

Public Hearing for the COPA Index Advisory Group

Appointed By the Tennessee Department of Health

Pursuant to Tenn. Comp. & R. Reg. 1200-38-01-.03

Listening Session #4 - External Stakeholders

Chairman: Gary Mayes, Director, Sullivan County
Health Department

Commissioner: John Dreyzehner, MD, MPH, FACOEM

Director: Jeff Ockerman, Division of Health Planning

TAKEN AT: NORTHEAST STATE REGIONAL
PERFORMING ARTS CENTER
2425 TN-75
BLOUNTVILLE, TENNESSEE

TAKEN ON: TUESDAY, APRIL 19TH, 2016

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Dr. Brenda White Wright, Former CEO, Girls Inc. of Kingsport

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3 CHAIRMAN MAYES: Okay. Good evening.
4 All right. Thank you. And thank you each and
5 everyone for being here tonight.

6 This is our fourth public meeting, and
7 this meeting is for our external stakeholders in
8 regard to the application. However, I want you to
9 please be assured that anyone that would like to
10 speak tonight certainly may do so.

11 Also, as part of our mission, our task
12 as an advisory group, the Commissioner of Health,
13 Dr. John Dreyzehner, wants to make sure that this
14 is a very transparent and public process.

15 And so I want to share with you that
16 tonight's meeting is being recorded by video and
17 audio and will be shared on the internet and will
18 be shared at the Tennessee Department of Health
19 website under the tag of COPA, C-O-P-A.

20 And we also have a court reporter here
21 tonight who is recording verbatim, and those
22 transcriptions will be posted on the website as
23 well and available for the Advisory Group.

24 So, and I would like to thank our
25 Advisory Group. It is our last public meeting

1 scheduled thus far, and so our attendance has been
2 great, and our active listening has been
3 wonderful. And so this is a great group, and I
4 appreciate your efforts so very much, and you've
5 done a great job so far.

6 So our next meeting will be a work
7 session at the Sullivan County Health Department,
8 and we will be processing all the public input
9 that we've had at various locations and working
10 toward our task of developing an index and
11 recommending that to the Commissioner of Health.

12 So tonight, as speakers approach the
13 podium, please be mindful to speak loudly so each
14 and every one on the Advisory Group can hear your
15 comments. If you need to pull the microphone
16 closer to you, please do so.

17 Each speaker will have three to five
18 minutes, and at 30 seconds I will advise you that
19 you have 30 seconds left so you'll know that you
20 can wrap it up for us. Okay? That keeps our
21 Advisory Group task on time, so be mindful of
22 that.

23 And so tonight, we'll begin with a short
24 and brief presentation by Jeff Ockerman, with the
25 Tennessee Department of Health. He really goes

1 into detail about what the Advisory Group's charge
2 is, what we'll be doing here tonight, and our
3 process.

4 So, Jeff, I'll kick it over to you,
5 DIRECTOR OCKERMAN: Great. Thank you
6 very much, Gary. Can you all hear me? Can you
7 hear me? Good.

8 I want to give you an overview of the
9 Certificate of Public Advantage process and what
10 your task is tonight, so we'll go right ahead
11 somewhere. This is supposed to work. Not
12 working.

13 Where did Allison go? She's upstairs,
14 and she's -- see if we can do something on this.
15 There we go. Thank you.

16 So what is a Certificate of Public
17 Advantage? We're calling it a COPA and for short.
18 The COPA is the written approval by the Tennessee
19 Department of Health that governs a cooperative
20 agreement between two or more hospitals, and the
21 purpose of that COPA is to protect the interest of
22 the public in the region and in the state.

23 So our COPA statute has been in
24 existence since 1993, and to the best of our
25 knowledge it has never been used until now. And,

1 really, we know it has never been used for the
2 purpose of a hospital merger, so we're creating
3 and breaking new ground here.

4 So to apply for a COPA, the hospitals
5 are required to submit an application with a lot
6 of detailed information and data about their
7 proposed merger. And examples of the information
8 that is required to be submitted include the
9 following:

10 The actual cooperative agreement to
11 merge, their plans to integrate services, any
12 financial details, a Plan of Separation that I'll
13 talk about a little bit later, a proposed Index of
14 Measures, which is part of the reason you're here
15 tonight, and there's some other information as
16 well.

17 So where are we right now? Mountain
18 States and Wellmont have given us a series of
19 documents, and we've given them some responses as
20 well.

21 So back in September, they gave us a
22 letter of intent that was required under the
23 rules. They gave us a pre-submission report in
24 January. We responded to that pre-submission
25 report and requested some clarification of a

1 number of issues.

2 The actual application was filed with us
3 on February 16th of this year, and then they filed
4 an addendum on March 16th, responding to a January
5 15th letter, our response, and they provided two
6 additional exhibits that were not contained in the
7 original application.

8 Then on March 28th, we sent a request
9 for additional information No. 1. And the fact
10 that we call it No. 1 makes you know that we
11 anticipate that we may have to send out some more
12 requests for additional information, and we've
13 requested some top-priority items.

14 In that cooperative agreement, there's a
15 document called the Council Memoranda, more than
16 one document, and we've requested that to be filed
17 with us. There was some information that was
18 actually excluded from the cooperative agreement
19 that we've asked for, and the Plan of Separation
20 that they filed lacks sufficient detail for us.

21 And we've talked with the applicants
22 about that and are expecting to get additional
23 information from them fairly soon.

24 So the application status: It has to be
25 deemed complete by the Department. It has not

1 been deemed complete because we are still missing
2 that additional information.

3 Once it is deemed complete, then the
4 Department has 120 days to finish its actual
5 analysis review of the application and then make a
6 decision on whether or not to grant the COPA.

7 So right now, the application continues
8 to be reviewed by the staff while we wait for that
9 additional information, and the information we're
10 waiting on includes some financial and other
11 information considered to be either confidential
12 or really competitively sensitive.

13 And we're having to go through a process
14 with the Attorney General's Office in order to get
15 that information submitted to us.

16 So once we determine that the
17 application is complete, that 120-day period will
18 begin. We'll conduct our review to determine
19 whether or not the COPA should be issued.

20 So under the rules and the law, the
21 Department shall issue a COPA if the Department
22 determines that the applicants have demonstrated
23 by clear and convincing evidence that the benefits
24 resulting from the agreement outweigh any
25 disadvantage attributable to a reduction in

1 competition.

2 So here we are today. We're talking
3 about the COPA Index. If a COPA is granted, we
4 will need to have an Index of Measures. And that
5 index is like a report card, and that's the
6 easiest way we think of to think of it.

7 If the COPA is issued, the Department
8 will assess the impact of the merger based on the
9 terms included in the COPA. This index is one way
10 that the Department would grade the proposed new
11 health system.

12 The Index Advisory Group here before you
13 will suggest different subjects, different
14 measures that will be included on this index, and
15 it will be like a grade point average. The grades
16 from the different subjects and different measures
17 will be averaged together to get an overall index
18 score.

19 So what subjects, what measures should
20 be included on this report card, this index? The
21 rules require that these subjects have to be in
22 these categories: population health, access to
23 health services, economic issues, and then other
24 factors that you all come up with or the Advisory
25 Group comes up with, or it could even be people in

1 the Department of Health with their expertise
2 comes up with.

3 So the COPA Index will be created and
4 used for the Department to evaluate the proposed
5 and Continuing Public Advantage of the COPA if the
6 COPA is granted. The Department will set a
7 baseline score and ranges for that score to
8 determine whether the advantage is clear and
9 convincing, and it would be reported publicly on a
10 regular basis.

11 If the advantage is not evident, go down
12 the road and the COPA is granted and the advantage
13 stops being evident, the Department could
14 terminate the COPA at that time. We could amend
15 it. We could go through some other negotiations,
16 but we could terminate the COPA.

17 And if that happens, then the merged
18 system would have to actually complete their Plan
19 of Separation that they are filing or going to
20 file with us. That Plan of Separation would have
21 to be updated at least annually.

22 So here we are again with the COPA Index
23 Advisory Group sitting right behind me. It's a
24 group of citizens representing northeast
25 Tennessee, this region. It's appointed by

1 Commissioner John Dreyzehner.

2 Following these Public Listening
3 Sessions, this group will recommend the
4 measures -- what we're calling the subjects -- to
5 be considered for the index, the report card, for
6 the Department to use to track the impact,
7 including advantages and disadvantages should the
8 COPA be granted.

9 This group's job is over once it
10 recommends the measures for the COPA Index to the
11 Department of Health. This group does not make a
12 recommendation on whether or not to approve the
13 COPA. And then we've got all of their names right
14 there in front of you, and all of this is posted
15 on our website as well.

16 Okay. So guidance for the Advisory
17 Group from the Department. The Department wants
18 guidance on big-picture concepts. We don't want
19 to get lost in the weeds on particular details on
20 what types of data sources are going to be used.

21 We want the big-picture concepts on
22 population health, on health care access, on
23 economics, and any other factors. We're concerned
24 with outcomes, not the process.

25 So if you think about that, if you are

1 going to grade the health system, you would want
2 to know how did the new health system do on its
3 test? Not how often did the new health system
4 study.

5 And we feel very strongly the
6 application process and the addendums that they're
7 making and additional information they're
8 submitting, that's how the hospital systems are
9 speaking to the Department of Health.

10 This is your opportunity to tell the
11 Department of Health and the Advisory Group what
12 you think is important. And again, this Advisory
13 Group represents community concerns, and our goal
14 is to have a clear and well-defined index that can
15 be easily understood by the hospital systems, by
16 the industry stakeholders, and by the general
17 public.

18 So the meetings that we're having. The
19 rules require that this Advisory Group hear from
20 external stakeholders. That's you guys here
21 tonight. You work in health care or in health,
22 and you compete with the hospital systems.

23 To include payers, health insurance
24 payers, self-insured employers, governmental
25 agencies, non-governmental agencies. Basically

1 anyone who doesn't get paid by Mountain States or
2 Wellmont. We've already heard from internal
3 stakeholders, and we've heard twice from members
4 of the community.

5 These are the sessions. Here we are on
6 April 19th, but the external one -- we have
7 another session on May 17th where the proposed
8 measures will be presented to members of the
9 community and for their comments.

10 And finally, we will have a meeting on
11 June 7th here at 5:30, and that's the actual
12 public hearing required by the rules to hear from
13 the public on whether or not they think the COPA
14 should be granted. You can also submit comments
15 to us by regular mail, by email, on-line, and we
16 provide all that information for you on our
17 website.

18 So today's process again, the Advisory
19 Group is here to listen to you. Speakers will be
20 called from the sign-up sheets. You get three to
21 five minutes each.

22 If you have questions, you can submit
23 them if you want to anonymously in our box over
24 here. You can also submit your written comments
25 in that box if you don't want to do them on-line.

1 And again, a reminder. This session is
2 being videoed and transcribed. And please help
3 our court reporter out by speaking clearly into
4 the mic. Don't do this. Don't turn away from the
5 mic, like I just did. Speak into the mic.

6 And you Advisory Group members also
7 speak into the mic so that we can get an accurate
8 transcription of the meeting today, and that's it.
9 Thank you very much.

10 Gary, back to you.

11 CHAIRMAN MAYES: All right, Jeff. Thank
12 you very much. Any clarifications from the
13 committee at this point? Any questions? All
14 right, great.

15 So as we call our first speaker tonight,
16 make your way to the podium. Jeff has mentioned
17 that you can place your comments also in writing
18 in case you're uncomfortable speaking in a public
19 venue in the box, and you're also welcome to visit
20 the website and send your emails.

21 And you may also speak with anyone
22 that's a member of the Advisory Committee as well
23 and share your feedback with them. And also for
24 the speakers that are on our list tonight, just
25 pause at the end of your presentation just briefly

1 and let me make sure that the Advisory Committee
2 doesn't have questions, because they may pose
3 questions at the end of your talk. Okay?

4 All right. So first tonight is Kandy
5 Childress.

6 KANDY CHILDRESS: My name is Kandy
7 Childress. I was born and raised in Kingsport.
8 Over the last five years, I've spent much of my
9 working career addressing the health issues
10 impacting our community.

11 As part of this work, I had the
12 privilege of serving as the Director of Community
13 Impact and Communications at the United Way of
14 Greater Kingsport. I now serve as the Executive
15 Director of Healthy Kingsport, a nonprofit
16 organization founded to promote wellness, enhance
17 infrastructure, and influence policy related to
18 community health in Kingsport.

19 Healthy Kingsport is truly a coalition
20 of many community partners including volunteers,
21 business leaders, churches, and partner
22 organizations, all who have joined together to
23 create a community who actively embraces healthy
24 living.

25 Last April, Kingsport was chosen as one

1 of Tennessee's nine pilot communities in the
2 Healthier Tennessee Communities initiative. We're
3 doing this by encouraging community members to
4 take small steps, what we call small starts,
5 toward a healthier lifestyle.

6 One example of this is our participation
7 in the national Live Sugar Free campaign, an
8 effort to combat Type-2 diabetes and obesity. We
9 are working with our partners to encourage folks
10 to drink water over sugary beverages.

11 According to the Public Good Projects,
12 the nonprofit that's spearheading the Live Sugar
13 Free campaign, adults in our region ages 18 to 45
14 drink an average of two sugary beverages a day.
15 One in seven local residences drink four or more
16 sugary beverages a day.

17 This type of public awareness and
18 education is a hallmark of our work at Healthy
19 Kingsport, and we are glad to have Wellmont Health
20 System and Mountain States Health Alliance and
21 many other wonderful partners take part in our
22 work.

23 Today we're at a critical juncture in
24 our community and our state when it comes to
25 obesity and diabetes, and that's why I ask that

1 this committee adopt measures to track efforts
2 designed to address obesity and Type-2 diabetes.

3 According to 2014 data provided by
4 America's Health Trust and the Robert Wood Johnson
5 Foundation, Tennessee has the 14th highest obesity
6 rate among adults in the nation. What's more
7 alarming is the rapid rate of increase in obesity
8 in our area over the last 25 years.

9 In 1990, the adult obesity rate was 11.1
10 percent. It was 20.9 percent in 2000, and today
11 we're above 30 percent. In Sullivan County alone,
12 if you look at people who are either in the
13 obesity or overweight category, our percentage is
14 73 percent.

15 This type of trend cannot continue.
16 According to the same data, in 2011 Tennessee
17 ranked fifth in the nation for childhood obesity.
18 One in five children were considered obese.

19 Unfortunately, this is causing a
20 preventable and costly epidemic of heart disease,
21 diabetes, obesity-related cancers, arthritis,
22 declining quality of life, long-term disability,
23 and more.

24 I believe this is one of the most
25 important single issues facing our children and

1 our community today, and I ask that you make this
2 a priority in your planning process.

3 Thank you for the opportunity to speak
4 tonight.

5 CHAIRMAN MAYES: Okay. Thank you,
6 Kandy. Any questions from the committee? Okay.
7 Seeing none, thank you very much.

8 All right. Next we have Courtney
9 Pearre, I hope.

10 COURTNEY PEARRE: We pronounce it Perry,
11 but I answer to anything that's close.

12 CHAIRMAN MAYES: I apologize.

13 COURTNEY PEARRE: I've been doing that
14 for years.

15 CHAIRMAN MAYES: You would think
16 somebody in health could just about read any kind
17 of writing there is, but my apologies, sir. Thank
18 you for that.

19 COURTNEY PEARRE: All right. No need to
20 apologize. Like I say, I'm very used to that.
21 It's spelled different than the way it's
22 pronounced.

23 Good afternoon. I'm Courtney Pearre.
24 I'm Senior Director of Government Relations for
25 Amerigroup. Amerigroup is one of the three

1 managed-care organizations in Tennessee in the
2 TennCare program.

3 Amerigroup is a wholly-owned subsidiary
4 of Anthem. Anthem also operates in Virginia as
5 one of the Blue Cross Blue Shield association
6 members in both the commercial market and in the
7 Medicaid market in Virginia.

8 Jeff did a very good job of setting it
9 up and explaining your task, and so I was going to
10 make some comments on that, but I will not.

11 I would like to say that, as he pointed
12 out, the application has not been deemed complete,
13 so it's kind of hard to make specific
14 recommendations until you know what the
15 commitments in the application are going to be
16 finally. But with that said, I'd like to make a
17 few points about the things we think the index
18 should consider.

19 First, the bedrock principle of
20 Medicaid, any Medicaid program, be it Tennessee,
21 Virginia, or elsewhere, is choice. Members must
22 have, TennCare members must have choice as to
23 payers, as to providers, and, well, as to payers
24 and providers.

25 The COPA application must assure that

1 the TennCare members in Tennessee have access to
2 the services that they need. It is crucial that
3 if the COPA is granted, that the merged entity be
4 required to assure access to needed services by
5 TennCare patients and that such access be closely
6 monitored and included in any index.

7 Two, the COPA in several places states
8 that Medicaid rates are not negotiable. That
9 might be true in a lot of states, states that have
10 state-mandated fee schedules, but Tennessee does
11 not.

12 The three managed-care organizations in
13 Tennessee use Medicare -- which is not
14 negotiable -- as the basis of their rates, but
15 then we each apply a percentage to the Medicaid
16 rate. It might be less than a hundred percent.
17 Normally it is. It could be more.

18 But those percentages are negotiated
19 with every payment, be it hospital or physicians.
20 It's crucial that the COPA, if the COPA is
21 granted, that the index requires the entity to
22 keep its prices constrained for its TennCare
23 patients.

24 Basically what the COPA, if it's
25 granted, it's creating a monopoly, and

1 monopolistic rates are regulated like public
2 utilities, and the index needs to be specific in
3 that regard.

4 No. 3, hospitals compete on quality.
5 And then the application, as it's worded right
6 now, the hospitals commit to do certain things in
7 quality but most -- or publish certain results,
8 but most of those are required to be published
9 anyway.

10 We think it's crucial, if the COPA is
11 granted, that the merged entity be required to
12 achieve certain minimal quality standards and that
13 these standards are monitored and included in any
14 index. And finally, as I said, it might be a
15 little premature to comment specifically, but I'd
16 like to emphasize two more points.

17 First, the index that you will be
18 advising the commissioner about must be
19 comprehensive and carefully considered. It has to
20 address multiple complex issues, such as health
21 care access, cost, and quality. And second, the
22 index must be dynamic.

23 If the COPA is granted, the hospitals
24 will be together probably for a long time, perhaps
25 forever. But what constitutes appropriate

1 measures of cost, quality, and access today might
2 not be appropriate measures in the future.

3 So the index must be dynamic, as I said.
4 That's a very challenging task. I don't envy
5 either you advising on it or the commissioner in
6 devising the final index.

7 I appreciate the time. If you have any
8 questions, I'll try to answer them.

9 CHAIRMAN MAYES: Okay. Yes, Dr. Kidd?

10 DR. TERESA KIDD: Thank you. You
11 indicated a recommendation that the index contain
12 minimal quality standards, but you said the
13 application contained quality standards that they
14 were already required to report on.

15 Did you have other standards that you
16 would recommend that they report on?

17 COURTNEY PEARRE: Well, again, I'm not
18 an expert in quality. We have people with our
19 company that are, and we'll be making specific
20 recommendations in writing.

21 But again, until we see a completed
22 application, it's hard to comment.

23 DR. TERESA KIDD: Thank you.

24 COURTNEY PEARRE: Yes, ma'am.

25 JAN TILLMAN: I wonder, I've had

1 experience with Amerigroup, and the problem is
2 that Amerigroup started assigning or TennCare
3 starting assigning patients to Amerigroup.

4 But none of the physicians or the people
5 we would refer to take Amerigroup, so we've had --
6 we're going back to the old days when we had to
7 refer to Knoxville or Nashville, way out of our
8 region, so we already have that problem.

9 I'm not sure how to improve it, except
10 to go to TennCare. And you're suggesting that
11 because of this merger, we might have more of a
12 problem like that?

13 COURTNEY PEARRE: Well, you have two
14 major hospitals that serve the eight-county area
15 now.

16 JAN TILLMAN: Right.

17 COURTNEY PEARRE: If it's approved, it
18 will be down to one.

19 JAN TILLMAN: I think the whole area has
20 been affected by the Amerigroup thing, so I hope
21 we can fix that.

22 CHAIRMAN MAYES: Okay. Any questions on
23 this end? All right. I want to clarify again, if
24 I may.

25 COURTNEY PEARRE: Sure.

1 CHAIRMAN MAYES: I have a question about
2 the quality standards. I recently read that the
3 hospitals have, with joint commission and all the
4 other regulatory agencies, some hospitals could
5 have upwards of 3,000 measures they have to
6 routinely report.

7 And that might have been what Dr. Kidd
8 was alluding to, so I want to make sure that you
9 said you would have your folks send us your
10 recommendation or your input into the quality
11 standards?

12 COURTNEY PEARRE: Yes. We intend to do
13 that, yes, sir.

14 CHAIRMAN MAYES: Okay, good, good. I
15 think that would be helpful for the committee

16 COURTNEY PEARRE: I'm not a --

17 CHAIRMAN MAYES: I understand.

18 COURTNEY PEARRE: I deal with the
19 legislature primarily, and I'm not an expert on
20 quality, and I can't give you specifics.

21 CHAIRMAN MAYES: Sure, and that's
22 understandable. But we will begin our working
23 sessions next week. So if the committee could
24 have that in advance at that time, I think it
25 would be helpful. Appreciate that very much.

1 COURTNEY PEARRE: Thank you. Anything
2 else?

3 CHAIRMAN MAYES: All right.

4 COURTNEY PEARRE: Thank you.

5 CHAIRMAN MAYES: Okay. Next is Lori
6 Hamilton.

7 LORI HAMILTON: Hello.

8 CHAIRMAN MAYES: Hello.

9 LORI HAMILTON: Thank you for allowing
10 me to speak.

11 CHAIRMAN MAYES: A little bit closer, if
12 you would.

13 LORI HAMILTON: Okay. I'm Lori
14 Hamilton. I've never been told that I was quiet
15 in my life.

16 I'm Lori Hamilton. I'm a registered
17 nurse, and I am the Director of Healthy
18 Initiatives for K-VA-T Food Stores, which do
19 business as Food City. We are based in Abingdon,
20 Virginia, and we operate 135 retail outlets in
21 Kentucky, Virginia, Tennessee, and Georgia as
22 well.

23 I am very proud to be involved with our
24 community and have worked with Wellmont, Mountain
25 States, and ETSU over the course of many, many

1 years. I also have served as the co-chairperson
2 for the Population Health and Healthy Communities
3 work group for the COPA.

4 K-VA-T is a self-insured employer with a
5 longstanding history of supporting our community.
6 The last six to seven years though, we have been
7 embarked on a very strategic focused attempt at
8 helping our community members, as well as our
9 associates, to live a better life.

10 And so from a nutrition and food point
11 of view and as a nurse, I often see the
12 significant impact that unhealthy choices make on
13 a person's life.

14 Unfortunately, as a health care
15 provider, and as many of us are aware, we don't
16 often see, we don't often see these individuals or
17 come in contact with them until they have
18 significant disease processes that are going on,
19 which is very, very sad.

20 We tend to be more reactive than
21 proactive, and so that is one of the things that I
22 hope, as this partnership goes forward, that we
23 are able to be more proactive in that approach.

24 So opportunity did knock for me. 35
25 years ago, if you would have said to me when I

1 received my nursing degree that I would be a
2 registered nurse for a grocery store chain, I
3 would have said you are crazy and you've lost your
4 mind, but this is an awesome responsibility that I
5 have to work with Food City for our associates and
6 the community members at large.

7 So my role allows me really to improve
8 and work to improve the regional health that we
9 have and prevent illness by looking at initiatives
10 that we can implement within our communities that
11 we serve.

12 And we want to keep individuals aware
13 and educate them about their healthy choices or
14 about those choices that they make. We are not
15 telling them what they have to do, but we are
16 providing them with awareness and education.

17 It is my privilege to work with nearly
18 16,000 associates in all of our states that are
19 working towards Food City's initiatives for health
20 and wellness. I also work with a wonderful
21 dietitian.

22 I work with many community partners,
23 Wellmont, Mountain States, ETSU, and we do cooking
24 programs. We do programs related to healthy
25 eating on a budget, fast and healthy, those kinds

1 of things, and we help them in terms of looking at
2 selections for them for their food and nutrition
3 as well.

4 I'm here tonight because I truly do
5 believe in the power of our community to address
6 the issues that we are faced with. We need to do
7 it strategically, and our continued partnerships
8 in these areas with our providers, community
9 organizations, churches, schools, businesses, and
10 many others are really going to bring this all to
11 fruition there.

12 From a professional and personal
13 standpoint, the investment and the future systems
14 is planning to make will help strengthen the local
15 efforts that we have on early detection,
16 prevention, and disease management.

17 As you develop your recommendations, I
18 encourage you to track the following, especially
19 to lower the prevalence of diabetes Type-2 in our
20 area, as well as heart disease, cardiovascular
21 disease. These are huge problems within our area,
22 and they are certainly affected by our lifestyle
23 changes and habits that we have.

24 So diabetes, cardiovascular disease,
25 tobacco use is also a huge factor, and for

1 individuals to get cancer screenings for early
2 detection and a better chance for successful
3 treatment. As we look --

4 CHAIRMAN MAYES: 30 seconds.

5 LORI HAMILTON: As we look towards the
6 future, I'm hopeful that our continued partnership
7 with our region, stakeholders, and increased
8 investments will result in a culture of health not
9 only for this generation, but for generations to
10 come.

11 Thank you for this opportunity very
12 much.

13 CHAIRMAN MAYES: Thank you, Lori. Any
14 questions from the committee? All right. Thank
15 you very much. Next we have Wally Hankwitz.

16 WALLY HANKWITZ: Thank you, Mr.
17 Chairman. My name is Wally Hankwitz, and I've
18 lived in Kingsport, Tennessee, since the late
19 1900s. I'm an independent health care management
20 consultant with 40-plus years of experience as a
21 senior health care executive.

22 I've been a hospital administrator.
23 I've worked with national accounting and
24 management consulting firms, investor-owned and
25 nonprofit hospital systems, and most recently

1 helped roll out a couple of very successful
2 accountable care organizations, including one for
3 the largest health care provider in a central US
4 state that was listed among the Top 10 of the ACOs
5 in the country this past year.

6 I understand health care reform. I've
7 been with it. I've been there. I've done it
8 community by community, from Denver to Cincinnati
9 to LA, Toledo, Springfield, and even Paducah,
10 Kentucky, and just to name a few.

11 I really, I believe I know what works,
12 and I know what doesn't work. I moved my family
13 to Kingsport from southern California two decades
14 ago, drawn by the great health community and the
15 area's strong Christian and family values.

16 Many of you might not appreciate the
17 attributes of this medical community. But more
18 than a decade ago, it was one of the 11 entities
19 selected by CMS to participate in a PGP
20 demonstration pilot.

21 Have you ever heard of Geisinger or
22 Dartmouth or Park Nicollet or ForeSight? Well,
23 they're nationally renowned medical systems and
24 also among the 11 entities selected along with
25 your own great medical community to pilot health

1 care delivery reform.

2 The excellence of the medical community
3 in your own backyard is really the best-kept
4 secret in the country. And this authority is you,
5 the authority, is in a position to either support
6 and encourage its continuation towards getting
7 even better or destroy it by allowing the merged,
8 the proposed merger.

9 The proposed merger will combine the
10 only two hospital systems in northeast Tennessee
11 and create a health care monopoly that will
12 control the way health care is delivered and
13 pricing for all commercial payers in these
14 communities.

15 The combined entity would own, operate,
16 and control the vast majority of the hospitals in
17 the area and all, if not a hundred percent, of the
18 general acute care inpatient hospital services
19 rendered to all the residents of the Tri-Cities.

20 The result would likely be significant
21 harm to consumers, with rising health care costs
22 and diminished incentives to upgrade services and
23 improve quality. This merger will significantly
24 increase the combined systems bargaining power
25 with health plans -- pointed out by Courtney --

1 which, in turn, will harm consumers by bringing
2 about higher prices and lower quality.

3 I reference an article written by Dr.
4 Eric Schneider and published in the Commonwealth
5 Fund in November of last year, which states, and I
6 quote. It's a couple of sentences here I'm going
7 to read.

8 Based on historical data, we know that
9 horizontal mergers, hospital to hospital,
10 generally raise prices and spending. Hospital
11 mergers may even accelerate the growth in prices
12 over time. Likewise, physician group mergers seem
13 to be associated with higher prices for common
14 procedures.

15 I continue the quote, and they ask the
16 question: Could the price increases be justified
17 by higher quality? Answer: Not really.

18 Studies in the US and England tell us
19 that quality tends to be higher when patients can
20 choose among competing hospitals. So this
21 article, I'm submitting this article as an
22 attachment to my testimony. Okay?

23 Now could these points be applicable
24 here to our own Tri-Cities community? Yes. And
25 to wit: A recent series of health delivery

1 initiatives, independently undertaken by each of
2 the two hospital systems and a group of
3 independent physicians, prove these points.

4 CHAIRMAN MAYES: 30 seconds, Wally.

5 WALLY HANKWITZ: Specifically, each of
6 these three entities independently rolled out an
7 accountable care organization, and each of the
8 entities serving its Medicare members effective
9 January 2013, and a schedule showing the results
10 of this is attached also with this testimony.

11 Bottom line, it shows that the combined
12 results of the two systems experienced higher
13 costs and lower quality, significantly less value
14 than the entity sponsored by the independent
15 physicians. This documented evidence that this
16 merger will harm consumers by bringing about
17 higher prices and lower quality.

18 The proof, ladies and gentlemen, is in
19 the pudding, cooked in your own kitchens, in your
20 own backyard, by your own entities.

21 Grading the initiatives by using the
22 system introduced by the gentleman from the
23 Department of Health, I would give Wellmont a D,
24 MSHA a C, and the independent physician entity an
25 A plus, as it ranked among the Top 10 in the

1 country in the US this past year, among the Top 10
2 of all the 300-plus ACOs in the country.

3 CHAIRMAN MAYES: Wally, I'm sorry, your
4 time is up.

5 WALLY HANKWITZ: Thank you. The rest of
6 my testimony is on file. Thank you.

7 CHAIRMAN MAYES: All right. Pause just
8 for a second. Any questions from the committee?
9 Okay. Seeing none, thank you, Wally.

10 WALLY HANKWITZ: Thank you.

11 CHAIRMAN MAYES: All right. Next we
12 have Randy Sermons.

13 RANDY SERMONS: Hello. My name is Randy
14 Sermons. I'm an attorney, and I'm very glad that
15 I get the opportunity to speak with you tonight.

16 I moved to Johnson City in 1998 to join
17 a law firm that at the time represented Johnson
18 City Medical Center. I did that until 2005 when I
19 opened my own office.

20 And since that time, I've represented a
21 number of independent providers in our community,
22 including I am general counsel to Holston Medical
23 Group. I am general counsel to Qualuable Medical
24 Professionals, an ACO in our region.

25 I am also general counsel to OnePartner,

1 our local health information exchange, which is
2 discussed extensively in the application, and you
3 will hear from all three of these entities later
4 tonight.

5 I want to say as an attorney
6 representing independent providers in the region,
7 that I really agree that local control of our
8 health care is very important. It's like getting
9 a mortgage.

10 Sometimes it's really nice when you go
11 down and sit across the table from someone who is
12 so involved in your daily activities, and letting
13 that control go outside the region could present a
14 problem.

15 And I'm also very happy with the
16 application making so many commitments to enhance
17 additional services to really what are our most
18 needy citizens in the region, and so I applaud
19 those efforts.

20 But as an external stakeholder and as an
21 attorney representing external stakeholders, I
22 have to be concerned about the viability of the
23 rest of the health care community as we go forward
24 if this COPA is granted.

25 And so I want to address several issues,

1 and the first issue has to do a lot with
2 competition and really a lot with access,
3 something that this group has heard a lot about.
4 And in order to have sufficient access, it's just
5 not the hospital systems providing access, it's
6 the independent providers.

7 And when you look at the application,
8 there's a chart that defines a 29-county
9 geographic area, and it breaks down providers in
10 each of those counties for each of the service
11 lines and comes to the conclusion that there's
12 sufficient competition in the market. I'm not
13 sure that's really true.

14 If you look at that list, for example,
15 and you see CT MRI services being offered in
16 Boone, those services do not compete with the
17 services offered in Washington, Sullivan counties,
18 and others counties. It may compete with services
19 offered in Johnson County, Mountain City, parts of
20 Carter County.

21 However, when you look at the horizontal
22 merger guidelines published by the Federal Trade
23 Commission, you see that when you define a
24 geographic market for competition purposes, you
25 look at where the patients are willing to travel

1 for a service, and I'm not sure that Mountain City
2 residents can realistically travel to Kingsport
3 for MRI CT services or that Kingsport patients can
4 travel to Boone.

5 So I believe that the index must
6 establish a way to properly construct geographic
7 markets for competition. Right now, there are no
8 items in the proposed index that do that.

9 In addition, you have to compare apples
10 to apples. Let's go back to CT MRI services.
11 When you look at that list, it includes CT MRI
12 services offered by orthopedist offices.

13 Most orthopedist offices have those
14 services for their internal patients, but they
15 don't accept referrals from outside. They could,
16 but a majority of them do not accept referrals, so
17 including them in the list of competing facilities
18 overstates the amount of competition in the
19 market.

20 That's also true in the ambulatory
21 surgery center market, where that list includes
22 single-specialty and multi-specialty surgery
23 centers which do not compete for the same
24 patients. I would also note that the hospitals
25 have minority ownership in a number of surgery

1 centers.

2 And while it's a minority ownership, if
3 you peel back the onion there and look at the
4 operating agreements for those surgery centers,
5 they often contain special protections and
6 privileges for the hospital systems to control
7 membership, contracting, advertising, and a number
8 of other services that prevent those surgery
9 centers from being true competitors in the market.

10 I would also talk a little bit about
11 pricing. I applaud the efforts of the surgery --

12 CHAIRMAN MAYES: 30 seconds.

13 RANDY SERMONS: -- of the hospital
14 systems to agree to reduce their pricing to only a
15 quarter of a percent of the change in the medical
16 and the hospital CPI.

17 However, I would be also concerned about
18 those prices getting too low and driving
19 competitors out of the market. I feel the same
20 way about wages and benefits getting too high and
21 driving all of our qualified work staff from
22 competitors into the new health care system.

23 Finally, I would like to mention
24 something about debt. The hospitals have not
25 really addressed debt in too much detail in the

1 application. They have noted that their bond
2 rating should go up once they merge.

3 I would be concerned about them taking
4 on too much debt in the future. Part of our job
5 here is to keep local control. And if they get in
6 too much debt in the future, we could see another
7 purchaser outside the community wanting to buy the
8 merged system. Thank you.

9 CHAIRMAN MAYES: Thank you, Randy. Just
10 a second. Any questions from the committee?

11 DR. TERESA KIDD: Randy, would you just
12 repeat what you said? The first indicator was to
13 establish a way to construct geographic measures.
14 I lost the second part.

15 RANDY SERMONS: Geographic markets.

16 DR. TERESA KIDD: Thank you.

17 RANDY SERMONS: Yes, geographic markets
18 for competition purposes.

19 DR. TERESA KIDD: For competition. I
20 got the last part. Thanks.

21 RANDY SERMONS: Yes.

22 CHAIRMAN MAYES: Randy, the question is,
23 will you be turning in your comments in writing?

24 RANDY SERMONS: I can prepare some. I'm
25 not sure that what I've got in front of me is very

1 well written, but I will certainly, I have
2 prepared something to submit from the -- to the
3 Tennessee Department of Health that covers these
4 issues in detail.

5 CHAIRMAN MAYES: All right.

6 BRANT KELCH: Are you suggesting that
7 part of the index should look at the amount of
8 competition, whether it increases or decreases
9 over time?

10 RANDY SERMONS: Absolutely. I mean, you
11 know, you are -- the granting of the COPA will
12 create a monopoly of sorts. That's a hard term to
13 define.

14 And if you look at the technical details
15 of how you define a monopoly, it has to do with
16 the ability to change prices in the market by 5
17 percent. It goes on and on.

18 But, yes, in order to maintain access,
19 which is one of our main components here, the
20 hospital can't be the only provider of access to
21 health care services. There must exist this
22 independent provider market that can also provide
23 that access. Okay.

24 CHAIRMAN MAYES: Any additional
25 questions? Thank you, Randy.

1 RANDY SERMONS: Thank you.

2 CHAIRMAN MAYES: All right. Next we
3 have Dan Pohlgeers. Again, I apologize if that's
4 not correct.

5 DAN POHLGEERS: It's actually Pohlgeers,
6 Mr. Chairman.

7 CHAIRMAN MAYES: Pohlgeers, thank you.

8 DAN POHLGEERS: Thank you for the
9 opportunity. Do I get a prize for the tallest
10 speaker?

11 CHAIRMAN MAYES: Yes, sir, you do.

12 BRANT KELCH: So far.

13 CHAIRMAN MAYES: If you would, pronounce
14 and spell your name for the record. Thank you.

15 DAN POHLGEERS: Yes. It's Pohlgeers,
16 P-O-H-L-G-E-E-R-S. And I know that's not a very
17 common name in east Tennessee, but I promise you
18 that even though I was born and raised in
19 Kentucky, I am a northeast Tennessean by choice.

20 I've lived here about 20 years.
21 Actually have pretty vast experience here in
22 northeast Tennessee. Spent the majority of my
23 adult life here. Actually was recruited by
24 Johnson City Medical Center 20 years ago to start
25 their hand therapy program.

1 I'm an occupational therapist and
2 certified hand therapist by training. I worked at
3 the hospital for about four years.

4 During that time, I was actually present
5 while Johnson City Medical Center purchased the
6 other hospitals in the area and became Mountain
7 States Health Alliance. I've also worked for
8 independent practices, orthopedic practices in the
9 area.

10 And back in 2011, I started a
11 independent medical practice consulting business,
12 which I now do full-time and have been doing
13 full-time for almost 16 months.

14 I also have had experience working with
15 government relations. I was a appointed member of
16 the Tennessee Work Comp Advisory Council, first by
17 Governor Bredesen as a non-voting member, and then
18 I was elevated to a voting member by then Speaker
19 Kent Williams.

20 So I have some experience in the
21 legislative issues and how rules are promulgated,
22 and so I've taken a specific interest in the COPA
23 throughout the entire process.

24 Tonight I want to share just three
25 separate pieces of information with you that I

1 think should be considered while looking at the
2 competition. And in my business and what I do,
3 especially with cost analysis and management and
4 looking at practicing analytics for medical
5 practice, I always look at benchmarks.

6 And there are two. There are multiple
7 places where you can find benchmarks for the two
8 entities, but there are some that are pretty
9 commonly found. And one is the Tennessee
10 Department of Health, and that's the joint annual
11 report of hospitals. And I went ahead and copied,
12 and I will submit this to you all.

13 This is actually just one of the
14 hospitals, Johnson City Medical Center in Johnson
15 City. I know it's only one of the 19 facilities
16 that could potentially come together and merge,
17 but I think it's a plethora of information.

18 It has information in it on what can be
19 used for health care management. It looks at
20 admissions by specialty, procedures by specialty.
21 It looks at CTs, MRIs. All of that information is
22 here for the year ending in this report, the
23 fiscal year ending 6/14.

24 Also it has financial data, which I
25 think is also very important. Throughout the COPA

1 application, not only is it mentioned that local
2 control is an important aspect but a reduction in
3 costs due to reduction, and duplication of
4 services is also mentioned.

5 Also the, what Randy here has just
6 mentioned earlier, decreases in the amount of
7 increase in revenue is also discussed, and so this
8 data here is very evident as to how that all
9 occurs.

10 Just as a side note, gross charges for
11 Johnson City Medical Center for this fiscal year
12 was \$1.9 billion. Their net revenue received from
13 patients was 376, almost 377 million.

14 They also received some nonoperating
15 revenue and other operating revenue, which I
16 assume from the index and what is written here
17 comes from the foundation and those types of
18 areas, and I will give this to you tonight.

19 Another piece of information, again it's
20 another benchmark I actually just received last
21 Thursday, and this actually comes from the Health
22 Care Data Solutions, and this is actually an
23 organization that I just recently found out about.

24 I went to their website and put my email
25 address in, so they send me data based on the

1 largest single revenue sources, which is on the
2 books, and largely pay for the operating expenses
3 occurring to generate these revenues.

4 This report that came out last Thursday
5 actually shows that the inpatient revenue --

6 CHAIRMAN MAYES: 30 seconds.

7 DAN POHLGEERS: -- for hospital services
8 in our local market, Johnson City, for hospitals,
9 Johnson City ranks No. 1 out of 26 in per-bed
10 revenues. So I would assume that if we're going
11 to see reductions in costs, that those reductions
12 in costs would also come back to the consumer, and
13 this should also go down.

14 I also have some information here
15 concerning provider-based billing, which increases
16 costs when physician groups are purchased by
17 hospitals, and lastly I want to mention just one
18 thing.

19 There's been a lot of discussion here
20 recently about the separation agreement and the
21 need for a strong separation agreement. That was
22 something that Mountain States, at the emergency
23 rules hearing, felt like was not necessary.

24 But I just want to pose the question.
25 If so much of this COPA is dependent upon local

1 control, what would happen if after the merger
2 occurred, that an outside entity would come and
3 purchase the merged system?

4 And before you think I'm crazy for
5 saying that, there's at least one other person in
6 Tennessee that believes that that might be a
7 possibility. And in his letter on June 25th to
8 the Federal Trade Commission, Dr. Dreyzehner asked
9 this question:

10 I request the opinion of the staff as to
11 whether the sale of a merged entity, operating
12 pursuant to a COPA, would trigger an anti-trust
13 review when the new owner is not party to the
14 cooperative agreement or operating with the
15 activity state supervision pursuant to the COPA.

16 So if the only public advantage and the
17 most important public advantage to this COPA is
18 local control, I suggest that the index included a
19 trigger that if that local control goes away, that
20 the separation agreement is enforced.

21 CHAIRMAN MAYES: Time.

22 DAN POHLGEERS: Thank you, Mr. Chairman,
23 and I will submit this information.

24 CHAIRMAN MAYES: Thank you for the
25 records. Just a second. Any questions from the

1 committee? All right. Seeing none then, thank
2 you very much.

3 DAN POHLGEERS: Thank you.

4 CHAIRMAN MAYES: All right. Next we
5 have Charlie Glass.

6 CHARLIE GLASS: Thank you, Mr. Chair.
7 My name is Charlie Glass. I'm Executive Director
8 and CEO of the Greater Kingsport Family YMCA,
9 where I've worked for more than 21 years.

10 At the Y, we're dedicated to the
11 well-being of those who live in our community. We
12 serve folks of all ages, races, faiths, incomes,
13 and abilities, and we believe strongly that each
14 and every individual should have the opportunity
15 to live life to the fullest.

16 Today, and I'm sharing this input today
17 from speaking on behalf of all four YMCAs in our
18 region, which cover pretty much the same market
19 area that this new health system would be
20 covering.

21 I should also mention that I had the
22 opportunity to participate with Population Health
23 Work Group. The results of that work group and
24 the discussions were interesting but not
25 surprising.

1 To see this, it was interesting to me,
2 and not surprising, to see the same big three
3 concerns showing up: issues related to tobacco,
4 diabetes, and heart.

5 These are three critical issues in our
6 region, and it's important that this new health
7 system is involved in reducing the incidents of
8 those of people who are already, who already have
9 those chronic diseases as well as preventing those
10 from acquiring those chronic diseases.

11 It's also important that the new health
12 system engages with the community and the plethora
13 of resources that already exist to do that,
14 because there's some great resources out there.

15 In the COPA pre-submission report, I
16 noticed the division of the merger sets forth that
17 the new health system will, among other things,
18 build new population health models and leverage
19 electronic health records and community engagement
20 programs to reduce unhealthy behaviors and improve
21 the health status of our region, and I'd like to
22 share a couple thoughts about a possible
23 opportunity to facilitate that vision.

24 The first thing, I think it's important
25 that we realize that it's difficult at best to get

1 quality and timely data around community health
2 and behavior health.

3 So the first thing that it would be
4 important for me and for us is that a system is
5 developed to identify people who have or are at
6 risk to develop chronic disease, not just use
7 outdated data as a baseline, but we need to start
8 with a baseline that's relevant.

9 Then there needs to be mechanisms to
10 make sure people are getting referred to
11 appropriate community-based programs, whether
12 they're treatment programs or preventive services
13 and programs, and those programs need to have
14 measurable outcomes that show reduction in at-risk
15 indicators.

16 And there needs to be funding for those
17 programs for people who can't afford them
18 otherwise, so there needs to be a pathway that
19 includes measures along the way.

20 We need to screen the population. We
21 need to identify at-risk population that we want
22 to target. We want an effective referral
23 mechanism as in a coach and follow-up, and
24 enrollment in community-based treatment,
25 prevention, or cessation efforts with

1 evidence-based measures, measurable outcomes for
2 behavior change.

3 And those do exist. At the Y, we
4 currently have a prevention pathway in place to
5 reduce the risk of Type-2 diabetes in those who
6 are at higher risk to develop the disease.

7 CDC evidence-based programs, like the
8 YMCA's diabetes prevention program, have been
9 shown to reduce the risk to develop Type-2
10 diabetes by 58 percent, or in people over 60 by 71
11 percent.

12 Already in our region, we have this
13 pathway in place with five regional employers, two
14 in Sullivan County and three in Greene County.
15 Screening takes place to identify the at-risk
16 population.

17 Eligible employees are referred to the
18 program. We conduct intake sessions to enroll
19 participants. We provide measures all along the
20 way to show aggregate progress --

21 CHAIRMAN MAYES: 30 seconds, Charlie.

22 CHARLIE GLASS: Okay. This program, the
23 results and the measures were studied for three
24 years with over 7,000 participants by Medicare
25 actuaries to be reliable, consistent, and

1 accurate.

2 It's the first community-based
3 prevention effort to meet their criteria, and I
4 think it's important that we do focus on measuring
5 prevention. They found that at \$429 a person,
6 there's a 617 percent ROI in 15 months, finding a
7 savings of over \$2600 per participant in 15
8 months.

9 This is an opportunity to provide valid
10 and credible measures that already exist that can
11 be used to measure effective prevention efforts
12 that this system can work with community-based
13 organizations to provide.

14 CHAIRMAN MAYES: All right. Thank you,
15 Charlie. Any questions from the committee? All
16 right. Thank you so much, Charlie.

17 BRANT KELCH: I have one quick question.

18 CHAIRMAN MAYES: Oh, I'm sorry.

19 BRANT KELCH: Are you providing that
20 pathway to the committee?

21 CHARLIE GLASS: I'm sorry?

22 BRANT KELCH: Are you providing that
23 pathway you're talking about to the Department of
24 Health?

25 CHARLIE GLASS: To the Department of

1 Health or through?

2 BRANT KELCH: Yes, to the Department of
3 Health.

4 CHARLIE GLASS: If they would like to,
5 we would.

6 BRANT KELCH: I'd like that.

7 CHARLIE GLASS: Yes, absolutely. And
8 for those who can't afford to pay, we just need a
9 funding mechanism.

10 BRANT KELCH: And you think it's
11 realistic to basically see improvements that we're
12 talking about in those three or four different
13 disease categories in how many years, two, three,
14 four, five years?

15 CHARLIE GLASS: Yes. In fact, the five
16 employers that we're working with, we have
17 quarterly -- and I can share with you the
18 quarterly report that indicates that shows the
19 improvement and measures that we've had so far,
20 yes.

21 CHAIRMAN MAYES: All right.

22 CHARLIE GLASS: Thank you.

23 CHAIRMAN MAYES: Thank you. Just a
24 minute, Charlie. I'm sorry.

25 THOMAS WENNOGLE: Yes.

1 CHARLIE GLASS: Excuse me.

2 THOMAS WENNOGLE: Thank you. You know,
3 I would say to you and to some of your earlier
4 presenters too -- Kandy, and I'm sorry, I forget
5 the other one -- any detailed or specific examples
6 of how programs have been successful when
7 implemented with other hospitals would be greatly
8 appreciated by me anyway and I'm sure the rest of
9 the board.

10 I would encourage everybody to post
11 those on-line if you would for our benefit.

12 CHARLIE GLASS: Absolutely. Be happy
13 to.

14 MINNIE MILLER: And if you could, if we
15 could have the time frame showing those successes,
16 that would help.

17 CHARLIE GLASS: Well, yes. The Medicare
18 study was in 15 months, so there was -- those
19 results were within the first 15 months of
20 participation.

21 CHAIRMAN MAYES: All right, great.

22 CHARLIE GLASS: Thank you.

23 CHAIRMAN MAYES: All right. For the
24 committee and audience sake, I think we need to
25 take a 10-minute break. And I would ask our

1 committee, our Advisory Group, if you would
2 promptly return in about 10 minutes to your seat,
3 then we'll get started again.

4 So we'll adjourn for 10 minutes. Thank
5 you.

6 (A recess was taken).

7 CHAIRMAN MAYES: Thank you so much for
8 attending tonight, and thank you so much our
9 speakers and for giving us good, good feedback,
10 and thank you for the committee for really
11 actively listening again.

12 Again, we have three to five minutes at
13 the podium, and so please be mindful of the time,
14 and don't throw too many things at me for cutting
15 you off when the time is up.

16 Also you may submit your comments in
17 writing and submit those in the box or at the
18 Tennessee Department of Health website, so we
19 would be glad to hear from you there.

20 So we'll go ahead and get started. Next
21 we have Michael Longhouser.

22 MICHAEL LONGHOUSER: Good evening.
23 Mike Longhouser, State of Franklin Health Care.
24 I'm Chief Operating Officer. Thank you for the
25 opportunity.

1 We've heard about some concerns, and I
2 think those are valid concerns, but I think there
3 are probably some ways perhaps to work through
4 these concerns.

5 You also heard that locally we're
6 blessed, that we have some of the highest
7 performing independent medical groups in the
8 country. The ACO Qualuable, just your local ACO
9 owned and operated by your independent physicians
10 locally.

11 Depending on how you measure it, it's
12 one of the Top 10 in the country, and it's
13 certainly no worse than the Top 20. So I think
14 the independent physician community brings lots to
15 the table for the hospital system to assist and
16 facilitate this merger.

17 And, for example, on page 17 -- I'm
18 sorry, 37 of the application talks about a
19 clinical council. We think that something that
20 would be very productive and very helpful would be
21 that you have an appropriate percentage and makeup
22 of that clinical council of those independent
23 physicians, again who are some of the top
24 performers in the country, top ACO performer in
25 the country.

1 It just seems logical that rather than a
2 token representation, that you would have
3 meaningful representation from the individual
4 physician groups in the area.

5 Page 44 talks about physician
6 recruitment in the area. Talks about the parties
7 expect combined system to facilitate this goal by
8 employing physicians.

9 And where independent physician groups
10 are not interested in or capable of recruiting, I
11 would suggest that the independent physicians
12 group are very interested in and very interested
13 in recruiting physicians to the community.

14 What we want to do is we want to work
15 collaboratively with the health system in order to
16 do that. Frankly, that's what we do. We provide
17 outpatient care.

18 So, for example, we provide -- we have
19 about 80,000 patients that we provide care to. In
20 our ACO, there's another 22,000 patients. So we
21 think again, it's not for lack of interest or lack
22 of desire.

23 What we want to do is, we want to ensure
24 that there's a seat at the table for your
25 independent physician community relative to

1 physician recruitment throughout the region.

2 And we think as you think about indexes
3 and you think about metrics, I think you can
4 probably assign some type of metric or some type
5 of number that would require a certain minimum, an
6 opportunity for the independent physicians to have
7 right of first refusal or whatever the case might
8 be relative to these new hires.

9 The third area is probably page 36 in
10 the application relative to HIE and a common IT
11 platform. I think it's a great idea.

12 A common IT platform is an excellent
13 idea. Let me share with you that your --

14 CHAIRMAN MAYES: 30 seconds.

15 MICHAEL LONGHOUSSE: That your
16 independent physician groups in this region have
17 spent millions of dollars on IT and electronic
18 medical records. If the merged entity comes in
19 and potentially changes that, what that would mean
20 to your independent physician groups could mean
21 significant economic distress.

22 What we would hope again is that there
23 would be an index. There would be a quantitative
24 measure that the hospital would be required to
25 essentially assist your outpatient physicians,

1 your independent physicians to help offset
2 whatever additional costs would be incurred.

3 CHAIRMAN MAYES: I'm sorry, it's time.

4 MICHAEL LONGHOUSSE: Okay. Thank you.

5 CHAIRMAN MAYES: Hang on just a second,
6 Mike, if you would. Any questions from the
7 committee? I have one.

8 MICHAEL LONGHOUSSE: Sure.

9 CHAIRMAN MAYES: The common IT
10 infrastructure is something this committee has
11 heard before. So, and also I believe I've read
12 that both systems have invested significant
13 amounts of financial resources, I'm sure,
14 infrastructure into their system.

15 But is this -- are you speaking of an
16 internal investment or common IT, or are you
17 speaking of external where patients can access
18 their medical records and additional medication
19 beyond what they can now?

20 MICHAEL LONGHOUSSE: What I'm thinking,
21 what I'm speaking of is a regional health
22 information exchange that is accessible and
23 available not only to physicians in the hospital
24 but also those outside the hospital, your
25 independent physicians, your independent groups.

1 Again, what you have today in the region
2 is you have OnePartner. It's a health information
3 exchange. Your ACO, again one of the
4 top-performing ACOs, is using that HIE today.

5 We would hope and it would seem logical
6 for the systems to make a commitment fairly early
7 in the process, that assuming that system, it has
8 the same functionality, capability, and is
9 available to the systems at a reasonable cost,
10 that they would commit very early on that we're
11 going to use the regional HIE that's already in
12 place.

13 That would enable your independent
14 physicians again to kind of map that strategy on
15 the long-term, versus us kind of wondering where
16 are the systems going? What should we invest
17 today? Should we wait and see what's going to
18 happen?

19 Because if they change that
20 infrastructure, it could mean a significant
21 additional investment on our part. That's really
22 tough on the back of your independent physicians.

23 CHAIRMAN MAYES: Okay. I apologize.
24 I'm going to make sure at least I understand this.
25 Maybe the committee does.

1 But are we talking about a universal
2 access system regardless maybe of what the COPA or
3 the merged entity uses, but they'll be part of
4 that system?

5 MICHAEL LONGHOUSSE: Potentially, yes.
6 You want the universal, you want the regional HIE
7 to be in place. But if the hospitals should
8 choose to go from system A to system B, and that
9 move causes significant additional expense
10 potentially to all those outside the system, we
11 think that should be a consideration.

12 And frankly we should think that the
13 systems would be unable to make a decision that
14 negatively impacts your independent physicians,
15 again who have already invested millions of
16 dollars in IT infrastructure.

17 THOMAS WENNOGLE: So what kind of
18 hurdles are there for the independent groups to
19 participate in some sort of exchange that might be
20 used by the hospitals?

21 MICHAEL LONGHOUSSE: We have probably
22 maneuvered many of those hurdles over the past
23 three years. Your AC, your regional ACO is now in
24 its fourth year of operation. We are meaningful
25 users of the regional health information exchange

1 today.

2 What we really need frankly is a commit
3 from both hospitals that they will participate in
4 this regional health information exchange, again
5 which will kind of take that off the table which
6 will allow us to plan appropriately from a
7 strategic standpoint relative to how your
8 independent physicians invest their very precious
9 IT dollars.

10 CHAIRMAN MAYES: Okay. Very
11 interesting. Okay. Any other questions? Thank
12 you, Mike.

13 MICHAEL LONGHOUSSE: Great. Thank you.

14 CHAIRMAN MAYES: All right. Next we
15 have Dr. Gendron.

16 DR. RICHARD GENDRON: Thank you. I was
17 chomping on the bit. To pick where Mike, I didn't
18 know what he was going to say.

19 I want you to picture, those of you who
20 used your iPad today, that in 1968 I was standing
21 on a GYN floor at the University of Vermont
22 College of Medicine as a junior, and I was seeing
23 a 55-year-old female on a computer screen, 1968.

24 Six months later, I'm sorry, three years
25 later I spent a fellowship in Lawrence Weed.

1 Lawrence Weed is the father of the
2 problem-oriented medical record. That is the
3 standard of medical records in the whole country,
4 overseas also.

5 It is not an electronic problem-oriented
6 medical record now. We developed this system for
7 electronic. Now this is what happened after his
8 ideas came through.

9 Because if I try to defend myself with
10 my doctors, who have been suffering documenting
11 all over the place and with EMRs that don't always
12 work, that's not what it's about.

13 The problem-oriented medical record is
14 for accuracy, and it's for a way of physicians to
15 communicate. What has happened to that system, it
16 got taken over by software writers. It got taken
17 over by insurance companies.

18 Just ask the doctors. He's supposed to
19 put eight bullets, and there's no -- he's going to
20 get paid at all. So the problem is is in the
21 regions, these software situations become a big
22 deal.

23 The hospitals, I was medical record
24 chairman at one of the systems for 20 years. The
25 hospital just spent -- one of the systems just

1 spent a huge amount for a system, and this system
2 is well known by some that it is a monopolistic
3 system. Once they get that system, they shut you
4 off.

5 We have two letters on the health
6 information side, OnePartner, and we can expand on
7 it, from both systems to share their data. The
8 letters were found quite a way back. Let me
9 explain to you what I'm trying to take care of.

10 The 80-year-old ladies who get
11 discharged on Friday night and is on IV
12 antibiotics and on anticoagulants. Okay? You
13 have to see her on Saturday.

14 There's nobody around here who's going
15 to find that data between the hospitals and the
16 health care systems. So bottom line, the answer
17 to your question is this definitely has been some
18 control.

19 Secondly, if you're going to spend a lot
20 of money, and that's where you guys are at, you've
21 got to wonder what's this whole system going to do
22 once they're together?

23 Well, they're going to spend some more
24 money on IT we already know. The point of it is,
25 is it going to be -- it becomes more monopolistic

1 or not.

2 From the second point. Let me jump to
3 David and Goliath. We know who Goliath is going
4 to be. A \$2 billion business between Roanoke and
5 Knoxville is a Goliath.

6 You guys are here to make sure David has
7 a slingshot. And who's David? There's only two
8 parts of the system ultimately. There's real
9 estate, and there's the doctor's pen.

10 If my check comes from the Goliath, I
11 assure you my pen is not too free. So you've got
12 to make sure, following up on Randy Sermons'
13 comments, that when they tell you the statistics
14 of who's in the system and who's independent, it's
15 your job to dig it out and make sure they don't
16 have much false providers who are in the system,
17 the Banner Elk and the like.

18 No. 3, I've spent my 38 years here. And
19 just to give you an idea what's that's like. If I
20 had a dysfunctional teenager age 12 when I moved
21 here, he's now 50 years old. I've been in the
22 mental health system in the region all my career
23 here.

24 I hate to tell you, they're promising a
25 lot of things in this COPA. They've got a hard

1 time fixing that. We've had a monopoly, and it's
2 not a mega monopoly. I know Mr. Barney and Mr.
3 Good way back. They've done Frontier.

4 Frontier is a form of a monopoly. The
5 odd of it is, nobody else is spending money on
6 mental health except the state.

7 My hospice, who are the oldest and best,
8 longest-term hospital team inside Holston Valley,
9 managed by Holston Medical Group, have told me one
10 out of three elderly complicated medical
11 admissions would not have been admitted if their
12 mental health side had been taken care of.

13 That's not counterintuitive if you're in
14 the hospital. Remember, hospitals fill beds. Am
15 I really going to want to make sure this lady
16 doesn't commit if I fix her mental health? I have
17 my thoughts.

18 The other thing I think, the elephant in
19 the room that's going around in the region, and I,
20 you know, economically health care cannot be the
21 employer of default. If you're an employer, if
22 you run a business around here, you cannot have
23 health care as the default employer.

24 I can see what's happened in Lee County.
25 I can see what's happened in all these places

1 where the hospitals close. But I keep hearing
2 from a few of the senior people in the merger,
3 nobody is going to lose their job.

4 I am the senior oldest full-time
5 physician in both systems. I was working last
6 week. In the last two weeks, I've had 14
7 patients, for instance, who were held on the
8 pediatric floor not because they needed to be on
9 the pediatric floor, but there was no mental place
10 to send them.

11 They're all suicidal kids. So I live in
12 the system. You've got to make sure David gets a
13 slingshot.

14 No. 2, if the electronic medical record
15 is used as a way of controlling the group that
16 should be independent, then you need to look at it
17 very seriously. There are plenty of ways around.

18 Obviously the system that you're talking
19 about, as far as I've been there for a long time.
20 I told you I go all the way to 19 --

21 CHAIRMAN MAYES: 30 seconds.

22 DR. RICHARD GENDRON: I go all the way
23 back to 1968 in the year of my business. I assure
24 you all the others are retired and smarter than me
25 and gave up on fixing the system. Thank you very

1 much.

2 CHAIRMAN MAYES: Thank you. Just a
3 minute, Dr. Gendron. See if the committee has any
4 questions? All right. Seeing none, thank you
5 very much.

6 All right. Next we have Dr. Fowler.

7 DR. SCOTT FOWLER: First of all, thank
8 you for having me here tonight and letting us
9 speak a little bit. And thank you, Dr. Gendron,
10 and a lot of the other people who spoke.

11 My name is Dr. Scott Fowler. I'm an
12 OB-GYN in town. I'm also the president of Holston
13 Medical Group. Holston Medical Group has about
14 150 providers.

15 We have 15 locations, if you haven't
16 heard of us. We have about 800 employees. We've
17 been here since 1977 or so.

18 And we're originally started really as a
19 grant from the Robert Wood Foundation to bring
20 primary care to this region, and that's been our
21 mission from the start. We're a mission-driven
22 organization.

23 Our main goal to create environments
24 where patients can receive the care they need. We
25 know inside of Holston Medical Group, that there's

1 a lot of un-met need for care in our region.

2 And there's some things doctors can do
3 about it, and there's some things that we can't,
4 but we certainly have done some things that we
5 think are important in that area.

6 One of the things that we've done is
7 we've built this interoperability platform along
8 with other independent physicians in the region so
9 that a patient has a single medical record, so to
10 speak, as they see multiple physicians who might
11 be in different areas.

12 This is critical that that record be
13 available to those doctors at the point of care.
14 The institution, the Institute of Medicine has
15 identified the point of care as the most important
16 place where patients understand what they have
17 going on with them and what they ought to do about
18 it, so the decision-making occurs at that place.

19 Based on that sort of common record, we
20 put together an independent group that were using
21 those records to build Qualuable, which you've
22 heard of already. I'm the CEO of Qualuable,
23 mainly because this is, along with State of
24 Franklin and Mountain Region Medical Care LLC, the
25 larger independent medical groups.

1 This is our effort to actually address
2 the critical health care issue that's in front of
3 us, and that issue is is we have an expanding
4 group of patients who need care and no money to
5 pay for it.

6 So I don't -- we don't expect the
7 hospital merger to solve all the problems that are
8 out there. I applaud every one, the YMCA, the
9 everybody who's investing as a community. We need
10 to bring the community together so that we have a
11 common interface with the patient at the point of
12 care.

13 We're very concerned that the merger is
14 a distraction, quite frankly. I don't mean a
15 positive or negative thing for the hospitals and
16 the local community. Very important. We want
17 local community. We think health care is local.

18 We'd love to have a system where we have
19 the things that we need produced and developed and
20 available locally. There's very hard decisions
21 that have to be made. We really need to decide as
22 a community how we want to spend very limited
23 resources.

24 So it worries me that the hospital may
25 spend a hundred million dollars consolidating IT

1 systems into something that creates internal to
2 the hospital, I suppose, some sort of commonality
3 that allows them to function but doesn't address
4 interoperability issues outside.

5 Right now the key point, I guess I can
6 make in addition to what everybody else has made
7 is, we could reduce the health care, the cost of
8 health care in our community significantly if we
9 had more power to control some of the facility
10 related cost structure.

11 Currently we have almost none. We have
12 none in the inpatient side, and the outpatient
13 surgery center side we participate but as minority
14 members. We don't set contract rates.

15 We don't do that. We're prohibited by
16 the CONs from having any significant competitive
17 advantage in or competitive place in those
18 marketplaces.

19 So I would say an index issue has to say
20 that the health care system itself cannot use its
21 ability to borrow money or the fact that it's got
22 already almost a \$2 billion revenue system in to
23 create vertical markets in the vertical market,
24 the surgery center market, the diagnostic center
25 market, suite center market, birthing center

1 market.

2 Everything that just got opposed and
3 beat down on the CON law, which we tried to get
4 through. I believe both hospitals objected to
5 changes in the CON law, so I do believe this
6 committee has to look at that.

7 We can bring lower cost, higher quality
8 care. We're doing it in the ACO. You heard we're
9 in the Top 10. We can do it. Wherever we have
10 data and providers together with patients, at that
11 interface we can improve care in the region.

12 So I worry that the merger could impact
13 that. We're for it in the sense that we like the
14 local idea but --

15 CHAIRMAN MAYES: 30 seconds.

16 DR. SCOTT FOWLER: Yes. We worry about
17 that, too, because we don't know what happens if
18 another system wants to come in the marketplace to
19 compete. You heard what happens if they do better
20 and they want to sell.

21 Both systems actually could probably do
22 most of what they want to do without merging. So
23 those are the issues and the questions we have and
24 that we'd liked to see index points on. Thank
25 you.

1 CHAIRMAN MAYES: Just a second. Thank
2 you. I have one point of clarity. I want to make
3 sure, at least I understand. When you talk about
4 control of cost structure, you elaborated on that
5 a little bit, and you were phrasing it as "we."

6 And so I'm going to assume you're
7 speaking from a physician standpoint or a provider
8 standpoint?

9 DR. SCOTT FOWLER: Right.

10 CHAIRMAN MAYES: Okay, good. So can you
11 just give me an example, you know, just make an
12 example of how not having control of a cost
13 control structure of a merged entity --

14 DR. SCOTT FOWLER: Okay. So, yeah. So
15 the way the system is operated is that you can
16 actually, if you improve care and you lower cost,
17 you get to share some of that savings, okay?

18 So if we had control, let's say, of an
19 outpatient surgery center's contracting model,
20 right now a knee replacement or hip replacement is
21 about a 28,000 to \$32,000 cost if you use either
22 one of the systems we have here.

23 The in-or-out lateral knee can easily be
24 done in an outpatient surgery center, and it can
25 certainly be done for less money. 30 days all in

1 in almost every country in the world costs about
2 \$8,000. That's how far off we are and what it
3 costs in the United States.

4 These are standard hip replacement
5 surgeries that are done all over the world.
6 There's a significant delta there. We believe we
7 could offer that surgery in a surgery center for
8 more like \$10,000 instead of 38. If we had
9 control over that contracting, we might actually
10 do that.

11 The doctor's fee is irrelevant. It's a
12 tiny little part of the overall cost. The real
13 fee that gets charged there is that Part A fee
14 that comes out of the hospital. So it's a Part A
15 contract and a Part A hospital. A Part A
16 outpatient, even if it's outpatient center, then
17 that cost is relatively high.

18 In Qualuable, where we have an MSSP
19 contract with CMS, we share 50 percent of every
20 dollar saved. So we could reduce costs. We could
21 create more employment opportunity for ourselves
22 and provide better care at the same time if we
23 controlled some of those entities.

24 That's why for us, the CON law almost
25 has to go away in the outpatient marketplace for

1 this COPA to make a lot of sense to us.

2 CHAIRMAN MAYES: Okay. So I thank you
3 for that answer. But your comment again on the
4 CON, so are you suggesting the State of Tennessee
5 have like a CON-free zone in the NSA area?

6 DR. SCOTT FOWLER: I believe that would
7 be fine. That would allow competitors to decide
8 whether to invest in these services on an
9 outpatient basis. It would open up the
10 contracting so we could provides those services.

11 Let's say an Eastman patient has a
12 \$5,000 deductible, and they're going to have a
13 hysterectomy. They go to the hospital. That's
14 maybe a \$12,000 charge.

15 They pay their 5,000, and Eastman pays
16 the rest, pay it through their TPA Cigna. We
17 could do that all and anesthesia, outpatient
18 surgery, everything for probably \$5,000, and it's
19 being done all over the country.

20 That reduces the cost to Eastman. It
21 reduces the cost to the patient. Eastman probably
22 would pick it up. There would be no deductible.

23 So these are things that can happen, and
24 they are happening, the things we want to do. We
25 don't want to destroy the hospitals. They're very

1 important to us.

2 We understand that this merger could add
3 real benefit from the sort of local aspects of
4 medicine, but that's the example I would give.

5 CHAIRMAN MAYES: Okay. Thank you. All
6 right. Thank you very much. All right. Next we
7 have Gary Mabrey.

8 GARY MABREY: Well, good evening. I
9 usually introduce myself. I work at the chamber,
10 but I guess for the record I need to go through
11 all the formalities and share title.

12 I'm Gary Mabrey. I'm the President CEO
13 of the Johnson City/Jonesborough/Washington County
14 area Chamber of Commerce and want to thank you for
15 the work you're doing to cause the discussion to
16 be as lively as it is tonight and as has been in
17 other places.

18 It took our chamber a while to decide
19 where we wanted to be on the merger, and I want to
20 share with you a handful of the framework that our
21 members thought. Particularly, I work for 47
22 directors on two different boards for the Chamber
23 of Commerce.

24 And part of our list included things
25 like the repurposing of dollars, the new research

1 opportunities that would come, investment in
2 addiction and behavioral services, improved
3 recruitment. And I can't say enough about the
4 recruitment piece because we know, looking at our
5 academic Health Science Center at East Tennessee
6 State University.

7 You know, we recruit a doc. He wants --
8 he or she wants to research. He or she wants to
9 teach. And then we're able to address some of
10 those much-needed health care delivery services
11 that we need for our patients and our citizens,
12 opportunities to solve health problems in the
13 region resulting in an area of economic
14 development benefit.

15 I sell this region. When folks want to
16 come here, the first question they ask other than
17 schools or whatever is how is our health care?
18 I'm living proof the health care is good because
19 several of these folks who've talked tonight have
20 been practicing on me, and thank you, and I
21 appreciate the practice that they've been doing.

22 I think it will be, our guys around the
23 board decided that this would be a system that
24 could be competitive, that we would be proud of
25 it.

1 Community health will improve we feel,
2 and I'm painting the broad strokes. Community
3 health will improve as it relates to how we use
4 existing services, how we use the university, and
5 all the aspects of higher education access.

6 The thing that I've heard the most is,
7 you know, our physicians will be able to practice
8 across the various lines. I've been around a
9 while.

10 I've been here for over 20 years, and
11 I've seen, you know, where some physicians can
12 only practice here, and other physicians can only
13 practice there, and access by the physicians and
14 access by the patients where they seek to.

15 The regional health exchange, let's face
16 it, we are a region. We're northeast Tennessee.
17 We're southwest Virginia. I won't mention western
18 North Carolina, but there are 51 counties that are
19 in this macro metropolitan area that we call
20 northeast Tennessee southwest Virginia western
21 North Carolina.

22 Expanding of mental health programs,
23 addictive services, I've sat on the Frontier
24 Health board for a number of years. It has been
25 refreshing as a member of one of the committees to

1 hear how the discussion has generated and moved to
2 where we're talking about that form of treatment
3 and that form of health care.

4 Let's talk about the university a
5 minute. We have a medical school. We have a
6 college of pharmacy. We have a department of
7 public health, a college of public health.

8 It's the only academic health science
9 center that's equal to ours in northeast Tennessee
10 is the Ohio State University. So we're quite
11 excited to think that we can recruit the best,
12 serve the best, take care of our patients, take
13 care of our citizens.

14 And then as you've heard, maybe get into
15 those preventative services that we really need.
16 Maybe we need to spend those dollars in time so
17 that when we recruit, an industry or business will
18 say I want to go to northeast Tennessee.

19 Why? Because they're healthy. They can
20 come to work. They addressed their obesity.
21 They've addressed these things that maybe other
22 places haven't addressed as much.

23 In short, our chamber supported this
24 merger. The other business organizations in the
25 region worked together to support the merger. I'm

1 only speaking for our chamber, but I think the
2 business community in general spent a lot of time.

3 We did our due diligence as well, and we
4 appreciate what you're going to do to enhance what
5 we're going to be doing around here for a long
6 time in northeast Tennessee and southwest
7 Virginia.

8 The people question. We were concerned
9 about that, but we think that we will be able to
10 attract good folks.

11 CHAIRMAN MAYES: 30 seconds.

12 GARY MABREY: We'll be able to enhance
13 the team that's in place. We'll be able to
14 combine the best of each organization's work force
15 and service area, and we will become a top health
16 community again and again and again, and we'll be
17 competitive.

18 And then we'll be able to market
19 ourselves as the healthy northeast Tennessee
20 southwest Virginia, based on some of the things we
21 know where our statistics aren't as vibrant or as
22 much as we would like.

23 So thank you for that opportunity to
24 speak today. Appreciate what you're doing.
25 Looking forward to the results and your report.

1 CHAIRMAN MAYES: All right. Gary, thank
2 you so much.

3 GARY MABREY: Thank you.

4 CHAIRMAN MAYES: All right. Next we
5 have Wesley Combs.

6 WESLEY COMBS: Thank you all for the
7 opportunity to come up here and talk tonight.

8 CHAIRMAN MAYES: Pull the mic a little
9 closer.

10 WESLEY COMBS: Sure. So my name is
11 Wesley Combs. I run OnePartner Health Information
12 Exchange, which is local here in the region. I'm
13 from Rogersville, so I grew up here. Spent 37
14 years of my life here.

15 I have two kids both born in Holston
16 Valley Hospital. I have a 92-year-old grandpa
17 that also lives in the region, so my roots are
18 kind of in this region itself.

19 So we have, OnePartner Health
20 Information Exchange is who I'm kind of speaking
21 for tonight, which what it is is a technology
22 company that allows physicians to share data, no
23 matter what the EMR is. Interoperability is what
24 we do.

25 My background is computer science. I

1 went to East Tennessee State University.

2 Everybody on my team did as well, so we've got a
3 real passion for what we can provide to health
4 care in the region. We're not doctors or anything
5 like that, but we are programmers and IT talent.

6 OnePartner Health Information Exchange
7 was started about three years ago. We have about
8 750,000 unique patient records in our system
9 today.

10 We do about 200,000 messages daily, so
11 that's care events happening in our community that
12 come into our system and are available for care
13 providers to subscribe to this system to see those
14 events at the point of care in realtime.

15 So a patient goes to the hospital. The
16 next day they show up in the doctor's office. He
17 doesn't have to ask if they actually went to the
18 hospital. He'll see it right there in his system,
19 if he subscribes to the system.

20 There's about 1500 providers that
21 subscribed to our system in the region and/or
22 provide data into it. Wellmont and Mountain
23 States are both some of those that are putting
24 data into the system on a daily basis right now.

25 We're pretty proud of what we've built

1 here because the talent to build these systems is
2 something you don't get in a small region
3 normally. With CareSpark and the ones that were
4 before us, we had the opportunity to really learn
5 the technologies and the protocols that allow us
6 to share this data.

7 And we put a team that's pretty
8 passionate together, because most of my team has
9 children here as well. And what we want to see is
10 we want to see the health system in the future be
11 able to support them and their needs going forward
12 for the next generation.

13 So most of the people, most of the other
14 regions that suffer, they don't have people that
15 are passionate about it and actually want to make
16 it work to overcome all the hurdles that the EMR
17 vendors and/or other people will put in the way,
18 so we try to find ways around those, which has
19 really led to our success.

20 To date, we've put about \$3.3 million
21 into the system, and that's us as well as all our
22 supporting customers, Qualuable, State of
23 Franklin, HMG, Mountain Region.

24 We've had quite a large investment put
25 into that system and had to fight quite a few

1 battles to get the data flowing to where we can
2 actually share that with the providers for patient
3 care.

4 We support Qualuable, which was the top
5 performing -- one of the top performing ACOs in
6 the country. They actually use our system on a
7 daily basis, and we want to keep it that way.

8 So we provide them with realtime data
9 viewable at the point of care, and as well as the
10 ability to do analytics on that data for
11 population health management. We're trying to
12 help them manage the chronic conditions and keep
13 those out of the hospital and in the ambulatory
14 space as well where the cost is cheaper.

15 So with some of these investments we've
16 actually made and some of the -- the goal of
17 OnePartner's, a few things related to the index
18 that we would actually like to see in there.

19 We would like to require the new health
20 system to participate in data sharing, no matter
21 what system they use. We'd actually like it, even
22 if they don't merge, to fully participate in data
23 sharing through OnePartner HI and to continue to
24 maximize the investments that have already been
25 made regionally with great success.

1 The index must include measures to track
2 the following subjects: how well the applicant
3 leverages the existing community investment in the
4 HIE. We would hate to see what we've built, and
5 there's actually a nationwide model, that people
6 are looking to us, particularly in other regions.

7 We would hate to see that gone in our
8 region and not fully leveraged and maximized.

9 Hospital data is critically important to
10 the index and must -- the index must include
11 specific data sets, you know, and those are the
12 encounter when patients show up to the hospital,
13 to the lab, their medication, the immunizations,
14 the notes.

15 All those metrics and all those pieces
16 of data need to flow discretely over to the HIE on
17 a continuous and a really open basis to make this
18 work. That's part of population health, is having
19 all the data to actually know where to focus your
20 efforts within the community.

21 We need this to be available to
22 independent providers not just for the patient
23 care --

24 CHAIRMAN MAYES: 30 seconds.

25 WESLEY COMBS: -- but also for meeting

1 what their metrics are in their value-based
2 contracts, because that's what we're actually all
3 trying to get to here, and that's what CMS is
4 driving towards is 85 percent of the payments tied
5 to a value or quality contract.

6 The index must also require the new
7 health system to provide cost data back over to
8 the treating providers and patients so the
9 patients can make the informed decisions about
10 their care.

11 And the index must also include the
12 actual value of dollars spent by the applicant for
13 the health information exchange, excluding their
14 internal cost, so what they pay out in the
15 community for support of that system versus just
16 replacing their internal system. Thank you.

17 CHAIRMAN MAYES: All right. Just a
18 second. Any questions from the committee? I see
19 none. Oh, okay.

20 BRANT KELCH: One of the, I guess,
21 complexities in this type of environment to people
22 living here are doctors in general. We know of at
23 least 28 different EHRs that they're using.

24 Now this has been a problem basically
25 throughout the country in trying to find a way for

1 different EHRs to communicate with each other.
2 And it's my understanding that OnePartner has
3 basically found a way to enable diverse EHRs to
4 communicate with each other so doctors don't have
5 to chuck the system that they've learned.

6 WESLEY COMBS: Right.

7 BRANT KELCH: To start over anew and
8 invest hundreds of thousands or even more dollars.
9 Would you just comment on just how unique this
10 area is in accomplishing this?

11 WESLEY COMBS: Yeah. That's one thing
12 we actually pride ourselves on. We originally, my
13 staff participated in a NHIN 1 and NHIN 2
14 prototype. Those are National Health Information
15 Network things by Dr. David Railer.

16 And where we started developing the
17 skill set is we were set out at that point in
18 time, it was West Virginia, so we were sent to the
19 hills of West Virginia to find data out of these
20 systems that were written by somebody who hadn't
21 touched them in 10 years probably.

22 So we found ways around doing that,
23 around pulling the data out, put in the standard
24 format, and sending it into the larger aggregating
25 point. We still use some of those same techniques

1 today, because the industry standard protocols
2 that everybody is still developing are still in
3 development, so there is no easy button for
4 interoperability.

5 It's hard work, and that's one thing my
6 team prides itself in is going out and doing that
7 hard work. We just did one. We got access to an
8 EMR last week that we were told, no, you can't do
9 this, and the vendor was really pushing back.

10 We got on the phone with the president
11 of the EMR vendor company, and he's -- which is a
12 physician. And he was like, why would we say no
13 to this? Do what you need to interoperate.

14 And I got a message today from one of my
15 programmers that he finished the work already and
16 will start testing next week. So this is stuff
17 that normally takes anywhere from three to six
18 months.

19 And in a matter of four to five days,
20 we've done most of the work for that small
21 independent provider. I mean, it's a one-doc
22 practice that we did that for so...

23 CHAIRMAN MAYES: All right, Wesley.
24 Thank you so much.

25 WESLEY COMBS: Thank you.

1 CHAIRMAN MAYES: Okay. Next we have
2 Danelle Glasscock.

3 DANELLE GLASSCOCK: Hello. My name is
4 Danelle Glasscock, and I'm the Executive Director
5 of the United Way of Greater Kingsport.

6 On a personal note, I've had one child
7 born at Indian Path and two at Holston Valley, so
8 just to share that. We are better together.

9 In this role at United Way, I've had the
10 privilege of working with many people and
11 organizations in our community who are dedicated
12 to making life better for the people living in
13 this region. It's great seeing so many
14 organizations, including my friends from Healthy
15 Kingsport, the United Way of Washington County,
16 and also Frontier Health here tonight.

17 As you can likely tell, we are here
18 because we want to make a difference in the lives
19 especially of those who are low income and lack
20 convenient access to basic services, like great
21 education and also health care.

22 United Way believes there are three
23 building blocks to a quality of life. Those are
24 education, income, and health.

25 Education means that our children are

1 graduating from high school, college and
2 career-ready. One of our biggest strategies right
3 now is trying to help those third-graders read at
4 grade level.

5 Income, income means that we want
6 families to be financially sustainable on their
7 own, to have a living wage for which they can
8 sustain themselves, and then help is access to
9 good health care.

10 We are fortunate that we have so many
11 wonderful programs in our community that are
12 making a real difference. We often talk at United
13 Way about the root causes, long-lasting changes to
14 community issues, and that's what we have tried to
15 be about at United Way.

16 We really feel that if we can address
17 root causes, that we can impact our whole
18 community population. One of those root causes
19 that we would probably say is that when people
20 don't have access to good health care, then they
21 may be more likely to turn to pain medications and
22 then become drug addicted.

23 Drug addiction is one of the huge
24 problems in our community, and I would like to see
25 a metric from the combined systems on helping

1 reduce prescription drug abuse and other drug
2 abuse in our community. It is really impacting
3 the lives of children and our families in our
4 community in tremendous ways.

5 We partner with many other great
6 partners in our community. One, besides Frontier
7 Health, is represented here with Teri Kidd and her
8 great programs on mental health issues and abuse
9 issues that they work on, is our Friends In Need
10 health center.

11 It provides affordable care to those who
12 are uninsured and underinsured in our greater
13 Kingsport area, and it partners with many of these
14 organizations, Wellmont and Indian Path as well.

15 We also try to really help children in
16 our community with programs such as Mountain
17 Region Speech & Hearing Center and also many other
18 programs in our community.

19 As we all know, missing a few days of
20 work due to an illness can mean the difference in
21 someone being able to afford their rent for the
22 month or food for their family. I believe it's
23 critically important that the new health system
24 continues to offer tiered care for those who
25 cannot afford to pay.

1 I believe it's also important that our
2 access to care in rural communities be considered
3 as you develop an index to measure the advantages
4 the merger will provide to our area. Without
5 these services, people in our rural communities
6 would have to drive a significant distance to get
7 care, making it difficult for the elderly and
8 those without reliable transportation.

9 And in the case last week of my niece,
10 who had a nut allergy reaction in school and had
11 to drive 45 minutes to the nearest hospital to
12 save lives of people that have immediate needs.

13 28 percent of our children in our area
14 are living in poverty. We can't only just service
15 children. We have to serve their parents and
16 those families for those families to be
17 successful.

18 I've seen our community join together
19 time and time again to meet a need, and I'm
20 confident that we can work together to meet the
21 challenges facing our area.

22 At United Way, we often say the dollars
23 that are raised local stay local. We've also been
24 talking about the last couple of years a better
25 life for all, a better life for you, and we were

1 very excited when the Better Together theme came
2 out for the combined health system.

3 CHAIRMAN MAYES: 30 seconds.

4 DANELLE GLASSCOCK: That we were really
5 all on the same page, and that makes me think that
6 we are on the right path for our community.

7 I want to thank you. I appreciate your
8 work. I appreciate your commitment to ensuring
9 our uninsured and low income friends and neighbors
10 to continue to have access to the health care they
11 need.

12 Thank you. And are there any questions?

13 CHAIRMAN MAYES: Any questions? All
14 right. Thank you so much, Danelle.

15 DANELLE GLASSCOCK: Thank you.

16 CHAIRMAN MAYES: All right. Next we
17 have Dr. Platzer.

18 DR. PETER PLATZER: My name is Peter
19 Platzer. I'm a family physician in Kingsport, and
20 I'm representing an entity of one, which is me. I
21 am a solo family physician, so I'm not
22 representing anybody but me.

23 I came to Kingsport 19 years ago, after
24 20 years in the Navy. I had an opportunity in the
25 Navy to serve in a variety of capacities,

1 including running hospitals and clinics, as well
2 as an unenviable tour in Washington, D.C. where I
3 did officer personnel. Anybody who has ever tried
4 to tell a doctor where to go knows exactly what I
5 had to do.

6 At any rate, I am here mostly to speak
7 as a private physician, and I have to confess that
8 I am somewhat skeptical about the merger. The
9 merger to me will create a monopoly.

10 And though it may sound great, I am very
11 distrustful of monopolies. I would also point out
12 that in my practice, most of my patients are also
13 very distrustful of the merger coming down. I
14 have basically a blue-color practice, and there is
15 a big suspicion of large entities.

16 My experience with monopolies -- Navy
17 medicine was one -- is that they have a tendency
18 to, let's see, I lost my spot here. Okay. The
19 first part is that I believe that monopolies
20 increase costs.

21 When there is no competition, there is
22 no incentive to keep costs down. When the
23 hospitals can negotiate for higher reimbursement,
24 they can -- that's going to get passed on directly
25 to the patients, and most of my patients have

1 difficulty with their affordable insurance now.

2 My second perception of monopolies is
3 that there's a tendency for them to suppress
4 innovation. There are so many advances in modern
5 medicine, and they come at an incredibly fast
6 rate.

7 But if you're a monopolistic system,
8 then there really isn't a big incentive to get
9 that new next-best thing. Or maybe you'll put it
10 off for a couple of years because the guy down the
11 street, the other guy, isn't going to buy it
12 either.

13 The third thing is that I think
14 monopolies suppress wages. I think the health
15 system merger will cost jobs, regardless of what
16 anybody says.

17 I think particularly hard hit will be
18 Kingsport, because Kingsport is where the two big
19 Goliaths rub against each other. And they are
20 constantly competing, and that again is what I
21 see.

22 So I think that we will lose jobs not
23 only because of consolidation of services, but I
24 think that it will suppress the wages totally
25 because if you're the only game in town, you

1 certainly don't have to offer top wages.

2 So again, I think the competition is
3 good. Limiting it in Kingsport will limit the
4 choice of the patients, and I just don't have the
5 great belief in a monopolistic system that some
6 folks have.

7 Thank you for the opportunity to speak.

8 CHAIRMAN MAYES: Thank you, Dr. Platzer.
9 Any questions from the committee? I'm seeing
10 none. Thank you very much.

11 DR. PETER PLATZER: Thank you.

12 CHAIRMAN MAYES: All right. Next we
13 have Bert Smith.

14 DR. BERT SMITH: Good evening, and thank
15 you for your time. I'll be brief in the interest
16 of time at the late hour. I'm Dr. Bert Smith. I
17 am a physician here independent again, similar to
18 Dr. Platzer.

19 I have my own practice called Integrated
20 Health Transitions, who I specifically focus on
21 preventing readmissions from skilled nursing
22 facilities, lowering infection rates, many of the
23 quality measures that are currently included in
24 our health reform metrics.

25 And previously prior to this, I started

1 this company about three months. I worked for
2 Mountain States. I worked with them as a
3 hospitalist for a number of years, and so I've
4 been kind of in and out on both sides of the
5 fence, so to speak.

6 And so I think I've got some important
7 things that as I start this new business and this
8 new practice, taking care of patients, things that
9 are important as this merger goes forward that I
10 would like to see.

11 Many of these things have already been
12 discussed here tonight. Some of the things
13 specifically around IT, IT infrastructure, and
14 things like that, that certainly need to be
15 addressed. These things are things that I'm
16 hopeful that a merger will accomplish.

17 If we do see the merger come to
18 fruition, that is certainly a critical area that
19 results in a lot of avoidable readmissions to our
20 hospitals and things like that, because we cannot
21 access, as it's been mentioned, many times
22 previously we cannot access patient records in a
23 timely fashion at the bedside.

24 Another big area that's also been
25 touched upon here this evening and talked about is

1 mental health. There's so many things here with
2 the mental health patients in our area, things
3 that result in hospitalizations and so forth that
4 we need to see more done in that area.

5 For example, we've seen mental health
6 care and access decline in our area as a result of
7 competition with Mountain States and Wellmont, and
8 we previously had Indian Path Pavilion that
9 provided psychiatric care.

10 We've seen that leave our area since
11 then. We've seen those beds, you know, go away.
12 We really just have Woodridge, I think, now in the
13 area that provides mental health, and we see a
14 lack of services here.

15 So I would certainly want to see this
16 COPA include things around providing more mental
17 health. It's typically not an area that's
18 reimbursed really well, which is why we've seen
19 some of that access go away, and so we'd like to
20 see that addressed specifically.

21 And I know that has been mentioned by
22 the two systems. But again, as someone mentioned
23 earlier, it kind of gives David a slingshot, so to
24 speak. We need to make sure that these entities
25 do that.

1 And probably the third thing I'll talk
2 about that's really important, it was interesting
3 to hear Dr. Platzer talk about the other side of
4 it just a minute ago, but the clinical
5 standardization. We don't have a lot of clinical
6 standardization in our health systems.

7 I helped do a lot of that when I worked
8 with Mountain States. I felt like many times that
9 we were sort of reinventing the wheel, so to
10 speak, when Wellmont was also working on similar
11 problems, but we were not allowed to collaborate
12 or talk or help each other with those things.

13 And so it seemed to be very frustrating
14 to me as a physician that we had a lot of things
15 that both of us were working on that seemed like
16 we could really help and collaborate with each
17 other but weren't allowed to because of
18 competition.

19 And so there are some things, while I
20 agree that competition is a good thing and will
21 improve many aspects, there are some things that
22 we've seen competition hurt, and we've seen
23 competition that has eroded away at some of these
24 aspects that I bring up here specifically tonight.

25 So I would encourage you guys

1 specifically. I'm glad that this is being looked
2 at, but I'd encourage you guys specifically to
3 look at these things that I've mentioned here
4 tonight. I know many of them have been talked
5 about, but again, there needs to be some
6 measurable things in the COPA that we can track
7 and follow the progress of.

8 So questions? Thank you.

9 CHAIRMAN MAYES: All right. Thank you.
10 Just a second. Any questions from the committee?
11 All right. Seeing none, thank you.

12 DR. BERT SMITH: Thank you.

13 CHAIRMAN MAYES: All right. Next we
14 have Anthony Seaton.

15 DR. ANTHONY SEATON: Mr. Chairman, group
16 members, thank you. I am Anthony Tony Seaton.
17 I'm not the attorney. He does a great job at
18 advertising, but I'm actually an ophthalmologist.

19 I'm an ophthalmologist in Kingsport at
20 the Regional Eye Center. I've been practicing
21 medicine in Kingsport, Tennessee, now for 20
22 years.

23 I am also a member of Highlands
24 Physicians, Incorporated. Highlands Physicians,
25 Incorporated is a physician organization that

1 represents some 1500 physicians and other
2 practitioners in the area.

3 I've been actively involved with the
4 board at Highlands Physicians for all of my 20
5 years here, and I currently serve as the president
6 of Highlands Physicians.

7 Our medical community, as you've already
8 heard here this evening, is diverse and multiple,
9 but obviously two very important components of
10 that are the providers and the health systems
11 themselves.

12 And often these are joined at the hip,
13 and it's very important for -- to be able to
14 deliver good quality care to those that we serve
15 for both sides of that equation to work well with
16 each other.

17 Highlands Physicians' mission for the
18 last 23 years has been to work to improve the
19 quality and the value of health care in our
20 region, and we take this very seriously.

21 Therefore, we've watched very closely
22 the application of the COPA and the issues
23 regarding the discussions of the merger over the
24 last several months.

25 And we appreciate the opportunity to

1 come here this evening to bring our thoughts to
2 this group regarding the proposed merger of the
3 health systems and also to suggest metrics that
4 can be used by the Department of Health to assess
5 whether the merger is and whether it will continue
6 to produce a Public Advantage.

7 First, I'd like to say Highlands
8 Physicians does not oppose this merger. We can
9 certainly see the potential advantages to the
10 community, benefits such as theoretically exist,
11 such as eliminating duplication of services where
12 appropriate and where possible.

13 Cost savings by reducing the redundant
14 infrastructures, and obviously the improved buying
15 power that can be achieved as well as many others.
16 But we also see potential disadvantages that we
17 think are very important to discuss.

18 It's already been asked how many staff
19 positions at our facilities may be lost? How will
20 repurposing potentially affect our community?

21 Will the monopoly that would be produced
22 by this potentially exclude nonemployed physicians
23 and possibly result in physician migration, which
24 could affect long-standing physician/patient
25 relationships?

1 Also potentially loss of staff jobs in
2 those physicians' practices. How might all of
3 those potential issues affect the quality, the
4 access, and as well as the value of health care in
5 our region?

6 We have met with the CEOs of both
7 Mountain States and Wellmont to discuss our
8 concerns and have asked that specific things be
9 included in the COPA to hopefully help to prevent
10 potential disadvantages as we see those.

11 We have a great deal of respect for the
12 CEOs of both Mountain States and Wellmont, and we
13 have a great deal of confidence in them. But we
14 also understand that health care is changing and
15 what may be important at this point in time two,
16 three, five years from now as things change may be
17 different.

18 And also administrations change, and the
19 thought processes and the goals and the concerns
20 of future administrators may be different than the
21 ones that we currently have. And that's why we
22 feel that it would be very important to try to
23 address the potential issues that we see of
24 potential disadvantages, especially in the COPA
25 language on the front end.

1 With regards to metrics, we feel that
2 they should be broad and robust. We think they
3 need to be objective, accurate, and independently
4 verifiable. We certainly would suggest patient
5 satisfaction surveys in regards to quality,
6 access, costs, and service levels.

7 We would suggest physician satisfaction
8 surveys, both for employed and nonemployed
9 physicians, in regards to things such as financial
10 impact to the practices, influences over clinical
11 decision-making.

12 CHAIRMAN MAYES: 30 seconds, Dr. Seaton.

13 DR. ANTHONY SEATON: Okay, thank you.
14 Perceived unfair treatment. Exclusion from
15 contracts. Disruption in patient/physician
16 relationships, and loss of ability to provide care
17 and value of care to a patient.

18 We would also suggest payer surveys,
19 looking at various metrics that the payers may be
20 able to introduce, and we would love to see
21 transparency in the whole process.

22 So in closing, again, thank you for this
23 opportunity, and thank this group. You are true
24 community servants to sit up here and listen to us
25 drone on now for hours and hours, I'm sure many of

1 you, like me, without having your supper yet.

2 But we would just like to say that we
3 think this can be a very good thing, but we would
4 certainly like to see potential disadvantages
5 looked at and potentially have these potential
6 disadvantages looked at from an independent
7 standpoint, not necessarily just generated from
8 the health system itself. Thank you.

9 CHAIRMAN MAYES: Thank you. Just a
10 second. Dr. Kidd?

11 DR. TERESA KIDD: Would you mind just
12 repeating the physician satisfaction indicators?

13 DR. ANTHONY SEATON: Yes.

14 DR. TERESA KIDD: Financial impact to
15 the practice. Disruption in patient
16 relationships.

17 DR. ANTHONY SEATON: Yes. Financial
18 impact. Influence over clinical decision-making.

19 DR. TERESA KIDD: Thank you.

20 DR. ANTHONY SEATON: Perceived unfair
21 treatment. Exclusion from contracts. Disruption
22 of physician/patient relationships, and the
23 ability to provide quality care and value to our
24 patients.

25 DR. TERESA KIDD: Thank you.

1 DR. ANTHONY SEATON: You're welcome.

2 Thank you.

3 CHAIRMAN MAYES: All right. Thank you,
4 Dr. Seaton. All right. Next we have Clark
5 Jordan.

6 CLARK JORDAN: Good evening. My name is
7 Clark Jordan, and I'm Vice President and Assistant
8 General Counsel at Eastman Chemical Company.

9 Eastman has been part of this community
10 since 1920. We employ over 60,000 -- 6,000.
11 Sometimes seems like 60,000 employees in the
12 region, and we have a very strong history of
13 supporting the communities in which we operate.
14 Safety and wellness are one of our key priorities
15 as a company.

16 As Eastman seeks to grow in this world
17 and in this region, we must develop a diverse and
18 inclusive work force. Access to high-quality
19 health care and quality educational systems are
20 critical factors considered by those that we seek
21 to employ.

22 Products that Eastman produces in this
23 region compete in a very broad, competitive global
24 marketplace. Eastman is self-insured, meaning
25 that we assume financial responsibility for

1 providing health care benefits to our employees.

2 For our products to remain competitive,
3 we must control the health care costs that the
4 company faces in providing the benefits that our
5 employees and their families deserve.

6 As we evaluated options presented for
7 the region's health care, Eastman carefully
8 considered which option most closely aligned with
9 our interests of controlling health care costs,
10 improving the quality of health care, and
11 expanding access to health care throughout the
12 region.

13 We felt that it was important for the
14 region to retain control of its fate, if it was at
15 all possible. When the prospect of the Wellmont
16 and Mountain States merger was announced a year
17 ago, we expressed our support, and we continue to
18 support the merger.

19 However, our support is conditioned upon
20 the merging entities agreeing to firm and
21 measurable commitments to achieve positive
22 outcomes for the region and proper supervision by
23 the states of Tennessee and Virginia and oversight
24 through strong governance of the combined entity.

25 We have a great deal of experience in

1 mergers and acquisitions. I lead those on behalf
2 of the legal department for Eastman Chemical
3 Company.

4 Signing the merger and closing the deal
5 is just the beginning. The true success is
6 determined by the integration of the combined
7 companies.

8 We know from our experience, that cost
9 of just doing the integration can erode the value
10 of the two companies that are merging, so we
11 encourage Mountain States and Wellmont to be good
12 stewards of the resources that they manage
13 together if this merger is to go through.

14 Likewise, we know that the merging
15 entities have to make choices to be sustainable
16 for the future. And as we think about those
17 choices, we encourage them to do it in the best
18 interests of the community as a whole.

19 To achieve success, the organizations
20 have proposed a three-phase approach, an immediate
21 reduction of 50 percent of all negotiated costs,
22 rate increases with principal commercial payers
23 for the first full contract year after the merger.

24 Placing a cap on the growth of rates
25 charged to principal commercial payers and health

1 care services to below the national average growth
2 for hospitals and implementing population health
3 and other initiatives designed to improve health
4 care of the region.

5 We support this approach. We believe
6 that additional transparency and clarity will
7 assist the community in understanding what these
8 mean. By way of example, we believe that the two
9 systems have current differing rates for the same
10 or similar circumstances.

11 It's unclear to us if one service is
12 rationalized, which cost will then begin to
13 control that service. We believe additional
14 transparency around the initial cost will assist
15 the community in understanding what the value of
16 the transaction will ultimately be.

17 In my mind, this merger has the
18 potential to be a win win win. Costs could
19 potentially decrease, quality of care could
20 increase, and those cost savings could be
21 reinvested within the community in critical areas
22 such as wellness, combating drug addiction,
23 preventative medicine, and mental health care,
24 which will benefit the region overall.

25 CHAIRMAN MAYES: 30 seconds.

1 CLARK JORDAN: Thank you. Within the
2 same vein, the future system has committed to
3 establish annual priorities related to quality
4 improvement and publicly report these quality
5 measures in an easy-to-understand manner. We
6 encourage this.

7 Again, I want to thank you for the
8 opportunity to comment. We support the merger,
9 but we think the devil is always in the details,
10 and we value the input that this group will
11 provide to ensuring that the actions of the merger
12 and those measures within the COPA remain in the
13 best interest of the community.

14 Thank you. I'm happy to take any
15 questions.

16 CHAIRMAN MAYES: Could you -- thank you,
17 Clark, for your comments. Could you elaborate?
18 I'm not sure I captured the concept of your
19 reduction in contractual cost. Was that speaking
20 of example, or was that a desire from your
21 company?

22 CLARK JORDAN: It's an example. One of
23 those things that is unclear to us is as these
24 systems merge, there will likely be some decisions
25 around which groups remain and which groups are

1 rationalized as part of creating synergies.

2 It's not clear to us at least which cost
3 structure might remain after that merger occurs,
4 after that integration occurs. So, for example,
5 if one service Mountain States may be the more
6 expensive provider and Wellmont was the lower-cost
7 provider, what cost will a payer ultimately pay
8 once those systems are merged and the two services
9 become one?

10 That's the question that we have that is
11 currently unclear to us and we would like clarity
12 around.

13 CHAIRMAN MAYES: Okay. Thank you for
14 that. Any questions from the committee?

15 CLARK JORDAN: Thank you.

16 CHAIRMAN MAYES: All right. Clark,
17 thank you very much. Next we have Lisa Tipton.

18 LISA TIPTON: Good evening. My name is
19 Lisa Tipton, and I am the Executive Director of
20 Families Free.

21 Families Free is a licensed mental
22 health and substance abuse treatment center that
23 is based in Johnson City, but we serve underserved
24 and vulnerable citizens across northeast
25 Tennessee.

1 Our primary focus at this time is a
2 family preservation contract that we hold with the
3 Department of Children's Services, so we serve
4 hundreds of individuals a year across the
5 northeast region who are involved with Department
6 of Children's Services because of child abuse or
7 neglect.

8 We also have a pilot program with the
9 Tennessee Department of Health that is designed to
10 be an outreach to moms who deliver NAS babies in
11 the northeast region, and we also serve women and
12 maternal incarceration, women who are affected by
13 substance abuse and maternal incarceration.

14 It has been a long evening. I'm just
15 going to read from my paper now.

16 Families Free is designed to build
17 better communities through the transformation of
18 vulnerable families, especially those impacted by
19 child abuse and neglect, maternal incarceration,
20 and substance abuse.

21 We provide evidence-based services
22 combined with faith-based principles, including
23 compassion, healing, and restoration. Our goal is
24 to promote positive lifestyle changes in our
25 region's most at-risk and overlooked population.

1 I was privileged to be able to serve on
2 the Healthy Children and Families Committee, and
3 our population that we work with at Families Free
4 was often referred to as the super utilizers of
5 services in the region, and I'm sure that's true.

6 In the past year, we served more than
7 500 individuals. I've seen firsthand how poverty,
8 lack of awareness, or access to needed services,
9 mental health issues, drug abuse, alcoholism and
10 much more can all contribute to hurting families
11 in our community.

12 I'm very passionate about the work we do
13 and proud of the work we do. We all know that
14 individuals who are healthy from a physical
15 perspective but also from an emotional, mental,
16 and spiritual perspective create healthy and
17 strong families, and strong families are the basis
18 of strong communities.

19 We couldn't do the work we do without
20 our community partners, and I'm very pleased to
21 see that Wellmont and Mountain States value the
22 role of community partnerships, as well as the
23 importance of investing in and promoting healthy
24 individuals, families, and communities.

25 Supporting our friends and neighbors who

1 are going through difficult times or need access
2 to certain specialized health care services is
3 critical.

4 As this Advisory Group considers the
5 public advantages of the future system, I would
6 encourage you to monitor the future system's
7 investments and access to these kind of critical
8 services, such as community-based mental health
9 services, intensive outpatient treatment programs,
10 and addiction resources.

11 These services should all be designed to
12 help struggling members of our community and
13 hopefully minimize inpatient psychiatric
14 admissions, incarceration, and other out-of-home
15 placements, which separates families rather than
16 keeping them together.

17 I'm excited to see that Wellmont and
18 Mountain States plan to invest \$75 million over 10
19 years in population health initiatives and will
20 prepare a healthy improvement plan that identifies
21 key health issues to focus on.

22 One of the initiatives already
23 identified is to promote a drug-free community by
24 investing in programs that prevent drug abuse
25 among all of our citizens, but particularly among

1 women and teenagers.

2 My organization will do everything to
3 support the future health system and these
4 efforts, and I encourage this Advisory Group to
5 track these kind of investments so we can see the
6 significant progress we seek to see over time.

7 I would really encourage each of the
8 members to think about what our region looks like
9 from the perspective of a vulnerable family. We
10 have extremely high incidents of children who are
11 placed in foster care in northeast Tennessee.

12 We have extremely high incidents of
13 neonatal accidents, and we're one of the highest
14 in the nation and also of maternal substance
15 abuse. We have very limited targeted resources.

16 At Families Free, we have staff that
17 goes all over the hills and hollows and community
18 --

19 CHAIRMAN MAYES: 30 seconds, Lisa.

20 LISA TIPTON: And we'll go and meet
21 these individuals in their homes, in the county
22 jails, in the hospital when they've given birth to
23 an NAS baby, and give an evidence-based strategic
24 approach to help these women and families overcome
25 the challenges in their life.

1 So I would encourage this advisory panel
2 to look at programs that would specifically reduce
3 placements in foster care by children in our
4 region, NAS babies, and maternal incarceration.

5 CHAIRMAN MAYES: Thank you, Lisa. Any
6 questions from the committee? Seeing none, thank
7 you very much, Lisa.

8 LISA TIPTON: Thank you.

9 CHAIRMAN MAYES: All right. Next we
10 have Kenneth Hopland.

11 DR. KENNETH HOPLAND: I think we're
12 lucky because my name was at the bottom of that
13 list, so I think that means that we're all in luck
14 here so...

15 I'm Kenneth Hopland, and I am a local
16 fellow here from Elizabethton and physician born
17 in Wisconsin but thankfully moved away pretty
18 soon. And my father brought me down to Tennessee,
19 so from age four, raised in Elizabethton.

20 Elizabethton High School, ETSU, James H.
21 Quillen, Bristol Family Practice, and from there
22 to Medical Care, which is a local primary care
23 provider here in Elizabethton and all over the
24 Tri-Cities, where we provide care to basically one
25 of the poorest counties in Tennessee.

1 So we have a high rate of dual-eligible
2 patient load, meaning they both are Medicaid and
3 Medicare eligible, as well as a high rate of
4 TennCare, and we're among the Top 10 in the whole
5 state of Tennessee for providing that care.

6 So we don't provide care to the elite.
7 I mean, blue collar even is maybe even generous.
8 And I see it as my position that I neither need to
9 come in support of nor in opposition to, but I see
10 it as my position that I need to come and point
11 out some possible shortcomings or concerns as a
12 independent physician who is not employed or
13 affiliated with any hospital system or insurance
14 company other than through contracting or
15 otherwise.

16 Because obviously the hospital systems
17 know the positives. I see it as our job as
18 independent physicians to point out what the
19 potential negatives are to us, because the
20 positives are obviously why they plan on merging.

21 So there's three areas of concern I see
22 from an independent physician that immediately
23 strike me. One is contracting, the second is
24 through physician recruiting, and the third is
25 physician access to hospital services for their

1 patient load.

2 And being a physician that practices
3 primarily outpatient, I'm no longer doing
4 inpatient care. I stay focused on the outpatient
5 basis in a lot of my thoughts, but some of these
6 do pertain to hospital privileges and physicians
7 who practice in the hospital as well.

8 As far as contracting, I think that my
9 big concern is when you have the two big hospital
10 systems merging, you have the potential for
11 bundling contracting for inpatient services with
12 outpatient services.

13 And I think that we need, in these
14 documents, something that guards against such type
15 of contracting practices. Because contracting
16 practices such as those provide an unfair benefit
17 No. 1, to competing nonaffiliated physicians,
18 because if there is need for hospitalization, and
19 that can be used to create better rates both for
20 your outpatient services, or you can discount
21 outpatient services to achieve rates that they
22 need for inpatient services.

23 It provides an advantage that is really
24 uncomensatable. And since this is done through a
25 Certificate of Need, so essentially this is a

1 government-granted monopoly, one that cannot be
2 duplicated by any other type of entity that
3 provides primary care other than a hospital
4 system.

5 And these hospital systems, when they're
6 combined, are going to be the number one employer
7 of physicians in the area, even when considered
8 the larger groups in the area, I mean, you know,
9 even excluding some of the independent physicians,
10 a smaller group such as my own.

11 But even the larger groups, which have
12 been spoken of, HMG, State of Franklin, these are
13 large groups in our area, but even they are
14 dwarfed when you talk about combining these two
15 hospital systems.

16 So there's a great deal of concern that
17 if their contracting has advantages that other
18 groups are unable to access, it really provides an
19 unfair environment to which physicians are, I
20 think especially independent physicians, become
21 very uncomfortable with very quickly.

22 The second thing is in recruiting. It
23 really sparks the same type of questions. When we
24 speak of recruiting for areas that are in need and
25 unable or unwilling to provide, I think first of

1 all there needs to be, if that is the case, there
2 needs to be somehow a demonstratable matrix or
3 otherwise that the nonhospital-affiliated
4 physicians are unwilling or unable to provide
5 those services.

6 And even if that includes some sort of a
7 board or regulatory committee that involves
8 nonhospital-employed and nonhospital-contracted
9 physicians to state whether or not those
10 recruiting is actually needed or whether or not
11 that is just being done to frankly just compete
12 with the outside nonhospital-associated groups.

13 And the other way that that can be done,
14 other than a committee that might oversee
15 recruiting that involves the other nonaffiliated
16 hospital groups, you could also possibly put in a
17 matrix that states that once this combined
18 organization were created, if it were created,
19 that it not gain a significant amount of market
20 share in the primary care or other market.

21 So, for example, if the Mountain merger
22 reached 50 percent of the physicians in the area,
23 that they would not exceed 55 percent in a certain
24 time period so that there wasn't a push for
25 acquisitions or takeovers or mass hirings to

1 promote lack of competition.

2 And the last thing being the access to
3 hospitalization is that once the hospitals have,
4 there isn't a competitory hospital, things such as
5 hospitalist and/or specialist access to hospitals
6 that they need to take care of their patients, and
7 hospitalist being a concern for mine, that outside
8 independent physicians have a say if there is
9 going to be, excuse me, a exclusive contract given
10 for a service within the hospital, the independent
11 physicians be allowed to have a say as to whether
12 or not that is an indicated move.

13 A hospitalist is being the one that
14 would be my primary focus, that they're not being
15 moved to create a exclusive contract with
16 hospitalists so that outpatient physicians, such
17 as myself, cannot choose which hospitals I might
18 use, which have a like-minded way of treating my
19 patients and/or a lower cost for treating my
20 patients.

21 CHAIRMAN MAYES: I'm sorry.

22 DR. KENNETH HOPLAND: Which is
23 absolutely critical.

24 CHAIRMAN MAYES: All right. Just to
25 make sure. I apologize for that.

1 DR. KENNETH HOPLAND: That's fine.

2 CHAIRMAN MAYES: I want to make sure I
3 understand. You're talking about access to
4 hospitalists? You're talking about access to your
5 own hospitalist within your practice, or are you
6 talking about the hospital-employed physicians?

7 DR. KENNETH HOPLAND: Actually both. My
8 concern is currently there is a mixture of
9 hospital-employed physicians as well as groups
10 such as Johnson City Internal Medicine. There is
11 IPC, Inpatient Physicians Consultants, and all of
12 those groups are able to provide the care such as
13 myself who has been doing hospital care to access.

14 And what I'm concerned about is that if
15 there were a exclusive contract given, and
16 particularly in a situation where there isn't a
17 competency hospital, they could in that case
18 eliminate my choices as a outpatient physician as
19 to what hospital system or hospitalist group I
20 might use.

21 CHAIRMAN MAYES: I understand.

22 DR. KENNETH HOPLAND: Okay. So that is
23 a great concern of mine. That's just one example.
24 I mean, there's obviously other specialties for
25 that concern, but that's a really easy...

1 CHAIRMAN MAYES: Thank you. Any other
2 questions from the committee? All right. Thank
3 you, Dr. Hopland.

4 BRANT KELCH: One quick question. The
5 number that you threw out when you were comparing,
6 I guess, employed physicians, independent
7 physicians 50 to 55, is that a number that you've
8 given a lot of thought to?

9 DR. KENNETH HOPLAND: It is not, you
10 know. I know that the merger does create the
11 largest group and that since it outweighs all the
12 other groups, my thought isn't about a specific
13 number.

14 It is more about a delta or a change in
15 that percentage. So, I mean, like I say, I'd have
16 to look at the actual numbers of physicians in
17 each individual group.

18 But, for example, if the current number
19 were 50 percent, I would think it would be
20 reasonable to set a matrix that could be measured
21 saying that would not, you know, go to a
22 percentage greater than 55 or otherwise, an
23 agreed-upon number, so that there doesn't appear
24 to be a movement for control of the marketplace as
25 a whole.

1 Any other questions?

2 CHAIRMAN MAYES: So just to make sure.
3 There have been some smaller mergers, I think,
4 that have tried to do that mainly with the market
5 share, with physician practices that can buy any,
6 and depending on what area you read, there's been
7 some issues.

8 There's been some successes. So I think
9 what's the magic number?

10 BRANT KELCH: North Carolina uses a cap
11 of 20 percent over in Asheville.

12 CHAIRMAN MAYES: Thank you.

13 DR. KENNETH HOPLAND: Can I -- and I
14 know that I will be going over my time limit.

15 The other concern I had was with these,
16 in all the committees where they speak of
17 physician versus community, community versus
18 employed physicians, and they have -- they will
19 state we're going to have nonemployed
20 hospital-employed physicians. I would love to see
21 the verbiage put in.

22 Also physicians that serve in an
23 exclusive contract with the hospital be considered
24 hospital employees. Because any of those
25 committees, for example, an ER physician or an

1 anesthesiologist that has no other employment
2 outside of the hospital, although he does not
3 receive a W-2, he is a contracted, you know, not a
4 1040 fellow.

5 He is by default from an outpatient, you
6 know, doctor, he is a hospital employee because
7 that is where a hundred percent of his income
8 comes from. And so I think if we consider some of
9 these boards and committees and oversight, that
10 those people should be considered the same as a
11 hospital physician.

12 Because otherwise although they don't
13 have employed physicians, they have physicians who
14 are deeply weighted in the hospital system. And I
15 think if you're going to get community input,
16 those people need to actually be community
17 physicians and/or community health care providers.

18 CHAIRMAN MAYES: Thank you, Dr. Hopland.

19 DR. KENNETH HOPLAND: Sorry to go over
20 my time.

21 CHAIRMAN MAYES: Jeff, would you mind
22 checking the table and make sure we've got...

23 DIRECTOR OCKERMAN: I already did. No
24 further names.

25 CHAIRMAN MAYES: All right. All right.

1 Any comments from the committee? Okay, great.

2 And again, I want to thank those of you
3 that have spoken tonight, done an outstanding job.
4 On behalf of the committee, I know we received
5 great input tonight and value your input.

6 And again, please check the Tennessee
7 Department of Health website. Tonight's
8 transcript will be placed there very soon, and
9 don't forget to submit your anonymous comments or
10 signed comments via the website.

11 So thank you, and thank you, committee.
12 We are adjourned.

13 THEREUPON, the meeting was concluded at
14 8:03 p.m.

REPORTER'S CERTIFICATION

STATE OF TENNESSEE)
COUNTY OF SULLIVAN)

I, Terry L. Kozakevich, LCR #394, Licensed Court Reporter, Registered Professional Reporter, **(and notary public)**, in and for the State of Tennessee, do hereby certify that the above meeting was reported by me and that the foregoing 127 pages of the transcript is a true and accurate record to the best of my knowledge, skills, and ability.

I further certify that I am not related to nor an employee of counsel or any of the parties to the action, nor am I in any way financially interested in the outcome of this case.

I further certify that I am duly licensed by the Tennessee Board of Court Reporting as a Licensed Court Reporter as evidenced by the LCR number and expiration date following my name below.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 19th day of April, 2016.

Terry L. Kozakevich, LCR #394
Registered Professional Reporter
Expiration Date 9/30/2017
Notary Public Commission Expires 7/24/18