Southwest Virginia Health Authority
Minutes of
Cooperative Agreement Task Force Meeting
January 3, 2020 at 4:00 PM

Virtual Meeting Through ZOOM ™

I. Call to Order

Chairman Kilgore called the meeting to order at 4:00 p.m.

II. Roll Call

Chairman Kilgore called roll. The following members were present: Mr. Block, Dr. Cantrell, Ms. Brillhart, Senator Carrico, Mr. Chapman, Ms. Copeland, Dr. Henry, Mr. Leonard, Delegate Kilgore, Delegate Pillion, Mr. Neese, Ms. O'Dell, Ms. Sayers, Dr. Rheuban, Dr. Rawlins, Mr. Prewitt, Mr. Weiting, and Ms. Shelton.

III. Declaration of Quorum

Chairman Kilgore declared that a quorum existed.

IV. Approval of Minutes

Chairman Kilgore moved on to the approval of the June 12, 2019 meeting minutes.

Chairman Kilgore mentioned that Ms. Brillhart sent in revisions after they had been circulated and then Delegate Pillion motioned to approve the minutes which are attached as Exhibit A. Dr. Henry seconded the motion. The motion unanimously passed.

V. Officers' Report

A. Treasurer's Report

Chairman Kilgore called on Dr. Henry to deliver the Treasurer's Report.

Dr. Henry stated that the Southwest Virginia Health Authority bank balance as of December 10th, was $41,705.20. Consultant, Mr. Barry, was paid $25,390.36. This leaves the current balance at $16,314.84.

Chairman Kilgore thanked Ms. Henry for the report.

VI. Old Business

A. Two Year Review

Chairman Kilgore introduced Mr. Barry and his colleagues, Mr. Brownlee and Dr. Massaro. He stated that they had been working hard to assist the Authority and Ballad in taking on the role of monitoring the Cooperative Agreement and facilitating communication between Ballad Health, the Department of Health, and the Community.

On behalf of the Authority Chairman Kilgore thanked Mr. Barry and his colleagues for all of the work they have put in over the past few months. Mr. Barry has taken the lead and the Authority will be receiving an update later on in the meeting.

Chairman Kilgore stated that Mr. Mitchell would be presenting for Mr. Barry since he was attending by phone.

Mr. Mitchell stated that he would run through Mr. Barry's prepared report only touching on the high points of the document and allow Mr. Barry to fill in any information that Mr. Mitchell missed. The document is attached as Exhibit B.

Mr. Mitchell provided a brief reminder of the merger that took place in 2018 that included about 21 hospitals, 15,000 people, and about $2 billion in revenue. No matter how much planning was done, Mr. Mitchell stated that this was an incredibly complex operation to put together and took some time to worth through.

Mr. Mitchell stated that an early draft of this report was circulated to everyone last night. Since then, there have been some small revisions, that Mr. Mitchell would review later, but wanted to emphasize Mr. Barry's conclusion which stated, "Based on my familiarity with other health care mergers, Ballad is proceeding expeditiously and confidently in fashioning a single organization from the two legacy organizations, but that process has not been completed." Mr. Mitchell stated that Mr. Barry's statement really spoke to the ongoing nature of what the monitoring activity is going to be in the future.

Mr. Mitchell stated that Mr. Barry's report goes into much more detail than he would discuss in this meeting. Most communication is handled by Mr. Barry. One of the reports that Ballad is required to produce is the annual report. Mr. Barry has worked very hard to condense that down in his report.

Mr. Barry really wanted to speak to what his role was and what the role of the regulators was within the merger. When the merger was approved, access, quality, and price were the three main issues that were focused on. Monitoring progress in those areas as well as monitoring progress against the commitments that Ballad made, was what Mr. Barry viewed his responsibilities as and working with the Department of Health and his counterparts in Tennessee.

Mr. Barry only wanted to cover today a high-level of his submitted report. Mr. Mitchell stated that if anyone had questions, that Mr. Barry's email address was provided inside the report and he encouraged people to reach out to him directly.

Mr. Mitchell stated that inside the report, Section 1.7, Mr. Barry spells out how the Authority should be monitoring this and they really should be looking at the measurement of success. He wanted to remind folks what the standard was and what the Authority should be doing. Mr. Mitchell paused for a moment to allow everyone to review that section of the report.

The first section that Mr. Barry wanted to address was, *Access*. In the report that he provided, he makes the very clear statement upfront that there is no material decline in access despite two healthcare centers being consolidated. Mr. Barry also wanted to point out to the Authority, something that Mr. Mitchell was certain every Authority member was aware of, that there is a significant investment that Ballad is making inside of Lee County to reopen their hospital. This was not a commitment that Ballad had signed up for. They had signed up to provide the same level of services in Lee County that they provide in a county that had a hospital in it if their hospital were

to ever close. Ballad has gone farther than what they are required to do. Mr. Mitchell stated that there was going to be an access of about $15 million to get the hospital reopened. Ballad opened the Urgent Care in Lee County and all reports from that facility state that it has been a great success.

Mr. Barry goes into more detail regarding Wise County in his report, but Mr. Mitchell stated that it was obvious to a lot from the outside that the Wise County situation with three hospitals was untenable going forward. The Tennessee folks approved a consolidation of that as part of their approval. One of the things that Ballad has been able to hold true to was one of the concerns that the Authority had, was the jobs. They have seen plans for repurposing in order to protect those jobs.

Mr. Barry added that Ballad had more surgeries done in Wise County in 2019 than in the proceeding year. Those were surgeries that in the past, would have been done in Kingsport.

The next area in the report is the Physician and Health Professional Recruitment. This included nurses and other health professionals. One key point to bring to the attention of the Authority is the level of recruitment that Ballad has done in the physician and general practitioner area. One hundred and fifty (150) have been recruited, 120 of them in the fiscal year 2020.

There was a concern on the Tennessee side that had come up in several meetings. The concern is that Ballad is driving off physicians. There is really no evidence of this, but Mr. Barry still wanted to address this. The Tennessee monitor had been requested to look into this.

Delegate Pillion asked if there was evidence of other healthcare professionals also being driven off. Mr. Mitchell asked Mr. Barry if he was aware of any. Mr. Barry responded that there were a few cases but it was not as high as the physician positions. Ballad is working on improving this and Mr. Barry stated that they were not driving off any of the professionals.

Mr. Mitchell moved to discuss the Charity Care. There had been some challenges with Charity Care because of definitions and how things are measured. At the time of the merger, the staff stated that they believed that the Charity Care programs were one of the more generous ones that they had experienced in their professional careers. Mr. Mitchell stated that he thought they still believed that, but there is some noise around it as people try to get on the same page in how it is measured in both Virginia and Tennessee.

Mr. Mitchell asked if Mr. Barry had any remarks to add. He stated that they were still looking into it.

Dr. Cantrell stated that there was some discussion about the project access model from Mr. Barry's slides. She wanted to know if it was still in discussion. Mr. Barry stated that it was being wheeled out county by county and perhaps market by market. He did not know if it had Virginia yet. Ballad has uninsured patients who turn to it fairly frequently. Once they are identified as falling under the Charity Care policy, they are given a card, that acts as a type of insurance card. Ballad is arranging so that it allows physician care and screening for those patients. The results should show better outcomes for the patients. They are using an outside contractor to manage this. In another year or so there should be some data to show on how it is working.

Dr. Shelton asked with the drop in the number of patients has there been any tracking to see if those patients are going outside of the region. Mr. Barry responded not to his knowledge but would add it to the questions he asks next week.

Ms. Sayers stated that her son had seen an article in the New York Times that was talking about Ballad Health and their billing practices and that they seem to send their uncollectable bills and patient to collections that are ten times higher than normal rates than at most other healthcare systems. She asked if they had seen it and if they were looking into that article. Mr. Barry stated that he was embarrassed to say no.

Mr. Mitchell stated that he would send to Mr. Barry.

Unidentified individual asked Mr. Barry if there was any provision for the underinsured and the impact of the high deductibles. Mr. Barry stated that there were.

Mr. Mitchell asked for any more questions and then moved to the next section of Mr. Barry's report, quality. There were quite a few discussions on the types of measurements and Mr. Barry provides more detail in his report, but Mr. Mitchell read through some of the high-level findings.

He stated that there were some considerable conversations about eight months ago when one of the agencies came out with their reports. Mr. Mitchell stated that one thing he learned from this was that when someone calls about one of those reports, make sure that you know where they are pulling their data and perhaps more importantly how current their data is. Mr. Barry agreed.

He added that he was concerned that Ballad was below their premerger deadlines on five areas and that their performance in 2019 was worse in some categories than 2018. Mr. Barry pointed out that Ballad was approved in more categories than not. One problem in data are the over reporting of pressure ulcers. Mr. Barry stated that it is common for patients to arrive to the hospital with pressure ulcers before being admitted, so the data could be showing a much higher count of patients experiencing this condition than was a result of the hospitals care. Mr. Barry added that this still is a quality point that Ballad needs to improve.

Mr. Mitchell asked for questions. He added that the focus on improving quality is coming from the very top down. He also stated that it was worth pointing out that 74% of Ballad's revenue is from Medicare and Medicaid. Ballad's operating margin was less than 2% in 2009. So, the numbers are really big and the room for error is really small. Most of the operating margin comes from non-governmental business and from the risk contracting that they do.

The very nature of this process puts some constraints on the price increases that Ballad can implement, because of a document called Addendum 1. Mr. Mitchell asked Mr. Barry if he wanted to discuss charges.

He stated Ballad was limiting its charge increases to the percentages that appeared in Addendum 1. There would be a quirk in the upcoming year that may generate patient complaints. Mr. Barry further explained that Mountain States' charges, historically, were higher than Wellmont charges. That difference continues in legacy Mountain State hospitals and legacy Wellmont hospitals. Ballad is bringing those two different charge structures in line. Mr. Barry stated that there is going to be a little more alignment, that has to occur, once they get their computer systems standardized for all of their hospitals.

Mr. Barry continued by stating at Mountain States' hospitals, charges are going down. At Wellmont hospitals, charges would be increasing by a greater percentage than stated in the Addendum 1 limitations. The Addendum 1 limitation is being applied in the aggregate, that has been reviewed carefully by the Tennessee monitor. The Tennessee monitor believes that Ballad has done it right, that their aggregate charge increase is right. Mr. Barry stated that this does not mean that some

legacy patients at the Wellmont hospitals will say "well I went into the Emergency Room last year and the charge was 'x' for services and I went in this year and it is 'y' and that is more than the previous year." Mr. Barry explained that the charges do appear on bills and the patient would be correct in their statement that percentage increase may be higher, but it is compliant with limitations applied in the aggregate. He added that it was a necessary caution to align the charges between the two organizations.

Delegate Pillion asked Mr. Barry if they had a timeline on aligning these two charge structures. He further asked "(A) was there a reason that they did not align these at the beginning of the merger and (B) why didn't they and (C) when will they?" Mr. Barry stated that he believed that this was going to get them aligned in *pretty much* one step. There will be a second step that will be effective in nine months to one year. They did not do this a year ago because it is a labor intensive process to sort the charges across those two hospitals and they did not have the time to accomplish this before the merger. Mr. Barry added that they have been working on it this past year and have put a lot of time into it so far.

Mr. Mitchell thanked Mr. Barry and asked if there were anymore questions on the charges. No questions were made.

Mr. Mitchell added a comment on a contract with a payor that is currently in process, not in negotiation because Mr. Mitchell believed that Anthem was no longer negotiating. The Anthem contract with legacy Wellmont expired but is continuing on a month-to-month basis. The Mountain States contract expires later this year. Mr. Mitchell stated that there appeared to be one major sticking point, which is the ER group. Mr. Barry and Mr. Mitchell wanted to ensure that the Authority had the Anthem contract on their radars, because they may hear some issues surrounding the subject. Mr. Mitchell stated that he predicted there would be an intense negotiation once Ballad and Anthem began discussing this, but note that there is one sticking point that is outside of Ballad's control.

Mr. Mitchell continued by stating that it was going to be a very busy year for Ballad with their payors because a number of these contracts are coming up for negotiation in 2020. He shared that it was important for the Authority to remember that thirty percent (30%) of Ballad's insurance revenue has to come from risk based contracting. Risk Based Contracting is really the only way that Ballad can increase their margin. Mr. Mitchell stated that the good news was that there was room for improvement and the bad news was that it was going to become increasingly difficult to achieve increased revenues through those improvements.

Mr. Mitchell moved on to discuss commitments. Mr. Mitchell stated that the Authority probably remembered the number $32 million, which was the projected savings from the merger. Mr. Barry and other staff have been focused on ensuring that progress is being made on the commitments agreed upon by Ballad.

Mr. Mitchell stated that the Spending Target Satisfaction is still under review, although it is known that they have still been spending money. The spending that is required in the merger is more than the later years, so they have been watching it.

The Population Health Plan is alive, stated Mr. Mitchell. He added that there was much more detail regarding this plan and programs in the Authority's report.

Mr. Mitchell called on Mr. Barry to comment on the Graduate Medical Education & Research program. Mr. Barry stated that he had talked with the director of Graduate Medical Education &

Research. The director acknowledged that Virginia accounted for 35% of Ballad's revenue. The director stated, informally, that they would like to target fifty percent (50%) of spending for each state. Mr. Barry stated that they had a really long list of research projects and that they were building their infrastructure substantially for grant writers, for compliance, and just to coordinate research. Mr. Barry added that he was optimistic that the Authority would see substantial increase in research dollars coming into the area. Ballad committed to itself to spend money on research. Mr. Barry stated that what was really best for the region was that Ballad's money could be leveraged so that it would bring in multiple expenditure in research funding.

Mr. Mitchell thanked Mr. Barry but asked him to discuss the Children's Health Plan before he wrapped things up. Mr. Barry stated that Ballad had an aggressive plan to hire the specialist and subspecialist in pediatric care. They have had some difficulty in doing that and as Mr. Barry stepped back and looked at their plan, the statistics were not in their favor. The number of births were down nine percent (9%) in their region between 2018 and 2019, and the number of children in the area is dropping. Mr. Barry added that in addition to birth rates, Ballad has had difficulty in recruiting the subspecialist it was looking for, but Alan Levine sent out an email a few days ago reporting that they had been successful in hiring two pediatric surgeons. Mr. Barry added that they were sharing some resources with the Children's hospital in Knoxville, Tennessee. Mr. Barry concluded that his suggestion was that Ballad revise their Children's Health Plan and reassess their goals. He added that this would not affect their spending commitment that was part of the Cooperative Agreement, but how they spend the money would differ from the current plan.

Mr. Mitchell made a final comment, stating that the Task Force would be investigating the details of these plans in the upcoming year. He added that as a reminder the Authority members were not required to attend, but they had the option to if they would like.

Mr. Mitchell thanked Chairman Kilgore.

Mr. Block stated that he appreciated Ballad's efforts and their recruitment. He stated that East Tennessee State University has faced some difficulties in recruiting a pediatric subspecialist.

Chairman Kilgore thanked him for his comment and moved to the next item of business.

B(i). Consideration of Amended Chart of Task Force

Chairman Kilgore stated that during the June 2019 meeting, the Authority motioned to create the Southwest Virginia Health Authority Cooperative Agreement Task Force. The motion passed unanimously.

He explained that the purpose of the Task Force was to assist the Authority in monitoring the cooperative agreement. The Task Force is comprised of eleven individuals. They help reach a quorum and act as a local body that meets more frequently, communicate with the public, and provide a more active role for the Authority in monitoring the cooperative agreement. The Task Force is a subcommittee of the Authority.

Chairman Kilgore stated that the Task Force has met twice. Once in October 2019 and again in November 2019.

The Chairman made it known that at the first Task Force meeting, he resigned as the chair and nominated Delegate Pillion to become the Chairman of the Task Force. In Article III, Section 1 of the Charter states that the Chair of the Authority was automatically slated to be the Chair of the

Task Force, but Chairman Kilgore pointed out that he thought it would be more appropriate to have someone else hold the position. Chairman Kilgore stated that the Task Force decided to amend this section of the Charter to allow for someone new to hold the position as the Chairman of the Task Force.

He stated that the Task Force was recommending that the Article III Section 1 of the Charter be amended to delete the provision automatically slating the Authority Board Chair and to add a new provision to Article III, Section 3, stating that the Task Force will elect a Chair.

The Chairman stated that the elections for the Chair, along with Vice Chair and Secretary took place at the October meeting of the Task Force. Delegate Pillion was elected as Chairman, Dr. Cantrell was elected as Vice Chair, and Ms. Brillhart was elected as Secretary.

Chairman Kilgore stated that the only other change to the Charter was a minor typographical change in the first paragraph. "It is the Task Force's recommendation that we approve the Charter as amended."

Chairman Kilgore asked for a motion that the Board of Directors of the Southwest Virginia Health Authority approve the Virginia Cooperative Agreement Charter of the Task Force as amended. Ms. Brillhart made a motion to approve. Dr. Cantrell seconded the motion. It passed unanimously.

B (ii). Recommendation of Public at Large Members

The next item of old business that Chairman Kilgore addressed was the recommendation of Public at Large members. In the Charter of the Task Force, Article III, Section 3 states that up to four members of the public who are not already on the Authority Board of Directors may be appointed to the Task Force.

Chairman Kilgore stated that following the initial appointments, there are three vacant seats that remain open.

The Chairman spoke for the Authority stating that it was their belief that opening up seats on the Task Force to members of the Public at Large would significantly enhance the Authority's community ties, as well as allow for better communication of public opinion concerning Ballad and would also provide better representation of those opinions on the Board.

Chairman Kilgore and Delegate Pillion wanted to have a thoughtful and deliberate process in selecting the members from the public at large for the seats on the Task Force.

Chairman Kilgore called on Delegate Pillion for the report.

Report on the Task Force Status for Selecting Members

Delegate Pillion stated that at the first meeting of the Task Force, the members appointed a subcommittee of three members. The subcommittee is supposed to determine the process for identifying individuals to recommend to the full Authority for consideration. The three members of the subcommittee are Ms. Brillhart, Dr. Cantrell, and Delegate Pillion.

Delegate Pillion noted that the subcommittee met in October to discuss the process for selecting individuals from the public to recommend. At this meeting, it was decided that an application be

developed and distributed to the public. Interested parties were directed to submit their applications by November 1, 2019.

The subcommittee met again on November 14th to review the applications and determine what recommendation to make to the Task Force.

There were a total of four applications received. Delegate Pillion said that this was a surprisingly low number, considering that he had heard there was considerable public interest. He said that the time commitment required of the Task Force members could have acted as a deterrent to interested individuals.

The four applicants were: Mr. Meadows, Dr. Mullins, Mr. Robbins, and Dr. McQueary. Dr. McQueary was deemed unable to perform the duties required of the Task Force because of the language in the Authority's statue related to the participation of competitors of Ballad (Mountain States and Wellmont) in this process.

Delegate Pillion stated that after review of the remaining three applications, the subcommittee chose to recommend the three applicants, but upon further review, Mr. Robbins was not eligible to serve. The two recommended applicants were Dr. Mullins and Mr. Meadows.

Delegate Pillion then gave a brief summary of Mr. Meadows background and qualifications. Mr. Meadows has an extensive history in administering health plans and currently serves on the Board for Johnston Memorial Hospital. Even though his background is non-clinical, the subcommittee believes that his experience and interest in the community will be valuable on the Task Force.

Delegate Pillion also described the qualifications and background for Dr. Mullins. Dr. Mullins works as a community pharmacist and has hands-on experience that allows her to understand the pressures Ballad faces in the community and understand the various perspectives and voices in the community. The subcommittee expects her background to provide a unique perspective on the Task Force.

Delegate Pillion pointed out that there is still one vacant seat for the Public at Large members. He proposed a few options for next steps. One was that they could extend the application process to require interviews or further supplemental materials from the selected applicants. The second proposed idea that Delegate Pillion suggested was to allow more time for interested individuals to apply. Since two of the three available seats are ready to be filled.

He opened the floor for discussion so that the Authority could choose on how to proceed.

Delegate Pillion asked for a motion to appoint Mr. Meadows and Dr. Mullins. Delegate Pillion motioned to approve. Dr. Cantrell seconded this motion.

B (iii). Consideration of VDH Memorandum of Agreement

Chairman Kilgore thanked Delegate Pillion for his report and moved on to the next matter regarding the consideration of the Virginia Department of Health Memorandum of Agreement ("MOA").

Chairman Kilgore stated that at the June meeting of the full Authority, the MOA was circulated to everyone confidentially, since it was still under negotiation. It was determined that a small committee of three would be appointed and given power to execute the MOA on behalf of the

Board. The members selected to serve on this committee are Dr. Cantrell, Dr. Henry, and Chairman Kilgore.

Chairman Kilgore asserted that at the October and November meetings of the Task Force, the MOA was reviewed and discussed. It was approved for recommendation to the full Authority. Chairman Kilgore expressed that it was their hope that the Authority would be able to review the MOA and corresponding summary memorandum. If members were unable, Mr. Mitchell would give a brief overview.

Chairman Kilgore called on Mr. Mitchell to summarize the MOA.

The Chairman opened the floor for discussion.

Chairman Kilgore stated that it was the recommendation of the Task Force, as well as the subcommittee selected to approve the MOA, that the MOA be approved. He asked for a motion to approve. Mr. Neese motioned, and Senator Chafin seconded the motion. The motion passed unanimously.

B (iv). Staff Job Description Approval

Moving onto the last order of old business, the Staff Job Description Approval, Chairman Kilgore stated that Mr. Barry had previously taken the lead in assisting the Authority through the whole Cooperative Agreement process, and that it has been very beneficial to the Authority.

The Chairman stated that at the October meeting of the Task Force, Mr. Barry presented a job description for himself as Ballad Merger Monitor. Ultimately, Mr. Barry wanted to know what the Authority wanted to hear and see happen.

Chairman Kilgore asked Mr. Barry if he had anything he wanted to add.

The Chairman opened up the floor for discussion.

Chairman Kilgore stated that the Task Force has reviewed the description and recommends its approval to the Board. He asked for a motion that the Board of Directors of the Southwest Virginia Health Authority approve the job description drafted by Mr. Barry. Delegate Pillion motioned and Ms. O'Dell seconded the motion and the motion passed unanimously.

VII. New Business

A. Consideration of Revising Blueprint

Chairman Kilgore stated that in January 2016, the Southwest Virginia Health Authority approved a Blueprint of goals and strategies for improving the population health in the southwest region.

The goals outlined in the Blueprint included initiatives such as increasing prenatal care, decreasing drug/poison deaths, and creating a model for collaborative data and resource sharing for organizations in the region.

Chairman Kilgore pointed out the goals outlined in the Blueprint are intended to be activated by 2020. Since it is 2020, he said that it was time to revisit the materials in the Blueprint and update them to fit the current population health situations in our communities.

He stated that if the Blueprint is approved, that the revisions and updates would become a priority focus of the Task Force in 2020 and that it would be the duty of the Task Force to examine if the current goals in the Blueprint have been met and identify new goals or strategies that they feel should be implemented.

The Chairman stated that the process would be assisted by the efforts of Mr. Barry in his meetings with Ballad and the Department of Health. He stated that the Authority hoped that they could work collaboratively with organizations and individuals in the community.

Chairman Kilgore stated that if it was decided to move forward with revising the Blueprint, proposed revisions may be presented for approval at the December 2020 meeting for the full Authority.

Chairman Kilgore asked for questions.

Senator Carrico motioned to update the Blueprint in 2020. Delegate Pillion seconded the motion.

VIII. Announcements

Chairman Kilgore asked if there were any announcements.

He stated that Senator Carrico is leaving the Senate on January 8th and that his tenure on the Authority will end.

Chairman Kilgore shared that Senator Carrico had served for 18 years in the General Assembly and has worked diligently to advocate for the citizens of Southwest Virginia for the entirety of his time in office, especially on issues like health care.

Chairman Kilgore thanked Senator Carrico on behalf of the full Authority for his service to our community and congratulated him on his retirement from the General Assembly.

IX. Next Meeting of Authority

Chairman Kilgore noted that there were plans to have the Task Force meet at least four times in 2020 in the months following the staff meetings with Ballad. The meetings would most likely take place in February, May, August, and November.

He also stated that the Authority is currently planning to have the full Authority meet twice in 2020, once in June and then again in December.

Chairman Kilgore expressed that they planned to continue to have meetings on the third Wednesday of each month, unless another, more preferable option is presented.

X. Public Comment

The Chairman asked for any public comment.

XI. Adjournment

Senator Carrico motioned to adjourn the meeting. Ms. O'Dell seconded it.

Attached

Exhibit A. – June 12, 2019 meeting minutes

Exhibit B. – Staff Report – Ballad Merger Monitor for FY 2019

Exhibit A

Southwest Virginia Health Authority
DRAFT - Minutes of Meeting
June 12, 2019 at 3:00 PM
Southwest Virginia Higher Education Center, Classrooms 103 and 104
Abingdon, Virginia

I. Call to Order.

Chairman Kilgore called the meeting to order at 3:15 pm.

II. Roll Call.

Maggie Haynes called roll. The following members were present: Ms. Brillhart, Dr. Cantrell, Senator Carrico, Mr. Chapman, Mr. Givens, Delegate Kilgore, Mr. Leonard, Ms. Sayers, Dr. Henry, Delegate Pillion, Mr. Mosley, Mr. Neese, Mr. Prewitt, Dr. Tooke-Rawlins, Ms. Shelton, Mr. Vanover and Ms. Ward.

Ms. O'Dell was present by telephone *en route* to the meeting.

Ms. Baker, Senator Chafin, Ms. Copeland, Mr. Eaton, Mr. Horn, Ms. Mayhew, Mr. Block, Mr. Mulkey, Mr. Perdue, Ms. Rheuban, Mr. Sarrett and Mr. Wieting were absent.

III. Declaration of Quorum.

Delegate Kilgore declared that a quorum existed.

IV. Approval of Minutes

The Board then considered the following minutes from previous Authority meetings: August 26, 2016; October 12, 2016; October 26, 2016; September 27, 2017; October 12, 2017; June 27, 2018; and December 12, 2018.

Ms. Brillhart stated that she had noticed minor errors in the minutes that needed revision. The minutes were presented as amended. Senator Carrico made a motion to approve the minutes. Mr. Neese seconded the motion and the motion carried. Minutes were approved unanimously.

V. Old Business

(A) Update from Authority Staff – Mr. Barry, Dr. Massaro, Dr. Brownlee

Mr. Mitchell stated that there are two PowerPoint presentations that will be circulated as soon as the meeting is over.

Mr. Barry gave a presentation on the Authority's role to everyone on the list (which is attached as Exhibit A). He stated that the staff of the Authority are the same individuals who worked with the Authority when it was considering the application for the merger, *i.e.* Mr. Brownlee, Dr. Tom Massaro and himself. He noted that the Authority has been off to a slow start.

Mr. Barry discussed the lengthy duration of the process, stating: "This is a very large organization. It has over 20 hospitals, 15,000 employees, and a lot of clinics and other operations. It is a big ship and turning that big ship in any direction takes a very long time. These folks have been working really hard." Mr. Barry noted that the Authority staff (the three individuals mentioned above) are now fully part of the information exchange. He stated that Mr. Mitchell has been working with the Virginia Department of Health (VDH) on a formal Memorandum of Agreement explaining

what the Authority is doing and working out the mechanics with the VDH. He stated: "Ballad is treating us as if we are on board and as if everything is done, and we very much appreciate that. Also, we have a very good relationship with the Tennessee monitor, Larry Fitzgerald." Larry Fitzgerald was formerly the Chief Financial Officer at the University of Virginia Medical Center. Mr. Barry noted that Mr. Fitzgerald is an "extremely smart, well-qualified gentleman, and he worked with Dr. Massaro when Tom was at the medical center, and when I was practicing law at the University of Virginia; he was my client and Dr. Massaro was my principal contact."

Mr. Barry discussed the monitoring process, which includes reviewing reports and attending meetings he described as "eight (8) hours of show and tell," in reference to the March meeting in Nashville, which he attended with Mr. Mitchell. The meetings have a lot of back and forth discussion, he noted, and everything gets discussed to some extent. He noted that Ballad management was responsive to questions in the meetings, particularly at the May meeting he and Dr. Massaro attended. Mr. Barry stated that Ballad management was really putting a lot of effort into the regulatory review processes that are required of them, and stated that they are at present preparing for a meeting with the FTC on COPAs in which they look at three (3) instances of COPAs in Montana, North Carolina, and at Ballad itself. The meeting will be held on June 18, 2019, and Chairman Kilgore, Mr. Mitchell and Mr. Barry plan to be in attendance and submit comments. The comments are not due until July 31, 2019, so Mr. Barry thinks that it makes sense to see how the meeting evolves and what other comments come in, and to put in their comments pretty close to the end of the process.

Mr. Barry stated that he expects in the future to have frequent interaction with Ballad, visiting their facilities and coordinating with Mr. Fitzgerald monthly. Mr. Barry stated he wanted to do this in a way that avoids unnecessarily drawing upon Ballad's management resources.

Mr. Barry made closing remarks regarding his impression of Ballad, saying that the ultimate question is whether Southwest Virginia is better off under the Cooperative agreement than without it. He stated that there have so far been no problems with non-compliance or communication, and it appears that Ballad staff are working very hard, stating: "I have to say, I have been very favorably impressed by management." He elaborated on this, saying that what has specifically impressed him is the "depth and breadth of the quality of the management," but said that ultimately what they need to look at is performance. Overall, Mr. Barry is optimistic.

Chairman Kilgore asked if anyone had questions. Dr. Rawlins noted that much of the information they receive is from the press, and she believes this is a problem that needs to be addressed. She stated that she believes the staff and Ballad should figure out how to get more information to the Authority and to the press themselves.
Mr. Barry responded and referenced the article in The Roanoke Times. Dr Rawlins said this is not the article she is referring to; she was referencing an article about the Blountville meeting. Mr. Barry responded that Ballad would cover that topic today (regarding the trauma and the NICU). He stated: "Part of how we allocated our time was to allow Ballad to talk about it. I know what they are going to say, and I have no basis for disagreeing with what they are going to be saying about it." Dr. Rawlins stated she did feel as though Ballad would listen to them, then asked how Mr. Barry and the staff are monitoring Ballad and how Ballad is monitoring their progress aside from talking to hospital boards. Mr. Barry responded that they have a "work plan" in which Ballad furnishes them with summaries of financials which tie into their financial statements. In addition, Mr. Barry stated that the monitoring process includes monitoring of the Ballad website and the data posted on it and touring hospitals, referencing a tour of Wise County's hospitals that Mr. Barry, along with Virginia regulators, had attended. He stated that part of the plan is to get out and about and talk to people.

Mr. Mitchell added that the Ballad Health staff are inundated with calls, and there is a very non-human element to the data which is a growing challenge: "One such challenge is whether the stories that are out are true. That is the human side of the merger as opposed to the cost, and the patient numbers and those metrics." Dr. Rawlins agreed, stating: "I think you have to hear it from Ballad, and you have to hear it from the community."

Mr. Barry noted the desire to set up a group within the Authority that can meet with much greater frequency to hear and get input from the community and address issues. Chairman Kilgore stated that that matter will be discussed in New Business, and spoke in favor of the establishment of such a group, stating: "We need to set something like that up so we can listen to the public and we can have an open process so folks can come in and let us know what their concerns are, and we can get an answer. Right now, I have talked to businesses, Jeff, and others and communications have just not been that great." Mr. Barry said communication is one of the things that was requested for Ballad to talk

about right out of the box today. Chairman Kilgore responded, "Right. Any other questions? Thank you. I think we are now going to hear from the Virginia Department of Health."

(B) Update from Virginia Department of Health – Erik Bodin

The Chairman called on Erik Bodin, Director at the Virginia Department of Health's Office of Licensure and Certification. Mr. Bodin introduced himself and the VDH team for Southwest Virginia: Lenna Zimmerman, The VDH Cooperative Agreement's Richmond-based analyst, and Kevin Meyer, an analyst whose role is more on the ground compared to Ms. Zimmerman's. He noted that the hiring of Ms. Zimmerman and Mr. Meyer is helping the Department establish infrastructure.

Mr. Bodin stressed the Department's need to be able to triage complaints back and forth and determine if they are Cooperative Agreement related complaints or Licensure and Certification related complaints that they have been taking. He stated: "That office is situated with us in Richmond, so she [Ms. Zimmerman] is able to make that distinction, but if it becomes a Cooperative Agreement related issue or appears to have an impact from the COPA, it is Kevin's role to investigate in person. That is one of the reasons he is down here: so he can make those trips." Mr. Bodin noted that Mr. Meyer's secondary role is to be on the ground interface with the team, the local governments, Ballad, facilities, and the public: "He is spending a lot of time on the road going to facilities and meeting people. We have all been to Nashville and we have all been to a lot of meetings. So that is going to be Kevin's role. From this point on, from whatever report or update we are giving you, as well as whatever interaction we have directly with the Cooperative Agreement workgroup you all are setting up, Kevin will be our direct interface if that works for you all, and I will continue to participate by phone without even having to come down."

Mr. Bodin stated that most of the Department's activity was focused on standing up the infrastructure to monitor the Cooperative Agreement. He also discussed the technical advisory panel (TAP), whose role it is to make recommendations to the State Health Commissioner on the metrics and the measurements that are going to be used in assessing Ballad's progress. TAP met in December and early January and developed the additional set of metrics, which were adopted and issued. They met again in early April and discussed where Ballad stood with those metrics; a lot of that discussion revolved around whether the metrics are still appropriate to measure progress now that Ballad has more experience. This is also where the question of whether some of the metrics should be retired and/or are not measurable came up.

Mr. Bodin stated that one of the outcomes of these meetings was the establishment of another group in conjunction with Tennessee to look at some of the intermediate metrics. He said: "We didn't have anything that really told the story of whether there is progress, and we didn't want to get to several years down the road and find out what we were measuring didn't happen because it wasn't being pursued correctly or adequately. That subgroup is now being set up so we can develop and work with Ballad on instituting some intermediate metrics." This group is set to meet in November 2019 to look at the proposed intermediate metrics. Membership on this team, according to Mr. Bodin, consists of individuals from the internal supervision group, the Commissioner's Office, the Population Health Office, as well as Dr. Cantrell and Dr. Shelton. He reiterated how this subgroup is intended to maintain a very strong working relationship with colleagues in Tennessee. The group has weekly calls with counterparts and bi-monthly calls between Tennessee, Virginia, and Ballad together to talk about timelines and what is happening to ensure everybody is hearing the same thing at the same time by the same people.

Mr. Bodin noted that Virginia is trying to work with Tennessee and has very frequent contact with Mr. Fitzgerald. He noted that Virginia needs a group like the Tennessee local advisory group. He stated: "It didn't make any sense to stand up a new body. This body exists and has been intimately involved in the Cooperative Agreement process from day one; actually prior to VDH getting involved with it. That was the logical thing."

Mr. Bodin noted that an MOA is being established between the Department of Health and the Authority to create something like a local advisory council in Virginia. A dashboard is also being established to show a timeline to look at the metrics and measures. Chairman Kilgore asked, "How soon do you think that will be up and going? I am not asking for a firm date, but just a ballpark." Mr. Bodin advised they hoped to be ready within the next few weeks. Chairman Kilgore stated, "I think that would be good for the public to be able to log on and look and see how things are going and provide more detail to it."

Delegate Pillion asked, "What are you hearing and how do you think this is going?" Mr. Bodin responded: "I think, given the magnitude of what is going on, it is going as well as can be expected. I think there are bumps in the road. We are hearing a lot of the same frustration from the public with regards to communication and care as you all are, and that is one of the reasons that we are trying to determine whether we are looking at the Cooperative Agreement or we are looking at the Licensure, and in some cases, there are some overlaps. So yes, there are some issues. I think Ballad is working diligently to correct them and that is one of the reasons we are there: to watch and make sure that is happening."

Mr. Bodin stated that he and his team will also be attending the FTC meeting (including Deputy Commissioner Joe Hilbert and his staff). He said: "We have read the literature. We have read the reports. We want to see what we can learn from what happened to them, so that we can bring that back to Virginia."

Dr. Rawlins stated that communication seems to be a major issue, and she thinks the dashboard would be a good addition. She stated: "We did set milestones at the Authority level and I think the dashboard would help Ballad and all of us." Mr. Bodin stated: "That is our goal and that is what we are looking for."

Mr. Bodin addressed the trauma consolidation plan and the pushback that has come from that: "One of the conditions in the Commissioner's order is that if they make changes to the Trauma system, they have to provide us with a plan for the Commissioner's review that addresses the impact that it will have on the citizens of the Commonwealth. We have now received that plan, and we are in the process of looking at it. They are required to provide us with notice nine months prior to making changes, and we did get that notice. We just recently received that plan and we are reviewing it with regards to the impact it is going to have."

Mr. Bodin also addressed the NICU changes, stating: "The order from the Commissioner did not address NICU care. All of this is happening in Tennessee, and there was nothing in the order that addressed our ability to even look at the impact this would have on Virginia. However, because of the close, constant relationship we have with our colleagues in Tennessee, they have been very open in discussing with us prior to making any decisions; so, we at least had a word into it before they made their final decision."

Mr. Bodin stated that the Virginia Department of Health is in the process of reviewing a plan for modifications of provision care for a hospital in the Wise County/City of Norton area. He stated: "Ballad Health informed us back in November that they would be making some changes. They have now sent us a plan, and we have some additional questions and they are making some additional changes. Ballad has designated the plan as proprietary at this point, and so we are obligated to reserve that. Our report is going to the Commissioner on it as proprietary as it references back to the plan, but we are working on that."

Delegate Pillion asked, "So, Ballad tells you what they are doing, they do it and then they send you a plan as to what they are going to do and then you determine if is ok or not?" Mr. Bodin responded, "They informed us." Delegate Pillion asked, "At what point does it become proprietary? Don't you have to approve that before they can make the change? Or do they make the change and then you approve it?" Mr. Bodin responded, "In an ideal world, it would be ask for, approve, and then change." Delegate Pillion said, "So, is that how it happens?" "This time it did not, no sir," responded Mr. Bodin. Delegate Pillion asked, "Did it happen with Norton? Did it happen with Trauma?" Mr. Bodin: "Trauma has not changed yet. Therefore, they are following up on that. With the Norton/Wise County modifications, I don't recall the exact dates of the changes being made, I recall that it was presented as an urgency which isn't contemplated anywhere, but that was the way that it was presented, and the plan did follow."

Mr. Bodin stated that Ballad has weekly meetings to try and reopen the hospital, and that VDH is continuing to monitor this issue and Pennington Gap. He noted that the Certificate of Public Need has been extended for several years into the future to allow adequate time to make all the changes happen. One of the conditions in the Commissioner's order requires that if the hospital had not opened by December of last year Ballad was on the hook for providing essential services to the residents of Lee County. He said: "We are not only watching what is happening with Lee County, but we are also asking for an update on what is happening in Lee County as far as meeting that obligation to ensure that those residents have care. We are trying to step up and figure out what active supervision means. It is an undefined term for us. We have been trying to feel our way through that process, not only to meet the needs of southwest Virginia, but to meet the needs of Ballad and the FTC. We are trying to actively supervise Ballad, not to manage Ballad. Somewhere there is a line between those two approaches, and I am not sure where that line is

right now." Mr. Bodin also stated that he and others are attending the FTC meeting, and that they are all trying to determine how to actively supervise.

The Chairman asked for questions, then asked Mr. Bodin: "Is this the first time you have ever had something this big in the Commonwealth?" Mr. Bodin affirmed that it was. The Chairman stated that the Authority is counting on Mr. Bodin's team to "help us through this and help the citizens of Southwest Virginia make sure the metrics are being met and that the COPA is being followed." Mr. Bodin thanked him and stated that the VDH is looking forward to formalizing the relationship with the Authority and with Dennis and the rest of the staff. The Chairman thanked Mr. Bodin for his team's hard work.

(C) Update from Ballad – Eric Deaton

The Chairman called upon Ballad Health for an update.

Eric Deaton, Chief Operating Officer for Ballad Health introduced himself and addressed the previous day's Roanoke Times article, stating: "First of all, let me say that Wise County continues to have strong 24/7 surgical services, and has ever since the merger happened. We have surgical services at two of the facilities in the City of Norton. Our safety and patient well-being is always the highest priority for us. As we make decisions, we put that as the top priority for us to ensure patient safety and execution of care is the very best."

Mr. Deaton stated that last fall Ballad had discussions with local community and clinical leaders and physicians in the counties at Mountain View and Lonesome Pine, and that it was asked of them to consider stopping the performance of elective cases at the Mountain View hospital. He noted: "That was because we were doing fewer than 20 cases per month there. As a matter of fact, in July, we only did 17 cases at Mountain View, and in August; we only had 12 cases. So, the real issue there has got to be a staffing issue. Our surgical team covers both Mountain View and Lonesome Pine. The staff basically operate as one hospital with two separate campuses sharing staff back and forth. There was a lot of pressure for them to cover both places at the same time and for the physicians to cover both places full-time and provide the care they felt like was called for." Mr. Deaton stated that this matter came up in the Roanoke Times article, and the article questioned whether Ballad had surprised the State with their decision. He responded to the article, saying that they did not "surprise" the State, but actually discussed extensively with the State about area consolidation plans before September, though not specifically about the Norton hospital consolidation. Additionally, he noted that the decision to discontinue elective cases at Mountain View hospital presently was supported by the local medical committee of physicians, the local Board of Directors that serve at Mountain View, and Alan Levine (Ballad CEO). He stated: "We did suspend elective surgical cases at Mountain View immediately, and we notified our General Council and notified the State of that action. This was more of an urgent issue. I would like to separate this issue from consolidation plans going forward. We have not nor will we implement any consolidations until we have directions from the Commonwealth to do that. We made this change as a result of what we felt was the proper care of our patients in the region. Our local physicians have communicated to our patients effectively if they required surgery to make sure they would be going to the proper location."

Mr. Deaton reiterated that their three emergency departments continue to work diligently to triage patients and get them the best care possible in the right location of Wise County every day. He stated that their emergency departments are strong in all three hospitals and will continue to move forward. He then asked Mr. Mark Leonard, Vice President and Chief Executive Officer at Ballad Health to speak.

Mr. Leonard affirmed Mr. Deaton's summary and noted: "Dr. Pillion, as a medical provider yourself, I would reiterate from your standpoint: we had surgeons coming to us as management saying: 'This is an unsafe situation. We are concerned about performing surgery at Mountain View, while also having the responsibility for a family birthing unit at Lonesome Pine. If an emergency C-Section comes into Lonesome Pine in Big Stone Gap and the team is at Mountain View, what do you propose doing?'" Mr. Leonard stated that Ballad's Common Leadership Team (containing common CEO, CNO, CFO, the Chief of OB, and the Chief of Surgery) last fall had noted the unsafe situation and had gone to Mr. Levine with their concerns, then subsequently took the issue to the executive medical committee for Lonesome Pine Hospital, who endorsed the decision to temporarily suspend surgeries at Mountain View pending the State's ratification of said decision. He stated: "It was not part of the consolidation in total because it was a patient safety and quality issue, but we did notify the State as to what we were doing and why we were doing it."

Delegate Pillion stated that we can all appreciate patient safety, then addressed the Chairman: "I think the problem is communication. That is the problem we have been continuing to have with this Cooperative Agreement. That is a continual problem that we have. I don't know why the Health Wagon was not notified. They are a pretty large medical provider in Wise County, but from this article, that is where a lot of this came from. I think just by notifying them that would have solved some of these issues." Mr. Deaton replied: "I will say for that particular issue most people go to the Emergency Department for care and they are triaged appropriately and then they are sent for surgery or whatever is necessary. I don't disagree communication is a top priority for us moving forward." He asked for questions, then continued.

Mr. Deaton addressed the challenges that they have encountered with the merger, stating: "It is the integration of two major systems and bringing teams together. We are managing and supporting our local team members, and the impacts made to them. We have two separate HR systems, two IT systems, and two payroll systems that we are in the process of merging, so there is a lot of work around that." He noted that a lot of management changes have accompanied the merger, as there are over 7,000 policies between the two different health systems in the merger. He stated that this is why communication needs to be a top priority: "We want to look for better ways to communicate, not just to you or our team members, but to all of the communities that we serve. We have local boards of directors that we work with, and we will continue to make sure they are well educated, and that they are part of the changes when we make those. We are committed to doing better."

Mr. Deaton stated that they need feedback in order to improve, and that they are trying to communicate with constituents via social media and news, but it is difficult to communicate with everyone at the same time as they want to. That is why, he said, they need input on ways to improve.

He noted that there has been a decline in patient volume, which he does not regard as a negative. He stated: "I think we are doing a better job at managing patients on an outpatient basis. Physicians are doing a fantastic job at managing patients with chronic diseases. We see more patients being shifted to managed care, including Medicare patients. They are moving more towards managed Medicare. We are seeing a decline in ER visits as well and I think that is because of how they are being managed by their primary care physician."

He discussed how they have maintained and expanded regional care access. The Greenville market consolidation has been going "very well," he said, Unicoi County Hospital was opened, and both Laughlin and Unicoi were brought up on EPIC. He also stated that they saw a substantial pay rate increase for nursing staff, with the starting pay for a new nurse now being at $22 per hour (a $3 increase for new nurses), equivalent to $10m per year. He said that they are planning to continue with this going forward as they want to retain nurses and keep local nurses local with competitive rates. Delegate Kilgore asked, "Are we losing doctors and nurses? I hear that all the time." Mr. Deaton responded, "We actually have recruited a number of physicians and nurses to this region. We have a lot of doctors that come to schools from outside the region, and then go back to where they came from; so that is why we want to be competitive in our salaries to try to keep people here when they graduate."

Mr. Deaton stated that they had recruited 79 providers to the area and employed 65, and that 15 were recruited to independent practices. He said: "We have also been supportive in the Medicaid Transformation Project and you will hear more about this later on."

He also discussed the financial aspects of the merger, stating: "We have seen an improvement in our operating income from year to year, from 9 million ytd compared to 1 million last year. Quality improvement has been an emphasis for us where 12 of 17 areas of focus improvement have improved. We rank top 20% nationally by IBM Watson for our outcomes." He noted that they continue to make large capital investments in the region, with $160 million in facilities and outpatient services, and that they are looking at significant savings in the next year or so in their purchasing savings by consolidating their buying. He stated: "We will save a lot of money. It won't affect any jobs. Our bond ratings have been supported and affirmed. It has a rating of 'A' and is stable. We can borrow money at a much lower rate as a result of our bond rating. We have been an advocate for Medicaid expansion. It really does help the healthcare system and it really does provide access to many, many people that do not have health coverage otherwise. We really do appreciate that support."

He stated the achievements of the clinical council, which focuses on improving healthcare outcomes: "They reduced hospital-acquired C. Diff infection rates by 45%. They are working on decreasing radiation exposure in in-patient

testing. They are working on supply chain issues: what is needed to provide the best care. They provide and promote high value care. We have also reduced the yearly readmission rates by 15% by taking better care of the patient while they are in the hospital and making sure they are getting the appropriate care when they leave the facility." He stated that the "clinical experience project" was established to reduce physician burnout and retain physicians in the region by supporting them through their initiatives. Mr. Deaton also discussed recent physician/surgeon hires: "In Wise County, we have a full time Non-Invasive Cardiologist that started eight months ago; a Board- Certified Orthopedic Surgeon and Physician Assistant; a Pediatrician; an Assistant Program Director; an Internal Medicine Residency Program Director; and an OB/GYN Physician."

Mr. Deaton moved to discussing Ballad's commitment to re-opening Lee County Community Hospital and provided key dates in this mission: 6/19/19 – meeting with Lee County EMS to discuss their needs and identify gaps; 6/20/19 – Lee County Hospital Authority – to review terms of the Definitive Agreement; 7/25/19 – meeting to complete and approve the Definitive Agreement; Early August – submit Critical Access Hospital Application and September – Plan to open LCCH Urgent Care Center. He stated that updates will be provided on their progress.

Mr. Deaton noted: "Another thing that we have done is help create a dental residency program at Johnston Memorial Hospital. It has been a great opportunity for us to work with local providers to create this program. More than 68% of residents live without dental insurance and we all know that dental health plays a major role in overall wellness. We are very happy to be part of this program moving forward."

Mr. Deaton moved on to introduce Anita Peery. Ms. Peery has been named the Director of Trauma Services for Ballad. She previously worked for flight services for Wellmont Flight Systems. She also will serve as Ballad's EMS liaison; she has experience and will be a leader in these areas.

Mr. Deaton further discussed the nature of trauma and emergency care, stating: "Just something to remember, trauma is not a heart attack or a stroke. Our tertiary facilities will continue to have the same levels of care for stroke and heart attack patients. Trauma is actually a very low number. We see about 5,000 cases in our region. Only about 10% of those trauma cases would need to be seen in a Level 1 trauma center; 65% of our trauma cases are orthopedic and approximately 20% are neurosurgery related trauma injuries." He noted Ballad's continued work with local EMS to ensure that they have the resources they require, and how they are working with EMS through the transition, stating: "We are working with the Commonwealth on that transition, the timeline of moving from three trauma centers to one, and making sure that we are working with our local EMS that patient care is supportive."

Mr. Deaton discussed several recent trauma initiatives, including consolidating flight services: "We have had three flight services in our region. We are moving to one, Med Trans, that will be operating in this region for commercial flight services as a community flight service, but we are also supporting Medflight, which is located here in Abingdon with the Virginia State Police. We support that by providing about $800,000 per year for supplies and staff, and we will support that moving forward."

Mr. Deaton also discussed the consolidation of neonatal services, stating: "It really does help us to move neonatal and pediatric services to our children's hospital. It helps us by consolidating our services in one location. It helps us to recruit and to draw physicians to the area that are not here today. We really feel this is the way to go and it is supported by the State Health Plan in Tennessee, and we are working closely with the Commonwealth to ensure this is the proper way to move forward as we look at the best way to provide care to the children in our area. In the process, we are opening a new pediatric department in Kingsport and at Bristol Regional Medical Center to provide local support to children in our region."

Mr. Mosley asked why they didn't open an ER instead of an urgent care in Lee County. Eric Deaton responded that it took much longer to do that; it is quicker to get the hospital open as an urgent care with critical access and then do demolition and move from there working with EMS. Mr. Monty McLaurin, President of the Northwest Market at Ballad Health spoke up, stating that there were numerous difficulties in opening an ER and that is why the urgent care was established, but they are looking to establish an ER in its place in the future once they are better able to.

Mr. Mitchell noted to Mr. McLaurin: "You might also want to mention that the Lee County Commissioners that you worked with when this was first mentioned strongly encouraged you all not to do anything that would delay you all opening the hospital, and to do something that would only complement the opening."

Mr. Mosley responded, "I appreciate your answer, could you communicate this to the public?" Mr. McLaurin stated, "I am setting up a meeting with the Town Council on Friday so we are getting all the venues that we can possibly get to answer questions." Mr. Deaton stated, "We also have run articles in the local newspapers."

Delegate Pillion asked if the pay scale for nurses is the same in Tennessee as in Virginia. Mr. Norris stated that between MSHA and Wellmont there was a pay difference. Delegate Pillion asked if the difference had been corrected. Mr. Deaton responded that they are working on these issues, including pay differentials between traveling nurses and local nursing staff.

Delegate Pillion stated that he is asking questions to improve communication, then asked: "What problems are we having with ER staffing at JMH? As well as insurance reimbursement for the ER staff." Mr. Deaton stated that ER staffing at JMH has been functioning well and addressed that they do not employee ER physicians but use an outside group. He said they instructed them not to balance bill the patient with the independent physicians. He also stated that contract workers have been used to help with diversion issues, and that a recent meeting with Washington County Commission went well.

Mr. Eaton called on Mr. Todd Norris, Senior Vice President of Community Health and System Advancement for Ballad Health, to continue the presentation.

Mr. Norris stated that they have spent a lot of time with the Tennessee, Virginia, Authority staff, and others associated, and that the concept at this stage for the CA and the COPA is to ensure that the plans of the health system are aligned with the plans of the State and the region. Because we are over a year into this, he stated, new information has been acquired that has led to more questions; namely, information from the new Virginia and Tennessee administrations that has brought them to focus on children and families. He said: "How do we focus on root causes and break generational cycles that lead to repeated generations of poverty, substance abuse, poor health, etc. How do we get upstream of those issues?"

Additionally, he stated, they are hearing from two administrations, the Commissioners of Health and their Accountable Care Community, which has been a "bright spot" and a vision established in the COPA and CA. He stated: "The Cooperative Agreement actually sets forth our requirement that we create a regional two-state accountable care community. What we have found, if there was a value in the length of the merger process, is that it really created a lot of momentum behind the vision that was expressed in improving the health and well-being of the community, and that created a pent-up demand for organizations across the region to want to engage with that, and to engage with the investment that Ballad is going to be making over the next ten years." He reiterated that the investment is $308 million: $75 million in population health, $85 million in Behavioral Health, and so on. He noted: "That is a lot, not a drop in the bucket, but it doesn't fill the bucket. What we have known from the beginning, is that even though that is going to accomplish a lot of great things in the region, if we don't do something else transformational, we are not going to accomplish the goals that we set out to accomplish. We are not going to fully see this generational opportunity that we have here in our region."

The Affordable Care Community was created with Ballad and a partnership with United Way of Southwest Virginia and Healthy Kingsport. It is a two-state initiative with 250 organizations involved, including schools, faith-based organizations, health departments, governments, universities, and organizations like KVAT, Eastman Chemical Company, and other businesses. Mr. Norris stated: "What these organizations have in common is that what they want to see over the next ten plus years is resources align in our region in a different way to support the work that Ballad Health wants to advance to break these cycles and to bend these trends of poor health and economic disparity."

Mr. Norris continued, stating that in the fall they started with 80 organizations and went through all the plans that had been derived over the last few years, including the community health needs assessments, the blueprint, and the Virginia and Tennessee stakeholder plans to identify what the region's priorities should be. The goal of this initiative, he stated, was to stand up leadership for the ACC and have everybody move forward to get down to community level action that drives change in the individual communities across the 21-county region that they serve.

He further reiterated what this all means for them, stating: "The idea of driving collective impact really means, how can you create a lever big enough to really move the needle on some of these issues? The Accountable Care

Community is what the group has come up with. If you go back to the quotes in the presentation, you will see that it aligns nicely with what we are hearing from the Administrations from the Commissioners of Health in Tennessee and Virginia. If we are really going to make a generational change, we must focus upstream, we must focus on root causes, we have to seek long-term impact, and to do that, we have to focus substantially on children and families." He called this focus a "cradle to career" continuum where there is an interface for educational success, economic success and health success, all three of which are areas necessary to focus on. He stated: "We cannot just focus on health outcomes because education and economy, more than anything else, is what drives health outcomes; and we see this reinforced in the county health rankings. The one differentiator that the county health rankings point to for communities that are healthier is economic success and we know that economic success is driven by educational success. We know this cycle can either be a virtuous cycle or a negative cycle. What the Accountable Care Community wants to do is to positively disrupt that cycle, with a lever that is big enough to make a difference."

Mr. Norris introduced the four areas that the ACC is focusing on: strong starts, strong families, strong communities, and strong teams, which he said encompasses the cradle to career continuum. Regarding Ballad's partnership with the Accountable Care Community, Mr. Norris stated: "How can we as Ballad Health truly do what everybody has been asking us to do, which is to convene, facilitate, engage and ensure that we are truly driving public advantage from this merger moving forward? That is what all these conversations are about. How can we ensure public advantage and how can the states actively supervise it?" He stated that this is the solution they have reached: giving every child in the region the same shot at educational success, economic success, and health success regardless of whether they were born in a more urban or more rural area, born into poverty or not, born into families using substances, or not, etc.

The ACC's focus was introduced as being on "at risk" children and families; and the goal of Ballad is to take the opportunity to understand children born in their system, as well as their families, and engage with them differently and get them to programmatic interventions that are best practices and to identify the right package of those interventions that will truly bend the trend lines. Another goal is to make this a long-term study on these sorts of interventions and impacts. To go with the ACC, Mr. Norris stated, is a smaller set of metrics that focus primarily on children and families, including adult metrics that address issues such as drug deaths and smoking.

Mr. Norris continued by stating that they desire to use the ACC as a long-term study to examine the impact of the "right set of proven interventions, packaged up together on a community level" in the long term. To accomplish this, he stated, they are creating a rural research institute with their academic partners to do things like study the ACC work in a longitudinal study. He stated: "Some of you may be familiar with the Framingham Cardiovascular Study. We think this can be a comparable study to that and can be transformational."

Mr. Norris introduced a new part of the COPA and CA: a smaller set of metrics that would focus primarily on children and families and include some adult measures they view as essential to address, such as drug deaths and smoking in the region. These metrics, he stated, would combine with "all the other things that we are doing in Access, which are largely focused on the adult population, and our value based contracts, which are largely based on the adult population, to have a holistic approach for the benefit that we are providing to the region. What we are seeing here is in all the things that we have looked at, the blueprints, the Cooperative Agreement, the COPA, the Accountable Care Community; the alignment is around this set of metrics and the divisions around the States."

Mr. Norris stated: "Remember, the county health rankings say the differentiator on whether counties are healthy or not is education and economic success. That disproportionately impacts the social determinant of health, disproportionately impacts whether communities are healthy or not. A contributing factor to this, and something that is receiving a lot of attention nationally, is ACES (Adverse Childhood Experiences), and the idea of the developing brain in the developing child; which really means that a lot of what creates the pattern for our life (good or bad) relates largely to our childhood experiences and our ability to either develop positive or negative coping mechanisms." Such negative coping mechanisms include overeating, smoking, drinking, and substance abuse, while positive coping mechanisms include the healthier habits that we form. Mr. Norris stated: "As children, we either respond in fight or flight negatively or positively. We either have buffers or protective factors. Relationships in our families, in schools, in our churches or wherever allow for us to develop resiliency against these negative forces or cause us to move towards these negative coping mechanisms. Again, what we want to do is interject community-based resources and healthcare resources and disrupt the negative and increase the positive: increase the buffers, the positive factors, the supporting systems; help people be better parents, help the schools do the things they need to do when they are stretched very thin, and so on. What that will do is will allow us to affect health in the long-term, because people that

experience ACES have a significantly higher likelihood to develop chronic disease and to abuse substances." Mr. Norris referenced a visual in his presentation as what they are trying to avoid, which is essentially a pathway for childhood experiences to disrupt neurodevelopment, cause social, emotional, and cognitive impairment, instigate the adoption of health-adverse behaviors, and cause disease or early death. He stated: "There is a very high likelihood that kids that are at risk in this way will suffer premature death."

He continued by saying that they are trying to rebalance the scale, stating: "Think about it as a see saw. The future of our children, youth and teens are on one side and all the negative behaviors are on the other side with substance abuse and the opioid crisis right here in our region interrupting all the social resources. We hear the foster care system is overwhelmed, schools are overwhelmed, the health agencies are overwhelmed, the children's agencies are overwhelmed, all because of this issue. We know we must address this in order to make a difference. This is what we are looking for: not having an early death, but also having an optimum quality of life."

Mr. Norris stated that they are working on a proposal that will guide them for the next ten plus years to drive forward their initiatives. He also addressed concerns that adult health gets left out of their initiative, stating: "The adult population is extremely important, and they don't get left out of this at all. First, they don't get left out in the strong children and family model, because the family dynamics model is created for health and is very important. Second, remember that our definition of population health includes what we are talking about here, the community health side, but also includes all of our value-based contracts, things like Medicare shared savings programs and our Accountable Care Organization that all focus on the adult population. They focus on diabetes education and screening, cancer screening and prevention, smoking cessation, getting people to access the care they needed, primary care relationship, etc. All these things are extremely important to what we are talking about doing here." Mr. Norris stated that they have gotten positive feedback from the States about their proposals, then he paused to take questions.

Dr. Rawlins suggested holding meetings with the educational partners in the region. Mr. Norris agreed and stated that they would love to have them attend the educational meetings. He further addressed Dr. Rawlins, stating: "Dr. Rawlins, you made a point earlier about milestones and metrics. We are very aware of them and we are very engaged with the States and with the staff of the Authority. That is what we have been sinking our teeth in and going deep dive into. Where are we with the milestones and metrics? All of this relates back to what we call the six month and twelve-month plans."

Mr. Norris introduced the previously referenced plans, including the Population Health Plan, Rural Health Plan, Behavioral Health Plan, Health Information Plan, Academic and Research Plan, and Children's Health Plan, to help implement and track the programs discussed by Ballad. These plans are being tracked by a system called Mede Analytics, which Mr. Norris said is a planning software system that allows us to take things from the strategic level; to the initiative level; to the tactical level; and track through it all. He described it as the following: "We have the focus area, the strategy and the line of sight metrics. We can track the inputs into the metrics, which gives us that view of leading/lagging indicators so we can see how we do retrospectively, and also are we doing the things we need to be doing moving forward in that logic model approach?"

He emphasized that all of the initiatives being discussed are brand new for Ballad and often required the creation of new divisions, such as population health's department of community health and value based care, and the hiring of new people to engage with the community and help instigate change. He stated that the inputs with the Meda Analytics system will show how Ballad is doing on initiatives to develop the department, create the Accountable Care Community, improve their delivery system and information exchange, and improve staff and personal development and management. He reiterated the importance of community action and how Ballad has been juggling the many organizations who are participating in the ACC plan, stating: "The strength with community action is trying to understand all the programs and organizations that are working in this 21-county region and learn what they are doing. We have invited them to be a part of what we are doing, and we have narrowed down to a group that we are now going to be venturing some pilots with next year. We don't have a lot of funding yet but will have about half a million dollars next year to do some pilot programs. We are going to be working with organizations in the region to kind of test it. We want to know how we can reach a different population and create supportive environments within Ballad and within the community and building public health policy is a very core part of this. In a nutshell, that is the population plan."

Mr. Norris moved on to address Behavioral Health, where they are tracking 26 items and making a lot of progress, which he stated you can see when you study the plans. He stated that they have accomplished 24 this year. Moving on to their priorities, he highlighted developing supporting infrastructure, primary care and behavioral health as three. He stated: "How do we get behavioral health into primary care and primary care into behavioral health and supplementing existing regional crisis systems? There is a regional crisis system. We need to understand it better, and we need to see what gaps exist and we need to be working to flesh it out more, so we can get a response to emergency mental health issues in our region and prevent them." He reiterated the importance of additional and enhanced resources for addiction treatment in the region and stated that there is a huge gap in the region in addiction treatment and resources, whether in-patient or out-patient. He elaborated, saying that they are working to understand what the gap looks like and see how they can fill it; there has been a lot of progress in this understanding and they are moving to a place where they can better fill it.

Next Mr. Norris discussed Children's Health, where they are tracking 28 items and have accomplished 24. The focus has been on developing infrastructure, he stated; they have hired people to accomplish their stated goals, such as establishing a pediatric emergency department in Kingsport and Bristol. These initiatives, he said, will get pediatric access closer to populations. They are also working on developing telemedicine and specialty clinics in rural hospitals, where they previously had specialty hospitals, to try and get them closer to populations. He highlighted their initiative of incorporating mental health services into schools: "We are recruiting and retaining subspecialists and developing CRPC designation at Niswonger Children's Hospital. This is huge." He stated that it will be very difficult to recruit the sub-specialists that they need for the Children's Hospital. He continued: "Having a Children's Hospital in a largely rural area is essentially unheard of. We have it here because of the vision of Ballad Health and because of a philanthropist; without that, we would not have a Children's Hospital in the region. To sustain that moving forward is going to be a very difficult proposition. A lot of that challenge is whether we can recruit and retain the sub-specialist physicians that we need to operate the kind of Children's Hospital we want to operate. We are working hard on this, but we are competing with every other Children's Hospital in the country. This is a really important initiative, but it is harder than any of us knew that it was going to be."

Finally, Mr. Norris discussed the Rural Health plan. He stated that it is mostly about primary care in a rural environment and getting physician specialists in the rural environment, whether physically located or via telemedicine or rotating clinics. He stated the plan is grappling with the idea of taking pharmacy, behavioral health, primary care and other things and relating all of that to a team-based approach, and telemedicine or virtual care services. He said: "We have a lot of planning there to do. We have a lot of collaborative work to do. There are groups that are working on it and our plans have been approved, and now we are moving forward with that work. There is still a lot of ground work and preliminary work to do before we can understand what we need to understand to know how we can optimize the academic environment across the region, optimize the research opportunities that we have, and create an infrastructure to draw outside Ballad for research into the region, as discussed earlier regarding the longitudinal study."

Dr. Rawlins stated, "Truthfully, we don't have a plan. The plan and the by-laws got rejected by all the academic partners. It isn't a success currently. Fifteen years ago, we were 39th in the nation in retaining primary physicians, we are now eighth. I think we are doing a good job. I do think you have a lot of work to do to engage all your nursing schools to make them feel invested, and I think right now that is not happening.""

Mr. Norris responded, "Thank you, I appreciate that perspective." The Chairman said: "You know none of the things said in these meetings goes unheard. We take what we hear in the meetings and go back and discuss with the Administration." The Chairman thanked Ballad for their presentation.

VI. Treasurer's Report – Dr. Henry

Dr. Henry noted there was a written report in the board packet: "Currently, we have an ending balance of $17, 205.24. We are incurring expenses through the Cooperative Agreement. There is an agreement in place for $75,000 from Ballad that we need to pursue that Mr. Mitchell stated part of which is in the Memorandum of Agreement and there is some regulatory authority. Rather than have the full board deal with that, they may want to authorize you to deal with all of this." There is a recommended motion. Dr. Rawlins made the motion that the Executive Committee pursue this issue on behalf of the full board. The motion was seconded and carried. Mr. Mitchell mentioned that motion also

included approving Dr. Henry to pay outstanding bills for liability insurance, postal services fees and fees to use the higher education center.

VII. New Business

(A) Consideration of Amended and Restated By-Laws – Jeff Mitchell

Mr. Mitchell noted that the Authority has been discussing bylaws for some time, stating: "There were some that were originally enacted, I think in 2007; however, these by-laws follow the state code. Thanks to Dr. Cantrell's help, we pulled together the policies that you all have adopted over time and included them. Our recommendation is that you adopt them, and I am happy to answer any questions if you have them."

Chairman Kilgore asked, "Any questions on the by-laws?" Mr. Mitchell stated, "It basically follows the Code of Virginia. There is one addition that we called out in the briefing and that is that the Chair has the ability to reach out to any jurisdiction if their member is not consistently showing up; with two or three jurisdictions, we have had that problem; so we spelled that out in the by-laws." Chairman Kilgore stated: "If we have folks not attending, we can reach out and ask them. We need to have representatives here." Dr. Henry motioned that the restated by-laws of the Authority be adopted effective June 12, 2019 as the governing rules of the Authority. Dr. Rawlins seconded the motion. The motion was carried.

(B) Consideration of Charter of Task Force – Chairman Kilgore

Chairman Kilgore introduced the Task Force as being a group that deals with the struggles of getting a quorum. It would be a task force of up to eleven, with potentially four public sector nominated seats. The Chairman stated that members on the Authority that would like to serve on the task force need to come forward soon. The Chairman will do the appointed called meetings. Mr. Mitchell mentioned it is basically a subcommittee of this Authority. The Chairman stated: "I don't want to put you on the Task Force if you are not going to come to the meetings. It is going to have to be a working task force. As you can tell, we have got a lot of work to do on this COPA and with Ballad to make sure that the merger is successful. If you are interested in serving, contact me or Jeff, and if you have somebody you think would be an asset, or some group you think needs to be represented as part of the public, let me know too."

Dr. Cantrell mentioned that the MOA expands the role beyond the Cooperative Agreement and monitoring. Mr. Mitchell noted that the Chairman had asked Mr. Barry, the staff, and himself to determine a role for the Authority, so their draft of the MOA they returned to the Virginia Department of Health was detailed and was likely more than expected. "It is probably causing them to think through what it is that they really want the Authority to be doing," he noted. He also stated that the local committee on the Tennessee side is likely trying to do the same thing. He noted that if the MOA is approved it will be very specific so the members of the task force will have the ability to understand what the expectations of them are and what they are supposed to be doing.

The Chairman stated: "We are asking that you authorize a task force to be appointed, and then we would be working within the confines of the MOA that we work out with the Department of Health." He noted that the reason for doing it now is because the Authority is not set to meet again until December and they want to get the task force established and running now.

Mr. Mitchell noted that the Task Force would likely present a report at the December meeting and request that the full Authority ratify the actions they have undertaken. He stated: "One of the things that we wanted to make sure of was that the Authority was not abdicating its responsibility. The Authority would still be the body, but the Task Force would be the boots on the ground."

Dr. Tooke-Rawlins asked if the task force would be stationed in Abingdon. The Chairman replied affirmatively, noting that it would be comprised mostly of Authority members. Dr. Henry moved to create the Task Force. The motion was seconded by Mr. Neese, carried, and passed unanimously.

(C) Consideration of VDH Memorandum of Agreement – Jeff Mitchell

The MOA was circulated to the Board confidentially since it was still under negotiation, so there was nothing to vote on. Mr. Mitchell suggested that a committee be appointed to look at the MOA and execute it. Chairman Kilgore agreed and stated: "A committee of three and giving them the power to execute the MOA on behalf of the Board and finalize it." Sam Neese motioned to appoint Chairman Kilgore, Dr. Cantrell, and Dr. Henry to execute the MOA on behalf of the Board. The motion was seconded and carried.

VIII. Announcements

(A) Upcoming FTC Meeting – June 18, 2019 – Jeff Mitchell, Dennis Barry and Chairman Kilgore will be attending in Washington, DC. They will be listening. Ballad is the only COPA currently in existence, and the FTC pushed back hard against it. Mr. Mitchell stated: "The Authority will be making comments, so you all need to authorize the Chairman to make those comments." Mr. Neese made the motion. The motion was seconded and carried.

IX. Public Comment

There was no public comment.

X. Next Meeting of Authority

Next meeting is 2nd Wednesday in December.

XI. Adjournment

The meeting was adjourned at 5:21 p.m.

Exhibit B.

Staff Report – Ballad Merger Monitor for FY 2019

THE FIRST REPORT OF

THE BALLAD MERGER MONITOR

OF THE

SOUTHWEST VIRGINIA HEALTH AUTHORITY

TO

THE BOARD OF DIRECTORS

OF THE

SOUTHWEST VIRGINIA HEALTH AUTHORITY

January 3, 2020

Dennis Barry
dmbarry@verizon.net

Contents

I. INTRODUCTION

1.1 Merger Occurred on January 31, 2018 and Is Still Being Implemented

The Virginia Commissioner of Health approved the merger forming Ballad on October 30, 2017, and at approximately the same time by the State of Tennessee. The merger occurred on January 31, 2018. Health care is complex, and it takes time to form a unitary organization out of two large separate organizations with a total of 21 hospital facilities, many more nonhospital sites, approximately 15,000 employees, and more than $2 billion in revenue. For example, Ballad faces a major task in converting to a single computer system, and presently plans to complete that task with a "go live" date of October 1, 2020. As you can see driving around the region, Ballad has not completed changing the signs for all its sites and there are still many sites labeled Wellmont or Mountain States. As of today, there are different charge structures at legacy Wellmont and legacy Mountain States facilities, both in how items are charged and the amounts of those charges, although Ballad does have a plan for going to a unified charge structure. While most policies have been made uniform at all facilities, there are still some policies that are under review. Based on my familiarity with other health care mergers, Ballad is proceeding expeditiously and competently in fashioning a single organization from the two legacy organizations, but that process is not completed.

1.2 Ballad's Annual Report Was Submitted October 28, 2019 and Includes Confidential Information

Ballad has a fiscal year ending June 30. Thus, it has completed two fiscal periods since the merger on January 31, 2018, one short fiscal year of February through June, 2018, and a full fiscal year ending June 30, 2019. Ballad is required to submit an annual report for each fiscal year, and it submitted its annual report for FY 2019 on October 28, 2019. That annual report has two parts, one composed of more than 200 pages of nonconfidential material, and the other containing nearly 400 additional pages of material that Ballad has labeled confidential and protected from disclosure. We have not included in this report information that Ballad has characterized as confidential.

1.3 Other Ballad Reports and Active Monitoring

Ballad furnishes a detailed annual report, much shorter quarterly reports, and monthly quality data. Representatives from both states and this Authority meet monthly with Ballad's management, and also have a monthly conference call with Ballad. Tennessee created the Local Advisory Council to obtain local input, and Ballad participates in public meetings held by the Local Advisory Council. In both regularly scheduled meetings and conference calls, and in less formal telephone and e-mail communication, the state regulators and monitors discuss a wide range of subjects, and the scope of discussion extends beyond the bounds of Ballad's formal commitments. Ballad's management has been forthcoming with information and open in responding to questions.

1.4 Purpose of this Report and Reliability of Ballad Information Presented

This report is intended to summarize both information presented by Ballad and give insight into how well the merger is working in meeting the needs of the residents of southwest Virginia. We have relied on information presented in Ballad's written reports and have also included information garnered from meetings with senior Ballad executives, other members of the regulatory team, and personal observations. The information that Ballad furnishes is examined and tested for accuracy. Much of this testing is done by the Tennessee COPA monitor, who is an extraordinarily well-qualified CPA who worked as the chief financial officer of the University of Virginia for more than 20 years prior to his retirement.

1.5 Compliance Costs, Attempts to Avoid Duplication, and Likely Revision of Each State's Terms and Conditions

By agreement and as a condition of the states approving the merger, Ballad bears the costs of the states' and this Authority's monitoring. Those entire costs are substantial, approximately $2.5 million in FY 2019. This spending is essential, but it is also money that does not go into compensating employees, buying new equipment, or otherwise serving residents of the region. Accordingly, both states and the Authority's Monitor are attempting to minimize the costs of Ballad's compliance by scheduling joint meetings with Ballad and coordinating requests for information. Nevertheless, there are differences between Virginia's and Tennessee's requirements that cause Ballad to do extra work. It is likely that Ballad and the two states will re-examine the applicable requirements in the next year so as to minimize differences between the two states and to resolve ambiguities and uncertainties in the existing documents. In addition, the states are working together on selecting the metrics they will apply in such areas as population management so that Ballad does not have separate targets for each state. Both states' regulators have expressed a strong preference that all appropriate amendments to each state's terms, conditions, and requirements be addressed in a single process, so that the need for future amendments is eliminated or markedly reduced.

1.6 The Authority's Monitor's Job

As stated in the Authority's job description, the job of the Authority's Ballad Merger Monitor is:

> to preserve, protect, and enhance the benefits to the residents of Southwest Virginia of the merger creating the new entity Ballad Health that were promised and anticipated by Authority members voting to recommend approval of that merger.

As the Authority's employee, I solicit your feedback at any time on questions, issues that concern you about Ballad, or about my job performance. I can be reached at dmbarry@verizon.net. Also feel free to make comments to the Authority's counsel, Jeff Mitchell, jeff@mitchell-firm.com.

1.7 Measures of Success

Stepping back from the detail, the ultimate issue is whether the residents in this region are better off with the Ballad merger compared to what would have occurred without the merger. The harms that can be realized by less competition are: reduced access; reduced quality; and higher costs to payors, employers and patients. This report addresses each of these issues and concludes that access has not been adversely affected; quality has overall improved; and costs to payors and patients have been compliant with "Addendum 1" that both states use to bar the abuse of market power. In addition, Ballad is making investments in behavioral health, population health, rural health, and children's health that it would likely have been unable to fund without the savings realized from the merger.

II. ACCESS

2.1 Overall Data for the Region

Included below, *verbatim*, are the metrics on access that Ballad presented in its Annual Report for its Fiscal Year 2019:

	Measure	Source	Baseline	FY19	Source	
1	Population within 10 miles of an urgent care center (%)	Ballad Health	80.5%		80.1%2 (slight decline)	Census + Facility Address at Census Block
2	Population within 10 miles of an urgent care center open nights and weekends (%)	Ballad Health	70.3%		70.3% (maintained)	Census + Facility Address at Census Block
3	Population within 10 miles of an urgent care facility or emergency department (%)	Ballad Health	98.9%		98.8% (maintained)	Census + Facility Address at Census Block
4	Population within 15 miles of an emergency department (%)	Ballad Health	97.3%		97.3% (maintained)	Census + Facility Address at Census Block
5	Population within 15 miles of an acute care hospital (%)	Ballad Health	97.3%		97.3% (maintained)	Census + Facility Address at Census Block
6	Pediatric readiness of emergency department	Ballad Health	67%		68.2% (improved)	Survey tool created by NEDARC
7	Appropriate emergency department wait times (%)	Ballad Health	40.7%		42.1% (improved)	NHAMCS, CDC/NCHS

2.2 Lee County

As people in this region are painfully aware, Lee County Hospital in Pennington Gap closed in 2013. Ballad has agreed to reopen that hospital and is making a significant investment of approximately $15 million to do so. Ballad has acquired the physical plant and is busy making renovations. It opened an urgent care center on the premises in October, 2019, and the volume of patients seen at that site makes it one of Ballad's busiest urgent care centers. Ballad anticipates opening the hospital around October 1, 2020. The timing on opening the facility is dependent not just on renovation (including installation of a new computer and software system), but on processes not controlled solely by Ballad including obtaining "critical access hospital" status, and Medicare provider enrollment and certification (two separate processes). The opening of a hospital in Pennington Gap approximately 7 years after the hospital there closed is very unusual in rural America. Since 2010, 119 rural hospitals have closed nationally. (https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/) The rate of closures of

rural hospitals has accelerated with 18 occurring in 2019 alone. Of the 119 closures since 2010, a disproportionate number, 24 or a fifth of the national total, were in this region--Virginia (2, including Lee County), Tennessee (13), Kentucky (4), and North Carolina (7). In contrast, only 2 hospitals have opened in rural locations since 2010.

2.3 Wise County

Wellmont and Mountain States, as then competitors, were barred by antitrust law from conferring prior to their merger on what changes could be made to make service delivery more rational and efficient if their merger were permitted. However, no conferring was needed to realize that the operation of 3 full-service hospitals in Wise County, with a population of approximately 40,000, was not rational, especially with the very low average daily census at each facility. In 2016 in the course of the Authority's review of the merger application, the Authority's consultants made clear that changes in Wise County were very likely. After obtaining approval from Virginia in October of this year, Ballad formally discontinued surgery at Mountain View, moved inpatient and critical care services to Lonesome Pine, and will close the emergency room at Mountain View in January 2020 (and will direct patients to the very close Norton Community Hospital). Ballad has been working with a Visioning Committee composed of Wise County citizens to advise on the additional changes in service delivery in Wise County that make the most sense. Ballad is close to formulating a proposal for reconfigured services at its Wise County facilities, and plans to present that proposal informally to the Virginia Department of Health in the first half of January, 2020. After informal consultation with the Virginia Department of Health, Ballad will subsequently submit a formal application for the necessary approvals. It is our understanding that no services will be eliminated from the County and all three existing facilities will remain in use in some capacity. Indeed, in FY 2019, Ballad treated 700 patients in Wise County who previously would have been transferred out of the County. Many of these were surgical patients, and surgical volume in Wise County in FY 2019 increased 16 percent over the preceding 12 months. In addition, the linear accelerator at Norton Community Hospital will be upgraded during the winter and spring of 2020. (While the linear accelerator is out of service, Ballad will offer transportation or gas cards at its own cost for patients needing to travel to Kingsport for linear accelerator treatment.) It is likely that most employees will still be needed for positions in Wise County and those who may possibly not be needed will be offered the opportunity to work at other Ballad facilities.

2.4 Level I Trauma and NICU Consolidations from Kingsport to Johnson City

There were two Level I Trauma Centers prior to the merger, one at Wellmont's Holston Valley Medical Center and one at Mountain States' Johnson City Medical Center. Having two Level I trauma centers for a service area with a population of roughly one million was not a good use of resources. A measure of need for Level I trauma centers was set forth in a report by the American College of Surgeons as "one level I trauma center per one million population in the service area." (https://www.dshs.texas.gov/emstraumasystems/TX-Special-Report-Final_August-3rd.pdf) at p. 10.[1] Having two Level I trauma centers did not result in simply spending too much but also posed difficulties in maintaining quality. It is well demonstrated in health care that higher volume correlates with higher quality, and *vice versa*. The appropriateness of consolidating the two Level I trauma centers was so apparent that Tennessee (the state with jurisdiction over the hospitals with the trauma centers) approved the consolidation of the trauma centers as part of its COPA approval. In any event, the consolidation has now occurred. Prior to the consolidation proceeding, Ballad managers worked with ambulance service providers in the region to inform them of what services were affected (*e.g.*, major multiple trauma such as may be sustained in a bad automobile crash) and which were not (*e.g.*, heart attack and stroke). To assist emergency room physicians at Holston Valley Medical Center who treat infants suffering from trauma, Ballad has set up a telehealth link with Johnson City Medical Center pediatric trauma specialists. That telehealth link has recently been extended to the emergency room at Bristol Regional Medical Center.

A very similar analysis applies to the consolidation of the neonatal intensive care units (NICUs) to Johnson City where Niswonger Children's Hospital is located on the campus of Johnson City Medical Center. There was insufficient volume to support two NICUs. (More recent data shows a dramatic drop in the number of births in Ballad's service of 9 percent from 2019 to 2020.) The transition to one NICU went smoothly. Best practice is to transfer a mother with a fetus in possible distress to a NICU hospital prior to the baby being born. This has occurred almost all the time since the NICU consolidation and as of mid-November, only two infants had to be transferred from Holston Valley to the NICU in Johnson City.

Regardless of the apparent logic supporting the consolidation of the two trauma centers and NICUs, it is understandable that a segment of the public in the Kingsport area and adjacent Virginia communities resented the removal of two high-level services, trauma and a NICU, to Johnson City. Indeed, as this is written, protesters are still in the city right of way abutting the hospital protesting the Ballad merger and Ballad's actions. In hindsight, it is easy to criticize Ballad's communication about the consolidations; indeed, the Authority's Merger Monitor has discussed communications with Ballad's management. Nevertheless, it is clear to this Merger Monitor that the consolidation of Level I trauma and neonatal intensive care was necessary and appropriate. Whether the consolidation of Level I trauma care should have occurred in Kingsport rather than Johnson City may possibly be fairly debatable—that was an issue solely within the jurisdiction of Tennessee regulators and they approved the consolidations in Johnson City. Studying how both consolidations might have been implemented better is valuable only in informing both Ballad management and state regulators in how to deal with similar issues in the future, although Ballad management has informed the Authority's monitor that no changes of this materiality are on the drawing boards.

2.5 Moving of Infusion Therapy Center to Indian Path Hospital

Ballad closed a freestanding infusion therapy (chemotherapy) center in Kingsport and opened a new "hospital-based" infusion therapy center at Indian Path Community Hospital in Kingsport. Ballad operates a number of infusion centers, all of which have always been hospital-based both under Ballad and the legacy systems. The Kingsport center had previously been hospital-based but because of changes in the legacy Wellmont system, it temporarily became a freestanding site. It remained a freestanding site as changes were put on hold during the process of seeking the Cooperative Agreement and COPA approval.

[1] This population standard can vary depending on population density and transportation. In this instance, however, the two existing Level I trauma centers were in the same County in Tennessee and well-served by interstate highways.

Federal law requires pharmaceutical manufacturers to offer their best prices to certain governmental and nonprofit hospitals that serve a significant portion of low-income patients. This is known at the "340B" program, and the discounts are referred to as "340B pricing." While these discounts have always been significant, their importance has skyrocketed as the prices of cancer drugs have risen rapidly. Accordingly, 340B discounts are especially important now, but are available only to *hospitals*. By closing a freestanding infusion center in Kingsport and once again making it a hospital-based facility, Ballad realized drug purchasing savings well into seven figures.

From the perspective of physical access, the change had no adverse effect on patients; there was historically and continues presently an infusion therapy center for cancer patients in Kingsport.[2] There is, however, a disadvantage for patients. When outpatient treatment is furnished in a hospital-based setting, many patients have different, and higher, copayments required of them. To avoid any financial harm to patients being treated during the transition, Ballad held those patients harmless. New patients receiving infusion therapy at the hospital-based infusion center will have higher out-of-pocket costs under their insurance plans than they would have had if the prior freestanding infusion therapy center had remained open, although like all Ballad patients, they may be eligible for financial assistance based on Ballad's generous charity care policy. Finally, the charges stated on bills are noticeable higher, although so-called "billed charges" usually have little or no relevance to either the amount paid by a health plan or the patient's out-of-pocket costs. (See discussion of charges in Section IV, below.)

[2] Like most outpatient services in the region, there are also options to obtain infusion therapy at non-Ballad sites in or close to Kingsport.

2.6 Physician and Mid-Level Practitioner Recruitment

Ballad reports that it has recruited or assisted in the recruitment of 150 physicians or "mid-level" practitioners (such as nurse practitioners or physician assistants) to the region, and most of these were recruited in FY 2019. Ballad has four full-time physician recruiters, a substantial budget, and a number of strategies which vary from assisting an existing unrelated physician practice in recruiting new physicians to Ballad itself or employing or contracting directly with recruited physicians. Most recruited physicians are primary care physicians, but among the recruited physicians are an orthopedist and cardiologist in Wise County, and a cardiologist who serves Wythe County.

The Local Advisory Council in Tennessee has raised a concern with the Tennessee COPA monitor that Ballad is not "physician friendly" and its conduct has resulted in physicians leaving the community. The data do not show an alarming number of physicians leaving Ballad hospital medical staffs, but this issue is still being investigated by the Tennessee COPA monitor who is gathering data and intends to interview a sample of physicians who have departed the region. When we have more information, we will furnish a follow-up report to the Authority or its Task Force.

Ballad has completed a physician needs assessment that shows a need for hundreds of additional physicians and mid-level practitioners in the area. It is the judgment of the Authority's Merger Monitor that the generally accepted metrics used by the contractor who prepared that physician needs assessment are out of date and overstate need. Nonetheless, there is little question that more physicians, both primary care physicians and specialists, are needed in the community.

2.7 Nurse Recruitment

There is a national shortage of nurses as well as other health care professionals. The nursing shortage is particularly acute in this region and continues to affect Ballad. For example, one reason some patients remain in emergency room cubicles instead of moving into an inpatient room is because of the shortage of staffed beds (although Ballad's statistics on time from presenting to the emergency room to being moved to an inpatient bed do not depart materially from national medians). Ballad has materially increased nurse compensation, making a system-wide investment of $10 million a year in increased compensation rates for nurses and related occupations.[3] Ballad is taking other steps to improve its ability to attract and retain patient-care personnel including having a "career-ladder" for nurses, recruitment incentives (*e.g.*, student loan payments), and even "branding" the Appalachian Highlands (with other area employers) to highlight the attractiveness of the region. While Ballad is taking steps to recruit and retain more nurses, the nursing and allied health shortage will not be alleviated in the short-term and is likely to continue to affect Ballad and its patients for at least the near to mid-term future. One item on the Authority's Merger Monitor's agenda is to research more fully what Ballad is doing to address the problems caused by the nursing shortage.

2.8 Telehealth Services in Schools

Ballad has entered into an agreement with the Lee County Public Schools for the provision of telehealth services to nurses in each school location in Lee County, Virginia beginning in November 2019. We understand that Ballad will offer this service to other counties in the region.

[3] Ballad and its predecessor organizations have been active for years in trying to persuade CMS to change a portion of the Medicare payment formula called the "wage index" which caused Medicare rates to be substantially lower for hospitals in regions such as this which historically had lower labor costs. As the labor market for health care personnel has become increasingly national, the Medicare payment formula made it difficult for hospitals in this region, which had a very low wage index and hence lower Medicare payment rates, to compete with other areas for personnel. Ballad's efforts along with those of similarly situated health systems and hospitals finally bore fruit this year as Medicare implemented a 4-year change to its payment formula to give hospitals with low wage indices some additional funds so that they could pay more competitive compensation. This temporary adjustment to the wage index formula should give Ballad the opportunity to bring its pay up to higher levels which will hopefully be reflected in the Medicare payment formula in the future. There are uncertainties in how this will turn out eventually, but at least in the short to mid-term, the change in the Medicare payment formula is very beneficial to Ballad.

III. QUALITY

3.1 Applicable Quality Standards

At a national level, there has been increasing recognition that harm can and does occur to some hospitalized patients. Last decade, Congress directed CMS to create measures of quality and to change the Medicare payment formula to make a portion of payment dependent on each hospital's quality performance. Medicare separately penalizes hospitals which have more than the average number of readmissions and will not pay a hospital for care required to treat an infection or injury acquired or arising at that hospital.

"Quality" standards may be a misnomer since the quality standards selected by CMS have to do with avoidance of harm. While it may seem self-evident that harm should not occur to a patient in the hospital, that is much easier said than accomplished. The reason CMS selected the quality measures it has is because there is national data showing that there is room for improvement. Indeed, when most hospitals have successfully tackled a problem, CMS "retires" the applicable quality measure. The quality standards that Ballad reports to the two states are standards that CMS had identified, but there are differences in the source of the data and the timeliness. The CMS web site reports quality data as well as hospital ratings on a 5-star scale. Although the measures that Ballad reports to the states are CMS measures of quality, the results differ from what is shown on the CMS web site for two reasons. First, the quality data that Ballad reports is current; thus, the data Ballad reported to the states for FY 2019 was for patients treated in FY 2019. Data reported on the CMS web site for Ballad hospitals goes back as much as 5 years ago and none or virtually none shown there presently are from Ballad's FY 2019. Second, some of the CMS data is from Medicare claims forms, and thus excludes any non-Medicare patients, and also excludes Medicare Advantage patients for whom claims are submitted to nongovernmental health plans. Ballad's reported quality data is for *all* patients. The Tennessee COPA monitor is reviewing Ballad's systems for quality reporting to test their accuracy.

There are other quality reporting systems used, including Leapfrog. Ballad's performance under Leapfrog's standards is not as high as under the standards selected by the States. Part of this is due to Leapfrog data on Ballad, like Medicare's reported data on Ballad, being out-of-date. In any event, Ballad does not furnish data to Leapfrog directly since participation as a system would cost it several hundred thousand dollars annually, and Ballad believes that reporting the data the states have selected gives an accurate picture of how well it is doing. Although Ballad does not endorse all quality rankings, it happily reports:

> Recently, US News reported that all four of Ballad Health's flagship hospitals – Johnson City Medical Center, Holston Valley Medical Center and Bristol Regional Medical Center, in Tennessee; and Johnston Memorial Hospital in Virginia – are among the top-performing hospitals in Tennessee and Virginia in several specialties, with each hospital providing "top performing" services and programs in heart failure and COPD in both states. In each state, less than 30% of all hospitals had any top-performing programs, according to US News. In Tennessee, all three of Ballad Health's flagship hospitals were among the top-performing hospitals, while in Virginia, Johnston Memorial was among the top performers. (https://www.balladhealth.org/news/reports-annual-results-high-ranking-hospitals-strong-financial)

Norton Community Hospital ranks once again among top 10 percent of inpatient rehab facilities in the nation. (https://www.balladhealth.org/news/norton-top-10-percent-inpatient-rehab) Norton is also recognized as one of the best hospitals in the country for treating patients with black lung disease.

3.2 Ballad Performance on Quality Measures

Measure	Baseline	FY 2018	FY 2019	Performance
Pressure ulcer rate	0.29	1.10	0.53	X

Iatrogenic pneumothorax rate	0.38	0.23	0.33	Ok
In-hospital fall with hip fracture rate	0.10	0.01	0.08	Ok
Perioperative hemorrhage or hematoma rate	4.20	1.76	1.41	Ok
Postoperative physiologic and metabolic derangement rate	1.02	1.06	1.28	X
Perioperative pulmonary embolism or deep vein thrombosis rate	5.35	3.51	3.16	Ok
Postoperative sepsis rate	6.16	3.88	4.03	Ok
Postoperative wound dehiscence rate	2.20	0.99	1.48	Ok
Unrecognized abdominopelvic accidental puncture/laceration rate	0.90	0.98	0.27	Ok
Central line associated blood stream infection	0.774	0.65	0.616	Ok
Catheter associated urinary tract infection[4]	0.613	0.640	0.895	X
Surgical site infection-colon	1.166	1.900	2.285	X
Surgical site infection-hysterectomy	0.996	0.610	0.000	Ok
MRSA[5]	0.040	0.054	0.090	X
CDiff	0.585	0.623	0.352	Ok

On 16 measures shown above, Ballad has improved its performance in FY 2019 over the baseline from the pre-merger period for 11 measures. In 5 categories, Ballad's performance in FY 2019 was not as good as the baseline. More disturbing is that in 8 categories, Ballad's performance in FY 2019 was not as good as FY 2018, although in most of those categories it was still better than the baseline.

Virginia hospital performance on quality measures is generally good with Ballad reporting no instances for Virginia hospitals where they are outside the norm of the national performance on quality metrics. (https://www.balladhealth.org/sites/balladhealth/files/documents/COPA-Public-Reporting-July-FY19.pdf)

3.3 Ballad's Steps to Improve Quality Measure Performance

Ballad's Board has adopted a "no harm" policy. This may seem like a "no-brainer," but it has been generally accepted for years that there are risks to being hospitalized and those risks cannot be reduced to zero. Ballad probably will not reduce risk to zero, but its emphasis on avoiding harm to patients is coming from the top. Every business day, all the senior personnel at each hospital and in the corporate office meet at 9:45 a.m. for a "safety huddle," and any issue that arises as a quality/patient harm problem is reported. Ballad's quality report for the first quarter of FY 2020 generally shows improvement but there are still 4 categories where it does not meet the pre-merger baseline.

[4] This performance was affected by unsterile supplies furnished by a vendor. It is to Ballad's credit that it was able to trace the problem to a tainted product and then eliminate that source of infections.

[5] MRSA is an especially difficult problem in this region because of over-prescribing of antibiotics. Addressing MRSA is an initiative of the Tennessee Hospital Association

(Subsequent year reports will differ to some extent from the data shown above since some measures have been retired or combined, and new measures have been added.) An update on quality is a subject of the monthly meetings with the regulators and monitors about every two months—we are watching this very closely. On balance, Ballad is performing satisfactorily, but this is difficult, and it may take some time to see dramatic results from Ballad's focused effort. More information on Ballad's quality data can be found on Ballad's web site, https://www.balladhealth.org/quality-reporting.

3.4 Surveys of Ballad Facilities by CMS, State Agencies, and Accrediting Bodies

The Joint Commission, a private nonprofit accrediting body for hospitals, surveyed Holston Valley Medical Center in 2019 and found no deficiencies. This is to the hospital's credit; it is not unusual for surveys to find some deficiencies and to require a plan of correction. The Commonwealth of Virginia investigated a complaint at Johnston Memorial Hospital and also found no deficiencies.

IV. COST TO PAYORS, EMPLOYERS AND PATIENTS

4.1 Rates Set by Federal and State Governments for Most of Ballad's Patients

The vast majority of Ballad's payor mix is composed of Medicare fee-for-service patients, Medicaid patients, and indigent patients who do not pay at all (and for whom charges are waived under Ballad's charity care policy). For these populations, Ballad does not negotiate and cannot control prices, although the pre-set rates it receives may be affected up or down by factors unilaterally set by the payors including quality scores, readmission rates, overall costs per episode of care, and other factors. The only prices that Ballad negotiates with payors are with private health plans covering nongovernmental patients (about 27% of Ballad's payor mix), Medicare Advantage plans (for whom rates are often based upon a percentage above or below Medicare fee-for-service rates), and to a slight extent, with Tennessee Medicaid managed care plans.

4.2 Limitations on Ballad in Negotiating Price Increases

As part of both states' approval of the merger, Ballad has agreed to limit the prices it negotiates with payors to the annual Medicare rate update plus 0.25 percent for payors who also reward or penalize Ballad based on overall cost of care or other agreed upon measures of value. For fixed rate negotiated arrangements, the price cap is the Medicare rate of increase plus 1.50 percent. These limitations are applied cumulatively so that any "cap" not used in prior years will be added to increases permitted in subsequent years.

In the order approving the merger, Virginia strongly encourages Ballad to increase the number of patients covered by "risk" contracts, *i.e.*, contracts with payors under which Ballad can receive a bonus or suffer penalties depending on how costs for treating those patients differs from expected costs. Indeed, Virginia expects that by January 1, 2021, Ballad "shall" have "at least 30 percent" of its revenue from health insurance contracts (i.e., rates Ballad negotiates) "from risk-based model contracts." Commitment no. 10. Those potential bonuses/penalties are *not* included in the calculation of Ballad's compliance with price caps.

While the general principles applicable to Ballad's pricing are simple, they are contained in an extraordinarily dense document know as Addendum 1. The complexity of Addendum 1 arises from the perceived need to address multiple potential payment models. Whether Addendum 1 meets all possible contingencies remains to be seen. Since compliance with pricing limitations is so important under the Cooperative Agreement and COPA, the parties have agreed that Ballad will submit all contracts to the Tennessee COPA Monitor prior to signing them. The COPA Monitor's approval does not, however, relieve Ballad of annually showing that it has, in fact, met the requirements of Addendum 1. The parties are presently in the process of reviewing possible modifications to Addendum 1. There is no intent to modify its general principles or the caps on price increases. Rather, in trying to apply Addendum 1, the parties have encountered ambiguities, unnecessary verbiage, and other drafting issues. Work to make Addendum 1 more understandable is underway, and presumably will be reflected in amendments in the next several months.

As a practical matter, the Authority's Merger Monitor believes that in the near term, it is unlikely that health care insurers will agree to price increases that equal the cap on Ballad's pricing. Accordingly, we do not expect the application of the price increase cap to have much, if any, application. (The Merger Monitor does not, however, have any insight or information into the price increases Ballad will attempt to negotiate.)

4.3 Only One New Contract Since Merger

Since the merger occurred on January 31, 2018, Ballad has executed only one contract with a payor. That contract was for a Medicare Advantage product, and was effective July 1, 2019. Ballad agreed to a *reduction* in the rates it charged that payor, in this case a reduced percentage of the Medicare fee for service rates compared the percentage of Medicare rates the payor had previously agreed to pay Ballad.

4.4 Anthem Contract

Anthem[6] is the payor covering most Virginians who have health insurance but are not covered by Medicare or Medicaid. (Anthem may serve as the administrator for employer self-insurance plans as well, and as far as Ballad is concerned, those employer-self-insured patients are Anthem patients.) Anthem had a contract with some legacy Wellmont hospitals (Holston Valley, Bristol, Lonesome Pine and Mountain View) that expired, but both parties have agreed to a month-to-month extension under the rates in the old agreement. Thus, for these 4 hospitals, Ballad has gone without a rate increase when it otherwise would have expected to have negotiated such an increase. Ballad legacy Mountain States' agreement with Anthem will expire in September 2020.

There is ongoing communication between Ballad and Anthem, but to date, Anthem has refused to negotiate a new agreement. For Anthem, the sticking point is that the independent emergency physician group that furnishes physician services at Ballad's legacy Mountain States Virginia hospitals remains "out-of-network" for Anthem. This means that the physician group is not paid directly by Anthem, but instead bills the patient, and the patient is indemnified by Anthem at Anthem's rates for out-of-network physicians. Under Ballad's agreement with the physicians, the physicians do not "balance bill" the patients, meaning that the patients are not suffering financial harm because of the physician's out-of-network status with Anthem.

The emergency physician group has not agreed to a contract with Anthem because it does not want to accept the rates offered by Anthem. Ballad does not control the emergency physician group, does not negotiate payor contracts for it, does not dictate its rates, and receives no portion of the revenue earned by that group. Ballad is not, however, without influence in encouraging the emergency physicians to negotiate. The Merger Monitor has been informed that Anthem's current offer to the physicians is considerably below what other payors[7] pay both to this emergency physician group and what emergency physicians are paid by other health plans at Ballad's Tennessee hospitals. The Merger Monitor has had no communications with Anthem and does not desire or expect to become part of the negotiation either with the emergency physician group or with Ballad.

Typically, impasses between payors and hospitals are resolved, but not always. Thus, it is conceivable that the contract between Ballad and Anthem will lapse. If that occurs, Virginia patients insured by Anthem will be billed directly by Ballad and will have to seek reimbursement from Anthem, which reimbursement may or may not be sufficient to cover Ballad's bill (less any copayments). Even when there is a lapse in a payor contract, the parties almost always reach a resolution. The state regulators and the Authority's merger monitor query Ballad monthly on the status of the relationship with Anthem, and we will keep you informed of developments.

4.5 Future Contracts—2020 Will Be a Busy Year

Ballad has many payor contracts expiring over the next year and will be busy negotiating the terms of new agreements. Ballad reports having good relationships with its payors (including Anthem, notwithstanding the current contractual bottleneck).

Ballad has been clear with payors and with regulators that it plans to expand the number of patients for whom it is at risk, meaning that it has the ability to receive bonus payments if it is successful in reducing the payor's expected expenditures for a designated population. Ballad has participated as an "accountable care organization," a Medicare concept, where Ballad is one of the few organizations in the country that has for all years saved money over the targets set by Medicare for the enrolled Medicare population and earned bonus payments. Similarly, Washington County, Tennessee reported to Ballad that the County's costs for health care for its employees declined 10 percent from the prior year because of Ballad's better management of care. Thus, Ballad has a track record at being successful in managing care so as to reduce costs to payors.

---

[6] Anthem vigorously opposed the merger forming Ballad, and appeared at the June 18, 2019 FTC session examining COPAs and excoriated Ballad, principally because of the problem with the independent emergency physician group.

[7] We are informed by Ballad that the emergency physician group has contracts with all other significant nongovernmental payors.

Presently, Ballad has a low margin on operations, a little less than 2 percent.[8] While that is an improvement over financial performance compared to the immediate prior years, it is not as good as it needs to be for Ballad to make the investments it should make in future patient care and have a bond rating that will give it ready access to capital at the most favorable rates. Thus, it is commendable that Ballad has a strategy to improve its margin, and its pursuit of so-called "risk contracting" makes sense. As noted above, the Virginia commitments require Ballad to earn "at least 30% of [its] total health insurance contract revenue … from risk-based contracts."

The name of this strategy, *risk* contracting, however, points out that there is, indeed, some risk to pursuing this strategy. There are a number of ways this strategy can backfire: Ballad may fall short in how well it manages care; there may be adverse selection among the enrolled populations; or there could be one or more outliers who skew results badly. Ballad reports that insuring for this risk is so expensive that it is not worthwhile. Ballad is not alone in the strategy of pursuing risk contracting as many other hospitals are making the same bet. In the short to mid-term, it appears to be a sound strategy, but, by definition, is not without risk. One of the reasons that there appears to be a good opportunity here for Ballad is that there have historically been relatively high hospitalization rates in this region, and that historic data is what is used in setting performance targets. Just getting down to national averages will save a lot of money. (This is discussed in more detail in the section below on Ballad's finances.) Finally, whether or not risk contracting is a good strategy for Ballad is almost a moot issue; payors are pushing hard in that direction.

4.6 Charge Increases Effective January 1, 2020

Hospital charges are nearly irrelevant to payments from governmental payors and the vast majority of nongovernmental health plans. Those payors make payments based on rates, usually determined by the patient's diagnoses and/or procedures performed. Similarly, insured patient's copayment amounts are not ordinarily affected by a hospital's charges. Charges are relevant to payors with contracts to pay a percentage of charges, well under 1 percent of Ballad's business, and to uninsured patients whose payments are not waived because of financial need.

For uninsured patients, without regard to financial need, Ballad agrees to discount its charges, presently by 77 percent at legacy Wellmont hospitals and 85 percent at legacy Mountain States hospitals. Thus, $20,000 of billed charges at a legacy Wellmont hospital would be discounted to $6,600 for an uninsured patient. Then the patient may qualify for a reduction of that net amount in whole or in part based on financial need. If the patient's income is 225 percent or less of the federal poverty level, the patient's entire bill will be written off. Above that level, a sliding scale is applied up to 450 percent of the federal poverty level. This is the most generous uninsured/charity care policy the Authority's Merger Monitor has seen.

Nonetheless, hospital charges still exist, and Ballad plans to update its charges effective January 1, 2020. Legacy Mountain States hospitals have higher charges than legacy Wellmont hospitals. Ballad is moving toward having uniform charges at all its hospitals for the same service. To move in that direction, Ballad is *reducing* charges at its legacy Mountain States hospitals for 2020. Most Virginia hospitals are legacy Mountain States hospitals and overall charges at these hospitals will be reduced. In addition, Ballad is making uniform the uninsured discount for all its hospitals at 85 percent (an increase from 77 percent for legacy Wellmont hospitals). At the same time, Ballad is increasing charges at Wellmont hospitals. The weighted average charge increase *system-wide* will not exceed the percentage limitation in Addendum 1. The Tennessee COPA Monitor has reviewed the charge increase and has concluded that it is compliant with Addendum 1. *There will, however, be some charges at Wellmont hospitals that increase by more than the percentage stated in Addendum 1.* This is because the Addendum 1 charge limitation applies in the aggregate and not to individual charges.

[8] Ballad also has additional nonoperating income from investments of endowment and trust funds. That income includes unrealized gains and losses. While positive for FY 2019, nonoperating income fluctuates significantly from year to year, and can be a material negative amount in market downturns. The industry standard in evaluating financial performance is to focus on operating income.

Ballad's charges for an inpatient room will be uniform across all of its hospitals starting January 1, 2020, and will be $1,217 a day. The following table[9] shows Ballad's 2020 inpatient routine room charge compared to other hospitals in the region. Of 23 hospitals (not all of whom are included on the table below), Ballad's 2020 charge is slightly above the mean for the 2019 charges of the other 22 hospitals sampled (not weighted for patient days) of $1,176.

Hospital	Room Charge (current for all except Ballad)
Tennova Healthcare Clarksville (highest of the 23 surveyed)	$2,009
Central Carolina	$1,623
Carilion	$1,605
Harris Regional	$1,527
Danville Regional	$1,309
Ballad (eff. 1/1/2020)	*$1,217*
Lewis Gale	$1,091
Saint Francis	$1,008
Chatham, UNC	$915
Mission	$881
Transylvania (lowest of the 23 surveyed)	$557

4.7 Ballad Charges Compared to Charges at Freestanding Sites

Authority members may have received an anonymous e-mail comparing HMG charges with a Ballad hospital's charges for certain imaging services. This e-mail showed substantially higher Ballad charges than HMG charges for the same services. In the view of this Merger Monitor, this comparison was unfair for at least the following reasons:

- As discussed above, hospital charges have little relevance on what payors or patients actually pay;
- Hospitals have to meet regulatory standards under the Joint Commission standards or Medicare conditions of participation that do not apply to nonhospital sites;
- Nonprofit hospitals such as Ballad treat indigent patients and have a charity care policy, while freestanding sites typically limit services to only those who can pay (or have much lower levels of charity care than nonprofit hospitals such as Ballad);
- Hospitals must accept, screen, diagnose, and stabilize all patients presenting for emergency services without regard to the patient's ability to pay;
- Hospitals are open 24 hours a day 7 days a week, and necessarily have higher costs and less efficiency because of the need to maintain services in "off" hours.

[9] Ballad compiled this data using both hospitals it and the Authority Merger Monitor selected. The data is available since CMS requires all hospitals to post their charge data on their web sites.

In any event, the difference in charges between Ballad hospitals and freestanding sites has nothing to do with the merger creating Ballad. Indeed, as discussed above, hospital charges at legacy Mountain States hospitals are being reduced for 2020.

4.8 Physician Charges Reduced in Mid-Year at Some Sites

There were physicians in community practices and in urgent care centers who were employed by Wellmont and Mountain States. In mid-year, the physician practices from the legacy systems were brought onto the same computer software platform. Part of that conversion necessitated using a uniform physician charge structure. Ballad opted to use the lower charge structure, and hence physician charges at some sites were reduced by as much as 20 percent. Again, this made little difference for many payors because payments are based on rates tied to billing codes, but it did benefit some patients and payors.

4.9 Virginia Charity Care

"Charity care" may seem to be a clear term, but it is defined differently in different contexts. For example, the IRS and Medicare permit hospitals to report shortfalls in payment between Medicaid payments and the costs of treating those patients as charity care. The Virginia commitments require Ballad to "continue to provide charity care at a rate at or above the rate provided by the [legacy systems] 12 months prior to the approval of the cooperative agreement." The Virginia Department of Health is considering what this commitment means including without limitation whether it is applied by hospital, what the word "rate" means, and whether to use a base period of June 30, 2017 rather than the 12-month period ending October 29, 2017, since the order approving the Cooperative Agreement was signed October 30, 2017. Without this information as well as some more detailed information that we have requested from Ballad, it is impossible to verify with certainty whether Ballad has met its charity care commitment as interpreted by the Department of Health.

What we do know is that system-wide, the cost of care furnished to patients who qualified under Ballad's charity care policy in FY 2019 exceeded the cost of charity care furnished by the legacy systems in a base year ending June 30, 2017. This occurred even though the number of hospital admissions declined for all payor categories, including patients qualifying under Ballad's charity care policy.

V. FINANCIAL RESULTS

5.1 System-Wide Results

Ballad has reported the following results for its FY 2019:

- For the year ending June 30, 2019, operating cash flow improved to $228.1 million from $197.6 million in the prior year, a 15.4% improvement.
- Total cash flow (EBITDA) improved to $254.6 million versus $199.6 million in the same 12-month period prior year, a 27.5% increase.
- EBITDA margin improved from 9.9% in the prior 12-month period to 12.5% in the current 12-month period.
- Revenue for the year grew 1.3%, while expenses remained flat, leading to an improvement in the operating margin to 1.7% from 0.5% in the prior year.
- Operating income for the year improved to $36.5 million from $9.9 million in the same period prior year. (https://www.balladhealth.org/news/reports-annual-results-high-ranking-hospitals-strong-financial)

Ballad's net operating income of $36.5 million is a marked improvement over the net operating income for $9.9 million for the prior year. Ballad needs to continue to improve its margin, however, to maintain its access to capital at the most favorable lending rates. In FY 2019, Ballad committed to make capital expenditures of more than $158 million. Ann. Rept. At 14.

Ballad realized large efficiencies as a result of the merger, totaling more than $32 million. Ann. Rept. At 18. These savings came from supply chain standardization; consolidation of space in a number of locales; corporate office staff reduction; etc.

As executives for the legacy systems predicted during the application process, the merged organization faces a huge challenge as well as an opportunity because of the historically high levels of hospitalization in the region. The following table shows hospital inpatient days per thousand population for Ballad (and legacy systems in pre-Ballad years) and national rates.

	2016	2019
Mountain States/Wellmont and then Ballad	124.1	114.6
National	103	100

The dramatic decline in inpatient days at Ballad is mostly a result of reduced admissions, although shorter stays have contributed to that decline. This has caused a huge loss of revenue from what would have been earned with historic levels of inpatient utilization. Moreover, as this chart shows, hospitalization rates in the region remain well above the national average and continued material declines in inpatient revenue can be expected. This is a financial threat to Ballad, but is also an opportunity. To the extent that Ballad can negotiate risk contracts, discussed above, it can receive bonus or incentive payments to reduce costs below historic levels. The relatively high historical rates of hospitalization in the region give Ballad a good opportunity to achieve savings and to benefit from risk contracts.

5.2 Virginia Hospital Data

Ballad's Virginia hospitals have performed well in the areas of average daily census; observation visits; emergency room visits; outpatient encounters; number of full time employee equivalents (FTEs); and operating net income. Operating net income number is overstated for Virginia's hospitals since corporate depreciation, interest, and amortization costs are recorded at the corporate level and not on each hospital's internally reported results.

VI. PROGRESS ON PLANS TO IMPROVE HEALTH IN THE REGION

6.1 Plans and Measuring Progress

Ballad has submitted plans for: population health; children's health; rural health; and behavioral health; and research/graduate medical education. (The research/graduate medical education plan was not effective for FY 2019 and is not included in the following discussion.) These plans have been approved by both states (except Tennessee has not communicated formal approval of the rural health plan). The plans are the blueprints for spending moneys promised and committed by Ballad as part of the merger application and approval process. The plans contain specific steps with target dates for completion so that progress is measurable. The spending contemplated under these plans is "back-end loaded" since the first steps are planning how most effectively to make investments to advance the plans. In addition, Ballad is attempting to leverage its efforts with other funding such as grants or community resources, although such spending will not be counted toward Ballad's obligations. Spending is measured against a baseline so that only incremental spending above baseline spending is counted as meeting Ballad's commitments. The plans will be serially reviewed and revised after 3 years.

6.2 Rural Health

Ballad's rural health plan relies heavily on telehealth services. This is consistent with national trends and is a logical way to extend services to less populated and more remote regions. There are two obstacles: the lack of availability of broadband in some areas; and outmoded payment policies for telehealth services. Broadband access in rural areas is a national problem and Ballad cannot reasonably be expected to solve that problem. However, some progress is being made with the availability of federal grants, other state and local government help, and private sector activity. For example, fiber has been extended to Grayson County. Reimbursement policies are also being liberalized, and Virginia presently is considering and formulating policies to foster the growth of telehealth services.

Ballad is also focusing on recruiting primary care physicians and mid-level practitioners for rural locations. Ballad has recruited over 150 practitioners to the region, and has plans to recruit 120 more in its FY 2020. Recruitment to this region generally, and for rural areas specifically, is difficult.

6.3 Behavioral Health

Behavioral health is one of the most underserved needs across the nation. The reason is very simple—the behaviors that are most problematic cause individuals to lose their jobs or to be unemployable so that they are uninsured. While nonprofit providers such as Ballad have moral and, to some extent, legal obligations to furnish care to uninsured patients, providers also have a need to make enough net income to survive. Thus behavioral needs are among the greatest unmet needs. Those needs are especially acute in this region because it has been ravaged by opioid addiction. A single statistic brings this home—30 percent of the babies born in Wise County are born addicted.

Ballad is starting to address these needs. First, it has created a behavioral health division. It is opening a residential facility in Greenville, Tennessee for pregnant women who have substance abuse problems so that they can stay off drugs and protect their babies. Ballad is also moving toward increasing the availability of medically assisted treatment for opioid addiction. While it is controversial in some circles to treat opioid addiction with other opioid drugs (which do not create a "high" but which do satisfy the physical craving for the drug), medically assisted treatment has been shown to be more effective than other treatments. This service is heavily regulated by the federal government and there are other practical problems in providing it. Ballad has also started in Virginia a medical fellowship in addiction medicine which should add to the number of physicians in the region who are experienced in treating addicted patients. Expanding the availability of mental health evaluation services and outpatient treatment is also underway.

6.4 Children's Health Plan

With the benefit of hindsight, Ballad's children's health plan was too aggressive. The plan called for the recruitment of approximately 10 pediatric specialists, which are already in short supply nationally. While Ballad has made some progress in recruiting pediatric specialists, it acknowledges that its recruitment goals were unrealistic. In addition, there has been a recent marked downturn in the population of children in the region with a nearly 10 percent decline in births and children. Therefore, rather than proceed with what is now viewed by its own executives as an unrealistic plan, Ballad has informed us that it will develop a revised children's health plan. In the Merger Monitor's view, the error here was in creating an unrealistic plan in the first instance. Whether realistic or not when the plan was initially drafted, the sudden drop in the population of children compounds the problem of an insufficient number of patients to support the specialty services originally hoped for. In the judgment of this Merger Monitor, pulling back from the goals in that original plan and moving toward shared services or in other directions will be better for the region. Ballad has committed to produce a revised children's health plan in the spring of 2020. This means, however, that super specialist needs will have to be met by providers outside of the region such as Vanderbilt.

6.5 Population Health

Ballad's plan for population health focuses on children, and to focus on children it aims to support strong, healthy families. This means that Ballad is trying to improve prenatal health, have children grow up in homes with parents who are not addicted, have healthy environments where there is, for example, no smoking, have adequate exercise and avoid childhood obesity, have adequate nutrition, and can learn in school (attaining a third-grade reading level is a key predictor of health status). These are very aggressive goals, but also very worthy goals. The executives involved in this plan demonstrate a passion for making a difference that is energizing to witness. Ballad cannot, however, come close to achieving these goals by itself, and it recognizes that. Ballad has organized well over 200 organizations in the community to work together in a focused and organized manner to achieve these goals. By its very nature, a project of this type will take years to show benefits, but if realized, the benefits should prove to have the greatest return on investment of all the plans Ballad has.

Other measures are sometimes viewed as "population health," such as adequate screening, adult immunizations, proper treatment of chronic diseases such as diabetes, etc. Ballad does not include these items in its population health plan, but they are a focus for the organization. Often, there are targets in health plan contracts where additional payments are made for assuring that covered patients have screening tests and are immunized. In addition, a key to reducing inpatient hospitalizations is successful monitoring and treatment of patients with chronic conditions so as to avoid crisis hospitalizations. That is encouraged by Ballad's risk contracting models where cost savings are rewarded. But it is not all just about financial incentives. For uninsured patients in the region, Ballad will issue a card that functions as a health insurance card at Ballad facilities. For these patients, Ballad is contracting for managed care oversight to assure that there are appropriate immunizations, screening, and treatment of chronic conditions.

6.6 Spending to Implement the Plans in FY 2019

Part of each plan includes a spending target for each year covered by the plan. At present, the Tennessee COPA Monitor is examining Ballad's reported spending for each plan and has not yet presented any conclusions. In any event, Ballad made material expenditures to implement each of the plans discussed above. For the most part, Ballad has met the objectives it had set forth for itself in its plans for FY 2019, and to the extent that it has not done so, there are good explanations (and some goals not met by the hoped-for date have been met in the first quarter of FY 2020).

6.7 Future Activities of the Authority's Task Force

The Task Force may find it useful to devote a meeting to each of the plans discussed above and to have Ballad present what is in the plan and the progress toward implementation.