6-12-2023 [redacted]

I AM CARLEEN CLAYBAKER, RN BSN, RETIRED. FOR ME, I HAVE CONCERNS ABOUT BEST PRACTICES AND PUBLIC TRUST. I GRADUATED FROM ETSU IN 1973 WITH A BSN, AND STARTED PRACTICING AT THE JOHNSON CITY MEMORIAL HOSPITAL. THE COMMUNITY AT LARGE WORKED VERY HARD TO HAVE THE MEDICAL SCHOOL BE LOCATED HERE AND BUILT THE JOHNSON CITY MEDICAL CENTER. I WORKED BOTH AT THE HOSPITAL AND AT THE MEDICAL SCHOOL. IT WAS THRILLING TO SEE CUTTING EDGE EDUCATION & HEALTH CARE HERE IN APPALACHIA. I AM DEEPLY CONCERNED THAT, ONCE AGAIN, APPALACHIAN PEOPLE HAVE BEEN EXPLOITED FOR PERSONAL PROFIT. I AM CONCERNED ABOUT CONFLICTS OF INTEREST, WHEN WE SHOULD BE ABLE TO TRUST OUR ELECTED OFFICIALS AND HEALTHCARE PROVIDERS. THE FACT THAT THE CEO OF ONE FACILITY WAS INVITED TO AND PARTICIPATED IN A CARDIO-THORACIC SURGICAL PROCEDURE IS APPALLING TO ME. THE RESULTANT ATTEMPT TO COVER THAT UP, AS WELL AS NO REAL CONSEQUENCES HAVING RESULTED IS OF MAJOR CONCERN TO ME. FURTHER, WITH THE IMPACT ON MATERNAL/CHILD HEALTH RESULTING FROM LAWS BEING PASSED IN TN, SEEING A REDUCTION IN BOTH ACCESS TO AND EXISTENCE OF QUALITY HEALTHCARE TO OUR AREA THAT MANY PROVIDERS HAVE CHOSEN TO LEAVE TN DUE TO THE PERSONAL AND PROFESIONAL RISKS THEY FACE IS DISTURBING, AND I DO NOT BLAME THEM. I HAVE NOT SEEN ANY PUBLIC STATEMENT FROM BALLAD REGARDING HOW TO FACE AND AMELIORATE THIS CRISIS--- INDEED, I DON'T THINK I HAVE SEEN ANY ACKNOWLEDGEMENT THAT THIS CRISIS EVEN EXISTS. MUCH LESS ANY PLANS FOR PROVISION OF CARE UNDER THESE CIRCUMSTANCES. THIS RESULTS

IN NON-MEDICAL SERVICES ATTEMPT TO FILL THAT VOID WITHOUT ANY LICENSING, MONITORING, COMPLIANCE WITH REGULATIONS, AND THE FACT THAT THESE NON MEDICAL PROVIDERS PRESENT THEMSELVES AS MEDICAL PROVIDERS, MISLEADING THE PULIC WITH IMPUNITY. THE LEADER IN PROVISION OF HEALTHCARE SHOULD IN FACT LEAD, AND AGAIN, WE ARE BEING LET DOWN. I AM INSULTED THAT THE CORPORATION PRESENTS ITSELF PUBLICALY AS RECEIVING AWARDS FOR PROVIDING HIGH QUALITY CARE WHEN THERE IS PLENTY OF DOCUMENTATION THAT IS NOT THE CASE

Organization: Niswonger Foundation
Debra Bentley, Director of Project On-Track.

The Niswonger Foundation is proud to partner with Ballad Health in the area of early childhood and literacy initiatives.

Like Ballad, the Foundation believes that education is an essential component for a healthy life.

We hope to continue our partnership for many years to come.

Debra Bentley

June 12th, 2023

My name is Dennis Courtney,

I am the co-founder and CEO of STREAMWORKS, an initiative inspired to do good in the world with a specific mission task of helping young students develop a passion for learning.

I am here to speak on behalf of STREAMWORKS and the support we have received through Ballad Health. We have had significant impact in terms of bringing a heightened sense of STEM and workforce development awareness in the region. Along with ETSU, Ballad Health has ensured that the STREAMWORKS mission continues and will sustain for years to come, helping as many kids as possible.

Before I get into the more specifics of why this support is important, please allow me to share a quick story of a young high school student living in Virginia. This young man joined the robotics team at their school, not by choice, but as punishment for hacking into the school's computer grading system. Teachers soon discovered that this young man was brilliant. He also did not have the basic resources that most of us in this room take for granted, i.e. internet, washer and dryer, nor a telephone. Let me give you an example, Upon a recent team outing to a STREAMWORKS function, the team ordered Door Dash from Chick-Fila. The young man became very excited because he had never had Chick-Fila. This young man represents so many of our students that STREAMWORKS seeks to aid with providing opportunities of an exciting future career centered around STEM. Our goal and mission is so much more than showing kids how to build a robot. None of these opportunities for these kids would have been possible if not for Ballad Health.

In early 2018, STREAMWORKS partnered with the Marine Advanced Technology Education (MATE) organization and started a pilot program in Tennessee, the first underwater robotics program of its kind. We have worked closely with MATE ever since and in fact, hosted the 2019 MATE World Championships in Kingsport, TN and we now operate the SeaMATE Store fulfillment center with a cohort of college age interns. Through skillful recruitment and networking collaboration, our team has grown this annual event to one of the largest underwater robotics initiatives in the world, impacting thousands of young students across the Southeastern United States.

Since March of 2020, our world was rocked overnight by a global pandemic that predicted only uncertainty, STREAMWORKS was caught in the cross fire. Ballad Health had so many other emergency priorities at that moment but somehow made us a priority and did not forget us nor our important mission. We are forever thankful to Ballad Health for stepping up and tall to help our program succeed. We stand tall with Ballad Health.

Thank you for your time.

Sincerely,

Dennis M. Courtney

② Thankful that we have hospitals
Thankful for the Ballad dollars spent in our communities through civic and non-profit organizations

① Ginger Holdren
Carter Co Commissioner for 5 yrs
Realtor for 17 years

③ When I get a buyer lead, I'm usually asked in that initial conversation, "If we buy 123 Blevins Branch, how far is it to the closest hospital?" Someone in their family has a healthcare issue or the buyers are up in years. Every mile and minute matters to them. Carter County is considered a retirement community. Approx 1/4 of our population is age 65 and older. The median age of our citizens is 46.8 yrs. That means 50% of Carter Countians are 47 and older. Our Chamber of Commerce's Tourism dept advertises to attract older people and outdoor enthusiasts which both need frequent hos. On tnvacation.com theres a section called "retire TN." It states that Sycamore Shoals has complete inpatient and outpatient surgical services.
When potential buyers learn that services at SSH are diminished, they will

Ballad pumpall

choose another spot to call home.
Decisions made by Ballad are far-reaching. Decreasing services at SSH may affect our tax base through fewer homes being built and people moving which will affect tax rate, in employee pay, and county services.

Commissioners have been told many times recently about the recognition, awards status of Ballad. Local citizens tell a different story. I'll draw from personal experience to illustrate.
My husband fell 20' ~~while~~ trimming a tree in front of our home. He was taken to JCMC and treated ~~for~~, a concussion and 10 broken bones, mostly upper body. He was given painkillers and we waited ~~in a room~~ in the ER for hours for a room for overnight observation. When the orderlies wheeled his gurney upstairs, he asked to use the bathroom before transferring into the bed. He was left standing alone in the bathroom after all of the pain medication he had been given. The next sound I heard is

the most horrific of my life—my husband passed out and hit his skull (concussed) and broken body on the concrete floor. I cannot testify to patient safety in a Ballad facility.

On Dec 1, '22 my husband underwent C4 C5 anterior diskectomy and fusion at Holston Valley. He was in a recovery room for several hours bc there was no bed available for him elsewhere. Late that night, hospital staff decided to wheel him back into the pre-op area where our day began. It was an unstaffed area, but we were told someone would come by and "check on us."

5 spinal surgery patient left in unstaffed area overnight.

The PT did not see my husband till Day 2 when he told him not to engage his neck muscles when getting out of bed, this AFTER Tim and I struggled to get him back & forth to restroom—he had been engaging his neck muscles all night! I cannot testify to patient safety in a Ballad facility.

~~[illegible]~~ we already have feeder programs to address the staffing issue!

① EMS tells us that they have been re-routed to hospitals outside CC for years.

* Medically trained personnel have been fantastic! I believe the problems we've experienced are management issues.

I am extremely disappointed that all were limited to 3 minutes — 5 would have been more fair. I apologize for the state of these notes, but I was barely allowed to tell "my story." If I had known that I wouldn't get to read them, they would be typed for you.

It was a shame that the only people who spoke in favor of Ballad are receiving

monetary support from Ballad, either as employees or other organizations. I pray you will put emphasis on what people "off the payroll" have to say.

Again, I do thank you for the opportunity to share, however little time granted.

COPA MEETNG

Good evening, Ladies and Gentlemen my name is Lisa Childress and I'm a Carter County Commissioner I reside in the 5th District. Tonight, my topic for this meeting is the geographical size and the increasing population of Carter County. I will share the distance for some of our local schools to travel to Sycamore Shoals vs Johnson City Medical Center.

Carter County is approximately 348 square miles which comprise both urban and rural areas and contains approximately 700 miles of roadways.

According to the United States Census Bureau as of July 1, 2022, the estimated population for Carter County is 56,452 people. For anyone who has been paying attention will attest that the population of Carter County is increasing rapidly as people from other areas of the country are relocating here for various reasons. According to the Carter County Planning office from July 2019 to April 2023 (307) new construction residential housing permits were issued and (224) new permits issued for single and double wide mobile homes.

A common-sense approach will tell you that the increase in population will result in an increase in the need for a hospital in our county that can provide the necessary medical services for both life threating and non-life-threatening emergencies.

Here is the mileage for some of our schools: Cloudland High School 20.8 miles to Sycamore Shoals vs 28.1 miles to JCMC; Unaka Elementary 10.5 miles to Sycamore Shoals vs 20.2 miles to JCMC, Little Milligan Elementary 19 miles to Sycamore Shoals vs JCMC 29.8 miles, Hampton High School 8.5 miles to Sycamore Shoals vs 18 miles to JCMC. Considering the recent tragic events that have occurred at schools throughout our nation we need to remain vigilant and be prepared to provide the closet and fastest medical care for our students' whatever situation may arise. It is imperative that Sycamore Shoals be more than just a band-aid station for the citizens of Carter County.

Please note Carter County has an aging population and older residents typically suffer from medical conditions that could require frequent trips to the emergency room.

With Ballad Health making the decision to remove the ICU and PCU from Sycamore Shoals Hospital they are putting the citizens of Carter County at risk they are limiting access to much needed medical and emergency services in turn forcing them to seek medical care in surrounding counties who are already past full capacity. With increasing population how can Ballad Health justify having only one hospital for Trauma I cases, the Johnson City Medical Center whose ER department is already significantly overworked and consistently at full capacity. What about Ballad Health's promise to expand rural? Is Ballad Health just about corporate medicine and financial gain?

Ballad Health has a responsibility to provide the best health care at the most convenient location to the citizens of Carter County.

Thank you for your time and attention in this matter.

Cloyd, Melissa C

From: Roberts, Matt
Sent: Friday, May 26, 2023 7:34 AM
To: Cloyd, Melissa C
Subject: Fwd: COPA Public Hearing

Chairy please

Sent from my iPhone

Begin forwarded message:

From: "Fraysier, Donna C" [redacted]
Date: May 26, 2023 at 6:57:34 AM EDT
To: "Roberts, Matt" [redacted]
Subject: Re: COPA Public Hearing

Matt Roberts
Chief Academic Officer
King University

Speaking points:

- King University School of Nursing was able to purchase a simulation birthing mannikin funded in part by a generous donation from Ballad Health. This mannikin allows traditional nursing students to experience care of a laboring patient in a safe environment, before beginning their clinical rotation on the labor & delivery unit in the hospital.

- Clinical partnership with Ballad provides traditional BSN students diverse clinical opportunities, including medical-surgical, critical care, pediatrics, labor & delivery, home health, radiation-oncology, and diabetes treatment.

- Partnership with Ballad provides an opportunity to be a collaborative partner in the Appalachian Highlands Center for Nursing Advancement – speaking directly w/ leaders from Ballad and other nursing programs allow us to determine the regional needs & the specific subset of nursing programs as we develop.

- Balad Health provides multiple primary care and mental health clinical sites for our MSN Family Nurse Practitioner and Psychiatric Mental Health Nurse Practitioner Students.

- Traditional nursing student clinical placements are secured at Ballad sites through the Appalachian Consortium for Nursing Education and Practice. This consortium allows all schools who use Ballad for clinical placement an opportunity to secure the number of clinical slots needed each semester through a collaborative meeting among school representatives and Ballad clinical representatives.

Let me know if you have any questions about the above list, or if you need me to come up with more speaking points.
Thanks
Donna

Donna Fraysier, DNP, ACNS-BC
Associate Professor and Dean
School of Nursing
King University
[redacted]

From: Roberts, Matt [redacted]
Sent: Thursday, May 25, 2023 11:46 AM
To: Fraysier, Donna C [redacted]
Subject: FW: COPA Public Hearing

Donna,
Would you please prepare me 5 or 6 speaking points on the benefits gained from partnering with Ballad? This could be SIM equipment, clinical placements, whatever. Just give me some specifics. I have to go play the glad game!

Matthew Roberts, Ed.D.
Provost
Vice President for Academic Affairs
King University
[redacted]

From: Roberts, Matt
Sent: Thursday, May 25, 2023 11:38 AM
To: Laux, Shelly [redacted]
Subject: RE: COPA Public Hearing

Yes, I can do that. Would you please have Larry send me details or a few speaking points on Ballad's commitment for giving to the SIM lab last year—if there on ongoing conversations, plans, etc. I will also ask Nursing leadership for a few speaking points on relationship with Ballad.

Matthew Roberts, Ed.D.
Provost
Vice President for Academic Affairs

6/12/23 Submitted by Robbyn Mayfett [redacted]

I am here on behalf of Brenda Cole. She is unable to attend this meeting.

After two doctor office visits and a walk-in clinic visit, Brenda was still in a lot of pain from her condition. She went to Franklin Woods ER on May 30th. She was stayed in the ER for 3 days and nights and was told there were no rooms available. She is in her 70's and had to sleep on a stretcher. She was offered no shower, no wash cloth and had to walk down the hall to use a public restroom. The doctor gave her two antibiotics that were on her "Do not use" list which resulted in more unpleasant side effects especially with no immediate access to the restroom. The trash was overflowing for 2 days before it was emptied. No one ever cleaned, swept or mopped the room while she was there. There is mold on the ceiling and what appeared to be blood on the pull cord in the restroom (I have pictures). She was offered food from a Styrofoam container that was unfit to eat.

She was finally released without being fully recovered and then charged as an "In-patient". She is appealing this charge.

The next week she was in the JCMC ER where she waited form 3:00 pm – 8:00 pm before being taken to an ER room and then it was 12:30 am before she was seen by the ER doctor. She spent the night in ER and was taken to a room around 9 am the next day. This was just this past week.

My sister, Donna Williams had a similar experience at the JCMC where she spent two nights in the ER before being given a room where she waited 3 days for gall bladder surgery.

Talking Points for Suzan E. Moore, Executive Director, Medical-Legal Partnership
Tennessee Department of Health
Certificate of Public Advantage ("COPA") Public Hearing
Monday, June 12, 2023, at 5:30 p.m.
Northeast State Community College
Performing Arts Center
2425 Highway 75
Blountville, Tennessee

- On November 11, 2020, Ballad Health entered into an Agreement with Appalachian School of Law and Virginia Tech's Pamplin College of Business for the development of a Medical-Legal Partnership (MLP). The program was designed and implemented during the COVID 19 pandemic.

- The mission of the MLP is to improve access to health care and patient health through interdisciplinary collaboration to detect, address and prevent health-harming conditions for low-income patients through the provision of free legal services. Unmet socio-economic needs, such as substandard housing and lack of health insurance or nutritional support, have a profound impact on patient health outcomes.

- Pursuant to the MLP Agreement, Ballad Health is investing $2 million over 5 years, in the form of grants to ASL and VT. ASL students provide free legal services, under the supervision of licensed attorneys, including ASL faculty and attorneys from Legal Aid of East TN and Southwest Va Legal Aid. VT provides data analytics to assess the MLP program – making our MLP the first of its kind. ASL also offers a class, *Poverty, Health and Law*, which is open to law students as well as medical students and business students.

- The MLP began serving Ballad's low-income patients (125% of the federal poverty level) in January 2021, through referrals to the MLP made by Ballad Case Managers and Community Care Navigators. The services we provide include legal advice and representation in civil matters, as well as assistance in filing claims for government benefits. We address our clients' health-harming legal needs, such as Income, Housing & utilities, Education & Employment, Legal status & Personal & family stability.

- Through December 2022, the MLP has provided free legal services to 306 clients. Two hundred of those clients were TN residents and all were Ballad low-income patients.

- What we have learned from our first two years of serving low-income patients in this region is that by working together, with Ballad, VT, Legal Aid of East TN and Southwest Va Legal Aid, unmet needs for legal services can be effectively addressed, and the social determinants of health can be positively impacted for this significant patient population.

- In its first two years, the MLP has delivered nearly 800 hours of free legal services to low-income patients. Our case outcomes include securing Medicaid and other health insurance coverage, Social Security Disability Income awards, housing, utility services, child custody and support, wills and powers of attorney, and income and nutritional support awards for our clients. Ballad employees and VT and ASL students have gained invaluable experience from this interdisciplinary partnership.

- The MLP program is now being expanded beyond Ballad's hospitals to serve its low-income maternal health patients in Greenville, TN and Abingdon, VA in a pilot project launched this month.

- But for Ballad Health's leadership and financial support for this partnership program, the need for legal services, to help improve the social determinants of health for hundreds of low-income patients in northeast TN and southwest VA, would likely have gone unmet. On behalf of the Appalachian School of Law, we wish to express our appreciation of Ballad Health for this collaboration and their financial support of this important program serving the patient population with the greatest needs in our region.

Good evening. My name is Ginger Carter. I am an OB/GYN physician who has practiced in Johnson City since 2008. I feel very loyal to this community, having graduated from the Quillen College of Medicine in 2000. I am here tonight because I love this community- and I love my patients. I want our area to have a robust hospital system- and I want us all to have access to the best healthcare possible. Please hear the voice of this community tonight that has concerns about our current healthcare monopoly.

I am privileged to have been both educated and worked alongside some of the best physicians and nurses in the nation. I began my work in Johnson City very proud of the area's ability to meet the health care needs of my patients, having to rarely refer people outside of our region. Now, it is on a daily basis that I am sadly met with this comment from my patients, "please send me anywhere except a Ballad Facility".

There are several reasons for this request. Quickly- I summarize:

1. Cost. Just one example is the cost of imaging. Ballad currently has the highest cost to patients on imaging such as mammograms- while having some of the oldest mammography equipment at one of their busiest locations in the Tri-State area. I have reached out to both the radiologists as well as Ballad administration about this very subject on numerous occasions. I very much like the radiologists that work at Ballad's facilities- I have grown to trust them over the years.. BUT I CAN NOT justify sending patients there when their costs are up to 3 times greater than other free standing imaging centers. Now, we find the radiologists that work at Ballad also working at these other free standing imaging centers as well. Physicians know. Patients know.

2. 3. 4. Wait times/Quality Care/Safety. I think I have an example that will highlight all 3 of these areas. One data point that Ballad will publish is ER wait times. Data can be manipulated in various ways to show an improvement in ER wait times when in fact- the situation has not changed. In reality, the quality of care has digressed to conditions that just are not deemed safe. One example that has occurred is initiating medical care in the ER lobby. This care initiated in the lobby is documented to reflect a decreased wait time in the ER. I sent emails of concerns to

administration about the safety issues regarding instances of IV morphine being given in our lobbies on patients who were not being monitored properly...which goes national safety standards. Instead of improving the quality of this situation... a new policy was formed that allowed this unsafe practice to continue in the lobby. Physicians know. Patients know.

Instead of solely relying on data submitted by Ballad Health and blindly trusting that data- that may have been manipulated to share their narrative:-have a conversation with us. Physicians know. Patients know. This community knows and deserves more options in healthcare.

Thank You

From: Donna Fisher
Sent: Monday, June 12, 2023 8:53 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] COPA Hearing

I went to the COPA public hearing on Ballad Health. I wasn't there in hopes of a continued donations. Or to discuss a non profit partnership. I was there as a concerned citizen. Yet the roster on who could speak was already 3 pages long 15 minutes before the doors opened at 5pm. Turns out, only those in favor of the merger could sign each other in. So even though I was there before them, they were able to speak and many ordinary citizens were not.

5 1/2 years ago a COPA was granted and Ballad Health becomes a legal medical monopoly with antitrust immunity. The state supervision that was promised has been non-existent. I've watched the dismantling of the safeguards that were put in place to protect the citizens in this area. I've watched promises made that have never materialize. We were assured of price cap commitments, and a higher quality of care at our hospitals. We were promised improvements in the overall health of our region, and preservation of of our rural hospitals. None of which have materialized.

I wasn't afforded the time tonight to discuss in detail all the things I'd like to address, so I'll speak on the ones that have affected my family the hardest. Quality of care and the Uninsured.

I have not seen the quality of care go up since this merger. Way before the pandemic Nurses have been pushed to their limits with the amount of patients they must care for. So much so that the families are now having to stay at the hospital with their loved ones to make sure they get what they need and meds are delivered on time. But when it comes to billing, they greet you in the ER and everyday after that. There are others in this room way more informed than I am about the ins and outs of this issue and will go into more detail about just how bad the care has gotten.

Those involved in getting the COPA passed promised improved healthcare for the uninsured. This has not happened. All thats done for the uninsured is treatment of their symptoms. Then they're sent home with a referral to a doctor who wants a lot of money upfront before they even see you. It's not until the symptoms become life threatening, that the hospital staff can order the correct tests and addresses the medical issue in real time.

I have experienced this first hand when I lost my insurance of 20 yrs and had a major health crisis. When I had that fabulous insurance, every test known to man was done, and my issue was immediately addressed, but while I was uninsured, only my symptoms were treated, no testing, no treatment plan, as soon as I was stable, I was discharged (with a referral). It took a 3rd admission in a month and demands from my family before tests were done. Turns out, It wasn't COPD at all, but fluid on my heart. I had to have immediate open heart surgery. My family saved my life by pushing back and demanding adequate care. I watched as my daughter had an extended stay at the medical center because they couldn't get her pain under control, only to find out that one of the many traveling nurses they use was stealing her patient's pain medication. My daughter's hospital stay was doubled because of this, and what did she get other than a larger hospital bill, they give her free hepatitis tests for the next 6 months. They did nothing about her larger hospital bill.

In both these incidents, my misdiagnosis and the Nurses Professional misconduct experienced by my daughter were

compounded when both of us were told we made too much money to get assistance with our medical bills. Part of this agreement was a promise to help the uninsured, but the formula Ballard uses is so low that most would already qualify for Tenncare. The working uninsured are still out in the cold.

This treating of the symptoms and not the condition doesn't save citizens any money, and it sure doesn't provide better healthcare. it's a revolving door of suffering for the patients and a revolving door of profits for the hospital. I listened to a previous speaker talk about the great care he received during his heart issue. I bet he has good insurance.

And As important as this public hearing is, I'm worried that you're going to once again ignore the facts presented, and just like the February meeting, absolutely nothing will change.. My question is this, if the council says they have no authority over Ballad, who does? Is it you all at the Tennessee Health Dept?

As for the media in the room, you all need to start doing a better job at reporting these issues.

And for the Ballard Executives in the room. I understand they spent 4 years getting this passed, but it's not performing the way you promised. It's doing exactly what the FDA and your hired experts said would happen.

How many years do we have to keep sinking into the abyss before this COPA is deemed to have done more harm than good for the people in this region. The only ones winning are the profiteers.

I would like this email to become part of the official record since I was unable to speak at todays hearing.

Sincerely,
Donna Fisher
[redacted]

Sent from my iPhone

Last night I attended the COPA Public Hearing at Northeast State Community College. I was glad to see a large turnout, but very disappointed with the public comments. Someone should have explained the reason for the meeting: to assess whether or not Ballad Healthcare System was doing what it promised to do.

When the initial merger occurred between Mountain States and Wellmont hospitals (a merger most people did not want), we were promised better healthcare. The promises were glorious: local hospitals would remain open, new equipment and care would be available, we would have choices. But has that really happened? As someone who lived in Unicoi County most of my life, I have watched after Ballad entered the scene as that county hospital became a band-aid hospital with ten beds and few services. I realize that the hospital had been struggling some financially, but it still provided necessary services. In Johnson County Hospital we have the same result – a shell of the hospital that it once was.

I recently moved to Carter County, and I am appalled to watch as Sycamore Shoals Hospital, which used to have a reputation as a great hospital, is slowly being stripped of its services. Do you want to have a baby? Not in my area. Do you have a serious illness that requires time in the Intensive Care Unit? Not in my area. No, the leaders at Ballad Health have decided that folks in Carter County should not go to a 4-star hospital (which will surely be downgraded due to lack of services), but to the Johnson City Med Center, a 1-star hospital which has obvious problems with staffing and long wait times. I don't know any intelligent person who thinks that is a good idea.

What is causing the problems with Ballad? Some may say Covid. However, Covid is no longer a valid excuse. Now wait times are worse than during the major outbreak of Covid. The wait time in 2022 was more than 30 minutes longer than it was in the pre-merger years. The number of patients who left the Emergency department without being seen rose above the pre-merger levels in 2020 and have continued to climb, even after Covid. Staffing shortages appear to be worse also, which is confusing to me since we have several colleges and universities, as well as vocational schools in a 100-mile radius that are graduating nurses, LPNs, nurse practitioners, and physician assistants.

At our COPA meeting we heard about all the wonderful things Ballad is doing in the community. They sure like to give money away! But that was not the purpose of the meeting. The topic was healthcare. Is Ballad providing the communities it serves adequate healthcare? I know many wonderful doctors, nurse, and staff members. I realize they are working to their full potential in a very difficult environment, and many have left Ballad. They are not the problem. The reason we have poor healthcare is that we have a monopoly that the community didn't want that has failed us miserably. The system is broken on many, many levels. You would hear that if folks were not so afraid to speak up for fear of repercussions. My husband will be 80 next month, and I am concerned about our future and what will happen when we have healthcare needs. I am pleading with the Tennessee Department of Health to step in and do something to help us. Let another healthcare entity come into our community. Allow more CONs for

outsourced services so we can have options. Be creative. You are the experts, please come up with a plan that is not what we have now.

Thank you for allowing me to write,

Dr. Charlene Thomas

From: Katherine Qualls
Sent: Thursday, June 15, 2023 11:21 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Ballad HVMC

On July 30th 2022 my husband Jerry Qualls was taken by ambulance to HVMC ER they started on him when we got there, I was in the back with him because i refused to go to the waiting room I knew I needed answer questions and talk to dr Rana cardiac doctor who said Jerry need to go to Cathlab, I told him to call dr Jerry blackwell (Jerry's heart doctor since 2005) which he did and told me Dr Blackwell told him to go ahead and take Jerry to Cathlab, I ask for Dr Chris Metzger because he did Jerry's stints in 2012 , dr Rana said dr metzger was not on call and that he worked with him and would take care of Jerry, they took him to Cathlab and put in one stint . Jerry came out of Cathlab on a ventilator sedated and on a heart pump in the groin. He was in cardiac ICU the cardiologist Dr Shipeng Yu who I was told was new came to HVMC from Norton that same week was cardiologist assigned to Jerry he would not listen to anything I tried to tell him and would stomp out of the room mad several times , information he needed to know as his doctor . I repeatedly ask for Dr. Blackwell to contact me never did . Kept being told you can't request a dr you have to take whoever is working this week . Dr. YU , Dr. Rana , Dr . Metzger all said "nothing we can do ". Many times. Another Doctor (lung doctor I believe) stood beside his bed looked at me and said " don't kid yourself this is life support " I called Vanderbilt on July 31st myself and got Jerry on priority waiting list for the ICU he had to go to because he was on a heart pump keeping him alive, ask doctors at HVMC repeatedly to send his records, they never would finally on the 3rd or 4the day after me talking to Vanderbilt everyday I again demanded dr YU get Jerry records sent now , I handed him the number to Vanderbilt 5th floor ICU he told me " you call" I said I have everyday they have him on priority soon as a room opens, and point my finger in his face and said send the damn records now! Dr . Rana and Metzger both told me " Jerry wouldn't qualify for a heart transplant " I said I don't care you are not qualified to say who would qualify for a transplant I'm getting him to Nashville. It's like they were fighting me from sending Jerry to Nashville. Dr. Blackwell who Jerrys cardiologist he saw him every 6 months since 2005 had just saw him in June of 2022 a month before this happened and he said Jerry was doing great, we were never told in all that time Jerry had any kind of heart failure issues at all , he always just had vascular issues and was told all was good even up until his last appointment in June 2022. Never treated or told about heart failure at all . On august 5th 2022 i finally got Jerry transferred to Nashville, as we were leaving two of icu nurses came up to me and said " I'm so glad you are getting him out of here " you should not have to fight to get a family member records sent , you should not have doctors refusing to do anything to help you get your husband transferred for days , all the while repeatedly telling you things like " don't kid yourself this is life support" you shouldn't have doctors telling you " he won't qualify " for something they are not qualified for. And for his cardiologist of 17 years not to check on him or even call as I asked repeatedly is unacceptable . While my husband Jerry was in cardiac icu it was a total mess doctors telling you different things and some getting mad when you asked questions, he did have some good nurses thank god but their hands are tied having to follow what the doctors told them. People should not have to fight to get their loved ones out of HVMC and the dangerous mess it's turned into , how many families don't know to get a transfer and their loved one dies, my husband would have been dead within a few days if I didn't get him out when I did. And for the record my husband had a different and better heart pump put in his right chest soon as we got to Nashville so they could get him up from laying flat and off the life support ventilator & sedation. The laying flat was killing him faster. My husband had a heart transplant on aug 29th of 2022 at Vanderbilt and my husband is alive now because of Vanderbilt. After staying in Nashville for 6 months I got to bring my husband home

. And all his doctors are now at Vanderbilt they handle everything for him. We will not use ballad it's not safe . Shame on ballad health for what they have done to our hospitals people are dying and suffering because we have no quality of care here anymore.
Sent from my iPhone

Formstack Submission For: COPA Form
Submitted at 06/15/23 10:52 AM

Name:	Lisa Whaley
Email:	
Zip Code:	37659

My name is Lisa Whaley, director of development for the International Storytelling Center in Jonesborough and I am here on behalf of ISC to talk about the partnership we enjoy with Ballad Health.
The International Storytelling Center was born in 1973 as an arts, educational and humanities institution, dedicated to the folk art tradition of storytelling.
For more than 50 years, we've also become known for helping to foster storytelling into a professional and creative industry.
ISC is able to accomplish its work through community collaborations and partnerships, and that speaks to the valuable relationship we have with Ballad Health.
Our work with Ballad Health has included creating a storytelling channel for Ballad Health's in-patient televised programming, which has been utilized throughout their hospital system, including the Children's Hospital.
At the start of the pandemic, we also piloted a storytelling initiative — titled "Stories as Medicine" — with Franklin Woods Community Hospital in Johnson City to help Ballad healthcare workers and nurse practitioners use their own stories to foster care, resiliency and comfort for patients in a hospital setting. This program has been expanded to more than 300 healthcare workers across the country and has even reached Melbourne, Australia.

Comment:	More recently, in a special partnership with and an investment from Ballad Health, we have helped Ballad integrate storytelling into the design, training, patient interactions and community offerings of the Unicoi Country Hospital in Erwin, which will soon earn the International Storytelling Center's Storytelling Site of Excellence designation, the first of its kind awarded to a hospital system. This partnership included the establishment of a junior board in Unicoi County to encourage input from local youth. The board met regularly at the hospital facility to receive lessons and training, enabling these young youth leaders to develop skills needed to collect stories from their community, from peers, from teachers and students, and from their family members. The junior board was then asked to complete a special project benefiting both the hospital and the community. They chose to create a time capsule focusing on donated stories from the community which center around Unicoi County and the history of Unicoi County Hospital. The time capsule has been sealed inside a display case in the lobby of the Unicoi County Hospital and will remain there unopened for 25 years. As one junior board member stated, according to an article in the town's local newspaper, The Erwin Record, "Storytelling can help the hospital learn more about the community. Storytelling can help people heal." We strongly agree and ISC looks forward to future collaborations with Ballad Health to the benefit our communities and their members

From:
Sent: Monday, June 19, 2023 7:59 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Written comments for the public COPA hearing of June 12, 2023

Commissioner Alvarado and staff,

Thank you and your staff for coming to Northeast Tennessee for this very important public hearing. A COPA is an unusual and potentially helpful but also potentially harmful arrangement and public input is valuable. I came to the hearing and was signed up to speak, but time elapsed prior to my turn. So, I am sending these written comments and request that they be considered along with the verbal comments others made.

Like many at the meeting, I care deeply about Northeast Tennessee, being born and raised in Johnson City, educated in public schools, and graduated from ETSU. However, my perspective is an unusual one, in that I was able to participate as the independent pandemic consultant for Ballad Health. From April 2020 to April 2022 I was compensated for consulting and from May 2022 to present I chose to volunteer my time. I was included at all meetings of the Corporate Emergency Operations Center. I have never been a Ballad employee.

I also consulted on a volunteer basis with several other organizations in Northeast Tennessee during that time frame, including some non-Ballad medical practices, educational organizations, religious organizations, and civic leaders. So, I was able to see a cross section of the community and not just Ballad Health.

I appreciate the opportunity to submit these comments and your efforts to assure benefit to the population of Northeast Tennessee from the COPA.

Best Regards,
David Reagan

Observations on the COVID-19 Pandemic and the COPA

Introduction: Who I am and what perspective did I have during the pandemic? I am David Reagan born in Johnson City, graduate of ETSU, an Internist and Infectious Diseases physician with experience in Public Health as CMO for 7 years for the TN Department of Health and in hospital administration as the Chief of Staff at the Mountain Home VA Medical Center for 7 years. I served as Pandemic Consultant to Ballad Health from April 2020 through April 2022.

Convening and Collaborating

- Ballad served as convener and collaborator for regional healthcare response to the pandemic from April 2020, including convening regional meetings of diverse healthcare organizations, assisting with staffing Public Health mass vaccination sites, collaborating frequently with civic, business, and faith leaders, ETSU, and large regional practice groups.

Communication: Internal and External

- Ballad developed a daily internal communication system which served to keep 21 hospitals and outpatient medical practices on the same page and to identify new concerns.
- Ballad provided frequent public briefings by senior Ballad staff, often with daily media interviews, and developed a public daily scorecard. This was very different than any other healthcare entity in the region and was a welcome means of up-to-date information. ETSU College of Public Health was the only other entity that offered such frequently updated information.
- Ballad developed sophisticated models of upcoming inpatient demand using internal and external data (which were also made publicly available). As part of this effort, Ballad was an early adopter of wastewater testing data and initially paid for these services (while later federal funding became available). Obtaining samples required collaboration with regional Public Health organizations and municipal governments in the Tri-Cities.
- Ballad developed and staffed a nurse call line which answered questions from tens of thousands of people, many of whom were not Ballad patients.

Efficient Delivery of Healthcare services

- Ballad created the first corporate emergency operations center (CEOC) to oversee pandemic response. The structure of the TDH Emergency Operations Center was part of the design for the CEOC. This group oversaw the Ballad pandemic response and was recognized by the Business Journal of Tri-Cities TN and VA with a Community Service Award in August 2021.
- Ballad increased capacity in many areas to serve demands from patients, as there was almost no ability to transfer sick patients out of the region due to the nature of the pandemic. The CEOC also leveraged advantages of a 21-hospital integrated healthcare delivery system, including effectively acquiring scarce PPE and laboratory supplies, and

creating an innovative system to actively monitor people with COVID who were at high risk for severe disease but not quite sick enough for admission, and launched multiple new telehealth programs.

- Remarkably, Ballad chose to implement the EPIC medical record system as planned (pre-pandemic) where it was not already in use to assure a common EHR to facilitate quality of care and analysis of metrics region wide. Having assisted with implementing an EHR twice in my career, this was a bold and significant investment in quality of care and system cohesiveness.
- Ballad served the entire regional medical community by acquiring -70 C freezers early and standing up capacity to give large numbers of mRNA vaccines literally as soon as they were available.
- Prior to the availability of mRNA vaccines, Ballad partnered with ETSU Health to produce a series of e-newsletters for the regional medical community that explained the development, testing, EUA process, and known side effects and contraindications. This helped prepare healthcare workers in making their choice about being vaccinated and for advising their patients about vaccination.
- Ballad opened multiple public mass vaccination sites until medical practices and pharmacies were prepared to administer vaccines and they were available to them.

In summary, it is generally appreciated that the COVID-19 pandemic was the most severe challenge to healthcare in the last 100 years. During the last three years I have been impressed that public advantage was clearly seen in having one integrated healthcare delivery system which could identify a problem, debate solutions, decide on actions, communicate internally and externally as needed, and quickly implement solutions. I think this resulted in better health in the region during these most challenging times. Thank you for this opportunity to share my perspectives.

Formstack Submission For: COPA Form
Submitted at 06/22/23 2:47 PM

Name:	Claudia Byrd
Email:	
Zip Code:	37659
Comment:	COPA Public Hearing – SCC/Ballad Partnership Hello I am Claudia Byrd Executive Director of Speedway Children's Charities at Bristol Motor Speedway. We raise money to distribute to Non-Profit children's Organizations in 18 Counties in Northeast Tennessee and Southwest Virginia. Over the last 26 years we have given back almost 20 Million dollars to make life better for the children of our region but I have always had a desire to give more that a check every year to these amazing organizations. In 2018, Speedway Children's Charities and Ballad Health began having conversations regarding our desire to build a strong community alliance that could meet regional public health challenges. Our goal was to walk alongside organizations, individuals and teams that serve children and families, thus began the STRONG Kids collaborative. This partnership was birthed to improve children's health and chance at success by emphasizing a shared responsibility as well as building capacity by empowering and educating multi sector partners. We began with a ready-made network of children serving agencies and hosted in person objective focused forums to share best practices and other trainings for program development and tools creating collective impact. Forums are hosted quarterly and additional trainings are offered in

between forums based on needs and goals of the organizations and teams we serve. We have one goal in mind – to change the trajectory of children's lives in our region. We consistently hear from attending organizations that are serving children that are seeing change for the better because of the information they receive from STRONG Kids.

This partnership means more than just providing trainings and forums for those working with children and underserved populations. Ballad Health, Speedway Children's Charities and the STRONG Kids Community has been able

to provide hope to burned out personnel,

to provide free education and learning to organizations that would not have funding otherwise,

to highlight initiatives and pathways to see success.

Ballad Health has been able to utilize data and relationships to understand the needs of those in their footprint and then develop and implement strategies to combat public health issues. Together – we are giving opportunities where circumstances don't allow. We are grateful for the partnership with Ballad Health and look forward to continued service in our community.

Formstack Submission For: COPA Form
Submitted at 06/22/23 10:27 AM

Name:	Jeffrey Schoondyke
Email:	
Zip Code:	37604

Dear Dr. Alvardo:

My name is Jeff Schoondyke and I am a cardiologist in Johnson City, Tennessee. I am writing to submit my comments on the state of the COPA and the TOC. I was present at the public hearing held on June 12 at Northeast State University, but did not have the opportunity to speak due to time limitations. I hope you will consider my input in my role as a physician and a citizen, but most importantly, a patient advocate.

I have been a practicing physician in Johnson City since 1999, the year I started my residency at ETSU. I subsequently entered my fellowship in cardiology at ETSU and finished my training in 2005. I have a long history within the community and was practicing long before anything like Ballad was even an idea in our region. I am currently the senior partner at Karing Hearts Cardiology and I am the founding member of the practice, which started in April of 2011. Since that time, my practice was, currently is, and proudly remains the only independent cardiology practice in our region. I am sure you can appreciate how challenging the past 12 years have been given the current state of healthcare in general, as well as the challenges we face in our region related to our population, economics, and the creation of Ballad

Health. I hope my thoughts on the COPA will be helpful and insightful.

During your introduction at the public hearing on June 12, you and your colleagues stated that you take your responsibilities to the COPA very seriously and were there to solicit input from the public. You also asked for suggestions that may improve the effectiveness and success of the COPA/TOC and as a result help the citizens of East Tennessee. I appreciated your comments and I agree with you completely when you said (paraphrasing here) "the nation as a whole is watching us as we navigate this new endeavor." Despite the best efforts of many over the years, serious problems exist, and the process seems to have broken down and the real losers in this situation are the citizens the COPA/TOC was supposed to serve and benefit. I appreciate you have only been 'on the job' now for roughly 6 months and have an extremely difficult position. I hope my comments will help shed some light on the reality of our region's healthcare. Often there is a difference between perception and reality. Once uncovered, this difference can be rather intimidating and sometimes, just plain hard to believe. Listed below are a few of the issues that are real patient issues and are directly governed by the COPA/TOC.

Once the COPA was granted in 2018, the TOC was very clear regarding protections for the private sector. The FTC outlined these in detail and as you know advised against the formation of Ballad Health. The original TOC clearly defined a number of important points designed to protect the public and the private sector as the formation of Ballad progressed. Three of the most significant provisions were, 1) the "35% rule", 2) appointing a local advisory council, and 3) and perhaps the most important of all was prohibiting Ballad from opposing CON applications. Each of these provisions were intentionally designed and included in the TOC, despite Ballad's objections at the time, to help ensure that competition could exist and grow in the market and prevent a complete takeover of the physician labor market in our region. It was of significant concern while the process was unfolding that Ballad could use its monopolistic power to gain substantial advantage over the market and the delivery of healthcare to our citizens. The concern was that prices may increase, access could decline, and that quality might diminish. I am deeply concerned that these predictions are currently manifesting themselves.

The 35% rule (Section 5.05.e) was intentionally placed in

the TOC to prevent Ballad from flooding the market within certain specialties and all together 'run off' any remaining independent physician practices. We are one of those independent physician practices, Karing Hearts Cardiology, that sought protection under this provision of the TOC. Several waivers have been granted to this provision and at present the employed physician ratio in the cardiology department at Johnson City Medical Center is nearly 50%. This is simply wrong. State government oversight is the only protection the citizens and private sector has against a large monopoly, and we were let down.

Comment:

One of the changes that was made in the second restated TOC was to remove the local advisory council. This council could have been a mechanism for the public to provide input on proposed changes to the TOC. Once this was removed, Ballad need only lobby the Commissioner of Health, State Government and the Attorney General for a decision. This was wrong. This has become a very serious concern as illustrated with two very important decisions that the state made with no public input or discussion. One decision was to remove the prohibition of Ballad from opposing CON applications and the second being the closure of Sycamore Sholes ICU/PCU. It is appalling that these two decisions were made under the cover of darkness and without any public knowledge or input.

There is real concern among our citizens, physicians, local politicians, and business owners, that the State of Tennessee has turned its back on their obligations to the citizens and approved Ballad's repeated waiver requests. Unfortunately, over the years many of the protections in the TOC have been diluted and in some cases have been completely eliminated altogether. Ballad has been able to secure these changes overtime simply by receiving approval from state government. I am aware that you had nothing to do with this but here lies my first suggestion for improvement of the COPA/TOC. I hope you will consider retracting Ballad's ability to oppose CON applications and enforce the 35% rule as written and intended in the original version of the TOC. The State approved Ballad‘s request to lift the prohibition to oppose CON applications with no public input, no private sector input, or any form of discussion. This was wrong. Public input was a major tenant of the COPA, original TOC, the merger in general and is nonexistent today with the blessing of the state.

Please understand that I do not wish to sound disrespectful as I understand these issues are very complex, but more people from the community who provide medical care for our citizens should have had a seat at each of those tables. This was wrong and, in my opinion, a monumental failure of our state government.

Ballad has placed emphasis on substance abuse and treatment, and they are investing in the community by supporting many local nonprofit and charitable organizations and I think they should be applauded for these worthy efforts.

Take home message:

The previous Commissioner of Health and Attorney General have allowed too much revision of the TOC's original intent and protections it provided the private sector physicians and most of all the citizens. Bring back the local advisory council and expand their responsibilities for engaging the public, reinstate the original TOC and require Ballad to work together with the private sector to improve our region's healthcare. As an independent physician and citizen, I am very concerned about the direction our health system is progressing. Respectfully, I encourage you to understand that there is a difference in perception and reality in our region. Talk to us who take care of patients, who see the long wait times in our hospitals, who see the access problems and consider engaging us to help our citizens and our patients. I want a strong local health system and I want the opportunity to be included in policy decisions that ultimately affect our population, my friends, and many thousands of patients who are trusting me to care for them.

I hope I have not offended any of you. I have the utmost respect for each of you and your positions. The job you must do is difficult and many times there are no right answers - I concede this. Please, however, believe me when I say there is significant room for improvement.

I would love the opportunity to talk with you and express my views and sincerely offer suggestions that would help our region. After all, that is what you asked for wasn't it? I genuinely wish to contribute in a positive way to help the citizens of our region.

Sincerely,

Jeffrey W. Schoondyke, MD, MPH,FACC,CCDS

Formstack, 11671 Lantern Road, Suite 300, Fishers, IN 46038

Formstack Submission For: COPA Form
Submitted at 06/22/23 10:29 AM

Name:	Rob Gregory
Email:	
Zip Code:	37604

Hello, my name is Rob Gregory and I am the Practice Administrator/CEO for Karing Hearts Cardiology

The concern that I want to address is the diminishing public involvement in evaluating the COPA's effectiveness and the impact of proposed changes to the Terms of Certification.

Back in 2015/2016 as the vision of a merger was initially presented, the Department of Health appointed a group of local community leaders – the COPA Index Advisory Group - to engage more broadly with citizens of the community for the purpose of gathering information and input from the public about the merger. Input they received and submitted to the State was subsequently incorporated into the Terms of Certification. It seemed clear then, that the public's input would be a key pillar to success.

In 2018, when the merger was approved and as a requirement of the original Terms of Certification the Commissioner appointed a Local Advisory Council, an ongoing volunteer based group established to, at minimum, host an annual public hearing to provide a formal process for the public to comment on the New Health System's annual report AND the ongoing

Comment:

performance of the New Health System. They established a mission statement "To, among other things …. facilitate public input and report on information received".

In January of 2021 the Local Advisory Council hosted their last public hearing forum and submitted their final written report one month later in February of 2021.

In April of 2021 the Terms of Certification were modified and the obligation of the Local Advisory Council to facilitate annual public input forums was eliminated. At present it is my understanding that no such mechanism for the public to provide input exists today.

In July of 2022 the Terms of Certification were once again amended. One of the most substantial amendments in this version, in my opinion, was lifting the prohibition of Ballad Health to oppose Certificate of Need applications.

More concerning than this change itself is the fact that no one that I know or have talked with, many who have certainly been impacted by this particular change had any knowledge or awareness of the proposed amendment until after the announcement of its effective date.

Representation from Ballad has offered that each time the Terms of Certification has been amended, the State and Ballad have followed the provisions of the Terms of Certification to the letter. I submit this simple and humble observation, that often when we excessively focus on the letter of the law, we lose sight of the intent of the law.

The Certificate of Public Advantage, often referred to as the Community Protection Act was intended to ensure that the benefits to the public as a result of the merger would outweigh the likely disadvantages.

The public seems to have lost their voice in this process and we'd like to have it back. Thank you.

Rob Gregory

Formstack Submission For: COPA Form
Submitted at 06/13/23 7:58 AM

Name:	Suzan Moore
Email:	
Zip Code:	37620

Talking Points for Suzan E. Moore, Executive Director, Medical-Legal Partnership
Tennessee Department of Health
Certificate of Public Advantage ("COPA") Public Hearing
Monday, June 12, 2023, at 5:30 p.m.
Northeast State Community College
Performing Arts Center
2425 Highway 75
Blountville, Tennessee

• On November 11, 2020, Ballad Health entered into an Agreement with Appalachian School of Law and Virginia Tech's Pamplin College of Business for the development of a Medical-Legal Partnership (MLP). The program was designed and implemented during the COVID 19 pandemic.

• The mission of the MLP is to improve access to health care and patient health through interdisciplinary collaboration to detect, address and prevent health-harming conditions for low-income patients through the provision of free legal services. Unmet socio-economic needs, such as substandard housing and lack of health insurance or nutritional support, have a profound impact on patient health outcomes.

Comment:

• Pursuant to the MLP Agreement, Ballad Health is investing $2 million over 5 years, in the form of grants to ASL and VT. ASL students provide free legal services, under the supervision of licensed attorneys, including ASL faculty and attorneys from Legal Aid of East TN and Southwest Va Legal Aid. VT provides data analytics to assess the MLP program – making our MLP the first of its kind. ASL also offers a class, Poverty, Health and Law, which is open to law students as well as medical students and business students.

• The MLP began serving Ballad's low-income patients (125% of the federal poverty level) in January 2021, through referrals to the MLP made by Ballad Case Managers and Community Care Navigators. The services we provide include legal advice and representation in civil matters, as well as assistance in filing claims for government benefits. We address our clients' health-harming legal needs, such as Income, Housing & utilities, Education & Employment, Legal status & Personal & family stability.

• Through December 2022, the MLP has provided free legal services to 306 clients. Two hundred of those clients were TN residents and all were Ballad low-income patients.

• What we have learned from our first two years of serving low-income patients in this region is that by working together, with Ballad, VT, Legal Aid of East TN and Southwest Va Legal Aid, unmet needs for legal services can be effectively addressed, and the social determinants of health can be positively impacted for this significant patient population.

• In its first two years, the MLP has delivered nearly 800 hours of free legal services to low-income patients. Our case outcomes include securing Medicaid and other health insurance coverage, Social Security Disability Income awards, housing, utility services, child custody and support, wills and powers of attorney, and income and nutritional support awards for our clients. Ballad employees and VT and ASL students have gained invaluable experience from this interdisciplinary partnership.

• The MLP program is now being expanded beyond Ballad's hospitals to serve its low-income maternal health patients in Greenville, TN and Abingdon, VA in a pilot

project launched this month.

• But for Ballad Health's leadership and financial support for this partnership program, the need for legal services, to help improve the social determinants of health for hundreds of low-income patients in northeast TN and southwest VA, would likely have gone unmet. On behalf of the Appalachian School of Law, we wish to express our appreciation of Ballad Health for this collaboration and their financial support of this important program serving the patient population with the greatest needs in our region.

From: Donna Addington
Sent: Monday, June 12, 2023 6:37 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Concerns about Ballad health care in Bristol, TN

To the State of Tennessee,

I am deeply concerned about health care availability in the Ballad system in East Tennessee. Since Ballad has taken over care in our area, the health care system has declined due to a lack of employees to staff rooms. Moral is low and employees are leaving.

In February 2022, my mom was admitted to the ER a second time with an extremely severe case of cellulitis. She had to wait in the hallway behind the locked ER doors. She did not have an available bed or room and had to sit in an uncomfortable chair while hospital staff walked around her, not even acknowledging her. I had to ask them to bring her a blanket, I had to alert them that she was falling asleep in a chair and about to fall into the floor. I finally asked for a wheelchair for her so that she could sit in a chair safely. If I had not been there to advocate for my mom, I'm not sure what would have happened.

Also, notice I said that she was admitted a second time for care. Unfortunately, the first time she was admitted to the ER, Ballad staff did not consider her case serious. She was sent home to suffer and decline until her infection was so severe she had to be hospitalized for several days to receive IV antibiotics. Thankfully she got well.

In closing I want to plead with you.
As you consider Ballad healthcare and their proposal to streamline services, I ask that you to consider your family members. Would you want your mother, father, grandparent or friend to endure this type of health care?
If not, I ask that you require Ballad to provide quality, available healthcare.
This does not mean decreasing access to Intensive and Critical Care. It means that every patient's health is of upmost importance. It also means that services should remain available in local communities.

Thank you for your concern for quality healthcare in Tennessee.

Sincerely,

Donna Addington
Bristol, Tennessee

Sent from my iPhone

From: Ginger Ketron
Sent: Monday, June 12, 2023 5:12 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Concern

There are many people in this area that have died and/or experienced trauma at the hands of not the doctors or nurses because they did the best they could to save my father. The real problem here is the lack of finances provided by the administration of Ballad Health. Had there been accurate staff, my father would still be alive. Ballad sent Risk Management in an attempt to intimidate my family in asking for a legal right for an autopsy.

I was told there was another patient in the ER waiting room that witnessed the lack of care my father received.

This meeting feels to me like a waste of time and a action to say Ballad did there due diligence in asking our opinions.

I read every person would be given at least 3 minutes to give their statements. And the people here do not represent me or the way I would present my case.

If you reach out to me and allow me to tell my story,

I also KNOW that there are state government officials who are themselves stock members in the Ballad Health system and that is illegal.

My father went into ER waiting room on a Monday morning at 11:00 am. And was admitted and had blood drawn and was given a CT scan on his head. And then set in the ER waiting room. I finally reached the ER at 8pm where I was told someone was monitoring my father's vitals. When I found my dad, I was told no one had checked on him since having his blood taken earlier that morning. The only person I was allowed to talk with is the front receptionist who knew nothing. I informed her no one since 11ish am had been out to check on him. I asked if anyone had ensured my dad had food and water. She answered: "well, all he had to do was come up here and ask then we would have given it to him." I replied did anyone tell him because I don't see signs advertising. She replied "sorry I can't do anything". My dad had a heart attack right in front of me in the er waiting room and I went to the receptionist and gave her all his symptoms and she wrote them down and said she was taking it to the NP. No one came. My dad died at ballad health.

Ginger Ketron, LCSW
Clinical Counselor

[redacted]

From:
Sent: Monday, June 12, 2023 9:56 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Ballad Health COPA

To Whom It May Concern,

I am writing this to express my views that the Ballad Health Monopoly as it stands is BAD for our community.
All monopolies are bad for the Consumers who depend on them. History has proven this over and over again.
Our government officials were even warned that letting Ballad Health monopolize heath care would not be in
our citizens best interests. People here have to wait 3 days in the emergency room before they are admitted
to the hospital.
Please do everything in your power to end Ballad Health's Monopoly.

Sincerely,
Mitzi Cooper

From: Polly Wiley
Sent: Monday, June 12, 2023 11:05 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Please read this!

Unfortunately I cannot attend because I am currently in Johnson City Medical Center. Please, I beg you to not listen to the Ballad representatives about how wonderful their facilities are. I came to the ER on Saturday around 4 pm. I was triaged and had a CT within 20 minutes. That was fantastic. I then got moved to a stretcher in the hallway of the ER which was not ideal but better than being in a chair in the general waiting room. I was there for a few hours and then moved to what is called the old PACU. I am still on a gurney in an open bay room with anywhere from 5-7 people all waiting on rooms. Yes, I have been on a gurney waiting on a room since Saturday. We all share one bathroom. We are all on gurneys separated by curtains. I am sure HIPPA laws are being broken as I can tell you the age, living conditions, number of surgeries, medical conditions, and the medications the lady next to me is on. All I need now is her social security number. Please! You all are in town come see this for yourselves! Now, let me get to the nurses, they are wonderful. The nurse last night named Justin was hands down the best nurse I have ever had in my life. He needs to be recognized. Ballad spends money on advertising and travel nurses instead of paying their own people. The community knows how awful Ballad is and how the merger totally ruined our healthcare. JCMCH used to be a great hospital. Please don't allow this monopoly to continue. I ask for not only myself but for my 87 year old mother who I have sat with in the hallways of the ER waiting on a room for days as well. Something has to be done. Again, please come see us in the old PACU. The sad truth is that I waited for 7 days putting my life at risk doing everything possible to avoid having to come here because I know how awful it is. If that is not an indication of how bad it is then I don't know what else to say. Thank you for listening.

Polly Wiley

From: [redacted]
Sent: Monday, June 12, 2023 1:35 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Closure of SSH ICU

To Whom It May Concern,

My name is [redacted] and I am a registered nurse in Carter County, Tennessee. I have previous work experience at both Sycamore Shoals Hospital and Johnson City Medical Center. I am reaching out to you today to express my great concern regarding the closure of crucial units at Sycamore Shoals Hospital, and the routing of patients to Johnson City Medical Center.

First, I would like to mention that Sycamore Shoals Hospital is the closest hospital for most people who live in Carter and Johnson counties, including myself and my family. These counties combined have a population of over 73,000 people. With the closure of Sycamore Shoals ICU, over 73,000 people would have to travel to Johnson City in the case that they were in critical condition. This could be a drive of an hour or more. In the case that they would need to call EMS, the wait for EMS to arrive to their home could be unpredictable. Carter and Johnson counties have a limited number of ambulances, and sometimes those ambulances are unavailable right away. For someone having a heart attack, stroke, or an allergic reaction, the wait for life-saving medical care could be ***hours***. **People are going to die**. I'm also concerned that once the ICU at Sycamore Shoals closes, the entire hospital will close shortly after. The ICU allows for many other services to be possible at Sycamore Shoals Hospital, such as certain medication drips and surgical procedures. It is extremely important that we have a hospital nearby with these necessary resources available to serve those who live a farther distance away from Johnson City.

Second, I would like to mention that I have witnessed firsthand the number of patients Johnson City Medical Center and Sycamore Shoals see in their ERs and ICUs daily. Sycamore Shoals Hospital only has 12 beds in their emergency room. Often, patients are on stretchers in the hallways because there are not enough rooms available. If the ICU closes and critical patients are held in the ER while awaiting transport to JCMC, this will increase the number of patients in the hallways and the risk for injury or death. Nurses already have too many critical patients. Why should we add more to their workload, and risk harm for both patients and staff? In addition, ER wait times are already long before hospital closures, and JCMC's ICUs only have a limited number of beds available. When the ERs and ICUs are already full due to the influx of patients, where will the additional critical patients go? Who is going to take care of these patients? Johnson City Medical Center does not have the staff to care for their current daily number of patients, much less additional patients from other hospitals. Where are the safe staff-to-patient ratios in this situation? Ballad Health mentioned that employees from the closed units at Sycamore Shoals can transfer to Johnson City Medical Center. With the large number of health care workers becoming unemployed in this area, these jobs are not guaranteed.

On another note, I have also witnessed firsthand how life-changing Sycamore Shoals Hospital has been for many patients. I have heard numerous stories from patients about how the care they received in the ICU, and other units at Sycamore Shoals, was like no other. Sycamore Shoals has been a saving grace for countless numbers of people, including myself and my family.

To close, I want to express again how concerned I am for this region's healthcare. Due to the closure of crucial units at Sycamore Shoals Hospital, people in our area will lose life-saving resources, and **some will lose their lives**. We need to prioritize patients over profits. Please take into consideration how crucial it is to have Sycamore Shoals Hospital and all its' units up and running. Thank you for your time and consideration.

Sincerely,

[redacted] BSN, RN

From: Danielle Goodrich
Sent: Tuesday, June 13, 2023 9:15 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Ballad COPA hearing

My name is Danielle Goodrich I'm a momma bear who started Johnson city freedom to like Reagan said hand down freedom to our children to do the same.

And a monopoly that hinders choice, hinders freedom. I ask that we repeal con and COPA laws and reinstate healthcare choice.

The FTC spoke against the creation of a healthcare monopoly and warned against merging two healthcare systems into one. They said it would drive up costs and drive down quality.

Because it's well documented the government cannot regulate the market as efficiently as free market competition and we the consumer can.

Having choice and we the people determining which company we do business with based off of competing prices, competing services. Who offers the best product. Keeps prices low and quality high.

What this certificate of public advantage does, is takes choice away from the consumer, away from the people and hands it to the monopoly and to the government.

It strips the people of choice and sets up a freedom less system. Where government experts choose who we do business with instead of we the people choosing based on quality and success. And COVID showed us how mistaken experts can be. How beholden to pharmaceutical companies that line the pockets of politicians and fund campaigns can wrongly influence health decisions. How studies and medical journals can be bought. How big corporations and big government can work together against us.

As they use our tax dollars to fund and employ profitable one size fits all solutions. While they hold jobs hostage for compliance.

The ideology pushed is collectivism asking people to surrender their individual rights for the

supposed betterment of the collective. But health is not one size fits all. COVID hospitalizations were primarily in people with metabolic issues. Unless you want a government so powerful they can tell you what to eat and when to exercise which would mean zero freedom, one size fits all solutions don't work. Individual solutions do.

History proves Centralization of government and centralization of healthcare are dangerous. It's the first step to communism. Our founding fathers set up systems that were decentralized with intention. It creates more choices. And choices equal freedom. You don't have a free country without a free market. And you don't have a free market with a monopoly that gives the monopoly and the government too much power over the people.

I went to Nashville to ask our Representatives to vote for repeal of the certificate of need laws which would be a needed step back to the free market. And I was told from an advisor to our Senator and Representatives That slow repeal was better because there would be too many market disruptions. When I asked what the market disruptions were the advisor could not name a single one. When I pressured again what issues slow repeal was solving he said

That I needed to get people who don't want CON repealed on board because of their "investments?"

Who are these people? Why are their investments worth more than free market competition? Representatives aren't in office to protect peoples investments. They are in there to protect God given rights.

The Beacon center published an article calculating all the lost revenue to our Tennessee communities due to denied certificate of need applications.

The Cost to Washington County alone was $160,855,577.

They claim some of those were eventually allowed, missing the bigger picture. They shouldn't be denied by our government in the first place.

At the end of the day there is Representative Bud Hulsey's quote. "What happens when healthcare and the government are the highest law in the land?"

It's too much consolidated power out of the hands of the people. Repeal con and COPA. Reinstate choice. Thank you

I wrote this article about the hearing

So, as I was reading overwhat I wrote I realized I didn't mention some key points:

1. My dad died at a Ballad Health ran facility in Kingsport named Holston Valley Hospital on January 27th 2023. His arrival at this Ballad funded hospital began January 23rd 2023 @ 11 am eastern time. That is when he arrived at the ER. At some point around 11:30 am his name was put into the system, his blood drawn and for some odd reason he was given a CT OF HIS BRAIN and not his heart. Then he was placed in the ER waiting room with the promise he was first in line for a bed in the ER.
2. When I got off work, I headed 30 minutes drive to see what progress was being made with my dad. My husband went to find my dad and I sat down at the receptionist desk to find out if he was in the hospital system and was told yes. I then asked why he was still in the ER waiting room because he had been there since 11am et that morning. I was told "we are full, but he is next in line." I asked if I could speak with the head nurse who was in charge of the ER and was told yes. The receptionist left to give my message (I assumed) and informed me that she would come find me in a few minutes. Well minutes turned to hours. I went back to the receptionist and asked her what happened with the head nurse coming to check on my dad because he informed me that since he had had his blood drawn and CT of his head no one had checked on him. I was told the NP (nurse practitioner) had been checking on him. I asked when exactly that had happened and was told "not sure, but she is." I explained I did not understand how the NP could have done that since no one had checked on him since I had been there and he had no IVs or monitors on his body. No explanation.

I shall return to finish this extremely deathly experience! So keep waiting. If you care.

Ginger Ketron, LCSW
Clinical Counselor

[redacted]

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Dear Tennessee Department of Health Officials:

I am writing this on behalf of the many patients in Northeast Tennessee and Southwest Virginia who have relayed stories about their experiences with Ballad Health.

I am a dermatologist in private practice with the largest (by far) dermatology group in our area. We have 3 offices, 20 providers, and see hundreds of patients a day. We take Medicare as well as and Virginia Medicaid so we see the entire spectrum of the population. We see infants to the elderly. It's like primary care in the breadth of the type of patient we see but we see a much greater volume given the limited scope of our practice.

We stopped doing hospital consults when the hospitals started using Epic. So we were out of the hospital before the merger and really, I didn't have a strong feeling one way or the other about whether Ballad was a better situation for our patients than Wellmont/Mountain States.

I understand the purpose of this hearing is to get a fair and balanced assessment of whether the COPA and Ballad Health have, on balance, offered a net benefit to our community. I am in the unique position of not having any affiliation with either Ballad or either of the large multi-specialty groups in the area. I offer my insights purely on behalf of the patients that have shared their stories.

There is a bit of a joke in dermatology that we could take better care of our patients if they would stop talking and let us just do our exam. To that end, we try to elicit a very focused history. Imagine then my surprise when the stories about Ballad started rolling in nearly immediately after the merger. As I mentioned above, I do NOT ask about recent experiences with the hospital system. It simply isn't relevant to my care. But patients started having such negative experiences that they simply couldn't imagine it not being cogent to any interface with a health care provider.

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What I heard (and continue to hear) most:

Costs have gone up astronomically and are a real burden for many patients. My own child's INSURED self-employed drum teacher got a snake bite which led to dramatic swelling within minutes. The second bite he got was a $325,000 bill for a 15 hour stay and a few doses of anti-venom in the Bristol hospital ER. His bill was processed incorrectly as out-of-network but it took pulling strings and knowing the CLO at Ballad to get it fixed!! I really wish I had made some notes of how many of these stories I've gotten. Patients know we are not affiliated and so they don't want me to try to help them handle it. They have just been so traumatized by their bill they just want to feel heard.

Overcrowding in the ER is so bad that it is now the expectation of the patients that mention it to me that you will spend 2 days in the ER and may very likely sit in a hall. It is also well known that medical care is being delivered in the waiting room. I took a young friend to the Holston Valley ER and she gave her entire history to the nurse in the waiting room—a ridiculous privacy violation but better than the patient whose EKG was done sitting up in the waiting room. My friend was then "roomed" in what had been a fast-track asthma care chair for a day until discharge.

Patients do say that the doctors and nurses that deliver care at Ballad hospitals are empathic and seem well-trained. Our office is able to communicate with Ballad-owned physician practices and get records in a timely fashion. Ballad isn't all bad, of course, but if you were to ask me, an accidental collector of stories about patients' experience with Ballad if, on balance, our community is better off with this merger, my answer is no. The quality of medical care is down. The costs are up.

I know it has to be hard to distill all the voices (some very vociferous) but I have to say that the patients here deserve better. I hope you can be courageous and at least investigate the complaints about Ballad you are hearing.

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What do I want you to do with this letter?
Know that the VAST majority of the patients I see are VERY concerned about how Ballad is handling the hospitals in our area. I don't know what you're hearing but my patients are worried and alarmed. Ballad touts awards they received through CareChek which is a thinly veiled pay-to-play rating company. If you check their performance on more independent hospital ranking websites like Leapfrog, the story is very different. Here is the link to their most recent score:
https://www.hospitalsafetygrade.org/search?findBy=city&zip_code=&city=KINGSPORT&state_prov=TN&hospital=

Spoiler alert: they got C's and D's

Please hold Ballad accountable for the standards they promised for our emergency department—it feels like a third world country in there.

Please hold Ballad accountable for not price-gouging patients—the billing is predatory

I can't emphasize enough that I don't have a political or professional affiliation with the hospital so I don't care if Ballad stays in charge if they become better stewards of our patients and community resources. Please help us pressure them to help rekindle the amazing quality of medical care that I discovered when I moved here from Duke.

Thank you for your consideration.

Respectfully,

Joni Sago, MD

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Formstack Submission For: COPA Form
Submitted at 06/13/23 10:13 AM

Name:	Laurie Hubbard
Email:	
Zip Code:	37664

My name is Laurie Hubbard and I live in Kingsport, TN. I am writing to voice my concerns regarding the COPA in place that has allowed Ballad Health to monopolize this area over the last several years.

Our healthcare here has consistently gone downhill since Ballad took over. Before this all happened, you could put Holston Valley Medical Center up against any hospital in this entire nation. We had it all when it came to quality healthcare. Fast forward to 2023, and that is no longer the case. We have lost our NICU and our level 1 trauma center. Other specialties that have left are gastroenterology and neurology, among others.

If you are involved in an accident and are considered trauma, you have to be taken to Johnson City Medical Center, about a 25-30 minute drive, and since the ambulances stay so backed up at the understaffed ER, you most likely have to go by helicopter instead, which is not covered by most people's insurance. A ride for that short distance is about $30,000. Not much of a public advantage, right??? Oh, and by the way, once you get to JCMC, you are in much the same boat. They have most of what you need there as far as specialties, trauma, etc, but what they don't have is enough staff to care for the volume of patients coming through.

Comment:

Of particular concern though is the fact that our ER at Holston Valley is in the worst shape I've ever seen it. Because of Ballad's policies and treatment of it's nurses, no one wants to work for them. Travel nurses don't want to come here anymore either! They do not have the staff to take care of the demand, so people are being treated in the waiting room around everyone else. (I'm sure HIPPA laws must play a part in all of this.) I was in utter shock and amazement when I saw it for myself back in August of 2022. It looked like what you might see in a third world country. It was a sad sight for sure.

You see, I was there to see my aunt who was there the previous day for concerns of a stroke. She had had 3 in the past and she and her family knew the signs and symptoms. She was unable to put any weight on her legs and could not walk. This was related to EMS by 911 call. She was taken to Holston Valley, sat all day in the waiting room when finally blood work and a urine was done and she was told she had a urinary tract infection, given a shot of Rocephin and sent home. By the next morning, she was worse. 911 was called again and she was again taken back to Holston Valley. This time she received the proper testing, but unfortunately it was too late. She had indeed had another stroke and they missed the window to give TPA for her ischemic stroke which took place 24 hours prior. Her life and the lives of her family are forever changed. She no longer has the use of her right arm and can no longer stand and walk on her own.

It's honestly scary to think about my young adult children on the road, and also scary to think about getting older here in this community. My family and I have honestly considered moving because of the lack of accessible healthcare in this region. Even now, I've told my family that if we need an ER, unless it is down to life and death, we are either going to Knoxville, Pikeville, KY, or Asheville, NC. And if it is life and death and we have no choice but to use Ballad, we better pray hard that God intervenes. That's a terrible way to feel when you think of what you have to deal with here in case of a real emergency.

Yet, on TV and on billboards around, Ballad touts of their achievements and awards. There's the way they display themselves and then there's the way it really is, the way everyone else here in the region knows it is.

This monopoly has been anything but a public advantage. Ballad has taken away one of the best things Kingsport had going for it besides Eastman Chemical Company. Speaking of Eastman Chemical, if there ever happens to be an explosion or accident that affects a lot of people at one time, we're going to be in serious trouble, being the closest level 1 trauma center is 25 minutes away and the EMS system is already stressed as it is.....again, not a public advantage.

I attended the local COPA hearing at Northeast State last night. All I heard positive about Ballad are the partnerships and organizations they have helped to better. However, patient care was consistently reported as neglectful. Patients are reported having to wait at Holston Valley for as much as 90 hours with brain bleeds to be transported to Johnson City Medical Center to be seen by a neurosurgeon. Also reported was the fact that patient's are being treated in the waiting room of the ER around everyone else with no privacy and being given Morphine in the waiting room! This has to stop! We have lost services to the point of it being a danger for anyone needing emergency care.

So, I'm asking you to do the right thing and not allow this monopoly to exist any longer. All of us are praying for some relief , or at least praying that another hospital system come in and rescue us. We've got to have some competition in this area again. Where there's no competition, they don't have to strive to be any better.

Ballad's motto is "It's your story, we're listening". They didn't listen to my aunt and they haven't listened to countless others. We're asking that you listen to us and allow real change to happen in our healthcare system again.

Laurie Hubbard

From:
Sent: Monday, June 12, 2023 9:26 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] COPA

Thank you for allowing me to share my thoughts regarding COPA.

Our nation has always thrived under competition and the free market. From personal experience, I can tell you that competition made me a better, caring physician. It was also better when the patients had the freedom to choose a physician that they trusted.

However, when you introduce the government into the capitalistic experience, corruption and inefficiency soon follow. No matter how many times that we are told that consolidation and monopolies benefit the public better than competition, it never works that way.

I would ask that you allow competition to take place and allow the free market to operate instead of the government picking winners and losers.

Thank you.

Mark Donovan, M.D.

Formstack Submission For: COPA Form
Submitted at 06/13/23 8:47 AM

Name:	Nathaniel Foran
Email:	
Zip Code:	37615
Comment:	I am calling to lodge a complaint about the Ballad Health care system we have in East TN. Since the merger the availability of care and the quality of care has continued to erode here in the Tri-Cities area. I have personally experienced this many times when visiting the ICU as a patient and when visiting family. In 2021 I was a patient twice in the ICU at the Johnson City Medical Center. 1st as a COVID 19 patient and 2nd as a heart attack patient. Ballad let so many staff go and closed so many emergency rooms and other hospitals that I spent the night in a hospital bed in the hall way. It took hours to see a doctors, and with an incredible case load they were using travelling nurses from New Jersey to fill staffing needs instead of hiring local folks. We have to wait for months to see a specialist now. I'm taking my daughter to Vanderbilt over 4 hours away because of the lack of care in our area for her pediatric arthritis. My son can't get an appointment even after losing 45 lbs in 4 months due to a gastro-intestinal problem. The GI doctors office says, "that is really bad "we can see you in 4 months..." I have lived in this area for almost 25 years and lived oversees and in other states. The health care under Ballad is getting close to what I experienced in Brazil, a 3rd world country. My children actually received better care down in Sao Paulo than they have received here in East

TN.
Ballad needs to stop putting profits ahead of people. The lack of hospitals and lack of good doctors here in the area is shameful.
I know many nurses and doctors that have left this area to go do better hospital systems because of the way they have been treated. Holston Valley used to have a good gastro wing. Now they don't even have one. Even though they won and "award" for having a great program. It doesn't actually exist!!!

Formstack Submission For: COPA Form
Submitted at 06/13/23 4:54 PM

Name:	Petra Armstrong
Email:	
Zip Code:	37642
Comment:	We were told to submit any complaints about the Ballad Health COPA on line. I have lived in the Kingsport area for 50 years, worked for the health system here for a total of 28 years and have been proud to say I worked there, but not anymore. The care here since the inception of Ballad has been horrible and is now boarding on criminal. We heard complaints about cost- how is it cost effective to have to air lift victims of MVAs that happen less than 5 miles from HVMC to JCMC for treatment? How is it not criminal to tell patients they need to go to JCMC to save them , and in the same breath tell them that there is no bed available? Taking the biggest hospital in this area(HVMC) and moving services to JCMC who in no way can accommodate the needs of the entire area, denying patients needed care due to unavailability is criminal. How many patients did not live through the transport? You don't have to be a Level 1 Trauma Center to treat many of the services they pulled out of Kingsport and surrounding areas. Shame on all of you for allowing this to happen. Patients well-being is being placed in jeopardy by you and those that supposedly take this regions healthcare to heart. GI services, Neuro Services, Labor and delivery services and others should be available in every region in this area. I worked these hospital and know how much these services are needed and I am also aware, from personal experience how Mr.

Levin with the help of politicians and others manipulated this area and is sending us down the drain. I agree with other speakers check your numbers, data can be manipulated. Check the CM/S numbers and where these hospitals place overall when the awards can't be bought.

From: [redacted]
Sent: Monday, June 12, 2023 5:57 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Ballad Health

Hello my name is [redacted], MD. It is my firm opinion that Ballad delivers severely substandard healthcare. I am a fully trained neurologist with advanced training in stroke care. Ballad at the Johnson City Medical Center mismanaged my mother's care. She left the medical center with no speech and no movement of her right limbs. The improper nursing care left her with " bed sores". After Ballad purchased most of private doctor practices and most of the hospitals within a 100 mile radius, the quality of healthcare has declined markedly. Please consider this fact as this inquiry makes its decisions. Respectfully, [redacted], MD Sent from my iPhone

Formstack Submission For: COPA Form
Submitted at 06/13/23 10:02 AM

Name:	Keith Davenport
Email:	
Zip Code:	37620
Comment:	I worked briefly as a Corporate Staff Accountant for the Ballad Retail Pharmacy department but decided to resign after two months because I wasn't comfortable with their accounting practices. Having worked in Fortune 500 companies at Eastman, King Pharma/Pfizer, & GSK, we had tight controls in compliance with Sarbanes-Oxley regarding Financial Reporting. My biggest concern with Ballad was the lack of management over site prior to uploading JE's into the ledger in Lawson. There were many reviews after the upload, but from my experience, you never want that erroneous financial data to be posted to the ledger because it can get buried in the results. And in Retail Pharmacy, I discovered such erroneous data impacting revenue & COGS. As a result of the merger, Ballad still has a mix of legacy Mountain States and Wellmont systems with Epic vs Lawson. I would think that would merit greater management review of financial data PRIOR to it be posted to the general ledger. And it's an easy business process fix, just remove posting access from the analyst roles and only give it to the manager & above as part of their approval responsibilities. Again, I remember our external auditors requiring that sign off in compliance with Sarbanes-Oxley to ensure adequate management review. I reported my concerns to my immediate supervisor and her boss in a TEAM's meeting on 11/29/22 and my exit interview with the Work

Institute on 12/27/22 who flagged it as a potential compliance issue with COPA financial reporting in the State of Tennessee and similar agreement with the Commonwealth of Virginia. It might be worth auditing this business process by the Tennessee state auditors for the Ballad COPA. Thanks for allowing this public comment forum online.

From: Shea Sproles
Sent: Wednesday, June 14, 2023 12:23 PM
To: TN Health <TN.Health@tn.gov>
Cc:
Subject: [EXTERNAL] Ballad Healthcare-COPA input

Good morning. I was unable to attend the Ballad COPA Review Meeting at Northeast State in Blountville, TN on 6/12/23. I am reaching out to you to share our experience at Ballad-Indian Path Hospital in Kingsport February 20, 2023 regarding lack of access to emergency care.

My husband is a current cancer patient at Ballad as well as at Vanderbilt Medical Center. He is a Medicare patient. On Thursday, February 16 he had an outpatient procedure at Indian Path Hospital. From start to finish we had a good experience while he was at Indian Path that day. He started having some complications from the surgery on Sunday/Monday to the point it was becoming a medical emergency(blockage/blood clot). Monday afternoon(February 20) his doctor told him to go to Indian Path ER.

We arrived around 6pm. The waiting room was full. I told the receptionist he was a cancer patient and had a blockage. He was in so much pain and spent most of the time in the bathroom while we were there. I saw one person leave after being treated and one person be taken back the entire time we were there. Other patients waiting shared they had been there 4-5 hours. Based on those time estimates, there was no way my husband could wait that long while in that much pain. I never saw a nurse come out to check on anyone, take vitals, etc. There was NO TRIAGE while we were there. The Indian Path ER appeared to be like an urgent care clinic-first in, first out. We left without my husband being seen after talking to the receptionist, who verified it would be a long wait. My husband did get some relief after we left. If that hadn't happened we would have tried another hospital. His doctor saw him the next morning. He agreed his issue was a medical emergency that we could not get help for.

I have, unfortunately, spent a lot of time during the past five years in medical and hospital environments as my husband's caregiver. We spent two months living in Nashville while he underwent a stem cell transplant at Vanderbilt. He's had numerous medical procedures at Ballad and Vanderbilt. He's been a chemo patient for four years at Ballad Oncology. What I saw on 2/20/23

at Indian Path ER is not the way hospital ERs are supposed to work.

Ballad's response has been:
* Rebecca Beck responding to the email I sent her and Jennifer Bogni, a friend who is Chairman of the Board at Holston Valley/Indian Path.
* Kristin Looney, Indian Path ER Director, calling me to discuss the issues we had. She couldn't dispute any of the issues I identified. I reached back out to Rebecca Beck and Jennifer, letting them know the issues were not resolved.
* Rebecca Beck responded back and copied additional Ballad employees. I never heard from anyone else.

I filed a complaint with the State of Tennessee Health Facilities Commission(HDSA). Their investigation showed no laws were broken.
I plan to file a complaint with Medicare.

The issues with Ballad's Emergency Rooms are widely known. But when you experience it yourself it really opens your eyes. For people living in this region, Ballad is our only Emergency Room option. Ballad is a monopoly and with that comes great responsibility.

Shea Sproles
[redacted]

From: Teresa Stephens
To: Judi Knecht
Subject: [EXTERNAL] Re: FW: Ballad COPA Hearing
Date: Thursday, June 22, 2023 7:21:06 AM

Thank you, Judi! I appreciate you sharing this list. I should note that multiple people saw Miles Burdine (#2 on the list) arrive only moments before the session began. In fact, a Ballad representative was waiting on him in the parking lot to escort him in. Perception is that some individuals who spoke were signed in by others (Ballad reps) to make sure they were given priority. I did not witness this, but this is widely reported by multiple, reputable individuals. If identifications were not verified, this may have resulted in unfair advantage.

Again, thank you for sharing.
Tese Stephens

On Wed, Jun 21, 2023 at 1:57 PM Judi Knecht <Judi.Knecht@tn.gov> wrote:

> Teresa,
>
> Thank you for contacting the Tennessee Department of Health with your questions.
>
> Our Department was responsible for the sign-in process, and we had an employee handling the sign-in sheet. We allowed for 60 speaker slots in the time we had got the hearing.
>
> Each person signed themselves in. It wasn't permissible to sign multiple people in.
>
> Please find attached the list of speakers.
>
> Thank you,
>
> Judi
>
> **Judi Knecht, MPH, PMP** | Certificate of Public Advantage, Assistant Director
>
> Division of Health Planning
>
> Andrew Johnson Tower, 5th Floor
>
> 710 James Robertson Parkway

Nashville, TN 37243

615-253-9979

judi.knecht@tn.gov

tn.gov/health

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Our Mission – To protect, promote and improve the health and prosperity of people in Tennessee.

From: TN Health <TN.Health@tn.gov>
Sent: Wednesday, June 14, 2023 8:40 AM
To: Teresa Stephens
Cc: Judi Knecht <Judi.Knecht@tn.gov>
Subject: Ballad COPA Hearing

Thank you for contacting the Tennessee Department of Health. By copy of this email, I am sharing your email with the appropriate team member to address your inquiry.

Best regards

From: Teresa Stephens
Sent: Wednesday, June 14, 2023 7:21 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Ballad COPA Hearing

***** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. *****

Good Morning!

I am writing in reference to the Ballad COPA hearing held on Monday, June

12th. I am not a Ballad employee, but a nurse scientist and consultant who has worked with many of the nurses in the region.

Many individuals had followed the directions given in preparing to speak for 3 minutes, arriving early and signing in as directed. Several individuals who spoke early in the session were observed to arrive late and did not personally sign in. This has raised much suspicion on the ethical nature of this process.

Who was responsible for the sign-in process? Were individuals allowed to sign-in others who were not yet present? Where is the list available for review?

Thank you!

Teresa M. Stephens

--

Teresa M. Stephens, PhD, MSN, RN, CNE

Nurse Educator & Consultant, Resilience Researcher, & Chief Boat Rocker

https://rn-prep.com/

"For such a time as this....." Esther 4:14

Getting this email out of your working hours? We work at a digitally-enabled (often relentless) pace, which can disrupt our ability to sleep enough, eat right, exercise, and spend time with the people who matter most. I am sending this email at a time that works best for my life-work harmony. I do not expect an immediate response. Please feel free to respond, as appropriate, when convenient for you.

--
Teresa M. Stephens, PhD, MSN, RN, CNE
Nurse Educator & Consultant, Resilience Researcher, & Chief Boat Rocker
https://rn-prep.com/

"For such a time as this....." Esther 4:14

Getting this email out of your working hours? We work at a digitally-enabled (often relentless) pace, which can disrupt our ability to sleep enough, eat right, exercise, and spend time with the people who matter most. I am sending this email at a time that works best for my life-work harmony. I do not expect an immediate response. Please feel free to respond, as appropriate, when convenient for you.

From:
To: Judi Knecht
Subject: [EXTERNAL] Re: Input for Ballad COPA 6/12/23 Hearing
Date: Tuesday, June 13, 2023 9:12:39 AM
Attachments: Ballad COPA Analysis - R3-6.4.pdf

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Sorry. Here you go …

Wally Hankwitz

> On Jun 13, 2023, at 9:07 AM, Judi Knecht <Judi.Knecht@tn.gov> wrote:
>
> I see nothing attached. Please resend.
>
> Thank you,
>
> Judi
>
> Judi Knecht, MPH, PMP | Certificate of Public Advantage, Assistant Director
> Division of Health Planning
> Andrew Johnson Tower, 5th Floor
> 710 James Robertson Parkway
> Nashville, TN 37243
>
> 615-253-9979
> judi.knecht@tn.gov
> tn.gov/health
> Connect with TDH on Facebook and Twitter @TNDeptofHealth!
> Our Mission - To protect, promote and improve the health and prosperity of people in Tennessee.
>
> -----Original Message-----
> From: TN Health <TN.Health@tn.gov>
> Sent: Monday, June 12, 2023 5:19 PM
> To: awhankwitz@mac.com
> Cc: Judi Knecht <Judi.Knecht@tn.gov>
> Subject: Input for Ballad COPA 6/12/23 Hearing
>
> Thank you for contacting the Tennessee Department of Health. By copy of this email, I am sharing your email with the appropriate team member to address your inquiry.
>
> Best regards
>
> -----Original Message-----
> From:

> Sent: Monday, June 12, 2023 5:06 PM
> To: TN Health <TN.Health@tn.gov>
> Subject: [EXTERNAL] Input for Ballad COPA 6/12/23 Hearing
>
>
> *** This is an EXTERNAL email. Please exercise caution. DO NOT open attachments or click links from unknown senders or unexpected email - STS-Security. ***
>

From:
Date: June 30, 2023 at 2:38:48 PM EDT
To: Judi Knecht <Judi.Knecht@tn.gov>
Subject: [EXTERNAL] Ballad COPA Compliance - Updated and Revised

Hi Judi,

I wanted to get this to you before the ‘end of month’ deadline. Please replace the one previously sent w/this.

Thanks and enjoy the holiday weekend!

Wally

From:
To: Judi Knecht
Cc: James Mathis
Subject: Re: Automatic reply: [EXTERNAL] Ballad COPA Compliance - Updated and Revised AUGMENTED!
Date: Sunday, July 2, 2023 7:53:59 AM
Attachments: Ballad COPA Analysis- 6.30.23 updaterevised.pdf

Hi Judi,

Attached please find the report sent Friday, subsequently augmented by adding explanatory arrows to the schedules appearing on pages 15 and 16. Please replace the report sent Friday with the attached. Thank you.

Wally Hankwitz

REVIEW of BALLAD HEALTH'S COPA COMPLIANCE
Updated and Revised June 30, 2023

After years of public testimony, FTC remonstrance, community opposition, and political maneuverings, in late 2017 the Tennessee Department of Health (TDH) approved a Certificate of Public Advantage (COPA) allowing Mountain States Health Alliance and Wellmont Health System, the only two hospital systems serving a geographical area consisting of 10 counties in Northeast Tennessee and 11 counties and two independent cities in Southwest Virginia, to create a 21-hospital monopoly by merging into a single entity named Ballad Health. This action, in effect, replaced market competition with government regulation.

The TDH has the authority to issue a COPA if the applicant demonstrate that the **likely benefits** of the proposed Cooperative Agreement **outweigh the likely disadvantages** that would result from the loss of competition. As part of the COPA, the TDH requires Ballad Health to reinvest expected savings from the merger in ways that would substantially benefit residents living in the system's geographic service area. The State requires the formerly competing systems to agree to a number of terms and conditions that were set out in the Terms of Certification (TOC), a document governing the COPA.

The TOC states that the system would be "Actively Supervised" by the State and subject to an annual review to track and evaluate the demonstration of ongoing Public Advantage in four categories (sub-indices):

- Economics
- Population Health Improvement
- Access to Health Services
- Other (primarily quality of care)

Presentation and discussion of data from Ballad's Annual Reports and other reliable publicly available sources addressing each of these four categories appear below.

ECONOMICS

Financial Health

Ballad's financial health, although not currently rated negatvely by Wall Street analysts, is not sufficient to fund the entirety of the monetary commitments made in the COPA without cost-shifting or some other action drastic to the community. Cost-shifting typically consists of increasing commercial rates (those charged to local employers) significantly higher. Ballad is precluded from increasing its commercial rates above the maximum thresholds designated in the COPA without TDH approval.

Ballad reports that about 75% of their business is Medicare/Medicaid, receives about the lowest Medicare reimbursement in the country, and carries an annual debt service

of about $100 million. A schedule portraying Ballad's aggregate Profit / (Loss) from inception (2/1/18) through 3Q23 (3/31/23) appears below:

Ballad Health Financial Profit/(Loss) from Inception - 3Q FYE23				
Reporting Period	**CARES Act (Covid) Relief Funds**	**System Revenues**	**System Profit / (Loss)**	**Cumulative Profit / (Loss)**
5 mos ending 6/30/18	$0	$858,769,000	-$35,735,000	-$35,735,000
FYE 6/30/19	$0	$2,106,465,000	$94,919,000	$59,184,000
FYE 6/30/20 *	$82,493,999	$2,077,520,000	-$27,760,000	$31,424,000
FYE 6/30/21	$96,673,520	$2,191,638,000	$267,219,000	$298,643,000
FYE 6/30/22	$62,614,723	$2,312,916,000	-$135,262,000	$163,381,000
3Q FYE 6130/23	$0	$1,757,164,091	$38,156,385	**$201,537,385**
Source: Financial statements prepared by PYA, Ballad's auditors				
Footnotes: * Ballad received approximately $200 million in advanced payments Service revenue includes Covid and other relief funds				

Ballad generated an aggregate profit of $201.5 million since inception. This aggregate profit includes in excess of $241.7 million in Covid and relief funds, specifics of which appear in the schedule below.

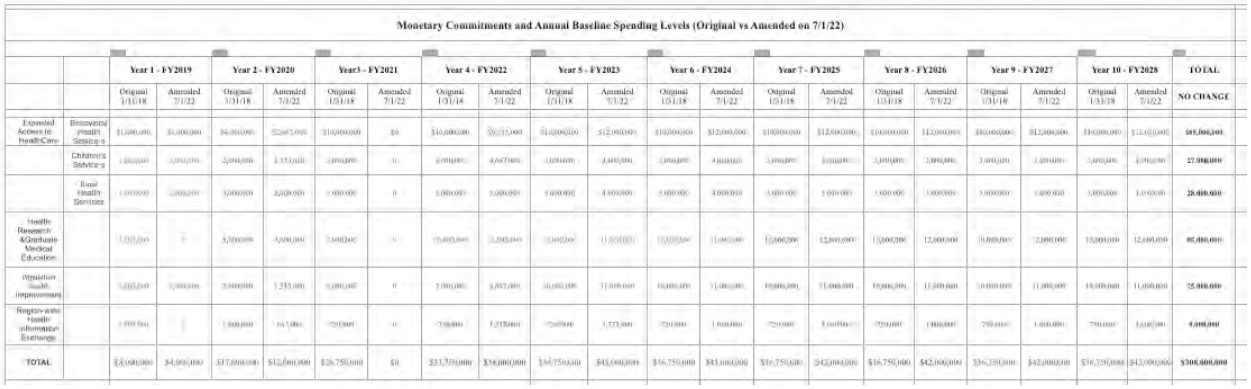
Ballad Health Financial Profit/(Loss) from Inception - 3Q FYE23 w/out Covid Relief Funds				
Reporting Period	**CARES Act (Covid) Relief Funds**	**System Revenues**	**System Profit / (Loss)**	**Cumulative Profit / (Loss)**
5 mos ending 6/30/18	$0	$858,769,000	-$35,735,000	-$35,735,000
FYE 6/30/19	$0	$2,106,465,000	$94,919,000	$59,184,000
FYE 6/30/20 *	$82,493,999	$2,077,520,000	-$110,253,999	-$51,069,999
FYE 6/30/21	$96,673,520	$2,191,638,000	$170,545,480	$119,475,481
FYE 6/30/22	$62,614,723	$2,312,916,000	-$197,876,723	-$78,401,242
3Q FYE 6130/23	$0	$1,757,164,091	$38,156,385	**-$40,244,857**
TOTAL Since Inception	$241,782,242	$11,304,472,091		**-$40,244,857**
Source: Financial statements prepared by PYA, Ballad's auditors				
Footnotes: * Ballad received approximately $200 million in advanced payments Service revenue includes Covid and other relief funds				

Without the Covid relief funds rescue, Ballad would have generated a loss of more than $40.2 million. It appears that Ballad's financial health is not sufficient to fund the entirety of the monetary commitments made in the COPA without government subsides, cost-shifting, or some other action drastic to the community.

Monetary Commitments

Based on a COPA amendment signed on 7/1/22, it appears that the $267 million profit in FY21 includes a complete waive of the $28.750 million originally committed when the COPA was approved in 2018. Even though Ballad accumulated an aggregate profit of nearly $300 million since inception through FY21, COPA compliance regulators decided to move the goal posts.

Below is a schedule showing the change in annual monetary commitments as of 7/1/22:



Monetary Commitments and Annual Baseline Spending Levels (Original vs Amended on 7/1/22)

		Year 1 - FY2019		Year 2 - FY2020		Year3 - FY2021		Year 4 - FY2022		Year 5 - FY2023		Year 6 - FY2024		Year 7 - FY2025		Year 8 - FY2026		Year 9 - FY2027		Year 10 - FY2028		TOTAL
		Original 1/1/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	Original 1/31/18	Amended 7/1/22	NO CHANGE
Expanded Access to HealthCare	Behavioral Health Services	$1,000,000	$1,000,000	$4,000,000	$2,267,000	$10,000,000	$0	$16,000,000	$9,375,000	$12,000,000	$12,000,000	$10,000,000	$12,000,000	$10,000,000	$12,000,000	$10,000,000	$12,000,000	$10,000,000	$12,000,000	$10,000,000	$12,000,000	$85,000,000
	Children's Services	1,000,000	1,000,000	2,000,000	1,133,000	3,000,000	0	2,000,000	4,667,000	3,000,000	3,000,000	3,000,000	4,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	27,000,000
	Total Health Services	2,000,000	2,000,000	6,000,000	3,400,000	13,000,000	0	18,000,000	14,042,000	15,000,000	15,000,000	13,000,000	16,000,000	13,000,000	15,000,000	13,000,000	15,000,000	13,000,000	15,000,000	13,000,000	15,000,000	112,000,000
Health Research &Graduate Medical Education		7,500,000	0	3,000,000	3,000,000	3,000,000	0	12,000,000	12,000,000	12,000,000	11,000,000	12,000,000	11,000,000	12,000,000	12,000,000	12,000,000	12,000,000	10,000,000	2,000,000	10,000,000	12,000,000	85,000,000
Population Health Improvement		7,500,000	7,500,000	3,000,000	1,733,000	9,000,000	0	7,000,000	6,667,000	10,000,000	11,000,000	10,000,000	11,000,000	10,000,000	11,000,000	10,000,000	11,000,000	10,000,000	11,000,000	10,000,000	11,000,000	75,000,000
Region-wide Health Information Exchange		1,000,000	0	1,000,000	667,000	750,000	0	750,000	1,375,000	750,000	1,375,000	750,000	1,000,000	750,000	1,000,000	750,000	1,000,000	750,000	1,000,000	750,000	1,000,000	8,000,000
TOTAL		$18,000,000	$11,000,000	$17,000,000	$12,000,000	$26,750,000	$0	$53,750,000	$48,000,000	$43,750,000	$43,375,000	$36,750,000	$43,000,000	$36,750,000	$42,000,000	$36,750,000	$42,000,000	$36,750,000	$42,000,000	$36,750,000	$42,000,000	$308,000,000

Review of the above schedule reveals that Ballad's commitment was initially back-end loaded: i.e., a small amount in the beginning escalating to much larger amounts in future years. The initial loading was $87.500 million (28.4%) in the 1st 4 years, with the remaining 71.6% being expended in the following 6 years. As of 7/1/22, Ballad's commitment was decreased to $54 million (17.5%) in the 1st 4 years, with the remaining 82.5% to be expended in the following 6 years.

Below is a schedule portraying Ballad's spend on monetary commitments revised by the regulators on 7/1/22 through FY22.

Ballad Health Spend Through FY 22 - Revised

COPA Plan	Total Spending Commitment	Revised COPA Commitment FY19-FY22	Actual Plan Spend FY19-FY22
Behavioral Health	$85,000,000	$13,000,000	**$9,944,442**
Children's Health	27,000,000	7,000,000	**7,914,362**
Rural*	28,000,000	8,000,000	**28,203,541**
Population Health	75,000,000	9,000,000	**16,371,959**
HR/GME	85,000,000	15,000,000	**19,583,944**
HIE	8,000,000	2,000,000	**631,145**
TOTAL	**$308,000,000**	**$54,000,000**	**$82,649,393**

* Includes credit for reopening Lee County Community Hospital

Red font indicates plans where spend is currently below commitment

Review of the above schedule reveals that even after the goal posts were moved and aggregating a cumulative profit of $163 million since inception, Ballad's monetary spend on COPA obligations was below commitment on two of the six areas.

Below is a schedule portraying Ballad's spend on monetary commitments based on the original COPA contract agreed to by all parties.

Ballad Health Spend Through FY 22 - Initial Contract

COPA Plan	Total Spending Commitment	Initial COPA Commitment FY19-FY22	Actual Plan Spend FY19-FY22
Behavioral Health	$85,000,000	$25,000,000	**$9,944,442**
Children's Health	27,000,000	9,000,000	**7,914,362**
Rural*	28,000,000	10,000,000	28,203,541
Population Health	75,000,000	15,000,000	16,371,959
HR/GME	85,000,000	25,000,000	**19,583,944**
HIE	8,000,000	3,500,000	**631,145**
TOTAL	**$308,000,000**	**$87,500,000**	**$82,649,393**

* Includes credit for reopening Lee County Community Hospital
Red font indicates plans where spend is currently below commitment

Review of the above schedule reveals that if the goal posts were not moved, its aggregated cumulative profit of $163 million since inception, thanks to government Covid relief funds, would be more than sufficient to fully fund and spend on all of the original commitments made. The $5.1 million difference between the initial $87.5 commitment and $82.6 actual spend would have been a mere 6% of Ballad's aggregated cumulative profit since inception.

Because of the government's influx of Covid relief funds, Ballad's financial health would have been sufficient to fund the entirety of the monetary commitments made in the COPA. Without such funding going forward, however, leaves Ballad Health with seven options: 1) raise another round of capital at unfavorable (high interest rate) terms, 2) cost-shift to charge rates higher than the limits agreed to in the COPA, 3) initiate more employee layoffs to save cash, 4) sell the system (as Mission did in North Carolina), 5) obtain more TDH waivers to the TOC, 6) unwind the merger and allow market competition to prevail, or 7) close more hospital services that displaces staff and impedes community access as has been done at Holston Valley Medical Center (close the NICU and downgrade Trauma), Bristol Regional Medical Center (downgrade Trauma), Sycamore Shoals (close the ICU), etc.

Charity Care

Ballad Health is a very large "non-profit" monopoly that exercises enormous market power in competition with independent community healthcare providers. Ballad's "non-profit" designation allows them to avoid paying taxes. Unlike for-profit companies, like independent providers and most other small businesses, "non-profit" hospitals pay no

taxes. They pay no property tax, no state excise tax, no federal income tax, and no sales tax. In exchange, a charitable organization is supposed to plough what they would have paid in taxes back into the community, largely by way of maintaining lower healthcare costs or providing free charity care for those who can't otherwise afford it.

Is that what Ballad and other systems doing as a "non-profit" hospital system? Or are would-be tax dollars going into seven-figure executive salaries, boondoggle retreats, extravagant galas, billboard ads, and to fund special interest lobbyists whose job it is to make sure the politicians sway legislation and regulation in the systems' favor?

"Ballad officials said they filed about 5,700 lawsuits against patients in its first fiscal year as a health system .... That's up from nearly 5,400 in the prior year … The not-for-profit health system has also filed roughly 900 liens in two Tennessee counties since it was formed." https://www.modernhealthcare.com/providers/ballad-health-sued-thousands-patients-poor-rural-area Is this how Ballad strives to stay true to its Mission, Vision and Values proudly displayed on its website?

The COPA TOC requires Ballad to provide a minimum level of charity care annually. A schedule portraying Ballad's charity care as a "non-profit tax exempt 501c(3)" hospital system appears below.

Base Charity	FY2017 Baseline	FY2017 Baseline Adjusted by FY2018 HIA*	FY2017 Baseline Adjusted by FY2019 HIA*	FY2017 Baseline Adjusted by FY2020 HIA*	FY2017 Baseline Adjusted by FY2021 HIA*	FY2017 Baseline Adjusted by FY2022 HIA*	FY2022 Actual as of 6/30/2022**
7(a) Charity Care 7(b) Unreimbursed	$ 35,034,403	$ 36,067,918	$ 37,204,057	$ 38,413,189	$ 39,431,139	$ 40,594,357	$ 21,678,321
TennCare and Medicaid	61,605,896	63,423,270	65,421,103	67,547,289	69,337,292	71,382,742	50,999,268
Total	**$ 96,640,299**	**$ 99,491,188**	**$ 102,625,160**	**$ 105,960,478**	**$ 108,768,431**	**$ 111,977,099**	**$ 72,677,589**
					Variance from Baseline		$ (39,299,510)

Review of the above schedule reveals Ballad Health's shortfall in community charity care exceeded more than $39 million in FY2022, the most recently year for which charity care was reported to the TDH in an Annual Report. Of this $39 million shortfall, more than 70% ($51 million) is attributed to unreimbursed TennCare and Medicaid. As Ballad offers discounted rates that are not considered community benefits for most insured patients, why are discounts for Medicaid patients an exception? Should the true charity care shortfall be closer to $90 million?

Defining and quantifying a reasonable amount of charitable care is just one of many issues being addressed in DC by the House Ways and Means Committee and the Senate Finance Committee. They are currently referencing the original Finance Committee staff discussion paper on non-profit hospitals (that was the foundation for the later ACA reforms) that justifies a 5% expenditure of expenses as the charity care requirement for non-profit hospitals. Applying this standard to Ballad would calculate to a $114.3 million requirement in FY22, $2.1 more than the adjusted baseline in the above schedule and resulting in a $41.4 million shortfall.

Ballad Health was not in compliance with the COPA's TOC charity care minimum expense requirement. Per the TDON Monitor's report, "The amount of charity care provided in fiscal year 2022 was below the minimum amount required by the TOC", yet TDH awarded Ballad a COPA 'passing score'.

Resource Allocation

Of note in Ballad's FY21 financial statements is their reallocation of resources from "healthcare services" (the primary reason for the system's existence) to "support services" in the midst of an epidemic. As seen in the schedule below, while total costs increased by 5%, there was a similar 5% swing in costs for each classification, up for support and down for healthcare. The rationale behind this is questionable as actual provider staffing costs throughout the country escalated (overtime, wage increases, travel nurses, etc.) during this time period.

Expenses by Functional Classification FY20 & FY21

	FY2020	FY2021	Percent change from '20 to '21
HEALTHCARE SERVICES			
Salaries and Benefits	$770,406	$831,857	7.98%
Supplies and Other	$635,914	$556,199	-12.54%
Prov for Depreciation & Amortization	$84,621	$82,109	-2.97%
Interest and Taxes	$43,434	$28,400	-34.61%
Total	$1,534,375	$1,498,565	-2.33%
Percent of Grand Total	74.57%	69.32%	
SUPPORT SERVICES			
Salaries and Benefits	$251,877	$188,158	-25.30%
Supplies and Other	$212,408	$379,460	78.65%
Prov for Depreciation & Amortization	$57,645	$83,051	44.07%
Interest and Taxes	$1,267	$12,614	895.58%
Total	$523,197	$663,283	26.78%
	25.43%	30.68%	
GRAND TOTAL			
Salaries and Benefits	$1,022,283	$1,020,015	-0.22%
Supplies and Other	$848,322	$935,659	10.30%
Prov for Depreciation & Amortization	$142,266	$165,160	16.09%
Interest and Taxes	$44,701	$41,014	-8.25%
Total	$2,057,572	$2,161,848	5.07%

An area further explored is Ballad's management staffing costs. Past analysis reveals that these costs increased about 20% from 2017 to 2020 Might it be time for Ballad to flatten its management structure to devote more resources to Healthcare Services?

A deeper dive into Ballad's senior management compensation reveals some unusual bonuses being issued in years of system financial losses. A summary showing a 4-year compensation for the five highest paid executives in 2021 follows:

Ballad Health Management Compensation 2018-2021

Name & Title		2018	2019	2020	2021	2022	5 Year Cumulative	Percent Increase
Alan Levine, Pres/CEO	Total Taxable	$1,480,042	$2,225,690	$2,370,420	$3,061,924	unknown	$9,138,076	106.88%
	Bonus	$277,123	$750,000	$805,867	$1,577,573	unknown	$3,410,563	469.27%
Marvin Eichorn, EVP/CAO	Total Taxable	$791,871	$1,049,589	$1,140,425	$1,357,948	unknown	$4,339,833	71.49%
	Bonus	$128,590	$300,000	346798	$576,630	unknown	$1,352,018	348.43%
Lynn Krutak, EVP/CFO	Total Taxable	$676,141	$994,315	$1,026,003	$1,207,029	unknown	$3,903,488	78.52%
	Bonus	$104,168	$250,000	$304,398	$494,254	unknown	$1,152,820	374.48%
Eric Deaton, EVP/COO	Total Taxable	$638,372	$613,225	$867,461	$1,134,234	unknown	$3,253,292	77.68%
	Bonus	$196,460	$40,165	$235,353	$447,591	unknown	$919,569	127.83%
• Tim Belisle, EVP/Gen Cnsl	Total Taxable		$656,696	$779,709	$865,432	unknown	$2,301,737	31.81%
	Bonus		$161,656	$250,626	$345,976	unknown	$758,160	114.02%
..... Grand Total	Total Taxable	$3,586,426	$5,539,415	$6,184,018	$7,626,567	unknown	$22,936,426	112.65%
	Bonus	$706,341	$1,501,821	$1,942,962	$3,442,025	unknown	$7,593,150	387.30%
Bart Hove, Retired 2/1/18 •		$1,269,485	$1,314,710	$980,153	$0	unknown	$3,564,348	
Net Operating Profit/ (LOSS)		-$35,735,000	$94,919,000	-$27,750,000	$267,219,000	-$135,262,000		

Source: IRS 990 Schedule J and
Financial Statements prepared by PYA, Ballad's auditor

Review of the above schedule reveals that the system realized more expenses than revenues (loss) in 3 of its 5 years since inception. The schedule also reveals that bonuses totaling in excess of $7.5 million and consistent salary increases were granted regardless of the system's financial performance, bonuses comprising anywhere from 24 - 38% of total compensation… the 38% being Ballad's President/CEO's totaling in excess of $3.4 million. It is quite unusual for a business to grant a bonus, let alone a significant portion of a person's total compensation, when the business shows a negative financial performance.

Could a source of those bonuses be the federal Covid relief funds intended to help distressed hospitals, including "non-profit hospital systems" like Ballad's receipt of $241,782,242 in 'relief' funds, struggle through hard times? In that the system had a significant loss in FY22, should any of that bonus be clawed back, or was there yet another bonus paid along with more raises granted to these executives in FY22? Where is this entire issue of executive compensation addressed in the COPA?

Ballad Health relies heavily on government funding for its financial survival. About 65% of its payor mix is funded by Medicare and Medicaid and about 4% of its aggregate

revenues were from government Covid relief funds for 3 of the past 5 years. Congress has increased its review of non-profit hospitals in the areas of defining reasonable amounts of charity care (addressed earlier in this report) and executive compensation, the latter focusing on private inurement. One of the tests for executive compensation reasonableness is a comparison of compensation with executives of similarly sized organizations in the same geographic area.

Below is a schedule portraying FY21 compensation of the President/CEO of Ballad Health compared with Ballad's peers based on a percent of total system revenues during that same time period.

Hospital System CEO Compensations for FYE21

Name / Title	System	Location	Total System Revenue	CEO Taxable Compensation	Percent of Compensation to Revenue
Alan Levine / Pres & CEO	**Ballad Health**	**Johnson City, TN**	**$2,191,638,000**	**$3,061,924**	**0.14%**
Michael Ugwueke / Pres & CEO	Methodist Healthcare	Memphis, TN	$1,931,441,000	$2,268,402	0.12%
Dr Jeff Balser / CEO	Vanderbilt UMC	Nashville, TN	$5,534,629,000	$5,305,209	0.10%
Jason Little / Pres & CEO	Baptist Memorial Health	Memphis, TN	$3,401,524,000	$2,916,928	0.09%
Barclay Berman / CEO	Texas Health Resources	Arlington, TX	$5,538,102,000	$3,637,626	0.07%
Carl Armato / Pres & CEO	Novant Health	Winston Salem, NC	$7,396,146,000	$4,473,377	0.06%
Pres & CEO	UnityPoint Health	West Des Moines, IA	$4,858,490,000	$2,858,807	0.06%
Steven Arner / Pres & CEO	Carillion Clinic	Roanoke, VA	$2,203,408,000	$1,072,492	0.05%
James VanderSteag / Pres & CEO	Covenant Health	Knoxville, TN	$5,534,629,000	$2,333,514	0.04%

Source: hospital system audited financial statements

Review of the above schedule reveals that Ballad tops the list with compensation greater as a percentage of system revenue than its peers. In SWVHA Board and Task Force meetings earlier this week, it was noted that Ballad's quality was similar to Carilion's. With similar system revenues and quality performance, one might question why Ballad's President/CEO compensation as a percent of system revenues nearly 3 times more than Carilion's.

POPULATION HEALTH

Ballad Health provided information comparing their service area counties with what was indicated in the COPA TOC to be their 'peer' counties in Tennessee. The Tennessee Peer Counties are Anderson, Cannon, Claiborne, Cumberland, Jefferson, McMinn, Marion, Monroe, Putnam, Roane, Sevier and White.

Two schedules comparing Ballad's COPA counties directly with its Peer counties appear below:

2022 updated Population Health Data Table (page 1 of 2)

	Health Status Measure	TN COPA Counties Value	TN Peer Counties' Value	Ballad COPA Counties vs Peer Counties
BIG FOUR / Behaviors				
	Tobacco Use	COPA	PEER	
	Smoking (% *of adults*)	23.5%	24.1%	BETTER
	Smoking among those with a high school education or more *(%)*	20.6%	20.7%	BETTER
	Mothers who smoke during pregnancy *(% of live births)*	17.7%	15.9%	WORSE
	Youth tobacco use *(% of high school students)*	5.7%	4.5%	WORSE
	Youth -ever tried cigarette smoking *(% of high school students)*	17.4%	15.6%	WORSE
	Youth electronic vapor product use *(% of high school students)*	14.7%	16.2%	BETTER
	Physical Activity	COPA	PEER	
	Physically active adults *(% of adults)*	67.3%	62.7%	BETTER
	Physically active students *(% of high school students)*	48.0%	45.6%	BETTER
	Obesity	COPA	PEER	
	Obesity *(% of adults)*	36.7%	36.8%	BETTER
	Obesity among those with a high school education or more *(% of adults)*	37.2%	36.6%	WORSE
	Overweight and obesity among TN public school students *(% of students in grades kindergarten, 2, 4, 6, 8, and one year of high school)*	41.6%	40.9%	WORSE
	Breastfeeding Measures	COPA	PEER	
	Average mPINC (Maternal Practices in Infant Nutrition and Care) score	79	64	BETTER
	Breastfeeding initiation *(% of live births)*	74.0%	75.8%	WORSE
	High School Student Healthy Eating	COPA	PEER	
	Fruit consumption among high school students *(% of high school students)*	88.8%	87.3%	BETTER
	Vegetable consumption among high school students *(% of high school students)*	83.5%	86.2%	WORSE
	Soda consumption among high school students *(% high school students)*	79.5%	77.9%	WORSE
	Substance Abuse	COPA	PEER	
	NAS (Neonatal Abstinence Syndrome) births *(cases per 1,000 live births)*	33.8	20.9	WORSE
	Drug deaths *(deaths per 100,000 population)*	51.0	65.3	BETTER
	Drug overdoses *(non-fatal overdoses per 100,000 population)*	321.9	420.8	BETTER
	Painkiller prescriptions (prescriptions *per 1,000 population)*	1,249.5	1,059.3	WORSE
	Prescription drugs among high school students *(% of high school students using prescription pain relievers not prescribed by the doctor)*	9.0%	10.6%	BETTER
	MME for Pain *(Total morphine milligram equivalents (MME) opioids for pain per capita)*	755.1	711.7	WORSE

2022 updated Population Health Data Table (page 2 of 2)

	Health Status Measure	TN COPA Counties Value	TN Peer Counties' Value	Ballad COPA Counties vs Peer Counties
IMMUNIZATIONS				
	On-time vaccinations – children *(% of children that are up-to-date on immunizations at the time of kindergarten entry)*	95.2%	94.2%	BETTER
	Entity participation in TennIIS *(# of active TennIIS entities)*	424	364	BETTER
	Vaccinations – HPV Females *(# of HPV shots administered for females aged 11 to 17 years, either quadrivalent or bivalent)*	5502	4560	BETTER
	Vaccinations – HPV Males *(# of HPV shots administered for males aged 11 to 17 years, either quadrivalent or bivalent)*	5345	4417	BETTER
	Vaccinations – Tdap *(# of Tdap shots administered for patients aged 11 to 17 years)*	7025	6607	BETTER
	Vaccination - Flu, Older Adults *(% adults aged 65+)*	68.1%	70.5%	BETTER
	Vaccinations - Flu, Adults *(% of adults)*	42.2%	43.2 %	WORSE
COMMUNITY / ENVIRONMENT				
	Teen births (births *per 1,000 females aged 15-19 years*)	22.3	24.8	BETTER
	Third Grade Reading			
	Third grade reading level *(% of 3rd graders who score "on-track" or "mastered" on TNReady reading assessment)*	37.2%	33.9%	BETTER
	Third grade reading level - Higher density counties *(% of students)*	40.1%	35.6%	BETTER
	Third grade reading level - Lower density counties *(% of students)*	33.2	32.0	BETTER
	Oral Health			
	Fluoridated water *(% of population on community water systems receiving fluoridated water)*	92.4%	93.7%	WORSE
	Dental sealants – children *(% Medicaid enrollees aged 6–9 years)*	12.3%	11.5%	BETTER
	Dental sealants - adolescents *(% Medicaid enrollees aged 13-15 years)*	7.0%	6.1%	BETTER
OUTCOMES				
	Frequent mental distress *(% of adults)*	18.6%	18.9%	BETTER
	Frequent physical distress *(% of adults)*	18.4%	19.0%	WORSE
	Infant mortality *(deaths per 1,000 live births)*	6.2	4.3	WORSE
	Low birthweight *(% of live births)*	8.3%	8.5%	BETTER
	Child mortality *(deaths per 100,000 population for children aged 1-19 years)*	36.0	32.5	WORSE
	Cardiovascular deaths *(deaths per100,000 population)*	385.3	3285.9	BETTER
	Cancer deaths *(deaths per 100,000 population)*	269.6	268.1	WORSE
	Diabetes deaths *(deaths per 100,000 population)*	42.8	51.5	BETTER
	Suicide deaths *(deaths per 100,000 population)*	19.8	20.2	BETTER
	Premature death ratio *(ratio of deaths before age 75 per 100,000 population for higher to lower density counties)*	0.842	0.794	WORSE

Source: TDH 3/23 COPA Report

Review of the above schedules reveal that **39%** of the health status measures in Ballad's COPA counties are **worse** than those of its peer counties. Recall that Ballad Health has been in existence to address Population Health as a primary objective for more than 5 years. Believing that a positive score below 60% is failure, Ballad Health's positive score of 61%, just over that marker, is unsatisfactory.

ACCESS to HEALTH SERVICES

A key indicator of healthcare access is the extent to which patients are satisfied with their care. Below are schedules reporting results of Ballad Health's Patent Satisfaction surveys.

Ballad Health Patient Surveys - FY22 (page 1 of 2)

	Ballad Health FY21	Ballad Health FY22	CMS Baseline	Ballad FY22 Performance vs CMS Baseline
Patients who reported that their nurses "Always" communicated well	79.1%	74.7%	82.8%	FAIL
Patients who reported that their nurses "Usually" communicated well	14.0%	16.1%	13.6%	PASS
Patients who reported that their nurses "Sometimes" or "Never" communicated well	6.9%	9.1%	3.6%	FAIL
Patients who reported that their doctors "Always" communicated well	80.1%	75.6%	84.1%	FAIL
Patients who reported that their doctors "Usually" communicated well	11.0%	15.6%	11.9%	PASS
Patients who reported that their doctors "Sometimes" or "Never" communicated well	8.9%	8.8%	3.9%	FAIL
Patients who reported that they "Always" received help as soon as they wanted	66.9%	59.7%	72.8%	FAIL
Patients who reported that they "Usually" received help as soon as they wanted	19.0%	25.2%	20.6%	FAIL
Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted	14.1%	15.2%	6.6%	FAIL
Patients who reported that staff "Always" explained about medicines before giving it to them	57.7%	57.9%	68.1%	FAIL
Patients who reported that staff "Usually" explained about medicines before giving it to them	14.6%	16.7%	15.9%	PASS
Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them	17.6%	25.4%	16.0%	FAIL
Patients who reported that their room and bathroom were "Always" clean	75.3%	61.7%	73.9%	FAIL
Patients who reported that their room and bathroom were "Usually" clean	13.8%	19.3%	17.2%	PASS
Patients who reported that their room and bathroom were "Sometimes" or "Never" clean	10.8%	19.0%	8.9%	FAIL

Source: Ballad Health Annual Report to TDH

Ballad Health Patient Surveys - FY22 (page 2 of 2)

	Ballad Health FY21	Ballad Health FY22	CMS Baseline	Ballad FY22 Performance vs CMS Baseline
Patients who reported that the area around their room was "Always" quiet at night	63.5%	58.6%	66.5%	FAIL
Patients who reported that the area around their room was "Usually" quiet at night	23.6%	28.6%	26.9%	FAIL
Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night	12.9%	12.8%	6.6%	FAIL
Patients who reported that YES, they were given information about what to do during their recovery at home	85.6%	84.4%	87.2%	FAIL
Patients who reported that NO, they were not given information about what to do during their recovery at home	14.4%	15.6%	12.8%	FAIL
Patients who "Strongly Agree" they understood their care when they left the hospital	49.0%	46.2%	54.5%	FAIL
Patients who "Agree" they understood their care when they left the hospital	43.5%	46.5%	40.8%	PASS
Patients who "Disagree" or "Strongly Disagree" they understood their care when they left the hospital	7.5%	7.4%	4.8%	FAIL
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest)	69.7%	61.4%	73.3%	FAIL
Patients who gave their hospital a rating of 7 or 8 on a scale from 0 (lowest) to 10 (highest)	16.9%	23.9%	18.9%	PASS
Patients who gave their hospital a rating of 6 or lower on a scale from 0 (lowest) to 10 (highest)	13.4%	14.7%	7.9%	FAIL
Patients who reported YES, they would definitely recommend the hospital	66.4%	61.6%	73.7%	FAIL
Patients who reported YES, they would probably recommend the hospital	22.9%	20.1%	21.5%	PASS
Patients who reported NO, they would probably not or definitely not recommend the hospital	10.7%	10.2%	4.8%	FAIL
SCORE	21%	24%		FAIL

Source: Ballad Health Annual Report to TDH

Review of the above schedules reveal that Ballad Health access, as defined by patient surveys, has achieved a positive satisfaction rating of only **24%** of CMS' benchmarks; **non-compliance on 76% of the patient survey result measures**. This does not bode positive for acceptable patient healthcare access; it constitutes failure.

OTHER (Primarily Quality of Care)

Patient Care Quality Measures

Ballad's COPA TOC stipulates a series of specific legally defined patient care quality measures for which Ballad is to report compliance. Below is a schedule comparing Ballad's performance for these measures relative to CMS benchmarks.

Ballad Health Patient Care Measures - FY22 (page 1 of 2)

Measures	Ballad Health FY21	Ballad Health FY22	CMS Baseline	Ballad FY22 Performance vs CMS Baseline
Colonoscopy Followup				
OP29 Avg Risk Polyp Surveillance	96.9%	97.0%	76.1	FAIL
Emergency Department Throughput				
ED1b ED Door to Transport for Admitted Patients	365.9	460.1	227.3	FAIL
ED2b ED Decision to Transport	161.3	217.6	69.0	FAIL
OP18b Avg time ED arrival to discharge	151.9	158.4	124.5	FAIL
OP22 Left without being seen	1.6%	2.5%	0.9%	FAIL
OP23 Head CT stroke patients	69.6%	65.0%	84.7%	FAIL
Preventive Care				
IMM3OP27 FACADHPCT HCW Influenza Vaccination	98.0%	98.5%	97.0%	PASS
Pregnancy & Delivery Care				
PC01 Elective Delivery	2.17%	6.77%	0.50%	FAIL
Surgical Complications Rate				
Hip and Knee Complications	0.00%	0.00%	0.03%	PASS
PSI 4 Deaths among Patients with Serious Treatable Complications after Surgery	182.3%	189.7%	140.6%	FAIL
PSI 90 Serious complications	0.95	0.95	0.83	FAIL

Source: Ballad Health Annual Report to TDH

Ballad Health Patient Care Measures - FY22 (page 2 of 2)

Measures	Ballad Health FY21	Ballad Health FY22	CMS Baseline	Ballad FY22 Performance vs CMS Baseline
Readmissions 30 Days Rate				
READM30 CABG Coronary artery bypass graft (CABG) surgery 30day readmission rate	13.6%	13.3%	12.9%	FAIL
READM30 COPD Chronic obstructive pulmonary disease 30day readmission rate	21.2%	19.9%	20.5%	PASS
READM30 HIPKNEE 30day readmission rate following elective THA / TKA	4.9%	5.3%	3.8%	FAIL
READM30 AMI Acute myocardial infarction (AMI) 30day readmission rate	13.6%	13.3%	12.9%	FAIL
READM30HF Heart Failure 30Day readmissions rate	23.32%	23.9%	21.79%	FAIL
READM30PN Pneumonia 30day readmission rate	18.5%	18.0%	17.7%	FAIL
READM30STK Stroke 30day readmission rate	6.9%	11.3%	8.2%	FAIL
READM30 HOSPWIDE 30day hospitalwide allcause unplanned readmission	6.20	14.3%	12.0%	FAIL
Mortality 30 Days Death Rate				
MORT30 CABG Coronary artery bypass graft surgery 30day mortality rate	2.9%	2.0%	2.0%	PASS
MORT30 COPD 30day mortality rate COPD patients	3.3%	6.6%	1.8%	FAIL
MORT30AMI Acute myocardial infarction (AMI) 30day mortality rate	6.2%	7.4%	4.7%	FAIL
MORT30HF Heart failure 30day mortality rate	4.1%	5.1%	3.9%	FAIL
MORT30PN Pneumonia 30day mortality rate	8.0%	7.4%	4.7%	FAIL
MORT30STK Stroke 30day mortality rate-	6.9%	7.3%	0.2%	PASS
SCORE	44%	20%		FAIL

Source: Ballad Health Annual Report to TDH

Review of the above schedule reveals that Ballad Health met or exceeded CMS benchmarks in **20%** of the measures; **non-compliance on 80% of the patient care quality measures**. This constitutes failure.

‘Target’ Quality Measures

The Ballad COPA TOC states that any underperforming Quality Monitoring Measure for more than one (1) year may be reclassified to a Target Quality Measure, as determined by the Department in its discretion. The TDH weights Target Quality Measures more heavily in compliance scoring as Ballad’s longevity increases.

Per the original COPA TOC, “the Target Quality Measures identify areas in which the New Health System should show improvement in quality outcomes. Target Quality Measures will be evaluated for the entire patient population and will not be restricted based on the patient’s payor status. Specifically, these Measures will not be limited to the Medicare population. For the first year of the Affiliation, the New Health System will be required to maintain performance on the Target Quality Measures. For each subsequent year, the New Health System will be **required** to improve performance on Target Quality Measures.”

Below is a schedule comparing Ballad’s performance for these measures relative to benchmarks for the first five (5) years since inception.

Ballad Health Target Quality Baseline Measure Changes 2018 - 2022

Desired Performance	Measure	Benchmarks 2018 Initial	Benchmarks 2022 Revised	Change from 2018 to 2022
Identified as of 2018				
↓	Pressure Ulcer Rate	0.71	1.07	LOWER
↓	Iatrogenic Pneumothorax Rate	0.38	0.25	LOWER
↓	In-Hospital Fall with Hip Fracture Rate	0.06	0.06	-
↓	Central Venous Catheter Related Blood Stream Infection Rate	0.15	DELETED	-
↓	PSI 09 Perioperative Hemorrhage or Hematoma Rate	4.15	1.59	LOWER
↓	PSI 10 Postoperative Physiologic and Metabolic Derangement Rate	1.00	0.76	LOWER
↓	PSI 11 Postoperative Respiratory Failure Rate	14.79	9.24	LOWER
↓	PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	5.42	3.31	LOWER
↓	PSI 13 Postoperative Sepsis Rate	8.81	3.58	LOWER
↓	PSI 14 Postoperative Wound Dehiscence Rate	2.22	0.83	LOWER
↓	PSI 15 Unrecognized Abdominopelvic accidental Puncture/Laceration Rate	1.34	1.18	LOWER
↓	CLABSI	0.774	0.711	LOWER
↓	CAUTI	0.613	0.558	LOWER
↓	SSI	1.107	DELETED	-
↓	MRSA	0.040	0.047	HIGHER
↓	CDIFF	0.585	0.671	HIGHER
Added in 2019				
↓	SSI: COLON Surgical Site Infection	-	2.13	-
↓	SSI: HYST Surgical Site Infection	-	0.71	-
Added in 2020				
↑	SMB: Sepsis Management Bundle	-	56.9%	-

Source: Ballad Health Reports to TDH and VA State monitor

Review of the above schedule reveals that Ballad Health’s quality metrics continued to decline in FY22. Ballad Health met or exceeded the new revised benchmarks in **29%** of the measures; **non-compliance on 71% of the Target Quality Measures**. In FY23, Ballad Health met or exceeded the new revised benchmarks in **53%** of the measures; **non-compliance on 47% of the Target Quality Measures.**

Of particular note is the fact that over the past 5 years, the quality performance baseline metrics have changed. For example, the performance comparison baseline for Target Measures for FY22 was reset in May of 2021 using Premier, a national $18 billion conglomerate owned primarily by hospital systems providing group purchasing, technology, and advocacy, as its quality platform. This conversion enables Ballad to work with Premier to move the goal posts for all 2017 baselines. The baseline restructure was presented to the State and approved, with no local community input, as the official Ballad Health Baseline for Target Measures beginning with FY22.

Below is a schedule portraying changes to the quality performance baseline metrics over the past five (5) years.

Ballad Health Target Quality Baseline Measure Changes 2018 - 2022

Desired Performance	Measure	Benchmarks 2018 Initial	2022 Revised	Change from 2018 to 2022
Identified as of 2018				
↓	Pressure Ulcer Rate	0.71	1.07	LOWER
↓	Iatrogenic Pneumothorax Rate	0.38	0.25	LOWER
↓	In-Hospital Fall with Hip Fracture Rate	0.06	0.06	-
↓	Central Venous Catheter Related Blood Stream Infection Rate	0.15	DELETED	-
↓	PSI 09 Perioperative Hemorrhage or Hematoma Rate	4.15	1.59	LOWER
↓	PSI 10 Postoperative Physiologic and Metabolic Derangement Rate	1.00	0.76	LOWER
↓	PSI 11 Postoperative Respiratory Failure Rate	14.79	9.24	LOWER
↓	PSI 12 Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate	5.42	3.31	LOWER
↓	PSI 13 Postoperative Sepsis Rate	8.81	3.58	LOWER
↓	PSI 14 Postoperative Wound Dehiscence Rate	2.22	0.83	LOWER
↓	PSI 15 Unrecognized Abdominopelvic accidental Puncture/Laceration Rate	1.34	1.18	LOWER
↓	CLABSI	0.774	0.711	LOWER
↓	CAUTI	0.613	0.558	LOWER
↓	SSI	1.107	DELETED	-
↓	MRSA	0.040	0.047	HIGHER
↓	CDIFF	0.585	0.671	HIGHER
Added in 2019				
↓	SSI: COLON Surgical Site Infection	-	2.13	-
↓	SSI: HYST Surgical Site Infection	-	0.71	-
Added in 2020				
↑	SMB: Sepsis Management Bundle	-	56.9%	-

Source: Ballad Health Reports to TDH and VA State monitor

Review of the above schedule reveals that there were significant changes to Ballad Health's quality metric baselines over the past 5 years. Of the initial 16 measures, 11 were lowered, 2 were deleted, 2 were increased, and 1 remained unchanged. Since inception, 3 new measures were added. Most noteworthy is that all of those that were lowered were for clinical conditions with lower desired outcomes. Yet Ballad failed to achieve satisfactory performance.

QUALITY as MEASURED by NATIONALLY RECOGNIZED ORGANIZATIONS

CMS Star Ratings

The overall star rating for hospitals summarizes quality information on important topics, like readmissions and deaths after heart attacks or pneumonia. The overall rating, between 1 and 5 stars, summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital. The 5 measure groups include Mortality, Safety of care, Readmission, Patient experience, and Timely and effective care. The overall rating shows how well each hospital performed on an identified set of quality measures compared to other hospitals in the U.S. The more stars, the better a hospital performed on the available quality measures.

Ballad Health's overall Below is a schedule showing Ballad's hospital quality as reported by CMS Star ratings from 2016 (pre-merger) to 2022 (post-merger).

BALLAD HEALTH CMS QUALITY STAR RATINGS (2016 - 2022)

Pre-Merger Controlling Entity	Facility	2016		2022		Change
		CMS Stars	Letter Grade	CMS Stars	Letter Grade	
WELLMONT HEALTH SYSTEM						
	Bristol Regional Medical Center	3	C	2	D	WORSE
	Hawkins County Memorial Hospital	4	B	N/A	-	-
	Holston Valley Medical Center	3	C	2	D	WORSE
	Lonesome Pine Hospital	3	C	3	C	-
	Average Score	3.25		2.33		WORSE
MOUNTAIN STATES HEALTH ALLIANCE						
	Franklin Woods Community Hospital	4	B	3	C	WORSE
	Greeneville Community Hospital East ** (Laughlin Memorial Hospital)	3	C	2	D	WORSE
	Indian Path Community Hospital	3	C	4	B	BETTER
	Johnson City Medical Center	2	D	1	F	WORSE
	Johnston Memorial Hospital	3	C	3	C	-
	Norton Community Hospital	4	B	N/A	-	-
	Russell County Hospital	3	C	2	D	WORSE
	Smyth County Community Hospital	3	C	5	A	BETTER
	SycamoreShoals Hospital	4	B	3	C	WORSE
	Unicoi County Hospital	3	C	4	B	BETTER
	Average Score	3.2	C	3.0	C	WORSE
BALLAD HEALTH						
	Average Score	3.22	C	2.83	D	WORSE

Source: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalCompare

Review of the above schedule reveals that 14 of Ballad's hospitals were rated by CMS pre-merger. In 2022, 12 Ballad hospitals were rated. Of those 12 rated by CMS, seven (a majority of 58%) were rated **worse** post-merger than they were pre-merger, 3 stayed

at the “C” (satisfactory) level, and Ballad’s flagship, Johnson City Medical Center (Ballad’s only Level 1 Trauma Center), was rated at the **F (failure)** level. It can only be logically concluded the **benefits** of the COPA do NOT **outweigh the disadvantages** that result from the loss of competition using an identified set of quality measures compared to other hospitals in the U.S. Ballad’s overall hospital quality was worse post-merger than the independent system’s (WHS and MSHA) hospitals were pre-merger.

Leapfrog Hospital Safety Measures

Leapfrog is a nationally recognized organization that for over 20 years has collected, analyzed, and published health care data on safety, quality, and resource use to assist purchasers find high-value care and to empower people with the information they need to make better decisions. Below is a schedule showing Ballad’s results for 2019 through spring of 2023.

BALLAD HEALTH LEAPFROG HOSPITAL SAFETY GRADES (2019 - 2023)

Pre-Merger Controlling Entity	Facility	2019	2020		2021		2022		2023	Change
			Spring	Fall	Spring	Fall	Spring	Fall	Spring	2019 - 2023
WELLMONT HEALTH SYSTEM										
	Bristol Regional Medical Center	C	C	D	D	D	D	D	C	-
	Hawkins County Memorial Hospital	B	-	-	-	-	-	-	-	-
	Holston Valley Medical Center	NG	NG	NG	C	D	C	C	C	-
	Lonesome Pine Hospital	C	B	A	C	B	NG	NG	C	-
MOUNTAIN STATES HEALTH ALLIANCE										
	Franklin Woods Community Hospital	C	B	B	C	C	B	B	B	BETTER
	Greeneville Community Hospital East ** (Laughlin Memorial Hospital)	B	NG	C	C	C	C	C	C	WORSE
	Indian Path Community Hospital	B	C	C	D	C	B	C	C	WORSE
	Johnson City Medical Center	C	D	D	C	C	C	C	D	WORSE
	Johnston Memorial Hospital	B	C	C	C	B	C	C	C	WORSE
	Norton Community Hospital	A	-	-	-	-	-	-	-	-
	Russell County Hospital	NG	NG	NG	NG	NG	NG	B	NG	-
	Smyth County Community Hospital	NG	NG	NG	NG	A	A	A	A	-
	SycamoreShoals Hospital	B	C	C	C	C	C	C	C	WORSE
	Unicoi County Hospital	C	-	-	-	-	NG	NG	NG	-
BALLAD HEALTH										
	Average Score									WORSE

Source: https://www.hospitalsafetygrade.org/search?findBy=state&zip_code=&city=&state_prov=TN&hospital=&rSort=distance

Review of the above schedule reveals that of the 11 Ballad hospitals graded in 2023, the safety and quality at 1 hospital improved but **became worse at five (5) hospitals**.

How do these grades compare nationally? Twenty-nine percent (29%) of hospitals received an "A," twenty-six percent (26%) received a "B," thirty-nine percent (39%) received a "C," six percent (6%) received a "D" and less than one percent (<1%)

received an "F." Under Ballad's management, **JCMH (Ballad's 'flagship') digressed to a score of "D", ranking it among the lowest 7% of all hospitals reporting in the country**.

It can again be concluded in reviewing the above schedules that the quality and safety of Ballad's hospitals, as measured by quantified evaluations of nationally recognized organizations, has continually declined under Ballad's management.

Hospital System Peer Group Comparison

Ballad Health's COPA requires the Annual Report provide a comparison of similarly sized hospital systems using the following selection criteria, ranked by priority:

- Not-for-profit
- Net revenue
- Alignment with Premier (a GPO owned by participating hospital systems)
- Bed size and number of hospitals
- Rural hospitals and similar services
- Location – allows for travel to site visits
- EPIC electronic medical record
- Top performers

The six similarly sized hospital systems selected for inclusion in the Annual Report are Aurora Health, Baptist Memorial, Carillion Clinic, Mercy Health, Texas Health and UnityPoint Health. Of note, Mercy Health who merged with Bon Secours in 2018, now has a system of 38 hospitals.

New comparison organizations will be selected for next year in collaboration with Tennessee and Virginia as Ballad Health works with Premier to determine the appropriate health systems for comparison. Continually changing baselines creates difficulties in year-to-year comparisons. And could this pose a situation of the fox guarding the hen house as Premier is a national provider owned advocacy conglomerate?

Five of the six selected healthcare systems rank in the top 25 of the largest non-profit hospital systems in America. The sixth selection is a Virginia-based hospital system that meets most of the criteria, located close to Ballad. According to Ballad, having a Tennessee- and Virginia –based system was important in the selection process for comparisons and benchmarking purposes.

Schedules portraying similarly sized hospital group comparison of Patient Survey measures along with Clinical and Safety measures with Ballad Health for FY2020 appear below.

HOSPITAL SYSTEM PEER GROUP COMPARISON (page 1 of 2)

Patient Survey Measures	Ballad Health FY21	Ballad Health FY22	System Peer Group FY22	Ballad Health FY22 Performance vs Hospital System Peer Group
Patients who reported that they "Always" received help as soon as they wanted	72.1%	65.8%	64.3%	BETTER
Patients who reported that they "Usually" received help as soon as they wanted	19.8%	23.1%	25.8%	WORSE
Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted	8.1%	11.1%	9.9%	WORSE
Patients who reported that staff "Always" explained about medicines before giving it to them	64.8%	61.9%	61.4%	BETTER
Patients who reported that staff "Usually" explained about medicines before giving it to them	16.2%	17.5%	18.8%	BETTER
Patients who reported that staff "Sometimes" or "Never" explained about medicines before giving it to them	19.0%	20.6%	19.9%	WORSE
Patients who reported that their room and bathroom were "Always" clean	76.4%	70.6%	72.1%	WORSE
Patients who reported that their room and bathroom were "Usually" clean	15.1%	17.3%	18.5%	BETTER
Patients who reported that their room and bathroom were "Sometimes" or "Never" clean	8.5%	12.2%	9.4%	WORSE
Patients who reported that the area around their room was "Always" quiet at night	64.8%	62.2%	61.9%	BETTER
Patients who reported that the area around their room was "Usually" quiet at night	27.2%	27.8%	29.3%	BETTER
Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night	8.0%	10.1%	8.8%	WORSE
Patients who reported that YES, they were given information about what to do during their recovery at home	86.6%	85.4%	87.5%	WORSE
Patients who reported that NO, they were not given information about what to do during their recovery at home	13.4%	14.6%	12.5%	WORSE
Patients who reported that they "Always" received help as soon as they wanted	72.1%	65.8%	64.3%	BETTER
Patients who reported that they "Usually" received help as soon as they wanted	19.8%	23.1%	25.8%	BETTER
Patients who reported that they "Sometimes" or "Never" received help as soon as they wanted	8.1%	11.1%	9.9%	WORSE
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Patients who reported that their room and bathroom were "Usually" clean	15.1%	17.3%	18.5%	BETTER
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Patients who reported that the area around their room was "Always" quiet at night	64.8%	62.2%	61.9%	BETTER
Patients who reported that the area around their room was "Usually" quiet at night	27.2%	27.8%	29.3%	BETTER
Patients who reported that the area around their room was "Sometimes" or "Never" quiet at night	8.0%	10.1%	8.8%	WORSE
Patients who reported that YES, they were given information about what to do during their recovery at home	86.6%	85.4%	87.5%	WORSE
Patients who reported that NO, they were not given information about what to do during their recovery at home	13.4%	14.6%	12.5%	WORSE
SCORE	46%	46%		WORSE

Source: Ballad Health Annual Report to TDH

HOSPITAL SYSTEM PEER GROUP COMPARISON (page 2 of 2)

Clinical and Safety Measures	Ballad Health FY21	Ballad Health FY22	System Peer Group FY22	Ballad Health FY22 Performance vs Hospital System Peer Group
IMM2 Immunization for Influenza	98.4%	90.5%	86.6%	BETTER
PC01 Elective Delivery	2.56%	2.6%	1.9%	WORSE
Hip and Knee Complications	2.40	0.02	0.02	BETTER
PSI 4 Deaths among Patients with Serious Treatable Complications after Surgery	177.7	173.6	170.5	WORSE
PSI 90 Serious complications	0.99	0.97	0.96	WORSE
READM30 CABG Coronary artery bypass graft (CABG) surgery 30day	12.57%	12.2%	11.6%	WORSE
READM30 COPD Chronic obstructive pulm disease 30day readmit rate	19.63%	19.7%	19.7%	SAME
READM30 HIPKNEE 30day readmission rate following elective THA / TKA	4.01%	4.3%	4.0%	WORSE
READM30 AMI Acute myocardial infarction (AMI) 30day readmission rate	16.48%	15.8%	15.0%	WORSE
READM30HF Heart Failure 30Day readmissions rate	23.32%	22.4%	21.0%	WORSE
READM30 HOSPWIDE 30day hospitalwide allcause unplanned readmission	15.88%	15.6%	16.6%	BETTER
MORT30 CABG Coronary artery bypass graft surgery 30day mortality rate	3.7%	3.5%	3.1%	WORSE
MORT30 COPD 30day mortality rate COPD patients	8.7%	8.9%	8.6%	WORSE
MORT30AMI Acute myocardial infarction (AMI) 30day mortality rate	12.4%	13.1%	12.5%	WORSE
MORT30HF Heart failure 30day mortality rate	11.6%	12.7%	11.9%	WORSE
READM30 HOSPWIDE 30day hospital wide all-cause unplanned readmission	15.88%	15.6%	16.6%	BETTER
OP8- MRI Lumbar Spine for Low Back Pain	38.1	0.53	0.48	WORSE
OP13- Outpatients who got cardiac imaging stress tests before low-risk OPS	4.0	0.04	0.03	WORSE
PSI 3 Pressure sores	0.780	0.59	0.50	WORSE
PSI 6 Collapsed lung due to medical treatment	0.248	0.23	0.22	WORSE
PSI 8 Broken hip from a fall after surgery	0.115	0.10	0.09	WORSE
PSI 9 Perioperative Hemorrhage or Hematoma Rate	2.426	2.35	2.59	BETTER
PSI 10 Postoperative Acute Kidney Injury Requiring Dialysis Rate	1.450	1.54	1.55	BETTER
PSI 11 Postoperative Respiratory Failure Rate	7.325	5.27	5.69	BETTER
PSI 12 Serious blood clots after surgery	3.813	3.35	3.48	BETTER
PSI 13 Postoperative Sepsis Rate	4.885	5.06	4.84	WORSE
PSI 14 A wound that splits open after surgery on the abdomen or pelvis	0.964	0.94	0.86	WORSE
PSI 15 Accidental cuts and tears from medical treatment	1.111	1.12	1.26	BETTER
CLABSI NHSN Rate	0.551	1.261	0.912	WORSE
CAUTI NHSN Rate	0.806	1.043	0.915	WORSE
SCORE	32%	30%		FAIL

Source: Ballad Health Annual Report TDH

Review of the above schedules reveals that 54% (more than half) of Ballad's patent survey results were worse than those of similarly sized hospital systems, and 68% (more than two thirds) of Ballad's clinical and safety measures were worse than those of similarly sized hospital systems. Performance below the average of one's self-selected peers is unsatisfactory if not outright failure.

It is important to note that although established in the COPA's Terms of Certification section 4.02(c) (ii), Exhibit G, as being a required component of every Annual Report, this report was excluded from Ballad Health's FY2021 Annual Report. Such exclusion was not mentioned in the TN COPA Monitor's Report to the TDH.

SUMMARY & CONCLUSION

A recap of much of the above analysis is captured in the schedule below.

Ballad Health COPA Performance Summary for FY22

CATEGORY	MEASURE	SCORE	GRADE
Economics			
	Financial Health	-$135,262,000	unsatisfactory
	Monetary Commitments	-$31,333,000	Fail
	Charity Care	-$39,299,510	Fail
	Resource Allocation	-	unsatisfactory
Population Health Improvement			
	Peer Counties	61%	unsatisfactory
Access to Health Services			
	Patient Surveys	24%	Fail
Other (primarily quality of care)			
	Patent Care Quality Measures	20%	Fail
	Target Quality Measures	29%	unsatisfactory
	LeapFrog Safety Grades	C	satisfactory
	CMS Star Ratings	D	unsatisfactory
	Peer System Patient Surveys	46%	unsatisfactory
	Peer System Clinical Measures	30%	Fail
OVERALL PERFORMANCE			FAIL

A **Certificate of Public Advantage (COPA)** is the written approval by the Tennessee Department of Health (TDH) that governs a Cooperative Agreement (a merger) among two or more hospitals. A COPA provides state action immunity to the hospitals from state and federal antitrust laws by **replacing competition with state regulation and Active Supervision**. The goal of the COPA process is to protect the interests of the public in the region affected and the State. TDH has the authority to issue a COPA if applicants pursuing a COPA demonstrate that the **likely benefits** of the proposed Cooperative Agreement **outweigh the likely disadvantages** that would result from the loss of competition.

Continued review and analysis of publicly available documents leads to the conclusion that Ballad Health has not complied with nor is it capable of future compliance with the intent of the COPA. Ballad's performance as a hospital system has **not** demonstrated that the **benefits** of the COPA **outweigh the disadvantages** that would result from the loss

of competition. Ballad's performance been demonstrated to be sub-par and the system's position for future COPA compliance as a monopoly is highly doubtful in light of its worsening financial and quality performance.

The COPA should be revoked and Tennessee's Certificate-of-Need legislation repealed to allow new innovative healthcare delivery models and free market competition to successfully improve the populations' health of the community living in the geographical areas supposedly served by Ballad.

The COPA states that the TDH will consider the Index score; Ballad Health's degree of compliance with the TOC; Ballad Health's performance trends; and other factors to make an annual determination of the ongoing public advantage of Ballad Health to the Northeast Tennessee and Southwest Virginia regions. It appears that the TDH frequently moves the goal posts to Ballad's advantage without so much as notifying and seeking public input every time there's an issue with Ballad's satisfying a condition stipulated in the initial COPA. This has resulted in recurring "approvals" such as the one posted in the March, 2023 TDH Ballad COPA Annual Report stating:

"It is the Tennessee Department of Health's determination that the Ballad Health COPA continues to provide a Public Advantage."

The COPA TOC defines "Active Supervision" as the ongoing process of the Department, the AG, and their respective appointed agents and independent contractors of (a) **evaluating and determining** whether the New Health System's operations continue to result in Public Advantage, and (b) **enforcing the COPA**, these Terms of Certification and all other Terms and Conditions.

The information presented above clearly demonstrates findings and conclusions to the contrary. It's unclear as to how the TDH and its Ballad monitor arrive at their continuous positive conclusions and decisions in addition to continually moving the goal posts. Perhaps there's a need to add significant transparency to the process, allow for continual public input, closely monitor the state's monitors and decision influencers, and begin to **enforce the COPA's** Terms and Conditions to ensure accountability to the community.

Wally Hankwitz, MBA, LFACHE, CMPE
Retired Healthcare Executive / Consultant

AWH/6.30.23

From: William Baker
To: Judi Knecht
Subject: [EXTERNAL] Re: COPA Form
Date: Monday, June 19, 2023 9:12:11 AM

Any progress on my complaint? Larry Fitzgerald was the "COPA monitor" who decided my restrictive covenant complaint wasn't `worthy of any penalty to Ballad. Apparently, he's a consultant who was tasked to run interference for your office. The emails are available. I have them. Your boss, the COPA director failed to answer my questions re the public forum or to have a chance for me to speak.
William Baker MD

On Jun 14, 2023, at 12:29 PM, Judi Knecht <Judi.Knecht@tn.gov> wrote:

Dear Dr. Baker,

Thank you for your email regarding the Ballad Health COPA and the recent Public Hearing.

We appreciate the information you've provided and the concerns you've raised. Your comments are being reviewed.

Sincerely,

Judi

<image001.png>
Judi Knecht, MPH, PMP | Certificate of Public Advantage, Assistant Director
Division of Health Planning
Andrew Johnson Tower, 5th Floor
710 James Robertson Parkway
Nashville, TN 37243

615-253-9979
judi.knecht@tn.gov
tn.gov/health
Connect with TDH on Facebook and Twitter @TNDeptofHealth!
Our Mission – To protect, promote and improve the health and prosperity of people in Tennessee.

From: noreply@formstack.com <noreply@formstack.com>
Sent: Tuesday, June 13, 2023 6:35 PM

Formstack Submission For: COPA Form
Submitted at 06/13/23 7:34 PM

Name:	William Baker
Email:	
Zip Code:	24211
Comment:	Just read the WJHL story on the recent public hearing. Here's my response on their Facebook page. Let is also serve independently as a COPA complaint: I considered going since I've made 2 complaints in writing to Tenn Dept of Health re specific COPA violations. I wrote and asked if they would guarantee me a voice at the meeting and got no response. Seeing as they had what sounds like enlisted Ballad speakers, I'm glad I didn't waste my time. One complaint was a restrictive covenant in my physician contract that I had a copy of. After complaining they couldn't read the contract, they finally admitted I was correct but because I was the only physician who had complained it wasn't an issue. COPA Chief Compliance Officer works for Ballad and answers to Levine and the Ballad board. Tenn Dept of Health is not looking for examples of Ballad's

COPA noncompliance. They're doing everything they can to ignore them. It's a disservice to the region and one must question why.

Formstack, 11671 Lantern Road, Suite 300, Fishers, IN 46038

<~WRD3612.jpg>

From: Angelia M Reynolds
Sent: Wednesday, June 14, 2023 9:11 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Concerns with Ballad

Hello,

I would like to give my input on the Ballad Healthcare System.

Since Ballad has taken over our healthcare system in Southwest Virginia, I've not heard any of my friends, family, or co-workers have one good thing to say about our existing healthcare system. No one is happy and everyone feels that Ballad is monopolizing our healthcare. They want all control. It's bad enough that the insurance giants controls what care we can have even though we pay for our insurance and now we are being told what Ballad allows or doesn't allow. The decisions they have made on what facilities to close has hurt many citizens over the years. I wonder how many people have died because their hospital was closed in there county or town and they could have lived. It appears to many that they want to make Johnson Center Medical Center the place to go to for specialized care. When that happens, the citizens of Southwest Virginia have to pay an ungodly amount of money for a medflight. Our hospitals in Norton, Va. and Big Stone Gap, Va. seem to be Bandaid Stations now. This is an infringement on our freedoms.

They have now made it more complicated to get serum injections from offices that are not Ballad affiliated. This is causing patients to pay more for each injection. I was told my allergy doctor that one of their patients was paying $9 per injection and now they have to a Ballad facility and is paying $90 per injection. I can't pick up my allergy serums any longer from my non-affiliated allergy doctor. I was told by my allergy nurse that my serums were being made and told me the process they have to go through now to ship them to my Ballad doctor's office. When I checked on them today because I had my last injection from the current serum bottles, the nurse said they have to be shipped only on days when it's not too hot because my injections have to kept cold then there are only certain days that Ballad facilities accept the serums. This is ludicrous!!!! The hoops they are

making other medical offices and their patients go through is just so they can have all control.

The only reason I've not left my Ballad NP is because she and her nurse have taken such good care of my healthcare needs. Now that Ballad is making it more difficult to get my serums, it makes me want to find a doctor in the Holston Medical Group System especially now that we have an HMG office in Norton, VA. I guess though that Ballad is trying to figure out how they can control the care they give to their patients too.

My hope is that my concerns are considered in future decisions regarding the Ballad Healthcare System.

Best Regards,

Angelia Reynolda

Formstack Submission For: COPA Form
Submitted at 06/14/23 12:32 PM

Name:	Lou Ann White
Email:	
Zip Code:	37664
Comment:	Ballad health has been the demise of Healthcare in our entire region. Kingsport has lost so many specialties that Holston Valley has become a bandaid station. The ED has extremely long wait times with people sitting in the waiting room with IVs, leaking body secretions and instances of drugs like morphine being given with no patient monitoring. The COPA was supposed to be able to show a public advantage but there is no public advantage of this Ballad merger. It actually is the worst thing that has happened to our entire region. I spent 41 and. Half years working critical care and I can tell you they have undermined any advancements that ever took place in our hospitals. I have previously spoke at the other COPA meetings, I have previously sent in my comments and it has been a total waste of time. I hope that with the new director he will take the comments seriously. This last COPA meeting was a joke with Ballad filling up the speaking list with those they have given monetary support to. I know that there were people who spoke and came in when I did and moved ahead of others on the list. Just like the other meetings it was a waste of the publics time. I do hope things are looked at differently. This region needs to be treated better than what Ballad is dishing out

Formstack, 11671 Lantern Road, Suite 300, Fishers, IN 46038

From: Brenda Maddux
Sent: Friday, June 16, 2023 1:45 AM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Re: Ballard Health Meeting

I so don't like auto correct . Sorry I hope you can make out what I'm trying to say. The hospital should have my phone number. OK! It is 423-612-3210. Kingsport number.

On Jun 16, 2023, at 2:26 AM, Brenda Maddux < ... > wrote:

Begin forwarded message:

From: Brenda Maddux < ... >
Date: June 16, 2023 at 2:22:39 AM EDT
To: repharshbarger@mail8.housecommunications.gov
Subject: Ballard Health Meeting

I went there with my daughter to get to speak . They had already taken all the people to speak. The meeting started at 5:30. It was suppose to start at 5:30 and stop at 7:30. They tried to stop the meeting 7:00. All the people that signed up didn't get to speak. So people started yelling out what they wanted to say. You cold even hear what the speaker was trying to say. It was filmed . They didn't say when it would be revealed where, or when. People that were complimenting Ballard spoke with no response from the audience. The people that were speaking about what happened with their loved ones or the negligence they were getting got claps in agreement to what they were saying. More negative than positive.
Couldn't believe how much money was being give to Levine for destroying our Health Care. He needs to be fired.
I lost my husband at Holston Valley January 27th at 5:45 in the morning. I was with him at all times. Never saw a Cardiologist after his Catheter of his heart. One Cardiologist came and told me they had put a stint in one artery and were going to treat the others with medicine. I wasn't told anything about a tare in his heart that Monday/Tuesday morning.

I took him to Holston Valley ER because he had had a Kidney Failure about 3years ago. He was treated then nicely. I had to ask for our Urologist's to be a consultant for that issue. That time we were with Ballard Health form July 13-July 31st. He was given great care. I thought this year I'm January he was suffering from another Kidney Failure. Our Primary Care had us go to Holston Valley ER. Said he was probably dehydrated and they would give him a sayline IV and we could go home. That didn't work that way. The ER visit was on a Monday morning at 11:30 am. We got to see an ER doctor after a couple hours. He did some test and came back and told us he didn't find anything wrong with him. We could go home or stay an hour or to more and get a room in the ER. We waited. With my husbands Kidney issue he had to go to the bathroom. I went and ask the receptionist if she would unlock the ER door so he could go to the bathroom. That took to long so he wet himself. My daughter went to ask the receptionist if they had something he could put on. She gave her a hospital gown. She ask where we could go for him to change into it. She told her right there in the ER waiting area. Well that didn't happen. We were told someone was suppose to be checking on him. No one came to check on him. We weren't even ask if we need something to eat. My son lives in Orlando,Fla. he called a restaurant here and they sent food to us. The a patient in the waiting area ask if we had been ask if we need food. My daughter went back and ask. Why we weren't told to ask for food. The receptionist told her she was told not too! We had to wait until 11:30 that evening to get a room in the ER. The waiting area there was full. When we got back to the ER room. They took more blood and X-Rays and decided he had a heart issue. They called went to get the Cardiologist on duty. He had looked at the test and wanted to do the heart Catheter. So my husband said OK. I wish I had ask them to send him to Johnson City Medicial. I of one of the Cardiologist. His wife had helped my husband with his Kidney issue. He knew of us. His wife had talked to him about what nice people we were. He came to talk to me in the procedure waiting room with open arms and told me who he was. Told me what the plans were. I thought since she took good care of my husband before we were in good hands. NOT! After the procedure he came back and told me to go with him to this little conference room. He told me they had done the catheter and he had one artery 99% blocked and two other that the were going to give him medicine for. That is the last we saw of a Cardiologist. Nurses were taking care of him after that. Every day they were telling us he was going home the next day. Then on Friday morning at 5:00 a nurse came with medicine for him. It woke me up. That was OK. It was still dark in the room. He was use to eating earl so he ask her what she had he could eat. She named off something's and he told her to bring him a piece of Turkey between two pieces of bread. She gave him the medicine and went to get the food. While she was gone I heard a noise that sounded kind of like a jackhammer coping concrete. I

thought what are they doing in the hospital at 5:00am. When she came back I ask her what that noise was. With a surprised look on her face. She told me it was him trying to catch his breath? I think why. I didn't get to ask questions . They had a hospital Chaplin come and get me. After we left the room a group of people came to the room. I knew that wasn't good news. After awhile two people came to the waiting area and said they couldn't get him back. I think it took them to long to get to the room. That had happened while she was gone to get the food . It was dark I don't even think he was hooked up to a heart monitor at that time. They were going to let him go home that day. I didn't even know that. When our oldest daughter got there from Johnson City she ask for the Cardiologist. When he came

I heard him tell her that he had had a tear in his heart , he had a large heart and that tear problems busted and all the fluid from there in to the bubble that sounds his heart and smoothed him to death. I wasn't told anything about this part or I would have gotten help for him myself. I'm hearing of two many people dying at Holston Valley . They need more help. That knows what they are doing. The children ask for an autopsy. The hospitalist told the two ladies that he sent to talk to us that they weren't doing that. The children called ETSU. They said the couldn't do it. They were behind then. Our oldest daughter told the two ladies they had to because she knew those laws she is a license Social Worker in Johnson City. So the ladies went back to the Hospitalist and he said they would do it. We waited for weeks and didn't get results back so our youngest daughter called the Pathologist and he said he was finished with it. He would call her back the next week. My son had told them he would pay for it. The next week he didn't call so she called him back. He told her the hospital wasn't going to give it to use? Why we are the ones that ask for it. He said I alone would have to come to the hospital and talk with some people and let them tell me what happened. My Primary Card would let me do that because of a heart issue I have.

I had discovered by a Gastroenterologist that I had AFIB. I had to go to a Cardiology before he would do the colonoscopy that I needed. He said it was urgent that I do that. I couldn't get an urgent appointment with Ballard Health. So I went to Karing Hearts. I saw a Cardiologist at HMG in College Hts. He send me for lots of test in Johnson City. After the test I was put on Medicine. I was OK for awhile. Then I had a AFIB Flutter. They did . That had had helped. We buried my husband Feb 3rd. My son stayed with me for awhile after that. We had been out somewhere. When we came back home he told me to sit in the Livingroom and he was going in the kitchen. I was to let him know if I needed anything. Well I had to go to the bathroom. It was just down the hall so I thought I could stand up and go down the hall and not bother him. Well I stood up and everything started going around and I fell in the floor. He came in the livingroom and I had been able to get up and sit in another chair. I told

him I was fine. He said no Mom. This was on February 10th. He called 911. I don't remember that. I did regain consciousness once when I got in the Ambulance and noticed a man and woman taking care of me. I remember the doors being open and I no longer had shoes on. All my neighbors were standing out there. I don't even remember them closing the doors. My son told me he had told them to take me to Johnson City Medicial. Well the ambulance stopped about 5min. after leaving my house going 85 miles an hour. My son trying to keep up with them. They stopped by the side of the road and had to work with me for about 20 mins. told him they were taking me to Holston Valley ER I wasn't stable enough to get to Johnson City. He followed then there. Then the people weren't going to let him in the ER. To watch out for me. They even called security on him. He talked to them and they escorted him back to where I was. The Cardiologist came out and told him they were going to keep me. He told them no way. His Dad had died there and he wasn't going to let me die there. I don't remember any of this either. I don't remember the ride to Johnson City in the Ambulance either. I was taken to the ICU there. The next thing I remember after being in the Ambulance at my house was being rolled down the hall way and going to where they were going to do the procedure. The Cardiologist that was there. I was contusions r other to talk to Dr. Siv. With Karing Hearts (not the Cardiologist I usually see. He told me he could give me more medicine . I could wait until Monday and Dr. Coly could do the Pacemaker or he could do the Pacemaker. He assured me that they were all taught to do it the same way. So I told him to just do the Pacemaker. I didn't want to pay the hospital for bring there for two days just to wait. So he did it and I went home on February 13th. If it hadn't been for Holston Valley ER being able to get me stable I might not be here today . My husbands death was so sudden. I still go to the cemetery at least once a week.

Brenda Maddux. My husbands name was Preston Eugene Maddux. Thank you for your help. I went to Northeast State last Monday evening and talked with one of the board members. Praying he gets this message. I talk to him leaning against to wall on the steps of the Ballard Health Auditorium. He was a very nice man to stop and listen to me.

From: mary shortt
Sent: Wednesday, June 14, 2023 4:40 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Department of Health COPA

On June 12, 2023, there was a Tennessee Department of Health COPA Public Hearing at Northeast State Community College in Blountville, Tennessee. This meeting was supposed to let people speak about concerns with the Ballad Health Corporation. I certainly didn't get an opportunity to speak. First, I want to say that my husband and I are both college graduates and have lived and payed taxes in this state most of our lives. My husband is a retired engineer, and I'm a retired teacher. We are not illiterate, and I am speaking from experiences we've had there. I was born in Holston Valley Hospital; I was a candy striper there; and I have always been proud of the quality of care that this hospital and Indian Path hospitals provided us in this area. However, since the Ballad Health merger in this area, the quality of health care is not only dangerous, but also a complete disaster and failure. There are some local politicians who get large donations from the Ballad Corporation who have said that it is a great corporation. I'm sorry, but I feel these are only lies and rhetoric, because of the donations that Ballad makes to them. My families' experiences with Ballad have been disasterous, and my husband almost died from lack of care.

My first bad experience was when I had colon cancer. I had a Ballad Surgeon who did the surgery and told the board at Ballad that no further treatment was needed. The new CEO, Alan Lavine, was encourging more testing, etc. The board was going to give me radiation, and later one of the doctors decided to give me chemo. Upon the advice of my surgeon,I went out of state, and the doctors couldn't believe it. I didn't receive the treatment, because this new panel said it wasn't necessary. They said that it was "wreckless" to do this.

My husband got very sick and was passing blood. I took him to the Urgent Care, because of all the horror stories that came from the Ballad ERs. Urgent Care said he had to go to the ER. We went to Indian Path in Kingsport, because Holston Valley was too busy. They gave him an IV, did blood work, and said he needed hospitalization. He was going to Ballad in Bristol. There wasn't a chair in the room, and it was hours before he saw anyone. They kept saying he was on a waiting list for a bed. He kept asking for a pillow and blanket. They said they would have to go

upstairs when they could. I couldn't stay all night, because I didn't even have a chair to rest in with my bad back. I left him, and I came back the next morning. He had an IV and his street shoes still on. They were too busy to take them off. I took them off, and went and got another blanket, begging, to keep him warm. When they doctor came, I asked about a pillow for him. It was 2 days in ER, and there wasn't a pillow. He brought him a pillow without a case. Finally, that afternoon, I pitched a fit because I thought he was getting worse and dying, and he was transported almost immediately to Bristol, Tennessee, Ballad,where he was treated for 2 days and sent home. He got worse, and I had him transported back, and he finally got better. Just this last week he fell and had vomiting and diarrhea. I called EMS, and they came and said that they'd transport him to the ER, but he was scared to death to go. He said he'd go to the State of Franklin Urgent Care at 8:00 AM where he could get scans and X-Rays. We did this and got great care. This is not fair for Ballad Health to treat our community this way. People should not be scared of going into the dirty, understaffed hospitals that the Ballad Corporation has merged together. It is a lie to say that the services are better and not duplicated. They are nonexistent. The nurses all told us the same story. Since the merger with Ballad Health, they are understaffed and underpaid while Alan Lavine got a 1.7 Billion Dollar Bonus from the corporation. Their morale was very low, and they said they are afraid to say anything. They encouraged and implored us to tell our story to the COPA group. Ballad may make many charitable donations, but they are a disgrace to the healthcare system. Alan Lavine and his cronies do not care about the citizens of this town. The healthcare of this area should be about quality care and not about how great they are to make donations to certain organizations. Many people are suffering and dying. Moreover, I do not blame the staff of physicians and nurses in these Ballad facilities, I blame this Ballad monopoly that is ignoring the dirty facilities and the lack of staff to maintain quality care.

Please, please consider not allowing this monopoly to continue. It is said that people who have worked are their lives are subjected to mistreatment and lack of proper care in the Ballad facilities.

Most respectfully, Mary Shortt Phone [redacted]

Formstack Submission For: COPA Form
Submitted at 06/17/23 12:21 PM

Name:	Vickie Beam
Email:	
Zip Code:	37620

I am writing to express my concerns about the COPA in the tricities area. In my view it is NOT an Advantage. to the patients outside the Johnson City area, but it is finiancal advantage to Ballad. I have observed a decrease in services for all areas except for Johnson City. Doctors are retiring early or moving away from the area. The following areas are some that have been affected cardiology, gastrology, Neuro, urolgy, familypactrice.internal medicine. Ballad recently moved all urology to Johnson City and are planning to move Cardio to Johnson City. They may say the aren't but employees working in cardiology know that is the plan and the doctors are trying to fight it. There are many patients that don't have transportation except for the city bus which doesn't go to Johnson City so they are out of luck seeing the droctors they need. I have a friend that had surgery they could not get the catherter in and called urology to come 1 1/2 hours later they arrived. They had to start the surgery without the cath in place due to the schedule.That is NOT am advantage in my view is it your view? I have another friend who went to the cardiologist with heart attack symptoms in April. First available appt for a stress test middle of June. Hope you live to do the test. Now ortho is in Johnson City and Ballad is planning to let only one ortho group come to the hospital in an emergency (can we say monoply). Johnson City ER can

Comment:	not handle the current emergencies 1 lack of staff 2 lack of space. Patients are being treated in the waiting rooms to say they are meeting the wait time. I also know that patients are being held in ambulances for hours until they can find room for the patient this should be unacceptable I would think this is a violation of may laws including HIPPA guidelines ie patient name and symptoms told publicly. I have a family member who had surgery @JCMC and after surgery they couldn't find a room available for about 24 hours except in ICU. Don't know if it was lack of rooms or if it was lack of nurses. I know in Bristol it is lack of staff when they can't find a room. I live 3.2 miles 7 min. drive to BRMC, 25.2 miles 39 min (in good weather light traffic) to JCMC How is it to my advantage to go to JCMC for a cardio event, broken bone, urolgy problem or a nuero (stroke, brain bleed) problem when time to treatment is important. I have talked to Ballad employees and they are scared of being fired if they tell the truth about the services and lack thereof, so don't ask them to give their opinons and facts they know. I know Ballad will say thats not true but..... Ballad talks about duplication of servicesbut how is it duplication of services when there are different cities/towns. In closing, I want to say that The Certificate Of Patient Advantage is not an Advantage to the Citizens of the tricities area and the surronding area. The advantage appears to be in the pockets of the CEO,CFO and other high ranking administrators. I attended the COPA meeting and of the 17 speakers for Ballad all 17 had monetary gain from Ballad, which should be taken into consideration. Would they be pro Ballad if they had not received money from Ballad??? If their family member died going to JCMC because they could not receive services at their local hospital. HVMC was ranked a top hospital in this area as was BRMC higher ranking than JCMC. Now we have poor emergency care in all areas. I hope you look carefully at the HARM this COPA has done to patients.Patients have died will continue to die, be permantenly harmed ie lack of treatment in a timely manner for strokes, brain bleeds, heart attacks, etc. Thank you for your consideration and inclusion of this letter.

Formstack Submission For: COPA Form
Submitted at 06/17/23 2:10 PM

Name:	Kathy Christian
Email:	
Zip Code:	37642
Comment:	The Ballad Health Monopoly is killing people. Ballad Health has taken away this areas Trama centers leaving only Johnson City medical Center. Before the merger I could get to the best Trama center in the area (Holston Valley Medical Center) in 10 to 12 minutes from my home. Now a trip to the only top level center is 45 minutes away. I live in Church Hill. I have friends who live in Rogersville, Sneedville and back in the valleys. They can't get to ER outside of the golden hour. Please, Please DO SOMETHING!! Johnson City Medical Center got as a one-star rating from the Center of Medicaid and Medicare. A ONE STAR FROM AN OFFICIAL GOVERNMANT ORGANIZATION!! Please help us. When my daughter was diagnosed with a 4.5cc brain tumor (this was after a hospital stay 2 months earlier in which they missed it) I refused to be transported to JCMC and insisted on going to UT medical center 1 hour and 35 minutes from home to get away from ballad. I am blessed that I could take off work and stay with her but what about those who can't? I say again PLEASE HELP US!! Get the politics and the good ole boys out of the way and for all that is Holy help my community, my family and myself!! I have so much more but I know you don't have time to read it. My phone number is 423-612-2592 Please feel free to call.

Formstack, 11671 Lantern Road, Suite 300, Fishers, IN 46038

Formstack Submission For: COPA Form
Submitted at 06/19/23 1:09 PM

Name:	Arthur Boyd
Email:	
Zip Code:	37660

I attended the certificate of public Advantage Public meeting on June 12, 2023 at Northeast State community College. I left totally disgusted as did most of the public attendees. This meeting was totally staged by Ballad Health. We were told to be there at 5:00 to sign in if we wished to speak. The list was full by the time they opened the door. As we listened to the presenters it was obvious that they were hand picked by Ballad and their comments were directed at the benevolent contributions Ballad had made to various community organizations. Only one or two attendees were presenting complaints about healthcare.

I was born in Holston Valley Hospital in 1947 and I and my family have received health care there as long as I can remember. In 1968 I left to attend medical school and received my medical degree and residency training from The University of Tennessee and affiliated hospitals in Memphis. There I was exposed to the finest up to date cutting edge physicians and hospital care anywhere.

In 1977 I chose to return to my home town of Kingsport to practice and practiced with two outstanding medical groups the last of which I myself started in 1985. I practiced for a little over 40 years. Although I was apprehensive of moving to a smaller community, I was in total awe of the expertise of Holston Valley Hospital and it's physician staff. This was the primary referral hospital

Comment:

for upper east Tennessee and southwest Virginia. We had one of five Level 1 trauma centers in Tennessee and considered by most in the top two.
As time passed Holston Valley Hospital an Medical Center merged with struggling Bristol Memorial Hospital to form Wellmont. We continued to be strong with excellent health care. Then in 2018 a political take over occurred with the formation of Ballad Health System made possible by the approval of the COPA. We here that glowing reports are presented to the Department of Health about all the great accomplishments of Ballad many by politicians on the payroll of Ballad.
Left me tell
You some real truths about health care in my hometown. They began by stripping our NICU taking it to Johnson City Medical Center. Then they moved our world class trauma Center to the Ill equipped JCMC. They took our only Neurosurgeons to JCMC. They forced our only gastroenterologist group out of our hospital with none of their "owned" group to replace them. Then when a GI emergency presents or stroke patient shows up at Holston Valley ER JCMC says their beds are full and they can't take them.
Many are referred to Knoxville or Asheville, NC.
I am now almost 6 years retired and I and many others fear what would happen if we had an emergency. Where could we get care??
All this was allowed by the approval of the COPA and the false reporting that gets to Nashville. Yet their CEO has a base salary of 2.3 million dollars plus bonuses and multimillion dollar salaries of board members. And we heard at the COPA meeting from community organization that receive large checks of support. Then spread sheets that show that Ballad is going further in the red by billions are available.
I and many other citizens feel this organization is not only criminal but a sin against God. Our prayers are going up that the Tennessee Department of Health will open their eyes and see what is going on. I would love to have an opportunity to sit down and discuss this with you anytime outside a fixed meeting as we attended last Monday.
Thank you for taking time to read this and for your efforts to provide excellent health care for the people of Tennessee.
Sincerely,
Arthur M. Boyd, MD, FAAFP
[redacted]

Formstack, 11671 Lantern Road, Suite 300, Fishers, IN 46038

Formstack Submission For: COPA Form
Submitted at 06/19/23 10:31 PM

Name:	Ethan Cruze
Email:	
Zip Code:	37708
Comment:	Yes, I was in a car accident in Johnson City,TN in July 2022. I was taken to Ballad's flagship hospital. Evidently at 64, I still qualified, along with about 50 more people, to be routed and treated through the Pediatric ER. I came in on a stretcher with a neck brace and my shirt half cut off because of a side impact from an airbag and another vehicle. I could not hear much over the very loud ringing in my ears and the extreme pain in my left side. Some X-rays were taken and I was walked to a wheelchair in the very crowded ER. I waited on some more imaging tests and was eventually told by someone-MD, Nurse- no name tags that they did not see anything broken. After about 6 hours I was told I could go home. I was able to have a local friend take me to the VA from JCMC pediatric ER. My neck still hurts and the constant tinnitus is still with me along with some brain fog. I was referred to a neurosurgeon who said surgery was needed due to spinal cord impingement. I guess the ER folks missed that. I can only imagine how much the guy who hit me's insurance company is going to feel the pain of Ballad's billing because at another Ballad facility I received notice that they had billed both the VA AND Medicare for the same service and it was not cheap. The supposed public benefit of the COPA has FAILED to materialize. As one Level I Trauma center with an

inadequate ED is not enough to handle the number of patients who even manage to make it to their ONLY Trauma center. Anyone outside of the Johnson City city limits is pretty much SOL.

Formstack Submission For: COPA Form
Submitted at 06/19/23 12:17 PM

Name:	Mary Kathi Boyd
Email:	
Zip Code:	37660
Comment:	I attended the COPA hearing on June 12. I was absolutely enraged when I left. The people who were allowed to speak were organizations that have been given money by Ballad. This has nothing to do with the care you receive from our health care providers. Our health care has been decimated. I was a charge Nurse in the ER for many years, I have never seen such a decline in health care. Ballad wants to own all health care and physicians private groups. They have succeeded to a horrific result. I know you have prob received many horror stories about experiences pts have had. My friend and former supervisor was hospitalized last year. She came very close to dying. I sat with her every night and her husband during the day. She is someone very important to Holston Valley hospital and the entire city, she and her husband. Google their names and you will see. Rosalee and Bruce Sites. She was instrumental in getting Holston valley a level one trauma center and started the parish nurse program. To say her care was subpar is a gross understatement. I was there every night for a month sitting with her. You better have someone with you or you are in trouble. The lobby of the ER looked like we were in a third world country. People bleeding from injuries, vomiting blood, extremely short of breath and diaphoretic just to name a few. My daughter was in a head on collision, was hit so

hard, all airbags deployed and her shoes were knocked off her feet and were in the backseat. EMS told her the ER was full she just needed to go to a walk in orthopedic clinic. Her husband had to come pick her up from the accident and bring her to the hospital where she sat in the lobby for hours. We have no health care.
Kingsport has the potential for disasters at anytime with Eastman, BAE,etc.
As a former ER nurse I have taken care of a lot of severe injuries and deaths from different work related accidents. We have the potential for a massive critical incident and in no way are we prepared for that! The general consensus now is you have to go to Knoxville or Nashville for treatment. That's not an option for most people. We BEG of you to please take a long hard look at the care in our area. Holston Valley had been the HUB for transfers from Va, Ky and surrounding areas. Johnson City cannot handle the load. Treatment is being delayed or non existent! PLEASE HELP OUR COMMUNITY.
Thank you for your time.
Kathi Boyd RN

Formstack Submission For: COPA Form
Submitted at 06/19/23 8:23 AM

Name:	Tammy Fillers
Email:	
Zip Code:	37663
Comment:	I was in the hospital in Dec. of 2022 overnight because of having a heart ablation. It was an overnight stay I sent my husband and son home because I thought I would be fine because I could go to the restroom by myself. I ask for ice water 2 different times during the night and never got it. I will NEVER go back alone. My insurance paid around 136,000 if I read it correct and could not even get a glass of water. Their billing is terrible you can never figure out a final cost you have to keep paying the bills and hope you don't get overcharged but no way to know. I did end up according to their records 25.00 to much and got a refund. Before the week was up I ended up going to the ER because I thought I had a blood clot in my growin I signed in people everywhere sitting in cars in the parking lot , I was told it was a 6hr wait. I went home and waited to go see my Dr on Monday, Which it was a blood clot. This was at Holston Valley. My husband had about the same treatment this year at Indian Path, he was treated in the hallway at Indian Path medicine given in the hallway. My husband never made it to a room. These hospitals are like in a third world country. The amount they are charging is not reflecting the treatment given. I do not blame the nurses or the drs this is poor management drs and nurses are doing the best they can, even seen drs changing bedding. So please tell me something is going to be done! We pay their outrageous charges I deserve

better.

Formstack, 11671 Lantern Road, Suite 300, Fishers, IN 46038

From: Bill Spooner
Sent: Tuesday, June 20, 2023 7:07 PM
To: TN Health <TN.Health@tn.gov>
Subject: [EXTERNAL] Ballad Health COPA Comments

June 21, 2023
Tennessee Dept of Health – COPA

Dear sirs:
While I was unable to attend the June 12 hearing on Ballad Health performance in respect to the COPA, I would like to offer some input. Most of my observations are positive, yet I do have some suggestions.

In the interest of transparency, I served on Ballad's I.T. Strategy Committee during the early years following the merger, and I served on its Epic Steering Committee through 2022. I have worked in healthcare finance, information technology and administration for over 45 years. I retired in 2014 from a west coast delivery system and have done various advisory services in the I.T. area since then. The west coast system was a pioneer in value-based purchasing in various forms, typically rated well in both quality and patient experience metrics and, notably, earned the Malcolm Baldrige quality award in 2007. With that background, I can comment constructively on Ballad.

One can argue whether the merger forming Ballad should have been approved, but the worthwhile discussion should center on how well Ballad is serving its community in this special monopoly arrangement. I will cite a few examples to provide a view into its conduct in this trusted position.

Beginning on a high note, Ballad could not have done better in serving the community through the COVID pandemic. The single voice from the dominant health system was exemplary throughout, especially in the face of strongly different community opinion of isolation, masking and vaccination. Three executives, Eric Deaton, Lisa Smithgall and Jamie Swift provided compassion, thoughtful guidance and reassurance in their regular updates to the community. All are as good as you'll find anywhere.

With a number of hospital visits myself and with family members throughout the pandemic, I was able to learn from several members of the nursing team. Not a single nurse conveyed any dissatisfaction with the difficult work they were doing, despite tight staffing, risks of exposure, stressed-out family members, and the like. Lisa deserves huge credit and recognition for her leadership throughout this difficult time. As a matter of constructive commentary, it is disappointing to see that Ballad's executive leadership, as shown on its web site, does not include the Chief Nurse Executive but does include two lawyers. Interesting perspective!

Ballad encountered strong community resistance soon after the merger when it moved to consolidate trauma services. This consolidation, in my view, was executed well and was the right move. The more recent controversy in Elizabethton regarding ICU closure at Sycamore Shoals appears justified, although a tightly-knit community has been offended. Ballad could learn some valuable lessons:

- Greater public input should sought before the decision, even when Ballad has concluded that the change is necessary.

- It is positive to learn of recent conversations with local Chambers of Commerce. Chambers of Commerce, however, represent the business community, not the patient community. I am aware that some administrators are getting out to other community organizations. (Kenny Shafer recently spoke to my Kiwanis club – he's another star!) This activity will be helpful as it is done more widely.

- Ballad could consider its response to various items of criticism more carefully and compassionately. The conversation in Elizabethton is an example. Sometimes it plays better not to be the smartest one in the room.

As a senior citizen, I meet with more specialists than I would have imagined at a younger age. Almost to a person, these independent docs see Ballad as competing with their private practices. Some are unhappy with the State modifying the COPA terms to allow Ballad to contest CON applications, without public hearing. One wonders whether the Dept of Health is inappropriately looking out for special interests, as the affected physicians would attest. Other physicians see aging hospital equipment and wonder when and how it will be upgraded or replaced. Others express concern on the availability of surgery spots and available beds. Financial performance was stressed across the industry during the pandemic; independent physicians should not suffer disproportionately.

Ballad is to be commended for its commitment to extend the Epic computer applications throughout the system, at no small investment. They did a fine job with the implementation, and patient care has to benefit from this advanced system. Even greater opportunities await as Ballad optimizes Epic to more closely meet its clinical practice.

Ballad is to be complimented for the numerous quality awards they have earned. As it progresses, there are opportunities for even greater recognition – Medicare Stars, Leapfrog, Magnet, etc..

Thanks for the opportunity for this input.

Bill Spooner
[redacted]

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Bill Spooner

Retired CIO & Industry HIT Advisor
[redacted]
[redacted]

Formstack Submission For: COPA Form
Submitted at 06/21/23 2:37 PM

Name:	Makenna Anderson
Email:	
Zip Code:	37600
Comment:	My grandmother is currently at Indian Path Medical Center. She is being made to Zoom in with a doctor instead of receiving in person care. This is during regular business hours and is ridiculous. She should be seen in person.

Alan J. Aiken, D.O.
Marc A. Aiken, M.D.
Jonathan D. Bryant, D.O.
D. Christopher Carver, M.D.
Robert J. DeTroye, M.D.
Parker P. Duncan, M.D.
Richard W. Duncan, M.D.
Tyler M. Duncan, D.O.
Jason A. Fogleman, M.D.
Jeffery J. France, M.D.

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Thomas W. Gill, M.D.
Joseph R. Hurst, D.O.
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Scott R. MacDonald, D.O.
Mark T. McQuain, M.D.
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Bristol, TN 37620
Telephone (423) 282-9011
Fax (423) 573-3111

June 22, 2023

TN Department of Health – COPA
710 James Robertson Parkway
Nashville, TN 37243

Dear Commissioner:

My name is Greg Stewart, and I am the physician president of Watauga Orthopaedics, a twenty-partner private orthopedic practice with locations in each of the Tri-Cities. I attended the public forum to address issues with the COPA that helps oversee the merged Ballad healthcare. I appreciate the open public forum but was disheartened at how much time was spent discussing Ballad's philanthropy at the expense of discussing its healthcare delivery—its highest priority. Thank you for allowing us to share our written comments.

You heard a few anecdotes of less-than-optimal healthcare delivery that night. I believe these are downstream problems of a more worrisome trend. By consolidating healthcare delivery into a single entity, the labor market in our area has been profoundly affected, especially those frontline workers—nurses in the EDs and ORs, scrub techs, rad techs. The recent pandemic highlighted an already present problem.

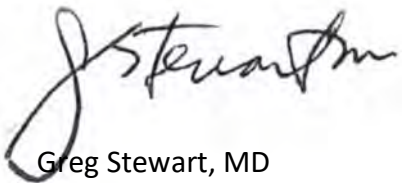
With the constraint of services into one entity in the merger, the labor market became less competitive, and Ballad was able to wield some control over wage and hiring; however, in that setting, they remained a good community partner and our workforce remained strong. With the pandemic, the frictions that normally keep workers in place, such as the lack of desire to move to start a new job, were diminished, and we witnessed the rise of 'traveling' nurses and other workers. This phenomenon has led to a much more competitive labor market.

During this period of a more competitive labor market, Ballad appears to be actively recruiting, but like all healthcare systems, they have struggled to maintain pace. More worrisome is the reduction of services both at Johnson City Medical Center as well as many hospitals within the system. The closure of ICUs, the vacant ORs not being utilized at Holston Valley Hospital, the clogged Emergency Departments with patients waiting to be moved upstairs into hospital wings that remain understaffed are signs of a reduction of the workforce in our area.

“Economic theory shows that firms with monopsony power have an incentive to employ fewer workers at a lower wage than they would in a competitive labor market. What the monopsonistic firm loses in reduced output and revenue, it more than makes up in reduced costs by paying lower wages. In other words, by recruiting less aggressively, paying less, and sacrificing some employment, employers with monopsony power can shift some of the benefits of production from wages to profits.” (1)

These effects to our labor market may not be intentional actions from Ballad but stem from the economic forces that occur from constraining services into a single entity. I would ask that this committee evaluate the labor market within our region in order to maintain healthcare delivery to our community.

Respectfully,



Greg Stewart, MD
Watauga Orthopaedics

(1) “Labor Market Monopsony: Trends, Consequences, and Policy Responses” Council of Economic Advisors Issue Brief October 2016, Obama Administration Whitehouse Archives

LABOR MARKET MONOPSONY: TRENDS, CONSEQUENCES, AND POLICY RESPONSES

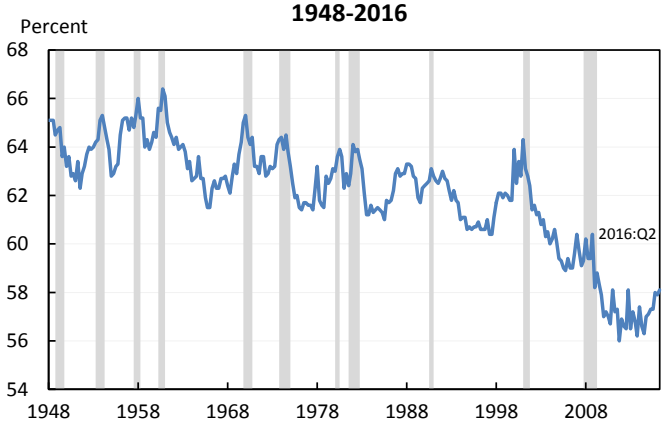
Introduction

In September, the U.S. Census Bureau reported that in 2015, the typical household saw its income grow by $2,800, or 5.2 percent, the fastest rate on record. Over the course of this business cycle, average annual wage growth has been higher than any business cycle since the early 1970s. This is real progress toward higher incomes for working Americans—a central goal of many of the policy initiatives the Obama Administration has undertaken since 2009.

But while these gains are a step in the right direction, more work remains to fully address long-term challenges of slow wage growth and rising inequality. Over the past several decades, only the highest earners have seen steady wage gains; for most workers, wage growth has been sluggish and has failed to keep pace with gains in productivity (CEA 2015, Ch. 3). Though the slowdown in wage growth is partly due to a slowdown in productivity growth since the 1970s, the share of income accruing to labor has also been falling.

Over the past 15 years, while profits rose, the decline in labor's share of national income accelerated, reaching its lowest level ever since World War II. And though this trend has begun to show signs of reversal since mid-2014, labor's share of income is well below the 2000 year level (Figure 1).

Figure 1: Labor Share of Income, Nonfarm Business Sector, 1948-2016



Note: Shading denotes recession.
Source: Bureau of Labor Statistics, Productivity and Costs

At the same time, labor income itself has become increasingly unequally divided. Researchers have focused on the divergence between worker skills and employer needs—a challenge brought about by technological change and a trend in educational investments that, while rising, has not kept pace with demand, which has risen even faster (Autor 2014; Katz and Murphy 1992; Goldin and Katz 2007). Others have examined more institutional hypotheses, including the erosion of the minimum wage (Autor, Manning, and Smith 2015), the decline of unionization (Card 2001), and changes in the structure of employment (Weil 2014).

There is also growing concern about an additional cause of inequity—a general reduction in competition among firms, shifting the balance of bargaining power towards employers (Furman and Orszag 2015). Such a shift could explain not only the redistribution of revenues from worker wages to managerial earnings and profits, but also the rising disparity in pay among workers with similar skills. These trends also have broader implications for the economy as a whole: instead of promoting growth, forces that undermine competition tend to reduce efficiency, and can lead to lower output, employment, and social welfare.

A growing literature has documented several indicators of declining competition in the United States, and economists have begun to explore the links between these trends and rising income inequality (Furman and Orzag 2015). While recent discussions have highlighted rising concentration among producers and monopoly pricing in sellers markets (*The Economist* 2016), reduced competition can also give employers power to dictate wages—so-called "monopsony" power in the labor market. While monopoly in product markets and monopsony in labor markets can be related and share some common causes, the latter has some distinct causes and policy implications.

This issue brief explains how monopsony, or wage-setting power, in the labor market can reduce wages, employment, and overall welfare, and describes various sources of monopsony power.[1] It then reviews evidence suggesting that firms may have wage-setting power in a broad range of settings and describes several trends in recent decades consistent with a growing role for monopsony power in wage determination. It concludes with a discussion of several policy actions taken by the Obama Administration to help promote labor-market competition and ensure a level playing field for all workers.

Implications of Monopsony Power for Wages, Employment, and Inequality

The concept of monopoly power is familiar to many: a firm with monopoly power has the ability to charge higher prices for a product it sells without losing all of its customers, due to a lack of competition from other firms selling the same or a similar product. The term "monopsony" is much less familiar, but the concept is similar: a firm with monopsony power has the ability to pay lower prices for its inputs (i.e. what it buys). In the important case of labor markets, a monopsonistic employer can pay a lower wage than would prevail in a competitive market without losing all its workers to competing employers. Like monopoly power, monopsony generally leads to economic inefficiency. And in the labor market, it also leads to redistribution from workers to employers.

The harms of limited labor market competition can be understood by first considering how wages (and any non-wage compensation) are determined when firms must compete with each other for workers. In a competitive labor market, each firm will bid up the wage to recruit workers from other firms as long as the revenue it can earn by hiring another worker exceeds the wage it must pay—establishing a close link between wages and worker productivity. Because firms in a perfectly competitive market all bid for the same workers, no firm can pay less than what others are willing to pay. If a firm did attempt to set wages below the market rate, its workforce would be quick to find alternative employment. As a result, competitive firms must all pay wages that are determined by the market, and compensation is equalized across similarly productive workers for similar types of jobs.

In contrast, when there are barriers that limit wage competition between firms, market discipline that compels employers to pay the going wage is weakened. In this case, assuming that similarly productive individuals vary in their "reservation wages" (the lowest wage they are willing to accept)—for example, because some must commute from longer distances—a monopsonistic firm faces a choice: it can set the wage high enough to recruit even those with high reservation wages, or it can limit employment to those who are willing to work for less and thereby keep wages low. Economic theory shows that firms with monopsony power have an incentive to employ fewer workers at a lower wage than they would in a competitive labor market. What the monopsonistic firm loses in reduced output and revenue, it more than makes up in reduced costs by paying lower wages. In other words, by recruiting less aggressively, paying less, and sacrificing some employment, employers with monopsony power can shift some of the benefits of production from wages to profits.

[1] While "pure" monopsony refers to the case of a single buyer in a market, in this brief, we follow the literature in labor economics and use the term "monopsony" more broadly to refer to any case where firms have some labor market power that allows them to determine wages.

As suggested above, the implications of monopsonistic wage-setting extend beyond the redistribution of wages to profits. First, it can lead to inefficient reductions in employment and output, where some workers who would have been willing to work at the competitive market wage are never hired, and the output they would have produced is produced less efficiently by other firms if at all. Notably, firms are willing to incur this reduction in employment only if it allows them to pay lower wages or to reduce costs through inferior benefits or work conditions. An important implication is that monopsonistic employers can be induced to hire more labor if their ability to set wages below the level in a competitive market is constrained—for example, by a collective bargaining agreement or a minimum wage.

A second implication of monopsony is a weakened link between labor productivity and wages. Because firms no longer compete aggressively for workers, monopsony power opens up the possibility that wages can differ—both between and within firms—even among workers with similar skills. Recent evidence suggests that much of the rise in earnings inequality represents an increase in the divergence of earnings between workers in different firms (Barth et al. 2016; Song et al. 2015). As Furman and Orszag (2015) have argued, this trend, and the concurrent rising dispersion of firm-level returns, are consistent with the notion that firms have wage-setting power. A similar conclusion is reached by Card et al. (2016) who also show that when competition between firms for labor is limited, then the wages of similarly-skilled workers may become tied to the productivity of their employers: while all firms have an incentive to restrict employment and depress wages below their competitive levels, more productive firms (with better technology, for example) will choose to hire more labor—and will pay higher wages to do so.

Further, if employers with monopsony power are able to differentiate among workers' reservation wages, then they can also set wages that discriminate among their own employees. In the extreme case of "perfect" wage discrimination, firms can pay each worker the minimum he or she is willing to accept, regardless of the worker's skills or productivity. More generally, differing degrees of worker bargaining power across different groups of workers—for example by age, race or gender—may lead to varying degrees of wage depression, promoting within-firm wage inequality. For example, if women's job mobility is more constrained than men's by family responsibilities, then women will be more limited in their choice of employers and be more vulnerable to wage discrimination (Manning 2003, Ch. 7).

To be sure, firms face a number of constraints in their ability to pay different wages to similarly qualified workers (or even to workers who perform different tasks), including legal constraints and concerns over internal equity or fairness.[2] However, employers may be less constrained by equity concerns when workers lack good information about the wages of their coworkers (Card et al. 2012). Firms can also circumvent internal equity constraints or fairness norms by shedding activities to subordinate companies through subcontracting, third party management, and other organizational forms. Such "fissuring" of employment makes wage discrimination feasible by transforming wage setting within the walls of a business to a pricing problem among subordinate firms (Weil 2014).

Sources of Monopsony Power in the Labor Market

In the strictest sense, monopsony arises when there is a single employer in a market; textbooks often cite isolated "company towns" in the late 19th and early 20th centuries as classic examples. Because such company towns are rare today, the concept of monopsony might appear to have few applications. On the other hand, however, the conditions of "perfect competition" that require firms to take the wage as given are also, arguably, quite rare. A perfectly competitive labor market requires that workers stand ready and able to change employers in response to even slight differences in wages or working conditions.

[2] For evidence that employee preferences for internal equity can constrain firms' wage-setting power, see Breza, Kaur, and Shamdasani (2016); Dube, Giuliano and Leonard (2015); Card et al. (2012).

In today's economy, product market concentration may play a role in limiting labor market competition. But several additional forces appear to limit workers' employment options and, in turn, to give employers some power to set wages rather than paying the going market wage. In some cases, such monopsony power is derived from deliberate actions by employers that artificially restrict competition. But importantly, wage-setting power can also occur naturally—even in markets with many employers—due to frictions that limit workers choices or mobility.

Market Concentration

The presence of a limited number of firms in the market for a particular type of labor may give each of these firms some power in setting wages. For example, factory line workers have fewer opportunities to "vote with their feet" in a town with one manufacturing plant relative to one with many. Holding other factors equal, higher concentration in a labor market may lead to lower wages just as higher concentration in a product market often leads to higher prices.

It is worth noting that this concentration in the labor market may be distinct from concentration in the product market. In some cases, a manufacturer could be competing internationally to sell its products, but could dominate a local market for a particular type of labor. Conversely, the market for surgeons may be national even though many metropolitan areas have only a limited number of hospitals.

Where labor markets align with product markets, firms can have both monopoly and monopsony power. Indeed, when promoting the Sherman Antitrust Act of 1890, Sen. John Sherman argued that a trust not only has the power to raise prices; it also "commands the price of labor….for in its field it allows no competitors" (Congressional Record 2457, 1890).

The antitrust laws apply to reductions in competition for employees as a result of mergers as readily as they do to reductions in product market competition. Yet few merger complaints have cited employment monopsony concerns as a reason to challenge a transaction. This may reflect the fact that mergers most likely to raise these labor market monopsony concerns would also likely raise concerns about product market competition, and courts are more accustomed to adjudicating product market claims. Even when product market and labor market harms do not coincide, the law compels antitrust authorities to protect competition in *both* employment and product markets (Hesse 2016).

The larger size of employers relative to individual workers tends to give employers a natural advantage in bargaining leverage over workers in the labor market. This uneven balance of power is one rationale underlying the collective bargaining exemption for labor unions from U.S. antitrust law.[3] By providing an important counterweight to bargaining leverage and the unilateral exercise of monopsony power, unions may promote higher wages, better working conditions, and even more efficient levels of employment (Boeri and van Ours 2008, Ch. 3).

Employer Collusion

Limited competition in a labor market also may facilitate implicit or explicit collusion among employers that allows a small number of them to act as one. Collusion can take the form of agreements not to hire each other's workers or the coordination of wage offers and raises in order to avoid competitive bidding. Like price fixing in product markets, such agreements among employers are illegal in the United States and subject to antitrust laws (Hesse 2016).

Collusion is more likely to occur when a small number of employers recognize their mutual effects on wages and working conditions, and when workers cannot easily find employment outside the colluding

[3] Section 1 of the U.S. National Labor Relations Act of 1935 states "the inequality of bargaining power between employees who do not possess full freedom of association or actual liberty of contract and employers who are organized in the corporate and other forms of ownership association substantially burdens and affects the flow of commerce."

firms: for example, a geographic area is dominated by a single industry with a few firms and the workforce has specialized skills that cannot easily be applied in other industries. Recent Department of Justice cases provide examples of collusion that restricted competition in hiring software engineers among technology firms in Silicon Valley and the pay of certain hospital nurses in Arizona. Private litigation has also alleged agreements to restrict the pay of hospital nurses in several cities with a small number of large hospitals (see below for further discussion).

Legal actions in cases of wage collusion have historically been less common than their product market counterparts (OECD 2008). But there is no reason to think the incentive to exercise market power is any less powerful in the labor market; indeed economists have long understood that employers have an incentive to collude to keep wages low. And when numbers of competing employers are small, this incentive may be matched by an increased ability to act. As Adam Smith wrote in *The Wealth of Nations* (1776):

> *What are the common wages of labor, depends everywhere upon the contract usually made between [employers and employees], whose interests are by no means the same. The workmen desire to get as much, the masters to give as little as possible. The former are disposed to combine in order to raise, the latter in order to lower the wages of labor. It is not, however, difficult to foresee which of the two parties must, upon all ordinary occasions, have the advantage in the dispute, and force the other into a compliance with their terms. The masters, being fewer in number, can combine much more easily … Masters are always and everywhere in a sort of tacit, but constant and uniform, combination, not to raise the wages of labor above their actual rate.*

Employer Use of Non-Compete Agreements

Employers can also shift the balance of power in their favor through legal, unilateral actions that do not rely on market concentration. The practice of including "non-compete" clauses in employment contracts—which restrict workers' employment options when they leave their current firm—is one such means.

Non-compete agreements are not always harmful to workers or to growth; by preventing workers with "trade secrets" from transferring technical and intellectual property of companies to rival firms, these agreements can be one means of facilitating innovation. However, employers also have other methods to protect their interests. And new evidence (discussed further below) suggests that the use of non-competes in the United States today extends well beyond cases where they are plausibly justified. In particular, the evidence shows that 30 million American workers are currently covered by non-compete agreements, and that these agreements are often imposed broadly on low-income workers or others with no access to trade secrets (U.S. Treasury 2015). In these cases, it is likely that the primary effect of these agreements is to impede worker mobility and limit wage competition.

Search Costs and Labor Market Frictions

As illustrated by the prevalence of non-compete clauses, labor market competition may be restricted even when the number of employers is large. Competition in the labor market requires that workers be able to switch employers easily in response to changes in wages or working conditions—and non-compete agreements explicitly restrict workers' ability to do so. More broadly, any factor that limits worker mobility or makes workers reluctant to change employers—even if not the result of any intentional action on the part of the firm—can give firms some wage-setting power.[4]

[4] Monopsony power in a market with many employers is often referred to as "dynamic oligopsony" or "monopsonistic competition" and has been described formally by Burdett and Mortensen (1998), Bhaskar and To (1999), and Manning (2003). But the importance of worker mobility constraints as a source of monopsony has long been understood, and was noted by Joan Robinson who coined the term "monopsony" (Robinson 1969).

Many such factors or "frictions" occur naturally in the labor market. First, there are numerous costs involved with searching for another job—including the cost of acquiring and processing information about alternatives.[5] To fully assess their options, workers need information not only on wages but also on benefits and working conditions—and the latter can be especially hard to obtain. The common use of websites that allow employees to share information about their employers suggests that workers value such information.

While information technology has reduced some information barriers, research suggests that they continue to be important. For example, Kuhn and Mansour (2011) find that internet job search appears to reduce unemployment duration but has little effect on wage growth between jobs. Direct evidence of information barriers is found in recent surveys showing that workers often accept jobs without knowing that they will be asked to sign a non-compete clause (Marx and Fleming 2012; Starr, Bishara, and Prescott 2016), and others have found that a significant share of job applicants are inattentive to details when completing applications (Mas and Pallais 2016). Benson, Sojourner, and Umyarov (2015) show that information about employer quality can be an important determinant of workers' job application decisions, suggesting that the absence of such information can have real impacts on job search. And Cardoso, Loviglio and Piemontese (2016) find that misperceptions about labor market opportunities can lead people to accept lower wages.

Even when workers have good information, heterogeneous preferences over job characteristics can limit the number of outside options that are equivalent from a worker's perspective to one's current job (Bhaskar, Manning and To 2002). One characteristic that clearly differs across workplaces is physical location. A recent study of online job applications shows that U.S. job seekers are 35 percent less likely to apply to a job 10 miles away from their ZIP code of residence than one in their own ZIP code (Marinescu and Rathelot 2016). But other unique features of a workplace can also make workers reluctant to seek alternatives. And when workers have few comparable alternatives, they have less leverage to demand higher wages or to negotiate wage growth from their current employers.

"Job Lock" and Employer-Sponsored Health Insurance

Employer-provided health insurance is a particular source of labor market friction that has long been studied by economists and policy makers (e.g., Madrian 1994; Farooq and Kugler 2016). Most workers in the United States younger than 65 years of age receive their health insurance through their employer or the employer of a family member. Prior to the Affordable Care Act (ACA), people seeking coverage outside the workplace often had very limited options. Health insurers offering coverage on the individual health insurance market were generally allowed to charge more, limit benefits, or deny coverage entirely for people with pre-existing health conditions, making seeking coverage independent of an employer unattractive for many workers. In addition, the tax code provided substantial subsidies to people with coverage through an employer since compensation provided in the form of health insurance was not subject to income and payroll taxation, unlike compensation provided in the form of wages, while similar assistance was often not available for people who wished to obtain coverage on their own. These features of the health insurance market may have made these workers reluctant to move to new jobs that do not offer health insurance, limiting their outside work opportunities. This phenomenon of workers' unwillingness to switch employers due to their employer's provision of health insurance is known as "job lock" and can lead to workers being stuck in jobs where they earn lower wages than they could secure elsewhere, are otherwise not satisfied, or their skills are not best utilized.

In addition to sacrificing productivity gains from better matches between workers and employers and stymied entrepreneurship, job lock can also weaken the bargaining power of workers and create the

[5] The notion that imperfect information about the labor market makes job search costly is central to modern theories of unemployment (Mortensen and Pissarides 1994).

potential for monopsony power. Like search costs that make it difficult for workers to seek other employment opportunities, job lock arising from employer-provided health insurance limits a worker's employment options.

As discussed further below, the Affordable Care Act reduced job lock by providing workers with affordable non-employer sponsored health insurance options and banning private insurance policies from setting different coverage terms based on health status. The availability of non-employer sponsored health insurance may strengthen the bargaining positions of workers who do not leave their employer, since they can better leverage the option of leaving.

Regulatory Barriers to Worker Mobility

Excessive regulations can also impede workers' ability to move and thus effectively limit their employment options and bargaining power.

One class of regulations that can present barriers to job mobility is occupational licensing laws (CEA, Department of Labor, and Department of the Treasury 2015). While licensing regulations can play an important role in protecting consumer health and safety, they also raise the cost of entering a licensed occupation. Today, roughly one in four U.S. workers requires a government license to do their job. For some of these jobs, the costs of obtaining a license can be significant while the health and safety benefits may be often minimal. In these cases, licensing can create unnecessary barriers to employment, restricting opportunities and depressing wages for those who are unable to obtain a license (CEA, Department of Labor, and Department of the Treasury 2015).

Because licensing restricts the supply of workers in a profession, licensed workers tend to earn higher wages at the expense of excluded workers. However, even workers who hold licenses can find their employment alternatives limited by existing licensing regulations, which often vary dramatically across States (Carpenter et al. 2012). In particular, the patchwork of State regulations and variability in State reciprocity make it harder for workers in licensed occupations to move across State lines (Kleiner 2015), and new data show that licensed workers are less likely than unlicensed workers to make such moves.

Other regulations—not necessarily in the labor market—can also present barriers to job mobility. For example, overly restrictive land-use regulations create costly barriers to housing development, limiting the availability of housing and increasing its cost (Furman 2015). In turn, higher costs of finding and purchasing or renting a new home can effectively narrow the labor market.[6]

Regardless of the source, barriers to worker mobility effectively reduce competition among firms in the market for labor. And with less competition, employers can profit from paying lower wages—even if this means forgoing some productive employment relationships.

Evidence of Labor Market Monopsony

There is increasing recognition among economists and policy makers that employers often have some degree of monopsony power in labor markets (Manning 2011). Evidence on this proposition ranges from court cases alleging collusive agreements, to studies of labor market institutions such as non-compete clauses, to analysis of wage and employment responses to policy changes.

Evidence on Collusion

Court cases provide some of the best direct evidence of employer collusion. In recent years, the Department of Justice (DOJ) brought suit against six major Silicon Valley employers for entering into no-poaching agreements not to recruit or hire away

[6] Historical research on the coal mining industry in the early 1900s suggests that the wage-setting power of mining companies in remote, one-company towns West Virginia was limited by the provision company-provided housing—which, along with a network of rail lines, reduced the cost of moving between towns and employers (Boal 1995; Fishback 1992).

each other's workers in violation of the antitrust laws (Department of Justice Office of Public Affairs 2014; Department of Justice Office of Public Affairs 2010). The firms later settled civil class-action suits that alleged that these agreements suppressed the wages of programmers and engineers (Whitney 2015; Rosenblatt 2014). The DOJ also brought suit against a hospital association in Arizona for agreement to set uniform bill rates for paying temporary and per diem nurses.[7]

Other suits have alleged collusion among hospitals to set wages for nurses. Since 2006, registered nurses in a number of metropolitan areas have filed antitrust class-action lawsuits alleging that local hospitals colluded in order to depress their pay (Blair and DePasquale 2010). In *Cason-Merenda et al. vs. VHS of Michigan*, a class-action suit against eight major Michigan hospitals, economic analysis indicated that the hospitals' actions reduced tens of thousands of nurses' wages by about 20 percent compared to what they otherwise would have been paid over a period of several years. The hospitals agreed to a total of $90 million in settlement (Cwiek 2015).

It is difficult to know whether these cases represent isolated examples or are part of a wider phenomenon. But consistent with economic theory, these recent court cases suggest collusion is most likely to be successful when employment is concentrated among a small number of firms.

Evidence on Non-Compete Agreements

Recent survey evidence suggests that 18 percent of the U.S. labor force is currently covered by non-compete agreements (Starr, Bishara, and Prescott 2016; U.S. Department of the Treasury 2015). More importantly, the evidence shows several signs that these agreements are often used to create or exercise market power. One indication of an unreasonable and likely unjustified use for these agreements is their prevalence among workers who are unlikely to have access to trade secrets—including those without a college degree and lower-income workers. Starr et al. (2016) find that these groups or workers are subject to non-compete agreements at similar rates as workers in general. And recent media coverage has raised awareness of the usage and enforcement of non-competes even in low-wage occupations such as fast-food employees, warehouse workers, and camp counselors (Gibson 2016).

Survey data suggests that in many cases, workers sign non-compete clauses without full information on what they are signing or how it will be enforced. A recent survey of electrical engineers finds that nearly 70 percent of respondents report that their employer presented them with a non-compete only after they had accepted the job offer, and nearly half of the time, the non-compete was presented to the employee on or after his or her first day of work (Marx and Fleming 2012). Further, Starr et al. (2016) find that these contracts are prevalent even in States where they are not enforced. Indeed, in California, which does not generally enforce non-compete agreements, 22 percent of workers report that they have signed one. The use of non-compete agreements where they are not enforced suggests workers are not well-informed, and raises the possibility of disparate impacts across workers with and without sophisticated understanding of the legal implications of these agreements.

This pattern of evidence casts doubt on the notion that non-compete agreements serve mainly to protect employers' trade secrets and investments in employee training. Instead, it suggests that many employers may use non-compete agreements to solidify their bargaining power vis-à-vis their workers. While further research is needed to fully understand the impact of non-compete agreements on wages, an analysis by the U.S. Department of Treasury (2015) shows that stricter non-compete enforcement in a State is associated with both lower wage growth and lower initial wages. Lessons can also be learned from research on historical institutions that placed similar restrictions on workers' ability to move between employers. For example, Naidu (2010) studies "anti-enticement" laws in the postbellum southern United States—which prohibited planters from recruiting one another's sharecroppers—and finds that these laws

[7] http://www.justice.gov/atr/cases/azhha.htm

resulted in less mobility and lower wages among African-American farm workers.

Indirect Evidence: Minimum Wage Impacts on Employment

A well-established body of economic research suggests that, even without engaging in collusive agreements or restrictive employment contracts, firms have substantial power to control wages in some markets—consistent with the notion that labor market frictions play an important role.

One set of evidence comes from studying the employment effects of minimum wage laws. Economic theory suggests that in competitive markets, wages are already bid up until they just equal the marginal value of labor to the firm; therefore if a minimum wage in a perfectly competitive market rose above the marginal value of labor, economic theory predicts that it would lead to a reduction in hours or jobs. But when labor markets are not perfectly competitive or when a monopsonistic firm reduces wages and employment below the levels that would prevail in a competitive market, there is scope for a higher minimum wage to raise both wages *and* employment.

Beginning in the early 1990s with the influential work of Card and Krueger (1995), research began to find evidence of minimum wage increases that were not accompanied by job loss. Surveys of the minimum wage literature since then show the estimated employment effects are mostly close to and centered around zero (Belman and Wolfson 2014).[8] This research has spurred many economists to question the conventional wisdom that labor markets are generally competitive and demonstrated that minimum wage increases can lift wages without impacting employment levels (Ashenfelter, Farber, and Ransom 2010).

Indirect Evidence: Wage-Setting and Wage Discrimination

Another set of studies measures how quickly workers leave their jobs if their wages fall for reasons unrelated to their own productivity. In a competitive market, quits should be very sensitive to differences between firms in wages paid to similarly productive employees. Yet research finds that this prediction is often not borne out in practice. Among groups of workers ranging from nurses and school teachers to retail employees, studies have found that employees are much less responsive to wage changes than would be expected if markets were very competitive. These findings imply that employers can set wages that are significantly below what would prevail in a competitive market without losing their workforce.[9]

Researchers have also examined the potential for monopsony-style wage discrimination to help explain wage differentials among workers with similar skills. In particular, several studies have found evidence consistent with gender-based wage discrimination due to gender differences in mobility constraints (Ransom and Lambson 2011; Ransom and Oaxaca 2010; Hirsch, Schank, and Schnabel 2010). Manning (2003, Ch. 7) argues that domestic responsibilities often act as a constraint on women's job search, and discusses evidence that women see smaller wage gains when they change jobs and are more likely than men to leave employment for non-market reasons. Recent research by Mas and Pallais (2016) suggests that gender differences persist in the way that family responsibilities limit job options. This study finds that women—and women with young children in particular—are more willing than men to accept lower wages for the option of working from home or the ability to avoid irregular work hours.

Finally, evidence of employment restructuring (or "fissuring") in a wide variety of industries can also be understood as an alternative to within-firm wage

[8] Recent U.S.-based studies that find evidence consistent with friction-induced monopsony power, see Dube, Lester and Reich (2016); Dube, Lester and Reich (2010); Giuliano (2013).

[9] For example, Ransom and Sims (2010) find that teachers' quit rates are sufficiently unresponsive to wage differences that their employers are able to pay roughly 25% below the competitive wage. Dube, Giuliano, and Leonard (2015) find similar quit responses among sales employees at a large retail firm. Staiger, Spetz, and Phibbs (2010) find even smaller quit responses and larger implied wage-setting power in a study of VA hospitals and registered nurses.

discrimination that allows employers to achieve the same goal. As explained by Weil (2014), firms have increasingly been able to reduce labor costs through outsourcing and subcontracting, which frees them from internal equity constraints. Research on the rise of outsourcing in occupations like janitors and guards also suggests that this practice allows for lower labor costs (Dube and Kaplan 2010), which may in turn lead to higher profits for the firm.

Together, this evidence suggests that, even in the absence of market concentration, firms may often exercise substantial wage-setting power.

Signs that Employer Discretion over Wages May Be Rising

This section considers several broad trends suggesting that employers may be increasingly able to exercise wage-setting power in U.S. labor markets. It first considers the evidence that market conditions may have become more conducive to monopsony power in recent decades. In particular, the evidence suggests both that industries have become more concentrated and that labor has become less mobile.

It then presents evidence of a decline in two institutions that historically helped to counter firms' wage-setting power: unions and the minimum wage. With these changes, employers may be better able to exercise monopsony power today than they were in past decades.

Rising Market Concentration

A variety of evidence points to a steady increase in product market concentration in the U.S. economy over the past few decades.[10] National statistics show that between 1997 and 2012, the majority of industries have seen increases in the revenue share enjoyed by the 50 largest firms (CEA 2016). While revenue share does not necessarily reflect market size, and while rising concentration can reflect increased efficiency from economies of scale, it can also indicate less competition among firms. If these firms compete with each other in specialized labor markets, rising concentration can have implications for labor markets.

When fewer firms compete for a given type of worker, each firm is more likely to exercise monopsony power. Smaller numbers of firms may also facilitate collusion. Indeed, evidence of rising market concentration and monopoly-style profits is especially strong in the health-care and technology sectors (*The Economist* 2016; Gaynor, Ho, and Town 2015), two sectors that have been the subject of recent litigation alleging collusion among employers (CEA 2016).

Rising concentration also reflects a decline in entry of new firms in the past three decades (Bureau of Labor Statistics, CEA calculations). This decline in "business dynamism" shields incumbent firms from competitive upward pressure on wages. It has also likely contributed to a decline in labor market "dynamism" (Davis and Haltiwanger 2014), as discussed below.

Declining Labor Market Dynamism

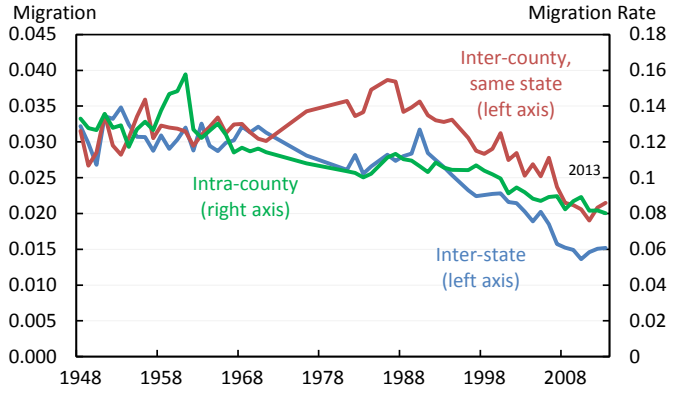
Labor market "dynamism" (or "fluidity" or "churn") refers to the frequency of changes in who is working for whom in the labor market.[11] While short-term trends show signs of increased dynamism in recent years, research has identified long-run declines in a variety of measures of labor market dynamism in the U.S. Evidence from multiple sources shows that that workers today are less likely to leave a job or to move to a new job than they were 20 or 30 years ago (Molloy, Smith, and Wozniak 2014; Davis and Haltiwanger 2014; Hyatt and Spletzer 2013).

Geographic mobility has also seen a decades-long decline (Figure 2; Molloy, Smith, and Wozniak 2014; Kaplan and Schulhofer-Wohl 2012). Industry, occupation, and employer transitions have also fallen markedly over a similar period, with declines in those measures accelerating since the 1990s (Figure 3).

[10] A CEA issue brief released earlier this year reviewed this evidence in more detail (CEA 2016).

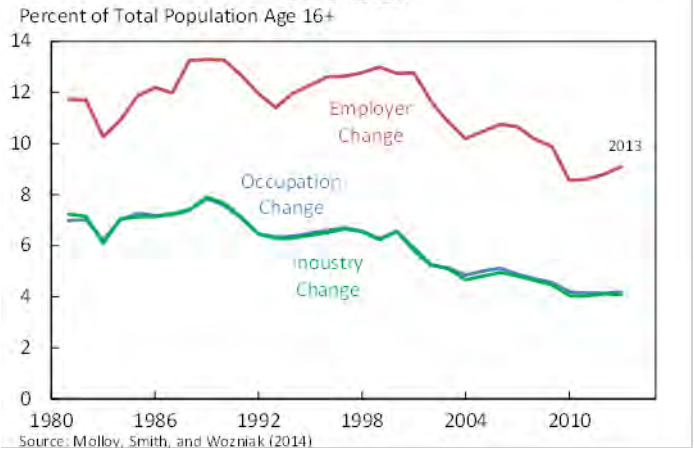
[11] For a detailed discussion of the decline in labor market dynamism, see Chapter 3 of the 2015 *Economic Report of the President*.

Figure 2: Migration Rates by Distance



Notes: Migration rates of the civilian population age 16 and up from the Current Population Survey. Post-1989 migration rates are calculated from microdata and exclude imputed values. Sample details are given in Molloy, Smith and Wozniak (2011) and Saks and Wozniak (2011)
Source: Molloy, Smith, and Wozniak (2014)

Figure 3: Employer, Occupation, and Industry Transitions, 1983–2013



Source: Molloy, Smith, and Wozniak (2014)

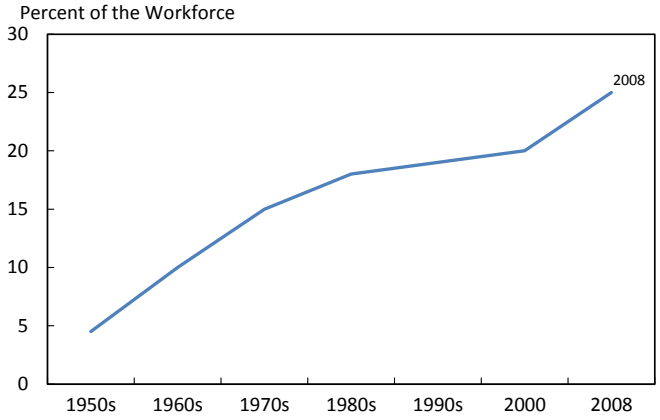
The consequences of declining labor market mobility depend on the underlying causes. While these causes are not well understood, it appears that changes in worker characteristics like age and education are not a key driver (Molloy et al. 2016). This suggests that the decline in dynamism instead reflects an increase either in the costs of moving or in the benefits of staying put.

If initial employment matches have improved and there is less need to move, then workers may be benefitting from fewer transitions and disruptions. But if the decline in mobility is a manifestation of rising moving costs or barriers to switching jobs, then this is a cause for concern. This latter explanation would imply that workers have fewer labor market options and thus that employers are better able to dictate the terms of employment.

There are several reasons to suspect that the downward trend in labor market dynamism is due to rising costs of switching jobs. One is that this trend has occurred alongside upward trends in regulatory barriers that impede worker mobility (Davis and Haltiwanger 2014; Furman and Orszag 2015). Relative trends in housing prices and construction costs suggest that land-use regulations have become more restrictive in recent decades (Glaeser, Gyourko and Saks 2005). Excessive regulations could explain rising housing prices in a large and growing set of cities (Gyourko and Molloy 2014), which in turn can make it hard for workers to move to where the best jobs are.

The past five decades have also seen a strong upward trend in the prevalence of occupational licensing requirements (Figure 4); during this time, the share of U.S. workers needing a license to do their job has grown roughly fivefold (Kleiner and Krueger 2013, CEA, Department of Labor, and Department of the Treasury 2015). CEA analysis shows that much of this increase has been due to an expansion of licensing into new professions, which may have negatively affected many lower-income individuals for whom the cost of obtaining a license can be especially onerous (CEA, Department of Labor, and Department of the Treasury 2015). The growth in occupational licensing has likely been restricting employment options and may be reducing bargaining power for less skilled workers. But further, because of the variation in licensing regulations across States, their increased prevalence also reduces geographic mobility for a growing number of workers in licensed occupations (Kleiner 2015).

Figure 4: Share of Workers with a State Occupational License

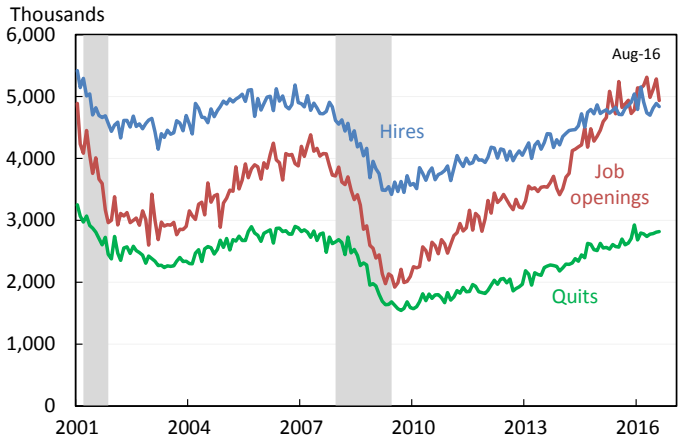


Source: Council of State Governments (1952); Greene (1969); Kleiner (1990); Kleiner (2006); and Kleiner and Krueger (2013), Westat data; CEA calculations

Another indication that the decline in job-switching reflects increasing switching costs (as opposed to increasing benefits of staying in one's current job) is that wages are increasingly likely to be determined by economic conditions at the time of initial employment (Molloy et al. 2016). In other words, wages in one's job are now less sensitive to current outside labor market conditions than was true in the past—which suggests that workers may be receiving fewer job offers and renegotiating wages less frequently. Worryingly, research also suggests that less educated workers are the least likely to move in response to geographic differences in labor market conditions (Wozniak 2010), which may make them more vulnerable to employer wage-setting power.

Finally, a comparison of recent trends in jobs vacancies and hiring suggests that in the years immediately following the Great Recession, employers have not faced strong competitive pressure in recruiting. In particular, series from the Job Openings and Labor Turnover Survey (JOLTS) show that while job openings rose sharply over the recovery, monthly rates of quits and hires rose at a slower pace, and the ratio of job openings to hires was higher in 2016 than in any other year since the series began (Figure 5). Some have suggested that this rising number of unfilled vacancies reflects a shortage of qualified workers. However, in a competitive labor market, such "shortages" should dissipate as employers competitively bid up wages to fill their vacancies. But counter to this prediction, Rothstein (2015) finds no evidence that wages have grown faster in sectors with rising job openings. Instead, the failure of hiring and wage growth to keep pace with the rise in job openings is consistent with the incentives faced by firms in an imperfectly competitive labor market; it suggests that companies have a strong interest in hiring workers at their offered wages, but have resisted bidding up wages in order to expand their workforces (Abraham 2015).

Figure 5: Total Private Job Openings, Hires, and Quits



Note: Shading denotes recession.
Source: Bureau of Labor Statistics, Job Openings and Labor Turnover Survey

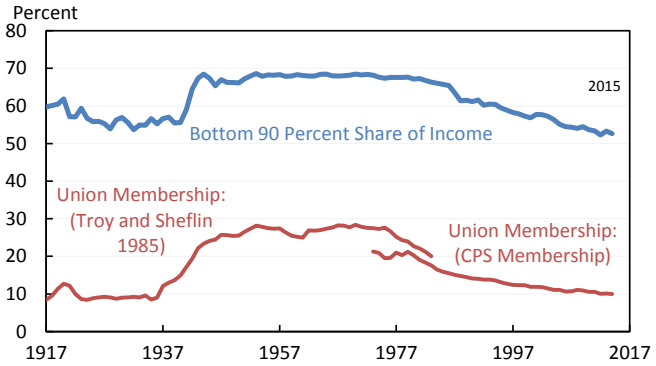
Decline of Unions and the Federal Minimum Wage

The trends toward rising industry concentration, declining labor market dynamism, and increasing regulatory barriers to worker mobility suggest that labor markets have in some ways become less competitive in recent decades, giving employers more power to dictate the wages and working conditions of their employees. In addition, employers may be better able today than in the past to exploit what market power they have. This is because in the past, even when employers were not fully disciplined by the market, they usually faced two other checks on their wage-setting power: unions and the Federal minimum wage.

Unions in the United States can help monitor for anticompetitive conduct that could violate the antitrust laws and report it to the antitrust authorities. They can also counteract employer wage-setting power through collective bargaining. However, union membership has declined consistently since the 1970s. Approximately a quarter of all U.S. workers belonged to a union in 1955 but, by 2015, union membership had dropped to about 10 percent of total employment, roughly the same level as the mid-1930s. Union membership

is even lower in the private sector, at just under 7 percent, and in some States, less than 5 percent of all workers belong to unions (Bureau of Labor Statistics 2016). Research suggests that declining unionization accounts for between a fifth and a third of the increase in inequality since the 1970s (Western and Rosenfeld 2011).

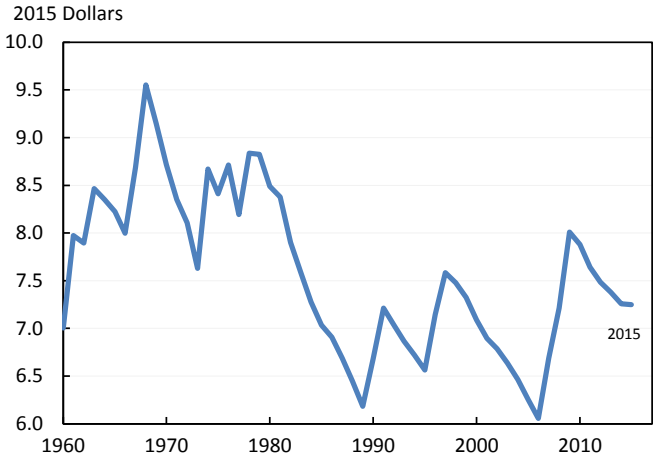
Figure 6: Union Membership as a Share of Total Employment and Bottom 90 Percent Share of Income, 1915-2015



Note: Total employment prior to 1947 is derived from estimates in Weir (1992). For 1948 to 2015, employment data are annual averages from the monhtly Current Population Survey.
Source: Troy and Sheflin (1985); Bureau of Labor Statistics, Current Population Survey; Weir (1992); CEA calculations

The Federal minimum wage has also provided a check against monopsony wage setting in the past—especially among the lowest earners, who are often the most vulnerable to wage-setting power by employers. In a trend that parallels the decline in unions, however, the real value of the Federal minimum wage has declined 24 percent since its peak of $9.55 (in 2015 dollars) in 1968, eroding its ability to protect those workers with the fewest options.

Figure 7: Real Value of the Federal Minimum Wage, 1960–2015



Source: Bureau of Labor Statistics; CEA calculations

Policy Solutions

In a perfectly competitive market, where wages are driven by labor productivity, the best solution to raising wages and reducing inequality is to invest in skills that boost productivity. But in the presence of anti-competitive firm behavior or labor market frictions that limit competition, policy must take a multipronged approach to promoting wage and job growth.

In a recent speech, Acting Assistant Attorney General Renata B. Hesse emphasized that anti-trust enforcement efforts are focused at "harm to the competitive process wherever it occurs," and benefit not just consumers but "also benefit workers, whose wages won't be driven down by dominant employers with the power to dictate terms of employment" (Hesse 2016). Detecting and prosecuting collusive behavior is an important priority for the antitrust agencies, both to eliminate the specific conduct in question and for its value as a deterrent in other settings. In the past decade, DOJ has brought a number of successful enforcement actions involving labor market collusion.

While enforcement of anti-trust laws can and does play a role in stopping anti-competitive conduct in labor markets, a firm's ability to exercise market power in the labor market depends on many factors. Promoting competition must therefore include, but not be limited to, aggressive anti-trust enforcement. Additional important policies include those that facilitate job search, increase worker options, and directly counter the wage-setting power of employers.

In April 2016, President Obama issued an executive order requiring agencies across the Federal government to consider specific actions to promote competition. Since then, the Administration has advanced and supported a number of steps to promote competition and level the playing field for workers in in the job market, building on a strong record throughout the preceding years.

Independent Anti-Trust Enforcement

The DOJ and Federal Trade Commission (FTC) are responsible for enforcing the nation's antitrust laws

and ensuring both consumers and workers reap the benefits of an open and competitive marketplace. Part of that mission includes prosecuting firms for entering into agreements with competitors to limit competition.

Like price-fixing or limiting competition in the product market, it is illegal for firms to fix wages or benefits, or otherwise agree to limit competition for workers in the labor market. Human resource (HR) professionals are well positioned to have knowledge of collusive conduct in employment settings. The DOJ and FTC are launching a campaign to educate firms and HR professionals about what constitutes collusion, how to spot it, and how to report it to the DOJ and FTC's antitrust hotlines.

Whistleblower protections support the reporting of workplace violations in many areas including discrimination, wage theft, overtime non-compliance, and health and safety issues. These protections prohibit employers from taking "adverse action" against an employee for reporting or otherwise participating in a proceeding regarding an employer's illegal behavior. These actions include, but are not limited to, demotion, discharge, intimidation or harassment, reducing pay or hours, and blacklisting. Similar protections may be appropriate for employees who report antitrust violations, such as agreements to fix prices or wages.

Reform Laws Pertaining to use of Non-Compete Agreements

Earlier this year, the White House and the Treasury Economic Policy Office released reports on the misuse of non-compete agreements in the United States. In August, the White House, along with the U.S. Departments of Labor and Treasury, convened economists, private-sector leaders, experts in employment and labor law, and others to discuss State policy best practices, as well as the State of research and data on non-compete clauses.

Today, the Administration has released a set of best practices and call-to-action for States to implement specific policy reforms to curb the use of unnecessary non-compete agreements and to increase the effectiveness of enforcement of laws regarding the use of non-competes. Key priorities include: banning non-compete agreements for categories of workers, such as workers under a certain income threshold, workers in public interest vocations, and workers who have been terminated or laid off without cause; improving transparency and fairness of non-compete contracts and employer practices; and encouraging employers to write enforceable contracts.

A more complete understanding of how non-competes affect workers and employers requires better data and further research. The Administration is therefore working with PayScale and researchers supported by the Ewing Marion Kauffman Foundation to develop and field new survey questions on non-compete clauses to learn more about who signs them, what they contain, and how they are negotiated, and to help raise job-seeker awareness about the use of non-compete agreements. New data will also allow researchers to evaluate reform efforts and to improve our understanding of how legal regimes can best allow firms to protect their investments while safeguarding against negative distributional impacts on workers.

Improve Information Available to Workers and Promote Pay Transparency

Despite the common use of online job sites, individuals still have imperfect information about alternative job opportunities, and obtaining this information can be costly. Lack of awareness reduces employees' ability to change jobs or leverage outside opportunities for higher wages and improved work conditions.

Policy that promote awareness can help ensure that employees have adequate information to make employment decisions.

In 2014, the President signed Executive Order 13665 Non-Retaliation for Disclosure of Compensation Information. The EO prohibits Federal contractors from discriminating against employees and applicants "who inquire about, discuss, or disclose their own compensation or the compensation of other employees or applicants." It represents one step forward in stopping the widespread practice of

firing or otherwise punishing employees for talking about their pay.

In the case of non-compete agreements, even in California where non-compete agreements are unenforceable, about one in five workers still sign contracts that include these clauses. This phenomenon suggests that workers may not be aware of local law, or that employers do not expect engagement. The MOVE Act proposed by Senators Franken and Murphy would require employers who use non-compete agreements to post information on how these clauses work in the context of their State policy on non-compete agreements, to minimize confusion and educate workers.

New data on the use of non-compete clauses that will be collected and reported by PayScale will also help to inform workers about the prevalence of these contracts in industries and occupations where they are seeking employment.

A lack of worker information can also lead to discrimination based on biases, both overt and unconscious. In September, the Equal Employment Opportunity Commission (EEOC), in coordination with the Department of Labor, published a final action to annually collect summary pay data by gender, race, and ethnicity from businesses with 100 or more employees, covering over 63 million employees. This step—stemming from a recommendation of the President's Equal Pay Task Force and a Presidential Memorandum issued in April 2014—will help focus public enforcement of our equal pay laws and provide better insight into pay practices across industries and occupations. It expands on and replaces an earlier plan by the Department of Labor to collect similar information from Federal contractors.

Promote Equal Pay

When firms have wage-setting power, they have an incentive to pay the lowest wage that workers are willing to accept—meaning that individuals who start out facing greater obstacles and fewer opportunities can end up being paid the least. This pattern may be contributing to the gender pay gap.

Women make up nearly half of the U.S. labor force, and are increasingly entering industries and positions traditionally occupied by men. Yet the typical woman working full-time all year earns only 80 percent of what the typical man earns working full-time all year. Despite passage of the Equal Pay Act of 1963, which requires that men and women in the same work place be given equal pay for equal work, the gender wage gap persists.

Since the beginning of his presidency, President Obama has taken a number of steps to close the national wage gap by combating wage discrimination. The first bill he signed into law was the Lilly Ledbetter Fair Pay Act which extended the time period in which claimants can bring pay discrimination claims, enabling victims of pay discrimination to seek redress when they otherwise could not. To build on this step forward, the Administration has repeatedly called on Congress to pass the Paycheck Fairness Act, which would ensure workers' right to discuss compensation without fear of retaliation.

The Administration has also put forward policies to combat other obstacles that women face. Because family responsibilities can limit workers', and especially women's, ability to easily switch jobs, steps that increase access to and the affordability of child care as well as provide for workplace flexibility could improve labor market competitiveness.

Expand Paid Sick Leave

Imperfect competition in the labor market allows firms not only to pay lower wages but also to lower costs through reductions in benefits. Policies that support minimum benefits are therefore an important complement to minimum wage and overtime laws to counter the market power of employers.

The United States is the only advanced country that does not guarantee paid sick leave or paid maternity leave to workers. An estimated 41 million private sector workers—roughly a third of the total private-sector workforce—do not have access to paid sick leave. Low- and middle-income workers are much less likely to have paid sick leave than high-income workers. While roughly 60 percent of workers are

eligible under the Family and Medical Leave Act (FMLA) to take unpaid, job-protected leave for family and medical reasons for more extended absences, many workers are without coverage for shorter-term health care needs and others may not be able to afford to stay home sick if it means the loss of pay.

That is why President Obama expanded paid sick leave to Federal employees with new children and to Federal contract workers to care for themselves, a family member, or another loved one. He continues to call on Congress to pass legislation that guarantees most Americans the chance to earn up to seven days of paid sick leave each year—and urges States, cities and businesses to act where Congress has not.

Reform Unnecessary Occupational Licensing Requirements and Increase Portability across States

In 2015, CEA, the Treasury Office of Economic Policy, and the Department of Labor released a report on the evidence that licensing requirements raise the price of goods and services, restrict employment opportunities, and make it more difficult for workers to take their skills across State lines. Too often, policymakers do not carefully weigh these costs and benefits when making decisions about whether or how to regulate a profession through licensing. Following the report, the Administration worked with Congress, State legislators, and experts to draft and present a series of best practices to help State and local governments better tailor their occupational licensing laws to meet consumer health and safety needs without acting as undue barriers to entry into particular occupations. Since the release of the White House report and recommendations last year, legislators in at least 11 States have proposed 15 reforms in line with these recommendations, and four State bills have passed so far.

The Administration has also worked with Congress to reduce licensing burdens for veterans, service members, and military spouses, who must often move across State lines. Under the President's direction, the Department of Defense established the Military Credentialing and Licensing Task Force in 2012, and with its help, thousands of service members have earned or are in the process of earning civilian occupational credentials and licenses through partnerships with national certifying bodies. Thanks to the leadership of Senators Blumenthal and Klobuchar, the President signed into law the Veterans Skills to Jobs Act in 2012, which requires Federal agencies to recognize relevant military training when certifying veterans for occupational licenses.

And this year, the Department of Labor announced the first ever Federal funding of $7.5 million in grants to support States' efforts to increase the portability of licenses across State lines.

Reform Land Use Regulations

Over the past three decades, local barriers to housing development—including zoning and other land use regulations—have intensified, particularly in the high-growth metropolitan areas increasingly fueling the national economy. The accumulation of such barriers has reduced the ability of many housing markets to respond to growing demand, and is limiting the ability of workers to move to areas with the best jobs for them. But a growing number of regions across the country have responded by modernizing their approaches to housing development regulation. States and localities can improve housing affordability, protect homeowners, and strengthen their economies. The White House released a Housing Development Toolkit that highlights the steps those communities have taken to modernize their housing strategies and expand options and opportunities for hardworking families.

Reduce Job Lock through the Affordable Care Act

By providing workers with affordable non-employer sponsored health insurance options and banning private insurance policies from setting different coverage terms based on health status, the Affordable Care Act reduced job lock. The availability of non-employer sponsored health insurance may also strengthen the bargaining positions of workers who do not leave their employer, since the possibility of doing so introduces greater competition for their labor.

Support Workers' Right to Collective Bargaining and Concerted Activity

While policy should aim to promote competition where possible, some market power is inevitable. So policy should also concern itself with how this power is balanced. Institutional supports like unions and minimum wage laws can help ensure that workers get a fair share of the economic returns to their labor. In fact, unions have certain exemptions from the anti-trust laws, in part reflecting a presumption that, in the absence of unions, employers tend to have greater bargaining power than do individual employees.

Unions have an important distributional impact: by raising worker bargaining power they help bolster wages and improve the working conditions of lower- and middle-wage workers. In turn, they help reduced inequality. In addition, when they work to counter monopsony power, they may help to limit inefficiently low employment that results when firms pay sub-competitive wages.

Modernize Overtime Regulations

In the absence of an up-to-date standard delineating who is exempt from the overtime protections of the Fair Labor Standards Act, monopsony power can allow firms to demand long hours from workers who are not eligible for overtime but who have relatively low salaries. The salary threshold below which most salaried, white collar workers are entitled to overtime is currently so outdated that it provides automatic overtime protections based on salary to just 7 percent of full-time salaried workers today, compared with 62 percent in 1975. In May, the Department of Labor published a final rule that will automatically extend overtime pay eligibility to 4.2 million workers when it takes effect on December 1st. The rule will entitle most salaried white collar workers earning less than $913 a week ($47,476 a year) to overtime pay.

Raise the Minimum Wage

It has been nearly a decade since Congress last passed an increase to the Federal minimum wage. Since the President first called on legislators to act in 2013, 18 States plus the District of Columbia have taken action to raise wages, which the Council of Economic Advisers estimates will benefit over 7 million workers by 2017. More than 60 cities and communities have passed bills or ballot initiatives to raise local minimum wages, whether for city employees or all local minimum wage workers. Businesses such as Costco, Gap, and Walmart have also announced raises to base pay for employees.

At the Federal level, President Obama issued an Executive Order in February 2014 to raise Federal contract workers' base pay, which the CEA estimates will raise wages for an estimated 200,000 contractors and sub-contractors by 2017.

The Administration continues to call on Congress to act and supports the Raise the Wage Act proposed by Senator Patty Murray and Representative Bobby C. Scott.

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