

Meeting Between Mountain States Health Alliance, Wellmont Health System,  
and Virginia Department of Health Staff  
Cooperative Agreement Application- Commonwealth of Virginia  
May 17, 2017

Attendees:

Virginia Department of Health

Dr. Marissa Levine - State Health Commissioner  
Erik Bodin - Director, Office of Licensure and Certification  
Peter Boswell - Director, Certificate of Public Need Program  
Joe Hilbert - Director, Governmental and Regulatory Affairs  
Dr. Adrienne McFadden - Director, Office of Health Equity  
Heather Anderson - Director, Division of Primary Care and Rural Health  
Doug Harris - Adjudication Officer  
Richard Corrigan - Deputy Commissioner for Administration  
Catherine West - Administrative Assistant

Virginia Department of Medical Assistance Services

John Stanwix - Formal Appeals and Final Agency Decision Supervisor

Virginia Office of Attorney General

Allyson Tysinger - Senior Assistant Attorney General/Chief  
Sarah Allen - Senior Assistant Attorney General/Unit Manager  
Ty Henry - Assistant Attorney General  
Amanda Lavin - Assistant Attorney General

Mountain States Health Alliance

Alan Levine - President and CEO  
Marvin Eichorn - Executive Vice President and Chief Operating Officer  
Tony Keck - Senior Vice President, Chief Development Officer  
Lynn Krutak - ~~Senior~~Executive Vice President, Chief Financial Officer  
Tim Belisle - ~~Senior~~Executive Vice President of Corporate Compliance and General Counsel

Wellmont Health System

Bart Hove - President and CEO  
Eric Deaton - Executive Vice President and Chief Operating Officer  
Todd Norris - Senior Vice President, System Advancement  
Todd Dougan - Chief Financial Officer  
Gary Miller - Executive Vice President and General Counsel

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

Claire Haltom - Counsel to Wellmont Health System

Hancock, Daniel, Johnson & Nagle, PC

Jim Daniel - Counsel to Mountain States Health Alliance  
Jenny McGrath - Counsel to Mountain States Health Alliance

Dr. Levine opened the meeting by thanking all of the participants for the time and effort that they have expended to date concerning preparation of the application and responding to VDH's supplemental requests for information. Dr. Levine explained that VDH is continuing to review the application and supplemental materials, and this meeting is considered to be part of the evaluation process. Dr. Levine said that it is her expectation that this is probably the first of what will be a series of meetings. She emphasized that a decision concerning the application still has not been made, and explained that Virginia's process is somewhat different than the process that is being followed by Tennessee. Dr. Levine also requested that the participants clearly identify any time during the meeting when they start to discuss information that is considered to be proprietary in nature. She explained that VDH would prepare a written summary - but not a verbatim transcript - of the meeting and that summary would be provided to the applicants for review to ensure that no proprietary information had been included. Finally, Dr. Levine requested that the participants provide VDH with the opportunity to ask questions concerning the various issues that were identified in the meeting agenda.

As a lead-in to her first question to the applicants, Dr. Levine explained that, since they decided to apply for approval of a cooperative agreement, that means that VDH's relationship with them is as a regulator, not a partner. She also told the applicants that her expectations are that, following a merger, competition will decrease and prices will increase. VDH intends to examine whether there are any resulting advantages in three areas: quality, cost-efficiency and population health improvement. Dr. Levine said that issues surrounding culture change as the result of a merger are critical, and that she believes that such a culture change has implications for governance. She said that if the cooperative agreement is approved, Ballard would need to be a different organization than either Wellmont or Mountain States, with a different level of clinical integration and a focus on population health. She also explained that, while a population health department has been proposed for Ballard, population health should not be "compartmentalized" within Ballard. Rather, Dr. Levine believes that the new organization needs to take a leadership role concerning the health of the people of southwest Virginia.

Dr. Levine said that VDH understands the applicants are preparing to transition governance of the two current systems into a governance system for Ballard. VDH notes that Ballard will be a very different type of organization than either Wellmont or Mountain States (for example, clinically integrated with independent physicians and with a focus on population health.) Dr. Levine asked, given the new type of business model that is being planned, do the applicants envision that Ballard's system of governance will need to change in the foreseeable future.

Mr. Levin responded by first acknowledging that VDH's relationship with the applicants is one of a regulator. He then said that the applicants are focused on identifying regional priorities that align with statewide VDH goals, such that there is agreement on the focusing of resources.

Mr. Hove also acknowledged that VDH's relationship with the applicants is one of a regulator. He also expressed appreciation for the opportunity to meet with VDH and for the work done by the Southwest Virginia Health Authority. He said that additional resources need to be devoted to address population health in the region. Mr. Hove also said that Virginia's Plan for Well Being dovetails with the approach of the applicants.

Mr. Levine began to discuss the approach used by the parties to prepare the cooperative agreement application, including development of the commitments. The parties examined COPAs that had been approved in other states. He said that those COPAs were generally limited to economic issues that mitigated economic disadvantages resulting from the reduction in competition but did not

address resulting advantages. Mr. Levine acknowledged that, overall, evidence shows that the merger of two health systems will lead to higher prices. None of the FTC's experts reference the protections they have put in. In discussing the Mission Health COPA in North Carolina, Mr. Levine said that over the past eight years the cost and charges per admission has been substantially lower than any of its peer systems.

He then mentioned that in Wise County there are currently three hospital s. However, if there was only one hospital and a COPN was submitted to open a new hospital, the COPN would not be approved.

Mr. Levine said that population health issues in the region are not being addressed. The region is ground zero for the opioid crisis. Furthermore, the ineffectiveness of the competitive marketplace is contributing to a failure to obtain the necessary healthcare workforce. The commitments contained within the application are focused on redirecting wasted capital into funding focused on community-based needs, such as residential substance abuse treatment and mental health resources.

Mr. Levine said that both Wellmont and MSHA evaluated other merger options, including out-of-market mergers. He said that every health system he spoke with was focused on a merger resulting in a large footprint with more hospitals, which could be used as a basis for increased negotiating leverage in order to obtain increased reimbursement from third-party payers. However, he said that Wellmont and MSHA didn't think that was the right approach. By combining the two organizations into Ballad, Mr. Levine said the synergy would be created which would remain within the community.

Mr. Hove said that in order for Wellmont to survive and maintain its support for community hospitals, it recognized that it needed to take a different approach to community health. The reason that Wellmont selected MSHA as a partner was because of shared goals and the opportunity to improve health in the region, in the face of a declining population, consistent with the goals of Virginia's Plan for Well Being.

Mr. Levine then discussed clinical integration and quality. He said that MSHA has all kinds of quality metrics, many of which are required by the federal government. Clearly there needs to be a commitment to quality. If we are investing resources in the community, there is an intangible measure of quality. He said that clinical integration is a component of the COPA application. [Mr. Levine emphasized that the Common Clinical IT Platform goes much farther than HIEs can.](#) The development of a common clinical information technology platform is a key part of clinical integration. A common platform will enable Ballad to understand the population and to identify gaps [and throw analytics on top of these to drive clinical integration and, in turn, population health.](#) He said that, without the merger, there are two approaches to care. [\[Applicants' Note: By "two approaches to care," it means that each system will be operating independently without the critical technology and analytics to enable them to meaningfully affect population health. The technology needed for population health management is not an investment either system can afford on its own and can only be acquired through savings from merger efficiencies.\]](#)

Mr. Levine also said that every hospital that MSHA operates in southwest Virginia has a negative operating margin and are facilities that were abandoned by other health systems that left the market. [\[MSHA Note: We wish to clarify the Department's summary of this discussion. The majority of the Parties' hospitals in Virginia has a negative operating margin. In addition, several of the hospitals were previously operated by for-profit and not-for-profit systems that left or abandoned the area or communities served. These hospitals include Smyth County, Russell County, Lee Regional and Mountain View. The other hospitals were independent hospitals that found they could not survive on their own, and chose to join larger systems.\]](#) The parties have committed

that those hospitals will remain open as health care facilities for five years.

Move into proprietary discussion

Return to non-proprietary discussion.

Mr. Stanwix said that one of the criteria for the review is whether there are available arrangements that are less restrictive to competition. He said further that although the parties note that some of the rural hospitals are not independently profitable, as health systems both Wellmont and Mountain States have significant financial assets. He asked what is holding back Wellmont and Mountain States from carrying out many of these initiatives at the present time without the Cooperative Agreement?

Mr. Levine responded by saying that one of the challenges they have is scale, specifically the number of patients. The merger would provide Ballard with enough critical mass in terms of the number of patients to approach DMAS with a risk-based capitation proposal. Currently, the region has a declining population. Furthermore, the region's inpatient hospital utilization rates, which are well above the national average, are not sustainable and are declining. Nevertheless, the parties have committed to keeping their hospitals open as health care facilities for five years. Mr. Levin said that commitment will not exist without the COPA. Currently, the larger hospitals in Tennessee and in Abingdon, subsidize the smaller rural hospitals. If a similar decline occurs in larger hospitals, it will be hard to continue subsidizing the smaller hospitals.

Mr. Hove addressed the question of why MSHA and WHS can't simply affiliate rather than merge. He said that there have been studies that show that affiliation doesn't work if the parties are still competitors in the same market. He said that the merger would allow the parties to focus on things that don't necessarily pay for themselves.

Mr. Levine said that the merger will eliminate redundant services and overhead and allow the parties to focus on the needs of the community. He also said that the parties can't collaborate on referral sources when they are in competition.

Mr. Hilbert said that the financial statements of the parties report billions of dollars in assets. He also said that VDH is having difficulty understanding why the parties can't make investments in the community without a merger.

Mr. Levine responded by saying that MSHA carries about \$950 million in debt. He explained that that amount of debt requires that MSHA maintain a certain level of cash flow in order to prevent a degradation of its bond rating. He said that currently MSHA has a BBB bond rating. However, a merger with a resulting combined balance sheet is expected to result in an improvement in that bond rating, to an A rating.

Mr. Hove said that Wellmont Health System currently has a 1 to 1.5% operating margin. He also said that there is currently no tangible business model to invest in population health. However, approval of the cooperative agreement would facilitate progress in the development of such a business model. Mr. Levine added that there is not as much free cash available within the systems as one might think. He said that \$100 million per year has to be reinvested into physical assets.

Mr. Corrigan said that there is a lack of specificity concerning the timing and rate of such population health investments. Mr. Levine, Mr. Eichhorn and Ms. Haltom all said that additional information could be provided.

Dr. Levine asked if the parties could provide more specifics concerning their plans for primary care.

Mr. Hove responded by saying that the parties are developing a collective strategy, and their plans include a focus on access to care by keeping existing facilities operating, urgent care facilities, access to telehealth, provision of transportation, and bringing caregivers to the individuals who need them.

Mr. Levine made reference to commitment 6, which references collaborating with local physician groups. He said that in some places throughout the region, the local physicians are independent and not employed by either WHS or MSHA. However, the parties can still collaborate with independent physicians and the concept of clinical integration supports that. Mr. Levine said that it is very hard to recruit physicians in the region. Consequently, MSHA is attempting to grow its own physician workforce by starting new medical residency programs. [\[Applicants' Note: MSHA has no plans to employ greater numbers of physicians. MSHA and WHS both support medical residency programs in the region with a goal of developing a larger pool of physicians who will remain in the region and serve this underserved area. As Mr. Levine later noted in the meeting, most physicians want to practice in the same area where they do their residency. The majority of physicians in the region are independent, and MSHA and WHS anticipate that this will continue to be the case. Like MSHA and WHS, Ballad Health's strategy will be to employ physicians only in limited circumstances, such as when independent practices cannot or choose not to employ needed physicians.\]](#) The COPA includes a commitment to develop a 10-year plan for a post-graduate training program. He also said that MSHA was recently able to recruit a surgeon to Norton because she is excited about the prospect of the merger. Mr. Levine also said that research collaboration and investment with institutions of higher education in Virginia and Tennessee is important, but which cannot be done without the merger.

Mr. Levine mentioned the COPA commitment to develop a plan for Physician needs assessment and recruitment. Mr. Hilbert asked how that plan would differ substantially, or have any greater likely impact on the region, than the health workforce needs assessment and recruitment activities that have been carried out separately by each of the applicants in their normal course of business?

Mr. Hove said that, [as an example, if](#) WHS does not currently have an endocrinologist [for SW VA](#), ~~but~~ with the merger one will be provided as part of the population health model. Mr. Levine said that when they decide what type of physician specialty to recruit for, they prioritize based on the expected return on investment. Certain specialties generate more revenue than others. He said that, in the current competitive environment, WHS and MSHA try to steal each other's physicians.

Mr. Hove said that WHS is not located in a growth market but rather in a shrinking market. He said that it is impossible to invest dollars in a shrinking market. Specialty physicians don't want to come to a shrinking market.

Mr. Norris said that WHS sees potential in the merger to bring about improvements in primary care and for inserting primary care into other environments (e.g., telehealth, urgent care centers). He said that WHS has progressive primary care physicians.

Mr. Levine said that in Wise County, with a total of three hospitals, MSHA had two general surgeons and WHS had one. WHS then hired an additional general surgeon, so MSHA had to hire another one as well [in order to maintain a competitive position](#). Wise County now has five general surgeons, but no endocrinologist.

He also commented that Anthem has an 85% market share in the region. Consequently, Anthem says here's what we are paying and we are not negotiating. [\[Applicants' Note: We wish to clarify the Department's summary of this discussion. In some products, Anthem has at least a 75% market share.\]](#)

and many times, we hear frustration from physicians that Anthem will not negotiate with them. The complaint tends to be that Anthem tells them what they will be paid, and it is typically a “take it or leave it” approach. Notwithstanding these ongoing comments from physicians, we have historically had a good working relationship with Anthem and our other payers, and if the merger is approved, we plan to collaborate with all of our payers to identify opportunities to improve outcomes and improve the health of the region. We believe Anthem and all of our payers will be good partners with Ballad Health.]

Went into a proprietary discussion.

Return to non-proprietary discussion.

Ms. Anderson said that the application states building and maintaining excellent health professionals is of the utmost importance and that Ballad will build substantial partnerships beyond what currently exists. She asked the parties to describe the "pipeline" Ballad will build for a healthy workforce to support the population health activities of the health care system. Specifically:

- How will the system attract health professionals?
- Where will these people come from?
- What disciplines will you be attracting?
- Who will your partners be?
- How will the students/trainees work in the system?
- Are there incentives you will offer?
- Is there a best practice model on which you will be duplicating or modeling your activities?

Mr. Levine responded by saying that most physicians want to practice in the same area where they do their residency. He said that that the merger will help with residency slots, and improve the parties' ability to move residents into other hospitals for specialty rotations. Currently, it is not easy to rotate residencies between two competing systems. He said that we have to understand the 10-year outlook for physicians. Young people are leaving the southwest Virginia area. He said that the merger will allow the parties to recruit locally. Mr. Hove said that we have to make ourselves attractive to physicians through enhanced technology, research, and electronic health records.

Mr. Keck said that the COPA will enable academic and research dollars to be invested in the region, and will also enable the parties to work together. Concerning production of a "pipeline" for physician development, there are various models. The COPA will provide a great opportunity to create such a pipeline.

Dr. McFadden said that issues and concerns related to the recruitment and retention of good physicians are not unique to rural Virginia. She also mentioned the concept of using community care centers in rural areas. Mr. Hove said the future model for health care delivery will not be in an institution but rather in a patient's home and in the community. Consequently, he said that health systems are going to have to broaden the scope of the physician training environment.

Dr. McFadden asked if the conversation has started with Virginia organizations regarding how Ballad will proactively engage the primary care network. Mr. Hove responded by saying “somewhat”. He said that focus groups have been put together to ~~deliver~~discuss the type of model they're talking about. [Applicants' Note: Mr. Hove's comments refer to the efforts of Community Health Work Groups launched by the Applicants in the fall of 2015 as the region's most substantial community health improvement assessment effort to date, bringing together partners from all sectors to participate. Four Community Health Work Groups were created to specifically focus on medical

needs of the medically underserved, identify the root causes of poor health in this region, and identify actionable interventions the New Health System can target to achieve a generational shift in health trends. The Work Groups' initial recommendations are still being assessed, but the reports are being used as guides for Ballad Health's plans and initiatives for community health improvement and integrated care model, including the template Community Health Improvement Plan. See the Applicants' responses to the Commissioner's Questions dated December 22, 2016 for more detail about the Work Groups (Response O-5) and Ballad's primary care strategy (Response P-2, in particular).]

Mr. Levine said that MSHA's biggest competition is posed not by WHS but rather by people leaving the region. Rural areas are starting to eat each other up. He said that within the region, collaborations are important and there is a deep desire to collaborate. The degree to which there is scale is important. Mr. Levine mentioned further that in North Carolina, after 20 years of Mission Health being under a COPA, cost is lower and quality is improved. Mr. Hove said that the parties recognize the need for partnership with VDH going forward.

Dr. McFadden mentioned the CMS Accountable Health Communities grant recently received by the parties. [Applicants' Note: The grant was applied for and received by MSHA independently. At the invitation of MSHA, Wellmont is a collaborating partner in the implementation of the grant program.] She said that it appears that the parties intend to hire seven patient navigators, who will be located at community services boards throughout Southwest Virginia and that these navigators will help coordinate access to services – like housing, food or mental health services – for randomly selected beneficiaries. She asked:

- Is this program specifically targeting individuals with comorbid behavioral health issues only?
- Are you able to provide us with a copy of your grant application?

Mr. Keck responded by saying yes, in partnership with community services board (CSB) the program will ~~specifically be targeting~~ include individuals with comorbid behavioral health issues. Patient navigators, who are already helping individuals address the social determinants of health, will be located in the CSB. Mr. Keck said that they have never employed navigators that have experience in some of these areas. He said the grant activity will result in the accumulation of significant data, which the parties will need to decide how to best utilize in support of broader population health improvement efforts. Mr. Keck said that the parties have reached out to DMAS to request that they serve as a member of the grant leadership team. He also said that they would like to have someone from VDH Office of Health Equity serve on the leadership team. Mr. Keck said that this is a good learning opportunity, and they want to change people's outcomes. The parties are looking for additional funds to hire more navigators. Mr. Levine commented on the limitations of the grant, specifically that it is only for Medicare and Medicaid beneficiaries but does not include the uninsured. Mr. Norris said the parties are looking for opportunities to really bring a cross section of people together for health transformation through the accountable care model. He said that the Accountable Health Grant is an opportunity for the parties to work together collaboratively. He also said that the way in which patient navigation is done will continue to improve post-merger.

Mr. Keck made some comments concerning the degree of scale necessary in order to enter into a risk-based contract. He said that the merger would accelerate the ability of the parties to enter into risk-based contracts. He also said that in the future, the reason that a patient is readmitted to the hospital won't matter. However, we don't get paid to think of those things right now.

Dr. McFadden discussed the importance of addressing the social determinants of health, and stated that the most significant determinants are economic in nature, related to the lack of economic

opportunity. She asked how the parties intend to address those types of determinants by, for example, growing their consumer base.

Mr. Levine responded by saying, should the merger be approved, no one can guarantee what will happen but without the merger, we can guarantee that it will not happen. He said that, as jobs disappeared, the economy got worse which contributed to the mental health crisis. There aren't enough resources in the region to deal with the current range of issues. He said further that this is an area where they can use collaboration with the state concerning identification of root causes and assessment of resource gaps. Mr. Levine said that this is an area where collaboration trumps regulation.

Dr. Levine asked how the parties know that the merger is not going to make regional economic conditions worse as a result of post-merger employee layoffs. Mr. Levine said that the savings will largely come out of Tennessee and Wise County. However, he cautioned that the parties are not yet allowed to make specific plans in this regard. He said that the parties are doing enormous pre-merger planning concerning which facilities might be repurposed. In Wise County for example, post-merger there might be only two hospitals -rather than three- with the other converted to some other type of health care facility. That would not result in a loss of jobs but rather in a shift in the types of jobs. [\[Applicants' Note: We emphasize that while Wise County has been identified as a location for potential consolidation, with three duplicative and under-utilized acute care hospitals, no decisions have been made regarding facilities in Wise County or in Tennessee.\]](#)

Dr. Levine then asked why WHS and MSHA did not hire a third-party consultant to assist with merger planning.

Entered into a proprietary discussion.

Return to non-proprietary discussion.

Mr. Bodin said that before any potential benefits of the merger can be realized the two organizations must meld into a single effective organization. It seems to VDH that given the importance and magnitude of that early step there has been very little done, or at least very little shared with VDH, in terms of very specific and concrete steps to create a functional merged entity. He asked:

- Could you address the details of this part of the process?
- What difficulties are anticipated in creating a common clinical platform and what mechanisms are being considered to address them?
- Does the slow incremental transition to what appears to be an organization that is only partially adopting a risk-based model of doing business set the risk-based model for failure while encouraging continued operations under the current fee-for-service model? What prevents that?

Entered a proprietary discussion.

Returned to non-proprietary discussion.

Mr. Stanwix said if the application for a cooperative agreement is granted, the New Health System would have such a large scale that it would be attractive for other health systems to make an offer to purchase. The parties have stated that there are no current plans for sale; however, if the cooperative agreement is approved, the Commonwealth would need assurances that the residents of Southwest Virginia would be protected if a sale occurred at any time. He asked the applicants to address the concern of a possible sale, especially regarding the terms, conditions, and commitments that would be

part of the cooperative agreement.

Mr. Levine responded by saying that the reason they are doing this is to avoid a sale. Furthermore, should there be a sale at some point in the future their intent would be that the cooperative agreement would convey with any sale. Dr. Levine said that, legally, the cooperative agreement cannot convey. Ms. Tysinger expressed agreement with Dr. Levine's statement. Dr. Levine said that the attorneys for the Commonwealth and the parties will discuss that issue. Mr. Levine said that they are not going to sell or merge with someone that would not honor the cooperative agreement.

Mr. Corrigan asked a question concerning the applicant's commitment to establish a cap on negotiated fixed rate adjustments of the Consumer Price Index (CPI) minus 0.25 percent. He noted that the commitment fails to discuss any attempts to reduce prices in an environment where market-based reimbursement rate adjustments are decreasing or remaining relatively constant. He asked if the applicants intend to implement any strategies to reduce prices in this type of rate environment.

Mr. Levine said that one year after the merger closes, rate adjustments will be lower with the merger than without it. Mr. Eichorn said that the commitment is for a rate adjustment ceiling but there is no floor. If rate adjustments are falling in the marketplace, Mr. Eichhorn said Ballard would ride it down.

Mr. Hilbert asked why, given that the actual negotiated rate adjustments for both parties over the past several years have been for much less than the CPI minus 0.25%, the rate adjustment cap commitment proffered by the parties was not for the CPI minus 1.0%. Ms. ~~Halstom~~[Haltom](#) responded by saying that questions concerning [each party's existing](#) rate adjustments can be discussed separately with WHS and MSHA. Mr. Levine agreed that that question should be discussed separately, and said that existing contracts govern rate adjustments.

Mr. Corrigan asked why the applicants made a distinction between principal and non-principal payers. Mr. Eichorn said non-principal payers, accounting for less than 2% of Ballard's net revenue, are more expensive to administer. Ms. ~~Halstom~~[Haltom](#) concurred with Mr. Eichorn's statement.

Mr. Levine commented further concerning the justification for the merger proposal, as opposed to some alternative proposal involving acquisition of MSHA by an out of market entity. Assuming that such a sale would cost the acquirer \$750 million (i.e. up to seven times annual revenues) to obtain the assets, ownership of the hospitals would turn over, MSHA would lose 600 jobs, a conversion foundation would be established but with no commitment for how those dollars are used. He said that would be bad for the regional economy.

Dr. McFadden asked if the applicants were able to share their criteria for an electronic health record system that would promote better population health improvement efforts. Mr. Keck responded that they could share the criteria, at a high level, in a couple of months. He also said that most health systems are not relying on their electronic health record systems for population health purposes. [\[Applicants' Note: Most health systems currently are not focusing on population health improvement and do not have the EHR or other IT systems capable of enabling them to do so.\]](#)

Mr. Hilbert said that the applicants have reported that about 70% of the primary care physicians in the geographic service area are independent of either MSHA or WHS, and that the application states that The New Health System intends to collaborate where possible with the independent physician community in procompetitive arrangements to build an array of service offerings that will be accessible throughout the region. Given that a strong primary care system is critical for

population health improvement efforts, and given that the Advisory Board indicates that Ballad's plans place significant reliance on the independent physicians Mr. Hilbert asked what evidence the applicants have that these physicians are actually on board with what Ballad wants to do, and willing to share financial risk.

Mr. Levine responded by saying that MSHA can't answer that question with Wellmont in the room, as it involves proprietary information. He did say that there is interest on the part of the independent physicians. The two issues that the independent physicians have raised is that Ballad not intrude with the independent groups, as well as a concern that Ballad will recruit new providers in order to put the independents out of business. [\[Applicants' Note: We have made substantial commitments in order to address concerns of independent physicians in the region, including to participate meaningfully in a health information exchange for the local physician community to share needed information \(Revised Commitment 5\); collaborate in good faith with independent physician groups to develop a local, region-wide, clinical services network to share data, best practices and efforts to improve outcomes for patients \(Revised Commitment 6\); maintain an open medical staff at all facilities, subject to the rules and conditions of the organized medical staff of each facility, with exceptions that may be made for certain hospital departments or services as determined by the NHS Board or the applicable hospital board \(Revised Commitment 22\); not require independent physicians to practice exclusively at NHS hospitals and other facilities \(Revised Commitment 23\); and not take steps to prohibit independent physicians from participating in health plans and health networks of their choice \(Revised Commitment 24\). We reiterate that Ballad Health's strategy will be to employ physicians only in limited circumstances, such as when independent practices cannot or choose not to employ needed physicians.\]](#)

Mr. Levine said further that the application contains a lot of protections intended to mitigate the reduction in competition. He also pointed out that there is still competition, including for health care labor, with institutions in Kentucky.

Ms. Anderson said that the application indicates that Lee County, Virginia is in the primary service area for the merger and yet there is very little mention of Lee County in the specifics of the application. She asked:

- Where does Lee County fit in for services?
- What will Ballad do for Lee County if the agreement with Americore LLC dissolves?

Mr. Hove said the situation pertaining to Lee County Medical Center was a painful decision for Wellmont. Wellmont still has physicians present in Lee County but there is no other inpatient provider. Wellmont has remained in contact with the Lee County Hospital Authority. Progress to re-establish an inpatient health care facility in Lee County has been slow. He acknowledged that Ballad cannot ignore the fact that Lee County is in the market. Mr. Eichhorn added that Ballad has committed to provide essential health care services in Lee County. Mr. Levine said that Ballad can't commit to a course of action if the facility is owned by someone else. But he said that Ballad will do what it can for the facility. [\[Applicants' Note: Neither MSHA nor WHS is the current health service partner of the Lee County Hospital Authority, which owns the facilities of the former Lee County Regional Medical Center. In October 2016, the Lee County Hospital Authority announced that it signed a letter of intent with a for-profit entity, Americore Health, to provide emergency services in the former Lee Regional Medical Center facility with the intent to apply for the necessary approvals to open a critical access hospital. Other Ballad Health hospitals will remain available to meet the health care needs of Lee County patients. If Ballad Health were to become the primary health service partner of the Lee County Hospital Authority, Ballad Health would be responsible for "essential services" in that community, as Ballad has committed to do in its current communities. Response T-30 to the](#)

[Commissioner's Questions dated December 22, 2016, lists the ongoing "essential services" identified by the Southwest Virginia Health Authority that Ballad Health will be obligated to provide in each of Ballad's current communities.](#)

Mr. Harris asked for clarification concerning Mr. Levine's earlier statement that prior COPAs had been focused purely on economics as opposed to population health. Mr. Levine said that he has worked in other rural areas and was unable to get the resources to meet the challenges. Consequently, when MSHA looked at its region, and seeing nothing on the horizon which indicated things were going to get better, they decided to come up with a local solution focused on improving population health. He reiterated that no other COPA, with the exception of a COPA in West Virginia, has ever tried to do what Ballad is committing to do. [\[Applicants' Note: While the recently approved West Virginia COPA includes commitments targeted at population health improvement, the population health commitments proposed by the Applicants' in their Virginia Cooperative Agreement and Tennessee COPA applications go significantly beyond those contained in the West Virginia COPA.\]](#)

Dr. Levine asked for confirmation that the applicants are connected to ConnectVirginia. They said that they are connected. Dr. Levine then expressed surprise at the applicant's prior withdrawal of their application with Tennessee.

Entered into a proprietary discussion.

Return to non-proprietary discussion.

Dr. Levine thanked all of the participants for the dialog and for their responses to VDH's questions. She said that she hoped that they could see that VDH takes this very seriously, in order to make the best decision for southwest Virginia. Dr. Levine said that she would review the meeting notes once they are drafted, and they would subsequently be sent to the applicants for their review in order to ensure that no proprietary information has been included. She also asked the applicants to identify any additional critical documents that they are going to provide to VDH based on the conversation. She appreciated the dialog and answers to the questions. Another meeting between VDH and the applicants will probably be needed, as well as meetings with each applicant individually concerning rates and rate caps. She said that VDH is committed to making a decision no later than September and is moving as expeditiously as possible.

Mr. Levine said that he is grateful for the work that VDH has done. He said that the applicants are committed to doing this the right way in order to achieve the results they all intend.