to address the following:

(i) A streamlined management structure, including a description of a single board of directors, centralized leadership and operating structure;

RESPONSE: Please see response to 11.b above.

(ii) Alignment of the care delivery decisions of the system with the interest of the community;

RESPONSE: A well-executed merger provides multiple opportunities to enhance care delivery and patient outcomes through the consolidation, integration, realignment and/or enhancement of clinical facilities and services (collectively the "Clinical Consolidation"). Clinical Consolidation can involve both concentration of services of a particular type in fewer locations and/or establishment of common protocols and systems across a common set of services with an ultimate goal of yielding improved outcomes, sustaining the most effective levels of services at the right locations, reducing costs of care, and related efficiencies. Where appropriate, these Clinical Consolidations are a standard and widely accepted mechanism for reducing unnecessary cost in health care, improving quality, and ensuring the services and programs offered by a health care delivery system are continuously evaluated to ensure efficiency and the best outcome for patients.

As a means to ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy that will allow the New Health System to utilize a rigorous, systematic method for evaluating the potential merits and adverse effects related to access, quality and service for patients and to make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The Alignment Policy will apply to the consolidation of any clinical facilities and clinical services where the consolidation results in a discontinuation of a major service line or facility such that any such discontinuation would render the service unavailable in that community. Additionally, for two years after the formation of the New Health System, a super-majority vote of the Board is required in the event a service is consolidated in a way that results in discontinuation of that service in a community. A copy of the Alignment Policy is attached as **Exhibit 11.13**.

A likely alternative to the proposed Cooperative Agreement merger would be for each system individually to be purchased by larger health systems from outside the region. Such an alternative is unlikely to be actively supervised to ensure overriding community benefit and would not come close to achieving the same level of efficiencies, cost-savings and quality enhancement opportunities as those proposed by the New Health System and outlined in this Application.

(iii) Clinical standardization;

RESPONSE: A well-executed merger can also improve patient outcomes if it results in improved performance management processes to assist leaders in identifying where (and why) problems are occurring and how to implement best practices to coordinate care across the system. The New Health System is firmly committed to standardizing its management and clinical practice policies and procedures to promote efficiency and higher standards of care throughout the New Health System. As evidence of this commitment, the New Health System will establish a system-wide, physician-led Clinical Council in order to identify best practices that will be used to develop standardized clinical protocols and models for care across the New Health System. These standardized practices, models and protocols will help reduce error and overlap, shorten length of stay, reduce costs, and improve patient outcomes. The Cooperative Agreement will allow the New Health System to share the clinical and financial information needed to integrate this process across the range of inpatient, outpatient, and physician services. The Clinical Council will be composed of independent, privately practicing physicians as well as physicians employed by the New Health System or its subsidiaries or affiliates as more fully described in **Section 8** herein. It would not be possible for the two competing systems to standardize procedures and policies for clinical best practices as effectively, or to develop such new care models, absent the merger.

Many of the initiatives to reduce variation and improve quality will be derived from new contracting practices designed to ensure collaboration between the New Health System and the payers. These practices will be designed to use the analytic strength of the payers to identify high cost services and processes, and then align the interest of the payer and the New Health System to reduce cost and improve the overall patient outcome. This approach to value-based purchasing will truly harness the intent of the changes in federal policy that encourage improved population health. From contracting to implementation, the objective is to identify where the opportunities for patient outcome improvement and cost reduction exist, and to then collaborate with physician leadership to execute legitimate and scalable strategies throughout the region to achieve the mutual objectives of the payer and the health delivery system.

(iv) Alignment of cultural identities of the parties to the Cooperative Agreement; and

RESPONSE: There are many specific steps the Parties will take to align the cultural identities of the two organizations, including merging the executive leadership, establishing a board made up of equal representation from both legacy systems, agreeing on the appointment of new, independent board members with expertise in integration, implementation of a Clinical Council, bringing together key providers of both systems and implementing a single information technology platform that will be used to promote system-wide communication, cultural integration, and implement common clinical standards for improvement of patient quality.

The New Health System's board of directors and management team will be composed of current executives from both Wellmont and Mountain States.

- The board of directors of the New Health System will be comprised of fourteen voting members, as well as two ex-officio voting members and one ex-officio non-voting member. Wellmont and Mountain States will each designate six members to serve on the initial board of the New Health System.

- Wellmont and Mountain States will jointly select two members of the initial New Health System board, who would not be incumbent members of either Party's board of directors.

- The two ex-officio voting members will be the New Health System Executive Chairman/President and the New Health System Chief Executive Officer. The ex-officio non-voting member will be the then current President of ETSU.

- The New Health System will have a new name and will be managed by an executive team with representatives from each organization serving in the following agreed-upon roles—Executive Chairman/President Alan Levine (currently Mountain States' CEO), CEO Bart Hove (currently Wellmont's CEO), Chief Operating Officer Marvin Eichorn (currently Mountain State's Chief Operating Officer) and Chief Financial Officer Alice Pope (currently Wellmont's Chief Financial Officer).

- All Board committees of the New Health System will be established with initial membership of equal representation from both legacy organizations. Likely committees will include: Executive, Finance; Audit and Compliance; Quality, Service and Safety; Executive Compensation; Workforce; Community Benefit; and Governance/Nominating.

Promptly after Closing, the New Health System will establish a physician-led Clinical Council (see **Section 8.A.iii**) to establish common standards of care, credentialing standards, quality performance standards and best practices. The initial Clinical Council will equally represent physicians whose primary practice venue is currently Wellmont or Mountain States.

As discussed in **Section 8.A.i**, the New Health System will adopt a Common Clinical IT Platform that will allow all providers in the New Health System to quickly obtain full access to patient records at the point of care and will be used for system-wide communication and monitoring of best practices and establishment of new protocols to improve quality of care.

The New Health System is committed to its current workforce and will honor prior service credit, address any differences in salary/pay rates and benefits, offer

competitive salaries, and combine the best of each hospital's career development programs as described more fully in **Section 11.f**.

Cultures will be further aligned by the increased emphasis on quality through the use of a common set of measures and protocols and the timely public reporting of many quality measures, as discussed in **Section 8.A.iv**. This combined emphasis on quality and public reporting of quality measures will significantly contribute to promoting a common culture emphasizing quality in the New Health System.

(v) Implementation of risk-based payment models to include risk, a schedule of risk assumption and proposed performance metrics to demonstrate movement toward risk assumption and a proposed global spending cap for hospital services.

RESPONSE: Wellmont and Mountain States believe the formation of the New Health System will greatly accelerate the move from volume-based health care to value-based health care. The Affordable Care Act is moving providers away from the fee-for-service reimbursement system toward a risk-based model that rewards improved patient outcomes and incentivizes the provision of higher-value care at a lower cost. CMS has stated that its goal is to have 85% of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. However, the movement to value-based payment requires comprehensive provider networks to form and contract for the total care of patients in a defined population. The formation of the New Health System will align the region's hospitals and related entities into one seamless organization, working together to enter into value-based contracts. The scale created by the merger will foster opportunities for cost-savings and quality-enhancement through risk contracting to a degree neither system could come close to achieving independently.

The New Health System intends to discuss risk-based models with its Principal Payers for some portion of each Principal Payer's business. Those discussions would address both New Health System's and Principal Payer's willingness and ability to successfully implement risk-based models and over what time period. Additionally, the New Health System will commit to having at least one risk-based model in place within two years after Closing. No payer has historically expressed an interest in a global spending cap for hospital services in this region. However, after completing its clinical integration/alignment, the New Health System is willing to engage in those discussions if requested by a reputable payer, and assuming the New Health System is extended an actuarially sound proposal.

As further evidence of its commitment to move towards risk-based payment, the New Health System is willing to commit to the following:

COMMITMENTS

- For all Principal Payers,* the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the system.

- Adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System. This fully integrated medical information system will allow for better coordinated care between patients and their doctors, hospitals, post-acute care and outpatient services and facilitate the move to value-based contracting.

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

(i) **REQUEST**: A description of the plan, including economic metrics, that details anticipated efficiencies in operating costs and shared services to be gained through the Cooperative Agreement including:

- Proposed use of any cost savings to reduce prices borne by insurers and consumers;

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term Population health improvements; and

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

RESPONSE: Funding the population health, access to care, enhanced health services, and other commitments described in this Application would be impossible without the efficiencies and savings created by the merger. By aligning Wellmont's and Mountain States' efforts in key service areas, the New Health System will drive cost savings through the elimination of unnecessary duplication, resulting in more efficient and higher quality services. The Parties have analyzed the anticipated efficiencies in three categories and calculated the following anticipated savings.

The Parties commissioned FTI Consulting, Inc., an independent, nationally-recognized health care consulting firm ("FTI Consulting"), to specifically perform an economies and efficiencies analysis regarding the proposed savings and efficiencies. The economies analysis was divided into three major segments. Segment One was the efficiencies and savings that could be achieved in the area of purchased services (the "Non-Labor Efficiencies"). Segment Two was the savings and efficiencies that could be achieved by aligning the two system's health work forces (the "Labor Efficiencies"). Segment Three

was the efficiencies and savings that could be achieved by clinical alignment (the "Clinical Efficiencies"). The findings of the FTI Consulting Report are more fully discussed below.

1. Non-Labor Efficiencies. The Parties have comparable size, and each has multiple facilities. Their purchasing needs are similar, including non-medical items such as laundry and food services, and clinical-related items such as physician clinical preference items, implantable devices, therapeutics, durable medical equipment, and pharmaceuticals. The larger, combined enterprise of the New Health System will be able to generate significant purchasing economies. These non-labor efficiency savings would include

    - Harmonization to a Common Clinical IT platform
    - Consolidation of purchased services (Blood/Blood products, Anesthesia, Legal, Marketing, Executive Recruitment, etc.)
    - Reductions in unnecessary duplication of Call Pay
    - Reductions in Locum Tenens and use of "Registry Staff"
    - Renegotiations of service, maintenance, and other contracts
    - Reductions in the duplication of subscriptions, memberships, licenses and other similar payments and
    - Added economies and efficiencies gained from the larger size of the New Health System.

    The Parties have identified potential savings from the merger in the areas of non-labor expenses totaling approximately $70 million annually that would not be possible but for the merger. The Non-Labor Efficiencies is "a reasonable estimate" of what can be achieved by the combination. It is characterized by FTI Consulting, and the Parties, as neither "conservative" nor "optimistic."

2. Labor Efficiencies. The workforce is the lifeblood of a health care organization, and the competition for the labor force will remain intense, both locally and regionally. As stated in **Section 6** herein, the majority of outpatient services will not be controlled by the New Health System, and other very significant inpatient providers are located nearby. Thus, the New Health System will remain competitive as it relates to salary and benefit offerings, and will be committed to the ongoing development of its workforce. As discussed in **Section 11.f**, the Parties are committed to their existing workforces and the New Health System intends to offer all current employees of Wellmont and Mountain States comparable positions within the New Health System. However, with time, including through attrition, the New Health System will reduce duplication, overtime and other premium labor costs. In many cases, employees can be moved into new or expanded roles to optimize existing expertise, competencies and productivity within the integrated delivery system. The Parties have identified potential savings from

the merger in labor expenses totaling approximately $25 million annually. These savings could extend across a variety of departments and areas:

- Administration;
- Biomedical Engineering;
- Patient Access/Registration;
- Finance and Accounting;
- Health Information Management;
- Human Resources;
- Facilities and Maintenance;
- Security;
- Supply Chain; and
- Other departments and areas.

It is very important to note, however, that a significant portion of these savings would be reinvested through financial commitments in the development of the many new programs and services outlined in this Application, including new clinical offerings, behavioral health services, community health improvement initiatives, and academics and research. While national trends in health care will apply in this region and could negatively impact the workforce over time, the Parties strongly believe the net effect of the merger on the health care workforce in the region will be positive rather than negative.

These Labor Efficiencies are considered "conservative" since the savings discussed do not include any clinical personnel, and the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

3. Clinical Efficiencies. The alignment of clinical operations of two previously independent hospital systems into a merged entity can yield improved outcomes, reduced costs of care and related efficiencies, and improve sustainability of the most effective levels of services at the right locations. To ensure that the care delivery decisions of the New Health System are aligned with the interests of the community, the New Health System will adopt a comprehensive Alignment Policy (discussed in **Section 11.h.ii**) that will allow the New Health System to utilize a rigorous, systematic method to evaluate the potential merits and adverse effects related to access, quality and service for patients and make an affirmative determination that the benefits of the proposed consolidation outweigh any adverse effects. The clinical efficiencies

generated by the Alignment Policy will result in operating efficiencies, improved quality and improved access that would not be accomplished without the merger. The anticipated clinical efficiencies generated by the New Health System are largely driven by the New Health System's ability to align duplicative health care services for better care delivery. Cost-saving and efficiency opportunities for the New Health System include consolidation of the area's two Level I Trauma Centers, consolidation of specialty pediatrics services, repurposing acute care beds and consolidation of certain co-located ambulatory facilities. The Parties have identified potential savings from the merger in clinical efficiencies totaling approximately $26 million annually. Much like the Labor Efficiencies, the Clinical Efficiencies are considered "conservative" since the clinical alignment process has only commenced with the identification of preliminary consolidation opportunities. As more fully discussed in **Section 11.h.ii**, the labor and clinical savings require an institutional process among the stakeholders in the community through the proposed Alignment Policy. It is not possible for the Parties to engage in this process without the protection of the COPA, and the Parties do not believe it is appropriate to undertake the process without the full and complete participation of community stakeholders after the COPA is granted.

The potential savings identified here are limited to the estimated dollar savings from the realignment of services and clinical efficiencies, and do not include the potentially significant benefits that are expected to be achieved through improved access, quality, and care in the optimal locations for access to care that will directly benefit these communities.

- Proposed use of any cost savings to reduce prices borne by insurers and consumers.

  RESPONSE: To ensure that savings and benefits are passed on from the merged system to patients, employers and insurers, while also investing in improving quality and patient service, the New Health System will make the following commitments.

COMMITMENTS

- For all Principal Payers,* the New Health System will reduce existing commercial contracted fixed rate increases by 50 percent (50%) for the first contract year following the first contract year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.

- For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant Index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that result in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable consumer price index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, New Health Systems agrees to mediation as a process to resolve any disputes

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

- Proposed use of cost savings to fund low or no-cost services such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services designed to achieve long-term population health improvements.

  RESPONSE: The New Health System is committed to improving community health through investment of not less than $75 million over ten years in science

and evidence-based population health improvement. Combining the region's two major health systems in an integrated delivery model is the best way to identify regional priorities, collaborate with payers to identify cost drivers and areas of need for improvement and to invest the resources it will take to effect material improvements. These efforts will provide resources that may be invested in more focused and meaningful value-based spending in the region – spending that helps expand currently absent, but necessary, high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. The New Health System would commence this process by preparing a comprehensive community health improvement plan that identifies the key strategic health issues for improvement over the next decade. The health improvement plan would be prepared in conjunction with the public health resources at ETSU. The process has already commenced through the four Community Health Work Groups described herein. Population health improvement funding may be committed to the following initiatives, as well as others based upon the 10-year plan for the region.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

The Parties believe that prevention services, such as immunizations, mammograms, chronic disease management and drug and alcohol abuse services, are all essential ingredients in achieving population health improvements and maintaining a population's long-term health and wellness. Certain counties in the service area have achieved noteworthy performance in specific areas. For

example, the Northeast region[9] ranks among the best in Tennessee in immunizations, and Sullivan County ranks well in mammograms. However, as a general rule, the health status of the service area population is in need of significant improvement. Targeted efforts to address immunizations and preventive screenings are expected to be explicitly derived from the MAPP community health improvement process outlined in this Application. The Parties intend to address chronic disease management as part of the "Helping Adults Live Well" strategy outlined in this Application. Specific plans regarding drug and alcohol abuse services are detailed in **Section 8.H** of this Application. It is anticipated that the Community Health Work Groups, the Advisory Groups appointed by the Commissioner, and the agreed-upon Health Index will reflect specific actions and strategies in connection with a broad range of prevention services, including immunizations, mammograms, chronic disease management and drug and alcohol abuse services. Further, the Parties believe there are significant opportunities to partner with all categories of payers to create effective systems of care for best practice preventative services and to extend those services to both economically and geographically underserved populations through effective collaboration with Federally Qualified Health Centers, charity care clinics, health departments and others. In addition, Mountain States operates drop-by Health Resources Centers which support chronic disease prevention and management in Kingsport and Johnson City and Wellmont owns and operates mobile health buses that are equipped to offer immunizations, cardiovascular and cancer screenings, mammograms, and physicals along with health education and coaching resources to engage with populations for effective behavior change and the extension of disease management resources. Mobile strategies will allow reach into populations with both economic and geographic barriers and can be further supplanted by a host of health IT and telemedicine strategies which are envisioned to be developed as part of the long-range community health improvement plan. Both organizations operate nurse call centers which are able to engage with populations for the development of wellness and prevention coaching and disease management programming to help overcome geographic and social barriers.

- Other proposed uses of savings to benefit advancement of health and quality of care and outcomes.

  RESPONSE: The savings realized by reducing duplication and improving coordination will stay within the region and be reinvested in ways that benefit the community substantially, including:

[9] The Northeast region includes the following counties: Carter, Greene, Hancock, Hawkins, Johnson, Unicoi, and Washington. The rate represents the percent of 24-month-old children in Tennessee that have completed their required immunization series. The rate ranges from a high of 93% to a low of 65.3%. Tennessee Immunization Program, Tennessee Department of Health. "Results of the 2013 Immunization Status Survey of 24-Month-Old Children in Tennessee. *See* https://tn.gov/assets/entities/health/attachments/ImmunizationSurvey2013.pdf *accessed* February 4, 2016.

Access to Health Care and Prevention Services. Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding. The New Health System will commit at least $140 million over ten years toward certain specialty services. It will also commit to create new capacity for residential addiction recovery services; develop community-based mental health resources such as mobile health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents; ensure recruitment and retention of pediatric sub-specialists; and develop pediatric specialty centers and emergency rooms in Kingsport and Bristol, with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals. These initiatives would not be sustainable in the region without the financial support created by the merger.

Improving Health Care Value. Lack of coordinated and integrated care increases costs and decreases overall effectiveness of care in this region thus contributing to the overutilization of costly inpatient services. The New Health System has the opportunity to use resources derived from efficiencies and the realignment of services to reduce overutilization of inpatient services in the region and stem the pace of health care cost growth for patients, employers and insurers. To ensure that savings realized by reducing duplication and improving coordination will remain within the region and be reinvested in ways that substantially benefit the community through new services and capabilities, the New Health System is prepared to make significant commitments related to pricing, consolidation of services, and standardization of practices which are described in more detail in this Application.

Investment in Health Research and Graduate Medical Education. The New Health System will commit not less than $85 million over ten years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty – all critical to sustaining an active and competitive training program. These funds will enhance the Parties' academic partners' abilities to invest in additional research infrastructure, a significant benefit to the State of Tennessee and Commonwealth of Virginia. Additionally, partnerships with academic institutions in Tennessee and Virginia will enable research-based and academic approaches to the provision of the services the New Health System intends to invest to improve overall population health. These initiatives would not be sustainable in the region without the financial support created by the merger.

Avoidance of Duplication of Hospital Resources. Combining the region’s two major health systems in an integrated delivery model is the best and most effective way to avoid the most expensive duplications of cost, and importantly, take advantage of opportunities to collaborate to reduce cost while sustaining or enhancing the delivery of high quality services. These efforts will provide resources that can be invested in more value-based spending in the region –

spending that helps expand (and where absent, implement) necessary high-level services at the optimal locations of care, improve access for mental health and addiction-related services, expand services for children and those in need, improve community health and diversify the economy into research. Enhancing the coordination, integration, sustainability and development of new models of care delivery across the community improves the health of this region's residents and the economy of its communities.

Improvements in Patient Outcomes. The region served by the Parties to the Cooperative Agreement faces significant health care challenges. In this environment, a key goal of the Cooperative Agreement is to better enable the Parties to sustain and enhance services and improve the quality of health care and patient outcomes in the region. The New Health System will adopt a Common Clinical IT Platform to allow providers in the New Health System the ability to quickly obtain full access to patient records at the point of care, supporting the regional exchange of health information to encourage and support patient and provider connectivity to the New Health System's integrated information system, establishing a system-wide, physician-led clinical council responsible for implementing quality performance standards across the New Health System, and publicly reporting extensive quality measures with respect to the performance of the New Health System to promote transparency and further incentivize the provision of high quality care. These commitments will result in the investment of up to $150 million over ten years to ensure a Common Clinical IT Platform and interoperability among the New Health System's hospitals, physicians, and related services.

Preservation of Hospital Facilities in Geographical Proximity to the Patients They Serve. The Parties recognize that it will be increasingly difficult to continue supplementing rural facilities over the long-term without the savings the proposed merger would create. Continued access to appropriate hospital-based and clinical services in the rural areas of these communities is a significant priority and a driving impetus for the Cooperative Agreement. Last year alone, Mountain States and Wellmont collectively invested over $19.5 million to ensure that inpatient services continued to remain available in these smaller communities. To address this, the New Health System will commit that all hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five years. In order to ensure higher-level services are available in close proximity to where the population lives, the New Health System will also commit to maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol. The proposed Cooperative Agreement is the only means to achieve the efficiencies and generate the resources needed to sustain hospital operations in these areas across the region to preserve and enhance access to quality care in these rural communities.

Enhanced Behavioral Health & Substance Abuse Services. In the region the Parties serve, behavioral health problems and substance abuse are prevalent, imposing an extensive societal cost that warrants priority attention. The largest diagnosis related to regional inpatient admissions is psychoses, yet significant

gaps exist in the continuum of care related to these services. As part of the public benefit associated with the merger, the New Health System commits to make major investments in programs and partnerships to help address and ameliorate behavioral and addiction problems. The New Health System will invest in the development of new capacity for residential addiction treatment with the goal of reducing the incidence of addiction in our region.

(j) **REQUEST**: Proposed Measures and suggested baseline values with rationale for each Measure to be considered by the Department in development of an Index. Proposed Measures are to be used to continuously evaluate the Public Advantage of the results of actions approved in the COPA through the Cooperative Agreements under active supervision of the Department. Measures should include source and projected trajectory over each of the first five years of the Cooperative Agreement and the trajectory if the COPA was not granted; Proposed Measures may include:

(i) Improvements in the service area population's health that exceed Measures of national and state improvement;

(ii) Continuity in availability of services throughout the service area;

(iii) Access and use of preventive and treatment health care services throughout the service area;

(iv) Operational savings projected to lower health care costs to payers and consumers; and

(v) Improvements in quality of services as defined by surveys of the Joint Commission.

RESPONSE: The region served by the Parties to the Cooperative Agreement faces significant health care challenges. For example, a 2015 Tennessee Department of Health report finds that all Tennessee counties in the Geographic Service Area exceed the national average for smoking. The state level obesity rate exceeds the national average and several counties within the Geographic Service Area have obesity rates of more than thirty percent (30%). According to the same report, three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for frequency of low birth weight births and three Tennessee counties in the Geographic Service Area are in the bottom third (worst group) for teen pregnancy rates. **Table 8.1** reports key statistics on the population of the counties in the Geographic Service Area, including metrics for obesity, smoking, death rates due to drug poisoning and childhood poverty.

The Parties share the State's concern about health disparities in the region and are aware of the acute challenges present in the individual counties across the Geographic Service Area. As a result, the Parties propose that ongoing evaluation of the Public Advantage resulting from the merger take into consideration the New Health System's pursuit of the Institute of Health Improvement's Triple Aim goals, commonly considered the national standard for evaluation of health care effectiveness. The Triple Aim objectives are to improve population health, improve patient experience of care (quality and access), and

manage the per capita cost of health care. In this application, the Parties have organized the necessary actions by the New Health System to pursue the Triple Aim objectives as follows:

- Improving Community Health
- Enhancing Health Care Services
- Expanding Access and Choice
- Improving Health Care Value: Managing Quality, Cost and Service
- Investment in Health Research and Graduate Medical Education
- Attracting and Retaining a Strong Workforce

In order to evaluate the public benefit provided by the New Health System on a continuous basis, the Parties propose that the Department adopt an **Index of Public Advantage and Community Health Improvement** comprised of five major categories:

A. Commitment to Improve Community Health
B. Enhanced Health Care Services
C. Expanding Access and Choice
D. Improving Health Care Value: Managing Quality, Cost and Service
E. Investment in Health Research/Education and Commitment to Workforce

A description of each category and the accountability mechanisms the Parties propose the State consider for each category are outlined in detail in the following sections.

A. Commitment to Improve Community Health

Community health is affected by a complex variety of factors including genetic predisposition, behavioral patterns, social circumstances, environmental exposures, and access to quality health care. Because of the complex set of influences that shape community health and well-being, effective improvement strategies must be developed through a combination of evidence-based approaches and an understanding of local and regional culture, capacity and resources. Plans that are adopted "off the shelf" from elsewhere, without community buy-in and adaptation, have less chance of success. Although there are similarities with other parts of Tennessee and Virginia, the southern Appalachian mountain region of Northeast Tennessee and Southwest Virginia has a distinct culture, capacity and resource base that results in a unique set of health issues.

There are tremendously valuable assets, organizations and individuals highly motivated to address the underlying factors that affect the poor health status of our region. ETSU's College of Public Health and Quillen College of Medicine are both nationally recognized for their contributions to rural community health improvement, along with a host of other academic institutions throughout the region. In addition, municipalities, community organizations such as local United Way agencies and YMCAs, Healthy Kingsport, chambers of commerce, and health departments are highly motivated to work in new, focused ways to improve community health.

Much of the work and investment devoted to these efforts in the past, however, has

lacked unified focus in combination with sustainable funding. While the Parties believe that motivated leadership and substantial investment from the New Health System will be transformational, they also believe that a sustainable collective impact model of community health improvement stands the best chance of creating long-standing health improvements.

To make sustained improvements in health, a portfolio of investments, interventions and performance improvements designed to impact specific long-term goals at a variety of intervention and prevention levels is necessary. **Figure 11.1** depicts the National Association of County and City Health Officials Mobilizing for Action through Planning and Partnerships ("MAPP") process for community health improvement. MAPP suggests that it is critical for the New Health System, the State and local Departments of Health and the broad community of stakeholders to work together in an Accountable Care Community arrangement to formulate the appropriate investments, interventions and performance improvements to populate a robust and dynamic community health improvement portfolio. This process includes 1) defining a common vision and goals; 2) conducting comprehensive assessments of community health status and well as community and public health systems culture, capacity and resources; 3) prioritizing health issues; 4) formulating goals and strategies; and 5) evaluation and monitoring.

Figure 11.1 - Mobilizing for Action through Planning and Partnerships

Some progress has already been made. Several local, state and national analyses have identified the key health issues in our region and there is considerable overlap in their findings. Groups such as the Southwest Virginia Health Authority, Healthier Tennessee, and Healthy Kingsport have organized to collectively address these findings, and important relationships have been formed.

Additionally, in cooperation with the College of Public Health at ETSU, the Parties launched the region's most substantial community health improvement assessment effort

in August. Four Community Health Work Groups have been created to specifically focus on medical needs of the medically underserved, identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. These workgroups are co-chaired by regional community leaders from both Tennessee and Virginia and are organized by Healthy Children and Families, Mental Health and Addiction, Population Health and Healthy Communities, and Research and Academics. The charters for these groups can be found in **Exhibit 8.2A**.

Analyzing the most current findings of the Tennessee State Health Plan, the Virginia Health Innovation Plan, Healthier Tennessee and the Southwest Virginia Blueprint for Health Improvement and Health-Enabled Prosperity, as well as initial feedback from the Community Health Work Groups organized by Mountain States and Wellmont, the Parties have identified five Key Focus Areas and several related Health Concerns in which the New Health System is committed to investing at least $75 million over ten years in population health improvement.

- ***Ensure strong starts for children*** by investing in programs to reduce the incidence of low-birth weight babies and neonatal abstinence syndrome in the region, decrease the prevalence of childhood obesity and Type 2 diabetes, while improving the management of childhood diabetes and increasing the percentage of children in third grade reading at grade level.

- ***Help adults live well in the community*** by investing in programs that decrease premature mortality from diabetes, cardiovascular disease, and breast, cervical, colorectal and lung cancer.

- ***Promote a drug-free community*** by investing in programs that prevent the use of controlled substances in youth and teens (including tobacco), reduce the over-prescription of painkillers, and provide crisis management and residential treatment with community-based support for individuals addicted to drugs and alcohol.

- ***Decrease avoidable hospital admission and ER use*** by connecting high-need, high-cost uninsured individuals in the community to the care and services needed by investing in intensive case management support and primary care, and leveraging additional investments in behavioral health crisis management, residential addiction treatment and intensive outpatient treatment services.

- ***Improve Access to Behavioral Health Services*** through new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region; as well as community-based mental health resources, such as mental health crisis management teams and intensive outpatient treatment and addiction resources for adults, children, and adolescents designed to minimize inpatient psychiatric admissions, incarceration and other out-of-home placements.

For the first category of the Index, the Parties propose an accountability mechanism for

the commitment to improve community health that the New Health System has set forth in this Application. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) in **Table 11.6**.

Table 11.6 - Proposed Commitment to Improve Community Health Measures

Index of Public Advantage and Community Health Improvement **A. Commitment to Improve Community Health Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	The New Health System is committed to creating a new integrated delivery system designed to improve community health through investment of not less than $75 million over ten years in population health improvement.	Annual report to State attesting to progress towards compliance until $75 million is invested.
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed-upon by the State and the New Health System in the COPA.	Commitment to Community Health Annual Report to State will attest to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.

In addition to the Commitment to Community Health Annual Report, described in more detail below, the Parties will submit a yearly report to the State attesting to progress toward the creation of a new integrated delivery system through investment of not less than $75 million and an annual report to the State attesting to compliance with the quality reporting obligations as outlined in the COPA.

The annual report to the State attesting to progress on the achievement of accountability mechanisms for each Key Focus Area (the "Commitment to Community Health Annual Report") would be developed as follows:

Proposal for Development of the Commitment to Community Health Annual Report

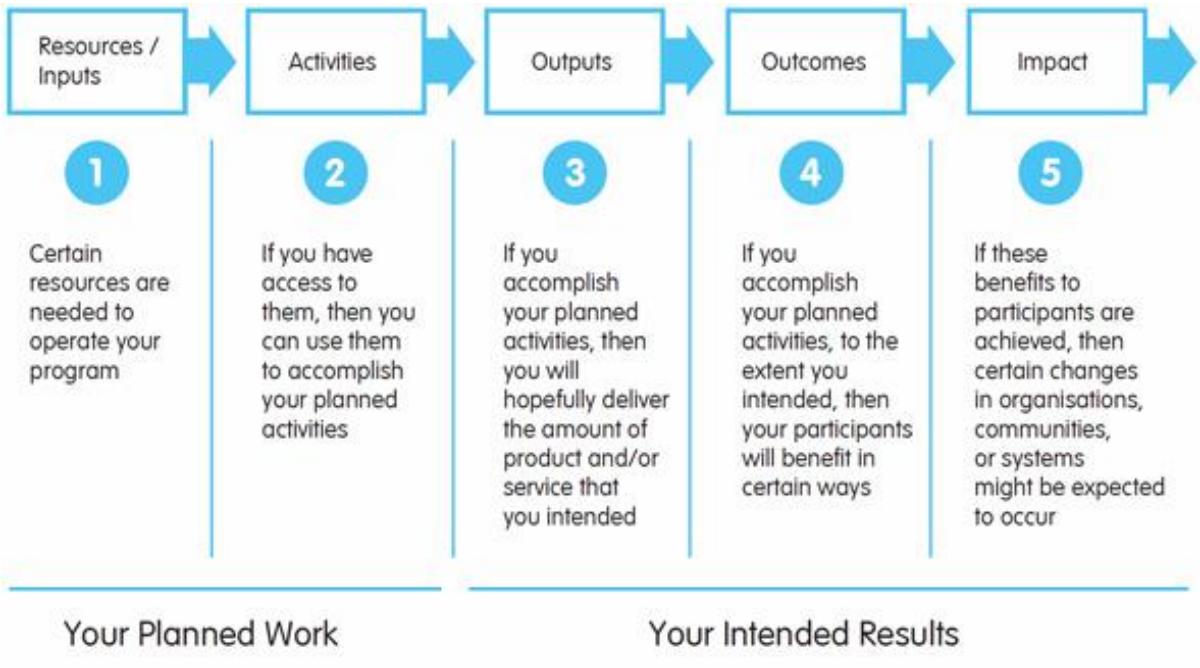
- As part of the State's process to determine the Application's completeness, the Department and the Parties will agree on the Key Focus Areas of the commitment to improve community health.
- After the Application is deemed complete, and during the Application review period, the New Health System and the Department, with input from community stakeholders (including the Department's Advisory Groups) will agree on a limited number of Health Concerns, Tracking Measures and relevant baselines within each Key Focus Area. Agreement on these specific Health Concerns for inclusion in the Commitment to Community Health Annual Report will serve as the guide for on-going development with the State and stakeholder community for the specific investments, interventions or performance improvements by the New Health System to improve community health in the region over the duration of the COPA.

- The COPA, if granted, will outline the specific Key Focus Areas, the individual Health Concerns, the Accountability Mechanisms, the Tracking Measures, and relevant baselines within each area agreed upon by the Department and the New Health System to be included in the Commitment to Community Health Annual Report.

Recognizing the complex interplay of inputs and activities in reaching desired population health outcomes, the Parties propose to use the Kellogg Foundation's Logic Model displayed in **Figure 11.2** for development of the Commitment to Community Health Annual Report Measures.

The evaluation of improvement in community health is complex and involves many factors, both short-term and long-term. Population health improvement programs can be characterized by their inputs, activities, outputs, outcomes, and impact. *Inputs* are the resources dedicated to or consumed by the program, including the human, financial, organizational, and community resources a program has available to direct toward doing the work. *Activities* are what the program does with its inputs to fulfill its mission. These include the processes, tools, events, technology, and actions that are an intentional part of the program implementation. *Outputs* are the direct products of program activities and may include types, levels and targets of services to be delivered by the program. *Outcomes* are the specific changes in program participants' behavior, knowledge, skills, status and level of functioning. *Impact* is the fundamental change occurring in organizations, communities or systems as a result of program activities often with longer-term time frames of 7 to 10 years.

Figure 11.2 - Logic Model for Evaluation



Under this model the State could evaluate progress toward *long-term* community health improvement outcomes under the COPA by measuring investments made in community health (Inputs) and the implementation of new programs or performance improvement (Activities). The State and the New Health System could track participation or service levels related to these programs and performance improvements (Outputs). Over time, the cumulative effect of these efforts is expected to result in the intended population health improvement (short and medium-term Outcomes and long-term Impact).

Table 11.7 identifies the proposed five Key Focus Areas in which the New Health System is committed to investing in community health improvement and which the Parties propose be included in the Commitment to Community Health Annual Report. Within each Key Focus Area, the Parties have identified specific Health Concerns (first column) that pose an important challenge and priority for health in this region; these are aligned with health challenges and priorities identified by the states. The second column identifies a common national measure and a reliable source of data used to track each county's status relative to this Health Concern. These measures provide for comparison with other areas in the states or nationally.

Column Three provides a *representative* investment, intervention or performance improvement that could be implemented by the New Health System to address a specific Health Concern. It is proposed that these be identified in partnership with the State and with regional stakeholders over time as part of the MAPP Community Health Improvement Process described earlier and that several investments, interventions or performance improvements are likely to be necessary to address each concern across the Geographic Service Area.

The fourth (highlighted) column provides the relevant Accountability Mechanism the parties believe reflects the New Health System's performance related to the investment, intervention, or performance improvement.

Column Five provides a representative progress measure that could be used to measure progress in the Geographic Service Area for this health concern. [10] The final two columns reference County level disparities as measured by the counties in the Geographic Service Area in Tennessee and Virginia that have the lowest/poorest measure. This recognizes the states' concerns that specific areas may warrant particular attention or intervention.

[10] In addition to consideration of Triple Aim objectives, the Parties also have considered the categories of health measures for access, cost, health, and quality identified in the Institute of Medicine ("IOM") Vital Signs Core Measures; each of the several areas that these investment, intervention, or performance improvement would target are aligned with specific IOM Core Measures.

Table 11.7 - Sample Commitment to Community Health Annual Report

Health Concern		*Health Concern **Tracking Measures** in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[11]
Key Focus Area #1: Ensure Strong Starts for Children							
1.	Low Birth-Weight Babies	Low-birth weight rate per 100,000 population	Establish evidence-based Home Visitation Programs in certain high-risk counties[12]	Establish agreed- upon number of evidence-based Home Visitation Programs[13] in specific counties by set date	Percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs	Johnson, Carter, Cocke[14]	Tazewell, Buchanan, Smyth[15]
2.	Neonatal Abstinence Syndrome	Percent of Births in New Health System with Neonatal Abstinence Syndrome	Establish residential treatment for pregnant woman with addiction in certain high-risk communities[16]	Establish agreed-upon number of residential treatment programs for pregnant woman with addiction in specific counties by set date	Number of women in high-risk communities initiating residential treatment	Hancock, Hamblen, Hawkins[17]	Dickenson, Wise, Tazewell, Buchanan[18]

[11] This column is based on data that includes the Virginia counties and Independent Cities within the Geographic Service Area.

[12] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,4,5,8, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[13] Nurse Family Partnership is one example of a Department of Health and Human Services "evidenced based early childhood home visitation service delivery model." Nurse Family Partnership is designed for first-time, low-income mothers and their children, from during pregnancy to when the child turns two. It includes face-to-face home visits by a registered nurse trained in the Nurse Family Partnership fidelity model.

[14] Tennessee: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

[15] Virginia: Percent of Low Birthweight. County Health Rankings. Accessed February 3, 2016.

[16] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,4,8,and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[17] As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

[18] As county-level Neonatal Abstinence Syndrome data is not currently available, adult drug poisoning deaths is used as a proxy measure. Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

Health Concern		*Health Concern* ***Tracking Measures*** *in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[11]
3.	Childhood Obesity	Percent children w/ BMI >= 95th percentile of the sex-specific CDC BMI-for-age growth charts	Expand "Morning Mile" Program in certain high-risk communities[19]	Expand "Morning Mile[20]" Program through investment of an agreed-upon amount by set date	Number of children participating in Morning Mile in high-risk communities	Hawkins, Sullivan, Greene[21]	Russell, Scott, Grayson, Washington, Wise[22]
4.	Third Grade Reading Ability	Percent 3rd graders reading at grade level	Expand "BEAR Buddies" program[23]	Expand "BEAR Buddies[24]" program through investment of an agreed-upon amount by set date	Number of children participating in BEAR Buddies in Tennessee & Virginia in high-risk communities	Hancock, Cocke, Carter[25]	Bristol City, Buchanan, Wythe[26]
Key Focus Area #2: Help Adults Live Well in the Community							

[19] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[20] The Morning Mile is a before-school walking/running program that gives children the chance to start each day in an active way while enjoying fun, music and friends. The Morning Mile is currently sponsored in the Geographic Service Area by Mountain States. Additional Information is *available at*: https://www.mountainstateshealth.com/medical-services/kohls-morning-mile

[21] As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Tennessee: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

[22] As county-level data on child obesity was not available, adult obesity rates were used as a proxy measure. Grayson, Washington, and Wise are in a three-way tie having the third highest obesity rate among the counties in the service region. Virginia: Percent of Adult Obesity. County Health Rankings. Accessed February 3, 2016.

[23] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[24] The BEAR (Being Engaged to Achieve Reading) Buddies program is a partnership between Niswonger Children's Hospital and local schools designed to help children achieve early reading proficiency. BEAR Buddies pairs high school mentors with students in first, second or third grade who are six months or more behind in their reading level.

[25] Tennessee: TCAP District Level Results – 3rd through 8th Grade Reading Level. Percent Basic through Percent Advanced. Tennessee Department of Education. Accessed February 4, 2016.

[26] Virginia: SOL Assessment – 3rd Grade English Reading Pass Rate for 2014 - 2015. Virginia Department of Education. Accessed February 4, 2016.

Health Concern		*Health Concern* ***Tracking Measures*** *in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[11]
1.	Premature death from Cardiovascular Disease	Age-Adjusted Death Rates for Diseases of the Heart per 100,000	Expansion of community-based smoking cessation programs in certain high-risk communities[27]	Expansion of community-based smoking cessation programs through investment of an agreed-upon amount by set date	Number of participants in smoking cessation programs in high-risk communities	Unicoi, Cocke, Hancock[28]	Tazewell, Smyth, Scott[29]
2.	Premature death from Diabetes	Age Adjusted Death Rates for Diabetes Mellitus per 100,000	Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications[30]	Establish Medical Staff Quality Improvement Project to reduce PQI Admissions for Diabetes Short-Term Complications by set date	Number of Physicians participating in quality improvement project	Hamblen, Carter, Greene, Sullivan[31]	Scott, Smyth, Tazewell
3.	Premature death from Breast, Cervical, Colon and Lung Cancer	Age Adjusted Death Rates for Select Cancers per 100,000	Establish Faith-based screening campaigns for selected cancers (e.g. mammograms, prostate cancer) in specific high-risk counties[32]	Establish agreed-upon number of Faith-based screening campaigns in certain counties by set date	Number of parishioner screenings in high-risk counties	Hawkins, Cocke, Johnson[33]	Bristol City, Smyth, Buchanan[34]
Key Focus Area #3: Promote a Drug-Free Community							

[27] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,7,8,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[28] "Ischemic Heart Disease in Tennessee." US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/.

[29] "Ischemic Heart Disease in Virginia." US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/.

[30] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3,7,8,9,10, and 11. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[31] Tennessee: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/. Greene and Sullivan counties tie for having the third highest rate among counties in the service area. Virginia: Diabetes Mortality Rate. US Department of Health and Human Services' Area Health Resource File. *Available at*: http://ahrf.hrsa.gov/.

[32] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,7,8,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[33] Tennessee: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer 2014. CDC Wonder Database. Accessed February 3, 2016.

[34] Virginia: Age Adjusted Mortality Rate from Breast, Cervical, Colon or Lung Cancer, 2014. CDC Wonder Database. Accessed February 3, 2016.

Health Concern		*Health Concern* ***Tracking Measures*** *in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[11]
1.	Addiction to Prescription Pain-killers and illicit drugs	Addiction death rate per 100,000	Establish a regional residential addiction treatment program[35]	Establishment of a regional residential addiction treatment program by a set date	Number of individuals participating in residential addiction treatment	Hancock, Hamblen, Hawkins[36]	Dickenson, Wise, Tazewell, Buchanan[37]
2.	Tobacco use in Teens	Percent of teens currently smoking	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco in certain high-risk counties[38]	Expand evidence-based teen anti-smoking campaigns such as Teens Against Tobacco through an agreed-upon investment by set date	Number of anti-smoking impressions in high-risk communities	Hancock, Carter, Greene[39]	Wise, Dickenson, Buchanan[40]
Key Focus Area #4: Decrease Avoidable Hospital Admission in the High-Utilizing Uninsured							
1.	Avoidable inpatient admission among the uninsured	PQI Admissions per 1,000 uninsured	Establish Integrated Care Management Program for Uninsured Community Super-Utilizers[41]	Establish agreed-upon number of Integrated Care Management Programs for Uninsured Community Super-Utilizers by set date	Number of Uninsured Community Super-Utilizers in Active Care Management	Hancock, Unicoi, Cocke[42]	Buchanan, Russell, Lee[43]

[35] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,8,10,11, and 14. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[36] Tennessee: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

[37] Virginia: Drug Poisoning Mortality Rate. County Health Rankings. Accessed February 3, 2016.

[38] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 11,2,4,6,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[39] As county-level data on teen smoking was not available, adult smoking rates were used as a proxy. Tennessee: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

[40] As county-level data on teen smoking was not available, adult smoking rates were used as a proxy measure. Virginia: Percent of Adult Smoking. County Health Rankings. Accessed February 3, 2016.

[41] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,4,6,7,8,9,10,11,14, and 15. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14**.

[42] As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Tennessee." County Health Rankings. Accessed February 3, 2016.

[43] As county-level data on avoidable admission among the uninsured was not available, preventable hospital stays for the Medicare population was used as a proxy. "Preventable Hospital Stays in Virginia." County Health Rankings. Accessed February 3, 2016.

Health Concern		*Health Concern* ***Tracking Measures*** *in the Geographic Service Area*	*Representative Investment, Intervention, or Performance Improvement*	*Representative Accountability Measures*	*Representative Progress Measures*	*Lowest Ranking Tennessee Counties in Geographic Service Area*	*Lowest ranking Virginia Counties in Geographic Service Area*[11]
Key Focus Area #5: Access to Behavioral Health Services							
1.	Access to community-based mental health treatment	Psychiatric Admissions through ER per 1,000 ER visits	Establish Crisis Receiving Centers in hospitals serving specific high-risk counties[44]	Establish an agreed-upon number of Crisis Receiving Centers in specific hospitals by set date	Number of individuals managed in Crisis Receiving Center.	Hancock, Cocke, Hamblen[45]	Wise, Dickenson, Tazewell[46]

Representative Example:

If the State and the New Health System agree that one of the Key Focus Areas in the Commitment to Community Health Annual Report should be Ensuring Strong Starts for Children, one health concern the Parties suggest targeting is low birth-weight babies. The baseline for tracking this health concern would be the Low Birth Weight Rate per 100,000 population for specific counties within the Geographic Service Area. One investment, intervention, or performance improvement that the New Health System could undertake to address this health concern would be to establish evidence-based Home Visitation Programs in certain high-risk counties. The Representative Index Measures would reflect the New Health System's commitment to the State to establish an agreed-upon number of evidence-based Home Visitation Programs in certain counties by agreed-upon dates. The Progress Measures that could be used by the State and the New Health System to measure progress in addressing this health concern would be the percentage of eligible women in high-risk communities participating in evidenced-based Home Visitation Programs.

[44] This Representative Investment, Intervention, or Performance Improvement targets IOM Vital Signs Core Measures 1,2,3, and 8. A copy of the IOM Vital Signs Core Measures is attached as **Exhibit 11.14.**

[45] As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Tennessee: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

[46] As county-level data on psychiatric ER visits per 100,000 was not available, the percent of individuals reporting poor mental health was used as a proxy measure. Virginia: Number of Poor Mental Health Days. County Health Rankings. Accessed February 3, 2016.

Periodic Review of the Commitment to Community Health Annual Report

The Parties recognize that population health is dynamic and the health challenges of a region will change over time. The Annual Report established when the COPA is granted should be periodically reviewed and updated to reflect these changes. The Parties propose that the initial Annual Report and its associated plan be established with the issuance of the COPA. On the fifth anniversary of the COPA, the New Health System and the State will evaluate the Annual Report to determine what adjustments, if any, need to be made to plan elements or accountability mechanisms. Once the New Health System and the State have agreed upon these changes, the updated elements of the Annual Report will go into effect on the sixth anniversary of the COPA for a period of five years. The Parties propose that the periodic review of the Annual Report be performed on the same intervals for as long as the COPA remains in effect.

B. Enhanced Health Care Services Measures

Some residents in Northeast Tennessee and Southwest Virginia have acceptable access to many services, but other areas are substantially underdeveloped or lacking services altogether. This is especially true for mental health, substance abuse and specialty pediatric services. These services have not been developed for two primary reasons: first, because patient volumes are disaggregated between the two health systems, and neither system has the critical mass necessary to support the service, and second, because the size of the serviced population is not sufficient to fully support full-time specialists.

Wellmont and Mountain States anticipate significantly improved access to health care under the Cooperative Agreement. The Cooperative Agreement will enable the hospitals to continue to offer programs and services that are now unprofitable and risk curtailment or elimination due to lack of funding.

For the second category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to enhance health care services. **Table 11.8** below indicates five areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.8 - Proposed Enhanced Health Care Services Measures

Index of Public Advantage and Community Health Improvement **B. Enhanced Health Care Services Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	The New Health System commits to spending at least $140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until $140 million is invested.
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities	Annual progress reports and One-time report to State attesting

	throughout the region.	to the creation of new capacity for residential addiction recovery services when complete.
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients' homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.

C. Expanding Access and Choice Measures

Investing in the development of new and expanded services is one way to improve access and choice in the region. Preserving services currently at risk and breaking down barriers for physicians to practice and patients to receive services where they choose is another. The New Health System is committed to both. By integrating the two systems, the Parties will help ensure that communities in the Geographic Service Area continue to have access to the care they need close to home and that care options are expanded rather than reduced.

For the third category of the Index, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to sustain and expand access and choice. **Table 11.9** below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.9 - Proposed Expanding Access and Choice Measures

Index of Public Advantage and Community Health Improvement **C. Expanding Access and Choice Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions	Annual report to State attesting to compliance for five years after formation of the New Health System.

	open.	
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to State attesting to compliance.
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.

D. Improving Health Care Value: Managing Quality, Cost and Service Measures

In addition to achieving reduced costs through improved efficiency and avoidance of waste and unnecessary duplication, the merger will also specifically enable the New Health System to reduce overutilization of inpatient services and stem the pace of health care cost growth for patients, employers and insurers.

As evidence of their commitment to manage quality, cost, and service, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to improve health care value. **Table 11.10** below indicates ten areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted).

Table 11.10 - Proposed Improving Health Care Value: Managing Quality, Cost and Service Measures

Index of Public Advantage and Community Health Improvement **D. Improving Health Care Value: Managing Quality, Cost and Service Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System	Annual report to State attesting to compliance.

	negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.	
	Commitment	*Proposed Accountability Mechanism*
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to State attesting to compliance.
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to State attesting to compliance.
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to State attesting to measurement of quality measures identified in **Section 8(A)(iv)** of the COPA Application.
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.	Annual report to State attesting to compliance.

9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.
10.	The New Health System will not engage in "most favored nation" pricing with any health plans.	Annual report to State attesting to compliance.
* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.		

E. Investment in Health Research/Education and Commitment to Workforce

A cornerstone of the proposed merger is the expansion of the health-related research and academic capabilities of the region through additional funding and closer working relationships with East Tennessee State University and other academic partners in Tennessee and Virginia. The investments made possible by merger efficiencies, and their specific applications in research and development, faculty, and expanded services and training can also contribute to the economic vitality of the area and the improved ability to attract medical professionals and business endeavors; thereby benefiting the communities both with health and economic well-being.

In addition to developing academic and research programs that attract talent to the region, the New Health System intends to attract and retain employees by becoming one of the best health system employers in the nation and one of the most attractive health systems for physicians and employee team members. The workforce is the lifeblood of a health care organization and the competition for the labor force will remain intense, both locally and regionally.

As evidence of their commitments to invest in health research and education and to attract and retain a strong workforce, the Parties propose an accountability mechanism for each of the commitments the New Health System has set forth in this Application to achieve these goals. The table below indicates six areas where the Parties have made commitments to investment, performance, or conduct in the COPA Application as the New Health System. The proposed accountability mechanism to track compliance with these commitments is displayed in the right column (highlighted) of **Table 11.11** below.

Table 11.11 - Proposed Investment in Health Education/Research and Commitment to Workforce Measures

Index of Public Advantage and Community Health Improvement **E. Investment in Health Education/Research and Commitment to Workforce Measures**		
	Commitment	*Proposed Accountability Mechanism*
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training slots, create new specialty fellowship training opportunities, and add faculty.	Annual report to State attesting compliance.
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State

		once complete.
3.	The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to State attesting to compliance after the first year after formation of the New Health System.
	Commitment	*Proposed Accountability Mechanism*
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to State attesting to compliance after the first year after formation of the New Health System.
6.	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to State attesting compliance.

Using the Index

The Parties anticipate that the Overall Achievement Score would be calculated annually and would be used by the State to objectively track the progress of the Cooperative Agreement over time to ensure Public Advantage. To calculate the Overall Achievement Score, the Parties propose that the State assign a "Satisfied" or "Not Satisfied" evaluation to each of the five categories of the Index and that the five categories be given equal weight in the scoring process. The score for each category will be the number of measures within that category successfully satisfied divided by the total number of measures within that category. The five category scores should be combined to determine the "Overall Achievement Score" for each year of active State supervision to ensure Public Advantage.

Representative Example:

For each of the five categories, the State would assign a "Satisfied" or "Not Satisfied" evaluation to the individual measures agreed upon by the New Health System and the State in the COPA as demonstrated in **Table 11.12** below. If the Parties agreed upon the following Index of Public Advantage and Community Health Improvement, the state would evaluate each individual accountability mechanism as follows:

Table 11.12 - Demonstration of Evaluation

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
A.	**Commitment to Improve Community Health**		
1.	The New Health System is committed to creating a new integrated delivery system designed to improve	Annual report to State attesting to progress towards compliance	Satisfied

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	community health through investment of not less than $75 million over ten years in population health improvement.	until $75 million is invested.	
2.	The New Health System is committed to investing in the improvement of community health for the Key Focus Areas agreed upon by the State and the New Health System in the COPA.	Annual report to State attesting to progress on the accountability mechanisms for each Key Focus Area as outlined in the COPA.	Satisfied
3.	The New Health System will commit to expanded quality reporting on a timely basis so the public can easily evaluate the performance of the New Health System as described more fully herein.	Annual report to State attesting to compliance with reporting obligations as outlined in the COPA.	Satisfied
B.	**Enhanced Health Care Services Measures**		
1.	The New Health System commits to spending at least $140 million over ten years pursuing specialty services which otherwise could not be sustainable in the region without the financial support.	Annual report to State attesting to progress towards compliance until $140 million is invested.	Satisfied
2.	Create new capacity for residential addiction recovery services connected to expanded outpatient treatment services located in communities throughout the region.	One-time report to State attesting to the creation of new capacity for residential addiction recovery services when complete.	Satisfied
3.	Ensure recruitment and retention of pediatric subspecialists in accordance with the Niswonger Children's Hospital physician needs assessment.	Report to State attesting to compliance after the third year after formation of the New Health System.	Satisfied
4.	Development of pediatric specialty centers and emergency rooms in Kingsport and Bristol with further deployment of pediatric telemedicine and rotating specialty clinics in rural hospitals to ensure quick diagnosis and treatment in the right setting as close to patients' homes as possible.	Annual report to State attesting to progress towards compliance until pediatric specialty centers and Emergency Rooms have been developed.	Satisfied
5.	Development of a comprehensive physician needs assessment and recruitment plan every three years in each community served by the New Health System. Both organizations know the backbone of a successful physician community is a thriving and diverse choice of practicing physicians aligned in practice groups of their own choosing and preference.	File the Comprehensive Physician Needs Assessment with the State every three years.	Satisfied
C.	**Expanding Access and Choice**		
1.	All hospitals in operation at the effective date of the merger will remain operational as clinical and health care institutions for at least five (5) years. After this time, the New Health System will continue to provide access to health care services in the community, which may include continued operation of the hospital, new services as defined by the New Health System, and continued investment in health care and preventive services based on the demonstrated need of the	Annual report to State attesting to compliance for five years after formation of the New Health System.	Satisfied

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	community. The New Health System may adjust scope of services or repurpose hospital facilities. No such commitment currently exists to keep rural institutions open.		
2.	Maintain three full-service tertiary referral hospitals in Johnson City, Kingsport, and Bristol to ensure higher level services are available as closely as possible to where the population lives.	Annual report to State attesting to compliance.	Satisfied
3.	Maintain open medical staffs at all facilities, subject to the rules and conditions of the organized medical staff of each facility. Exceptions may be made for certain hospital-based physicians, as determined by the Board of Directors	Annual report to State attesting to compliance.	Satisfied
4.	Commitment to not engage in exclusive contracting for physician services, except for certain hospital-based physicians as determined by the Board of Directors.	Annual report to State attesting to compliance.	Satisfied
5.	Independent physicians will not be required to practice exclusively at the New Health System's hospitals and other facilities.	Annual report to State attesting to compliance.	Satisfied
6.	The New Health System will not take steps to prohibit independent physicians from participating in health plans and health networks of their choice.	Annual report to State attesting to compliance.	Satisfied
D.	**Improving Health Care Value: Managing Quality, Cost and Service**		
1.	For all Principal Payers*, the New Health System will reduce existing commercial contracted fixed rate increases by fifty percent (50%) in the first contract year following the first full year after the formation of the New Health System. Fixed rate increases are defined as provisions in commercial contracts that specify the rate of increase between one year and the next and which include annual inflators tied to external indices or contractually-specified rates of increase in reimbursement.	Report to State after first contract year attesting to compliance.	Satisfied
2.	For subsequent contract years, the New Health System will commit to not increase hospital negotiated rates by more than the hospital Consumer Price Index for the previous year minus 0.25%, while New Health System negotiated rates for physician and non-hospital outpatient services will not increase by more than the medical care Consumer Price Index minus 0.25%. This provision only applies to contracts with negotiated rates and does not apply to Medicare or other non-negotiated rates or adjustments set by CMS or other governmental payers. For purposes of calculating rate increases and comparison with the relevant Index, baseline rates for an expiring contract will be used to compare with newly negotiated rates for the first year of the relevant new contract. For comparison with the relevant index, new contract provisions governing specified annual rate increases or set rates of change or formulas based on annual inflation indices may also be used as an alternative to calculated changes. Subject to the Commissioner's approval, the foregoing	Annual report to State attesting to compliance.	Satisfied

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	commitment shall not apply in the event of natural disaster or other extraordinary circumstances beyond the New Health System's control that results in an increase of total annual expenses per adjusted admission in excess of 250 basis points over the current applicable Consumer Price Index. If following such approval the New Health System and a Principal Payer* are unable to reach agreement on a negotiated rate, the New Health Systems agrees to mediation as a process to resolve any disputes.		
3.	The United States Government has stated that its goal is to have eighty-five percent (85%) of all Medicare fee-for-service payments tied to quality or value by 2016, thus providing incentive for improved quality and service. For all Principal Payers*, the New Health System will endeavor to include provisions for improved quality and other value-based incentives based on priorities agreed upon by each payer and the New Health System.	Annual report to State attesting to compliance.	Satisfied
4.	The New Health System will collaborate with Independent Physician Groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients and the overall health of the region.	Annual report to State attesting to compliance.	Satisfied
5.	The New Health System will adopt a Common Clinical IT Platform as soon as reasonably practical after the formation of the New Health System.	Annual report to State attesting to progress towards compliance until the Common Clinical IT Platform is adopted.	Satisfied
6.	The New Health System will participate meaningfully in a health information exchange open to community providers.	Annual report to State attesting to compliance once health information exchange is fully established.	Satisfied
7.	The New Health System will establish annual priorities related to quality improvement and publicly report these quality measures in an easy to understand manner for use by patients, employers and insurers.	Annual report to State attesting to measurement of quality measures identified in **Section 8(A)(iv)** of the COPA Application.	Satisfied
8.	The New Health System will negotiate in good faith with Principal Payers* to include the New Health System in health plans offered in the service area on commercially reasonable terms and rates (subject to the limitations herein). New Health System would agree to resolve through mediation any disputes in health plan contracting.	Annual report to State attesting to compliance.	Satisfied
9.	The New Health System will not agree to be the exclusive network provider to any commercial, Medicare Advantage or managed Medicaid insurer.	Annual report to State attesting to compliance.	Satisfied
10.	The New Health System will not engage in "most favored nation" pricing with any health plans.	Annual report to State attesting to compliance.	Satisfied
E.	**Investment in Health Education/Research and Commitment to Workforce**		
1.	The New Health System will work with its academic partners in Virginia and Tennessee to commit not less than $85 million over 10 years to build and sustain research infrastructure, increase residency and training	Annual report to State attesting compliance.	Satisfied

	Index of Public Advantage and Community Health Improvement Commitment	*Accountability Mechanism*	*Satisfied or Not Satisfied?*
	slots, create new specialty fellowship training opportunities, and add faculty.		
2.	With its academic partners, in Tennessee and Virginia, the New Health System will develop and implement a ten-year plan for post graduate training of physicians, nurse practitioners, and physician assistants and other allied health professionals in the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
3.	The New Health System will work closely with ETSU and other academic institutions in Tennessee and Virginia to develop and implement a 10-year plan for investment in research and growth in the research enterprise within the region.	Annual report to State attesting to compliance until 10-year plan is complete. File 10-year plan with State once complete.	Satisfied
4.	The New Health System will honor prior service credit for eligibility and vesting under the employee benefit plans maintained by Wellmont and Mountain States and will provide all employees credit for accrued vacation and sick leave.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
5.	The New Health System will work as quickly as practicable after completion of the merger to address any differences in salary/pay rates and employee benefit structures.	Report to State attesting to compliance after the first year after formation of the New Health System.	Satisfied
	The New Health System will combine the best of both organizations' career development programs in order to ensure maximum opportunity for career enhancement and training.	Annual report to State attesting compliance.	Satisfied

* For purposes of this Application, "Principal Payers" are defined as those commercial payers who provide more than two percent (2%) of the New Health System's total net revenue. The proposed commitments would not apply to Medicaid managed care, TRICARE, Medicare Advantage or any other governmental plans offered by Principal Payers.

In this representative example, the Overall Achievement Score would be calculated as demonstrated in **Table 11.13** below:

Table 11.13 - Demonstration of Overall Achievement Scoring

Category	**Measures Satisfied**	**Overall Achievement Score**
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	6/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	10/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	**30/30**	**100%**

Continuing Public Advantage

The Parties propose that an Overall Achievement Score rounded to the nearest tenth of one point that equals seventy percent (70%) or above shall be considered clear and convincing evidence of the Public Advantage and the COPA shall continue in effect. An Overall Achievement Score rounded to the nearest tenth of one point that equals fifty percent (50%) up to seventy percent (70%) may be considered clear and convincing

evidence of the Public Advantage depending upon the relative circumstances, and the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA. An Overall Achievement Score rounded to the nearest tenth of one point that is below fifty percent (50%) may be considered evidence, when considering the relative circumstances, that the Public Advantage of the COPA is no longer evident and the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification.

Due to the new and untested nature of the Index of Public Advantage and Community Health Improvement and the significant up-front and ongoing investments required for achieving community health improvement in the Geographic Service Area, it is critical that the Commissioner use proper discretion in determining whether the evidence of the Public Advantage is clear and convincing. Notwithstanding any provision to the contrary, the Commissioner shall consider any and all important public benefits, whether or not explicitly addressed in the Index of Public Advantage and Community Health Improvement. Further, the Commissioner shall have discretion to determine that the clear and convincing standard has been achieved during a particular period even if the Overall Achievement Score falls below the parameters outlined.

Representative Examples:

Example 1. If the New Health System was able to satisfy most of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.14**:

Table 11.14 - Sample Scoring for Example 1

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	3/3	
B. Enhanced Health Care Services	5/5	
C. Expanding Access and Choice	5/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	9/10	
E. Investment in Health Research/Education and Commitment to Workforce	6/6	
Overall Achievement Score	**28/30**	**93.3%**

An Overall Achievement Score of 93.3% is considered clear and convincing evidence of the Public Advantage and the COPA would continue in effect.

Example 2. If the New Health System was not able to satisfy some of the Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.15**:

Table 11.15 - Sample Scoring of Example 2

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	4/5	
C. Expanding Access and Choice	4/6	

D. Improving Health Care Value: Managing Quality, Cost and Service	6/10	
E. Investment in Health Research/Education and Commitment to Workforce	3/6	
Overall Achievement Score	**19/30**	**63.3%**

An Overall Achievement Score of 63.3% may be considered clear and convincing evidence of the Public Advantage, depending upon the relative circumstances considered by the Commissioner. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information in deciding whether to exercise his or her discretion in seeking a modification to the Cooperative Agreement. After considering the Public Advantage and the explanations for why any Measure has not been satisfied, the State, at the Commissioner's discretion, may seek a modification to the Cooperative Agreement under the terms of the COPA.

Example 3. If the New Health System was not able to satisfy several Index of Public Advantage and Community Health Improvement measures for a particular year, the scoring might appear as follows in **Table 11.16**:

Table 11.16 - Sample Scoring of Example 3

Category	Measures Satisfied	Score
A. Commitment to Improve Community Health	2/3	
B. Enhanced Health Care Services	2/5	
C. Expanding Access and Choice	3/6	
D. Improving Health Care Value: Managing Quality, Cost and Service	5/10	
E. Investment in Health Research/Education and Commitment to Workforce	2/6	
Overall Achievement Score	**14/30**	**46.7%**

An Overall Achievement Score of 46.7% may be considered evidence, depending on the relative circumstances, that the Public Advantage of the COPA is no longer evident. The New Health System would be given the opportunity to explain why any Measure has not been satisfied and the Commissioner would consider this information. The Commissioner would allow a reasonable period of time for a remediation plan to be developed, presented, accepted and implemented for re-evaluation. After considering the Public Advantage, the explanations for why any Measure has not been satisfied, and performance under the remediation plan, the State, at the Commissioner's discretion, may begin action to terminate the COPA under the terms of the certification. In deciding whether to take action to terminate the COPA under the terms of the certification, the Commissioner would have the authority to consider important public benefits that contribute to the Public Advantage even if those public benefits are not explicitly addressed in the Index of Public Advantage and Community Health Improvement.

Index of Public Advantage and Community Health Improvement Conclusion

The Parties believe that this Index of Public Advantage and Community Health Improvement proposal outlines a process for the New Health System to align its resources and commitments with the Triple Aim objectives to improve population health, improve patient experience of care (quality and access), and manage the per capita cost of

health care in the region. At the same time, the Parties believe that including the Department, the local departments of health, the Community Health Work Groups, the Advisory Groups, and other community stakeholders in finalizing these proposed Index Categories, Key Focus Areas, and Accountability Mechanisms will lead to greater community buy-in and adaptation of the population health improvement process. Ultimately, the Parties hope that this process will result in the highest chance of success for improving population health across our region.

Exhibits and Attachments

Exhibit Number	Description
Exhibit 11.4	Financial Summary for Mountain States
Exhibit 11.4 - Attachment A	Mountain States Bonds Official Statement for 2011 bonds
Exhibit 11.4 - Attachment B	Mountain States Bonds Official Statement for 2012 bonds
Exhibit 11.4 - Attachment C	Mountain States Bonds Official Statement for 2013 bonds
Exhibit 11.4 - Attachment D	Mountain States Covenant Compliance Certificates for the Last Five Years
Exhibit 11.4 - Attachment E	Mountain States Officer's Certificate Accompanying the Independent Auditor's Report for FY10 to FY14
Exhibit 11.4 - Attachment F	Mountain States Audited Financial Statements for 2009 to 2014
Exhibit 11.4 - Attachment G	Mountain States EMMA – Annual Disclosures for 2010 to 2015 and Material Event Disclosures
Exhibit 11.4 - Attachment H	Mountain States - Rating Agencies
Exhibit 11.5	Financial Summary for Wellmont
Exhibit 11.5 - Attachment A	Wellmont 2011 Bonds Official Statement for 2011 bonds
Exhibit 11.5 - Attachment B	Wellmont Audits – External Audited Financial Statements for 2011 to 2014
Exhibit 11.5 - Attachment C	Wellmont EMMA – Annual Disclosures for 2011 to 2015 and Material Event Disclosures
Exhibit 11.5 - Attachment D	Wellmont External Auditor Management Letters for 2011 to 2014
Exhibit 11.5 - Attachment E	Rating Agencies – Fitch and Standard & Poor's Reports
Exhibit 11.6	Current Annual Budgets for Mountain States
Exhibit 11.7	Current Annual Budgets for Wellmont
Exhibit 11.8	Five Year Projected Budget for New Health System
Exhibit 11.9	Mountain States Insurance Contracts and Payer Agreements
Exhibit 11.10	Wellmont Insurance Contracts and Payer Agreements
Exhibit 11.11	Existing and Future Business Plans of Mountain States
Exhibit 11.12	Existing and Future Business Plans of Wellmont
Exhibit 11.13	Alignment Policy
Exhibit 11.14	Institute of Medicine Vital Signs Core Measures