

**SUPPLEMENTAL REPORT REGARDING THE PROPOSED
MERGER BETWEEN MOUNTAIN STATES HEALTH
ALLIANCE AND WELLMONT HEALTH SYSTEM**

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I. BACKGROUND AND PURPOSE OF THIS REPORT

Mountain States Health Alliance (Mountain States) and Wellmont Health System (Wellmont) (collectively referred to as “the applicants”) are integrated delivery systems based in, respectively, Johnson City and Kingsport, Tennessee. These two sizable integrated health care systems have proposed to merge to create a single large health system that would be named Ballad Health. If the proposed merger is completed, Ballad Health would become the dominant health system in the region. The applicants have sought approval of the merger through applications for a Certificate of Public Advantage (COPA) from the State of Tennessee and for a Letter Authorizing a Cooperative Agreement (CA) from the Commonwealth of Virginia.

As part of its review of the proposed merger, the Federal Trade Commission (FTC) asked me to independently review materials the applicants have supplied in support of their applications for a COPA and CA and to offer my opinions about the likelihood of Ballad Health yielding the claimed benefits. To the extent that such benefits might be achieved, I was asked to also opine on how much those benefits would be due specifically and directly to the merger, separate and apart from other reasons or from other strategies that would be less harmful to competition. Said differently, I was asked to analyze the extent to which the claimed benefits are uniquely achievable only through this merger. Additionally, I was asked to opine on any likely problems which might impede implementation of the merger and, as a result, adversely impact achievement of the claimed benefits. In response to the FTC’s request for my independent assessment, I prepared and submitted a report to both the Tennessee and Virginia Departments of Health on November 21, 2016.¹ This report was intended to be and was made part of the public record on this matter.

On December 19, 2016, the applicants submitted a report to the Tennessee Department of Health that was apparently intended to rebut my assessment.² Later, they also submitted reports prepared by Advisory Board Consulting,³ Conduent Community Health Solutions,⁴ and

¹ Independent Assessment of the Proposed Merger Between Mountain States Health Alliance and Wellmont Health System, Kenneth W. Kizer, MD, MPH (November 21, 2016), <http://www.vdh.virginia.gov/content/uploads/sites/96/2016/11/Kennith-KIZER-INDEPENDENT-ASSESSMENT-MSHA-WHS-MERGER.pdf> and https://www.tn.gov/assets/entities/health/attachments/COPA_KIZER_INDEPENDENT_ASSESSMENT_MSHA-WHS_MERGER.PDF [hereinafter, “Kizer Independent Assessment”].

² Response by Applicants to Submissions of Federal Trade Commission Staff, Amerigroup Tennessee, Inc., Professors and Academic Economists, Kenneth Kizer, M.D., MPH, and Holston Medical Group to the Tennessee Department of Health Regarding Certificate of Public Advantage Application (December 19, 2016), https://www.tn.gov/assets/entities/health/attachments/Response_to_Public_Comments_Submitted_to_TN_DOH_wit_h_TOC2_.pdf [hereinafter “Mountain States and Wellmont Response”].

³ Dennis Weaver, MD, MBA, Advisory Board Consulting, *Independent Assessment of Ballad Health’s Likelihood of Successfully Navigating the Narrow Corridor in a Merged Integrated Delivery System* (April 7, 2017), https://www.tn.gov/assets/entities/health/attachments/Advisory_Board_4.7.17.pdf [hereinafter “Advisory Board report”].

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Compass Lexecon⁵ to the Tennessee Department of Health, providing the views of those entities regarding selected aspects of the proposed merger.

In this supplemental report, I respond to the applicants' assertions regarding my initial report in Section II, and I comment in Section III on two of the recent consultant reports that were commissioned by the applicants to support the proposed merger. I focus on the reports by the Advisory Board Consulting and Conduent Community Health Solutions because they purport to address my areas of expertise. While I carefully reviewed the Compass Lexecon report I am not commenting on its specific findings because it purports to be an economic analysis of the proposed merger. I would say, however, that this report did not provide me with any new insights or evidence that dissuades me from my prior assessment and conclusions about the proposed merger.

II. RESPONSE TO THE APPLICANTS' ASSERTIONS REGARDING MY ASSESSMENT OF THE PROPOSED MERGER

I have carefully reviewed the applicants' December 19, 2016 response to my assessment of the proposed merger of Mountain States and Wellmont to create Ballad Health, and I welcome the opportunity to comment further on the proposed merger and to respond to the applicants' mischaracterizations of my earlier report.

While the applicants mischaracterize and/or inappropriately dismiss some points made in my report, it is notable that they did not take exception to a number of its key points. In particular, the applicants did not attempt to dispute the evidence showing that competition among providers leads to improved health care quality and efficiency and that loss of competition tends to reduce quality and increase costs.

Like health systems across the nation, the applicants are trying to improve the quality and efficiency of their services in response to changing health care payment methods and other market dynamics. Such efforts are to be commended, but the proposed merger is not necessary nor the only way to achieve the desired gains in quality and efficiency. The central question, with regard to granting the COPA, is to what extent the proposed merger, in and of itself, catalyzes or augments the improvement efforts that the systems are already pursuing and whether the benefits of the merger would demonstrably exceed, by clear and convincing evidence, the harms resulting from reduced competition in the region. While some modest benefits may be expected in certain

⁴ Conduent Community Health Solutions, *Ballad Health Population Health Improvement Plan, Capacity and Preparedness Assessment and Recommendations* (2017) [hereinafter "Conduent report"], https://www.tn.gov/assets/entities/health/attachments/Healthy_Communities_Institute_4.7.17.pdf.

⁵ Margaret Guerin-Calvert, Compass Lexecon, *Independent Assessment of the Benefits and Disadvantages in the Proposed Merger of Mountain States Health Alliance and Wellmont Health System* (April 11, 2017), https://www.tn.gov/assets/entities/health/attachments/Compass_Lexecon_Report_-_Official_Version_4.11.17.pdf.

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areas as a result of the merger, the applicants have not objectively and convincingly demonstrated that the overall net benefit would exceed the anti-competitive harms.

In a competition-reducing merger of health systems such as this one, the applicants should demonstrate through objective and verifiable evidence that the merger's overall salutary effect on the quality and efficiency of care is greater than the harm caused by the loss of competition. Despite their attempts to counter my critique of their claimed efficiencies, the applicants continue to fail to objectively demonstrate that the merger is the only means to achieve the claimed benefits or that the benefits of the merger will be greater than the harms. After carefully considering the evidence presented by the applicants in support of their COPA application and the more recent consultants' reports, I do not believe the proposed merger would well serve the community's interest.

In the following paragraphs, I address a number of the criticisms and themes expressed in the applicants' response to my report.

First, the applicants inappropriately criticize me for not discussing all of the materials they have provided to the Tennessee Department of Health in support of their COPA application.⁶ The applicants' criticism is unfounded and misdirected.

I was asked by the FTC to independently review the merger-related materials presented by the applicants and to prepare a report of my assessment for the public record. Insofar as my assessment is intended for public review, I am legally allowed only to comment on materials that the applicants have made public. The applicants have decided to withhold a large number of merger-related documents from public scrutiny, and I cannot comment on such materials in my public report. To be clear, it is because the applicants have chosen to withhold these materials from public review that I was unable to comment on them. For the applicants to suggest otherwise is disingenuous. Of course, the applicants could choose to promote transparency and remedy this situation by making additional supporting materials available for public review.

Second, the applicants assert that I have a "condescending attitude" towards the region.⁷ Nothing could be further from the truth. Having spent much of my youth living in poverty – and much of that time in rural communities – I well understand the challenges faced by residents of the region served by the applicants. Further, having spent much of my early life in dysfunctional foster homes tainted by violence and substance abuse, I well understand and empathize with the

⁶ Mountain States and Wellmont Response, Section VI, Response by Applicants to Submission of Kenneth Kizer, M.D. MPH, at 1 (December 19, 2016), https://www.tn.gov/assets/entities/health/attachments/Response_to_Public_Comments_Submitted_to_TN_DOH_wit_h_TOC2_.pdf [hereinafter, "Applicants' Response to Kizer"].

⁷ Applicants' Response to Kizer at 27.

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challenges faced by some of the residents of the region. A few details of my experiences in this regard are provided in the Knight-Ridder newspaper article attached as Appendix 1.⁸

I have devoted the majority of my professional life to public service and to addressing the needs of underserved communities. My demonstrated commitment and dedication to working for the common good is a matter of public record, as noted in Appendix 1. The applicants' assertion that I have a condescending attitude for the region is grossly inaccurate.

Third, the applicants incorrectly assert that because I do not live and work in the geographic area served by Mountain States and Wellmont that I am not in a position to comment on the market dynamics and realities of the region. This is simply wrong. I gained significant familiarity with the region during the two years I worked as a quality improvement and patient safety consultant for Wellmont. Furthermore, I have carefully considered data about population health and health care delivery issues of the region and find these not dissimilar to the circumstances in many other communities. As the former chief executive officer (CEO) of the nation's only truly national health care system - i.e., the only health care system that has facilities and provides services in all 50 states (and in multiple locations in each state) - I have, perhaps, a unique perspective in this regard. While every community or geographic region has some unique individual local characteristics, the root causes of the population health problems across regions are typically quite similar. I have substantive direct experience with efforts to improve population health and health care delivery in many economically challenged communities.

Using a clinical analogy to illustrate the above point, the treatment of persons with diabetes mellitus generally aims to maintain the patient's blood glucose (sugar) level as close to normal as possible. This is done through three essential strategies: (1) administering insulin or other medications; (2) restricting dietary consumption, especially of carbohydrates and refined sugars; and (3) increasing physical activity (exercise) to increase the body's metabolism of blood glucose. Patients with diabetes may present with a variety of symptoms, but the abnormal physiology is largely the same in all diabetics and the basic approach to treatment is also the same, whether the patient is in Tennessee, California, or elsewhere. The fine details of how much insulin a patient needs or what foods he/she needs to avoid or how much exercise he/she needs to engage in will vary from individual to individual, as well as over time, but a doctor who knows how to treat diabetics in Tennessee would have no problem treating diabetics in California or elsewhere because the pathophysiology of the disease and essential therapeutic approach are the same regardless of where the patient lives. This same line of reasoning applies to population health problems. The presenting symptoms and granular details of what needs to be done for various problems may vary from community to community (whether in Tennessee or California), but the basic pathophysiology and essential therapeutic approaches are largely the same across communities.

⁸ Frank Greve, *A Lauded Health Care Reformer Moves On*, Knight Ridder/McClatchy Washington Bureau (November 27, 2005), <http://www.mcclatchydc.com/latest-news/article24451951.html>.

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Of note, it seems particularly ironic that the applicants criticize my report because I do not live and work in their service area, but then they chose consulting organizations based in Washington, DC (Advisory Board Consulting), Chicago, Illinois (Compass Lexecon), and Berkeley, California (Healthy Communities Institute, Conduent Community Health Solutions) to prepare reports in support of their COPA application.

Further in this regard, I find nothing to suggest that competition is less likely to promote health care quality as a result of the region's economic condition, or that the COPA would be a stronger catalyst for improving population health and health care quality than would competition or strategic collaborations between and among independent providers in the region. In general, there is neither compelling evidence, nor sound conceptual or theoretical arguments, to show that anti-competitive health system mergers have larger quality benefits, or cause fewer harms, in economically distressed areas than in wealthier communities.

Fourth, the applicants' assertion that I erred by considering only "benefits that could be achieved solely by the merger and not by other means"⁹ is misplaced. My approach is the correct approach and is wholly consistent with Tennessee's COPA law. To wit, the law states that it is a disadvantage if there are available "arrangements that are less restrictive to competition and achieve the same benefits or a more favorable balance of benefits over disadvantages attributable to any reduction in competition likely to result from the agreement."¹⁰

Fifth, the applicants inappropriately criticize my report for discussing the health care challenges facing the region but not offering solutions to these problems. This is plain misdirection on their part. I was charged to provide an independent analysis of the applicants' COPA application, including whether, if granted, the COPA would likely enhance population health more so than other possible strategies the applicants could pursue. It is the applicants' burden to provide clear and convincing evidence of their claimed benefits and to demonstrate that the merger is necessary to address the health challenges facing the region. And they have failed to do so.

In this vein, I will note that the root cause problems facing the communities of this region are largely of a broad socio-economic nature, not unlike the problems facing many rural communities, and the applicants on their own cannot fix these problems. For example, as health care systems, the applicants cannot on their own materially increase the number of well-paying jobs nor improve third grade reading scores. Addressing these types of problems requires broad-based community initiatives that are firmly rooted in stimulating and growing local economies and reducing poverty. That said, the applicants can support and assist in local community efforts to improve the region's population health through involvement in community-based partnerships. To some extent, the applicants independently participate in such partnerships now,

⁹ Applicants' Response to Kizer at 11, n. 30.

¹⁰ Tennessee Hospital Cooperation Act of 1993, Tenn. Code Ann. § 68-11-1303 (e)(3)(D).

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and they could at any time increase their level of participation independent of the proposed merger. Quite simply, Mountain States and Wellmont do not need to merge in order to participate more fully in collaborative community efforts to improve population health.

The applicants have not demonstrated any material advantage that they would have in this regard as a merged entity, as opposed to strategically collaborating with each other and with other community stakeholders as independent entities, as is being done to address population health problems in communities across the country.

Sixth, the applicants mischaracterize the current state of the regional health care market by calling it “fragmented.” For example, they state that, “[t]he new health system IDS will replace the largely fragmented health care delivery system in the Geographic Service Area.”¹¹ However, both applicants describe themselves as “integrated delivery systems,”¹² which is generally understood to mean a non-fragmented health care delivery system. As these two integrated delivery systems presently control a substantial majority of the health care services in the region,¹³ it is simply incorrect to assert that the health care delivery system in the region is “largely fragmented.”

Furthermore, to the extent that integrated delivery systems offer quality or efficiency benefits, such benefits are most likely due to the vertical relationships that are created between and among hospitals, ambulatory care facilities, independent practitioners, and other providers. But in the instant situation, each of the applicants is already vertically-integrated, and the proposed merger is primarily a horizontal combination of two already integrated systems. As such, the combination is unlikely to lead to enhanced clinical integration of care, or to offer

¹¹ Applicants’ Response to Kizer at 16.

¹² See, e.g., Mountain States Health Alliance & Wellmont Health System, Application for a Certificate of Public Advantage for State of Tennessee (February 16, 2016), http://tn.gov/assets/entities/health/attachments/COPA_application.pdf, [hereinafter “COPA Application”] at 11-12; About Us, Wellmont Health System, <https://www.wellmont.org/About-Us/> (“Formed in 1996 with the merger of Holston Valley Medical Center in Kingsport, Tenn., and Bristol Regional Medical Center in Bristol, Tenn., Wellmont is a not-for-profit, integrated health system guided by the mission to deliver superior health care with compassion and a vision to deliver the best health care anywhere.”); Mountain States Health Alliance, Building Healthy Communities, 2015 Community Report at 4, https://www.mountainstateshealth.com/system/files/documents/MTN-151119_AnnualReport_082316.pdf (“In addition to our hospitals, Mountain States’ integrated health care delivery system includes primary/preventative care centers, outpatient care sites and homecare services.”).

¹³ The applicants calculated a combined share of over 85 percent for inpatient hospital services, as well as a significant share of several outpatient services and physician specialties, in the geographic area that it plans to serve. Responses of Mountain States and Wellmont to Southwest Virginia Health Authority Questions, Exhibits 12A., 12B., 12C., and 12D., at 000096-000102 (July 13, 2016), <https://swvahealthauthority.files.wordpress.com/2016/07/msha-responses-to-questions-bates.pdf>.

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substantial quality or efficiency benefits from such integration. The applicants have not provided convincing evidence to the contrary.¹⁴

Seventh, the applicants mischaracterize my comments regarding the potential effect of the planned consolidation of trauma centers. In particular, they misstate my position regarding the volume-outcome relationship.¹⁵ The applicants state that I dismiss the benefits of the planned consolidation of trauma centers in the region by reference to an academic debate over findings with respect to volumes.¹⁶ The applicants appear to be referring to my comment that some recent research has cast doubt on whether volume-outcome relationships exist at all.¹⁷ While I did comment on this recent research in my report, the applicants misconstrue those comments with my primary argument - and the most salient point about the trauma care volume-outcome relationship - which is that even if a volume-outcome relationship for trauma care does exist (and the weight of the evidence still suggests that it likely does), the two trauma centers already independently meet the volume-outcome targets specified by the American College of Surgeons criteria for trauma centers. For this reason, their consolidation would not be expected to yield a significant improvement in outcomes as a result of treating a larger number of cases.¹⁸ That is, with their existing volumes, the trauma centers have already realized any likely volume-outcome advantage, and no significant additional advantage would be expected by a further increased volume of cases. In addition, consolidating trauma services increases travel times for some patients, which may be harmful for the most time-sensitive cases.

Eighth, the applicants incorrectly assert that the views expressed in my report conflict with what I did when I served as the CEO of the Department of Veterans Affairs (VA) health care system in the late 1990s, as well as with what I have written in various refereed journal articles. More specifically, they claim that while I advocated spending substantial funds to develop and implement an electronic health record (EHR) system when I was CEO of the VA health care system, and then touted the benefits of the new system, I now question the benefits of the applicants' plan to move to a single EHR if they merge.¹⁹ Regrettably, the applicants mischaracterize my comments and appear to be trying to obfuscate the matter by asserting an 'apples to oranges' comparison.

¹⁴ If this merger advanced the clinical integration of a fragmented health care system by improving coordination of different types of providers (for example, between a hospital and a physician group), then I would have to evaluate those potential benefits.

¹⁵ The volume-outcome relationship refers to the relationship between the number of cases of a particular condition that a provider (e.g., a hospital) treats, or the number of procedures that a provider performs, and the clinical outcomes that it achieves in those cases. In conditions demonstrating a volume-outcome relationship, the outcomes typically improve with higher numbers of cases (or procedures) up to a point, above which there is no significant further outcome advantage.

¹⁶ Applicants' Response to Kizer at 4.

¹⁷ Kizer Independent Assessment at 19.

¹⁸ Kizer Independent Assessment at 18.

¹⁹ Applicants' Response to Kizer at 5.

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I do not claim that EHRs lack significant value. Rather, as noted in my initial report and Appendix 1, I have been touting the value of EHRs since long before their use became a national health care priority. As stated in my initial report, however, both Mountain States and Wellmont have already implemented effective EHRs and each health system is already deriving considerable benefit from utilizing its EHR.²⁰ Unlike what I did almost 20 years ago at the VA when I implemented a system-wide EHR, the applicants are proposing that one of the applicants migrate from its existing EHR to a different one. In my initial report, I observed that the incremental value of moving from one EHR to another one (i.e., to a single EHR for both Mountain States and Wellmont should the merger be actualized) is likely to be modest and may well result in large costs and generate problems similar to those that have been experienced by many other health systems that have changed from one EHR to another EHR.²¹

Ninth, the applicants inappropriately dismiss my discussion of non-merger collaborations.²² Few of the applicants' asserted efficiencies are unique to the proposed merger, and the applicants have failed to demonstrate that non-merger collaborations between the applicants or a merger with a non-competitor would not be viable alternative strategies that could provide comparable opportunities to achieve the vast majority of the applicants' claimed efficiencies. Insofar as the applicants have not publicly revealed the alternative merger opportunities they have considered, then they are preventing the public from being fully informed and they are not allowing an open and transparent assessment of the benefits of such alternative scenarios, which may be substantively greater than the claimed benefits of this proposed merger.

Finally, the applicants incorrectly assert that I do not recognize the impact of their commitments to improve population health. While I commend the applicants' stated desire to improve population health in the region, their claim that such commitments cannot be actualized absent the merger (because the commitments can only be funded through merger-related savings) is simply not borne out by a review of the evidence they have provided to support their COPA application. Their claim is problematic for a number of reasons. For example, the purported merger-related savings are speculative. If they are not realized, then there will be no additional money to fund the commitments. Therefore there is no reasonable certainty that the commitments can be met. Further, it is not reasonable to conclude that a merger with a non-competitor would not yield comparable savings or that a non-competitor merger partner would not commit funds to address the region's needs. Any current non-competitor with which one of the applicants might merge would, by virtue of such merger, assume ownership of serving the region's health needs and have a vested interest in seeing the problems addressed.

²⁰ Kizer Independent Assessment at 26-27.

²¹ Kizer Independent Assessment at 27-28.

²² Applicants' Response to Kizer at 6.

III. RESPONSE TO THE APPLICANTS' ADDITIONAL CONSULTANTS' REPORTS

A. Independent Assessment of Ballad Health's Likelihood of Successfully Navigating the Narrow Corridor in a Merged Integrated Delivery System, Advisory Board Consulting; April 7, 2017

This report from Advisory Board Consulting states that its purpose is to assess Ballad Health's ability to successfully transition from a mostly fee-for-service health care payment paradigm to a fee-for-value reimbursement system, as well as its ability to be operationally successful in a future accountable payment environment that requires demonstrated competence in population health management, coordination of care across the continuum of services, and efficient and effective delivery of services.²³ I find this report to be deficient in numerous ways.

The Advisory Board report states that it relies extensively on interviews with stakeholders representing Mountain States, Wellmont, community providers, and community leaders.²⁴ While these interviews were a "critical component" of the assessment process,²⁵ the report provides no details about the criteria for and manner of selecting the interviewees (e.g., volunteers or random selection), who conducted the interviews and how they were conducted (e.g., by telephone or in-person; using interviewee written responses, interviewer interpretation and recall of interviewee responses, recorded and transcribed responses); who was present during the interviews; whether a standard set of questions was asked; whether and, if so, how responses were weighted; and many other details that are necessary to fully understand and interpret the findings of such a highly qualitative assessment. Failure to include such methodological details in the report, given the importance attributed to the interviews, represents a significant departure from the standard way qualitative studies are typically reported.

The Advisory Board report opines that "[o]nly by operating at scale and jointly committing to a value-based strategy will the systems be able to succeed in population health management and risk-based contracting."²⁶ However, insofar as the purported benefits from the merger are simply the product of an increase in scale, they are not merger-specific, as they likely could be achieved through any alternative merger partner of similar size. The report provides no meaningful consideration of alternative merger opportunities that might provide equal or potentially superior opportunities to scale operations. Alternative merger opportunities with a non-competitive health system might offer comparable opportunities not only in terms of scale, but also by providing particular expertise in other relevant subject matter areas such as rural health care, telehealth and the provision of virtual care, population health management, substance abuse management, and teen pregnancy prevention, to name some areas.

In making its assessment, the Advisory Board report also uses a narrow, clinical care-centric definition of population health that does not appear to materially embrace the social determinants of health that are critically important root causes of the population health

²³ Advisory Board report at 4.

²⁴ Advisory Board report at 8.

²⁵ Advisory Board report at 8.

²⁶ Advisory Board report at 31.

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challenges that must be addressed in the relevant geographic service area. As I have commented upon in other sections of this report, as well as in my initial report, the applicants have limited ability to influence the socio-economic and environmental factors that broadly influence population health. The Advisory Board report offers no new insights into how Ballad Health might positively impact the social determinants of health that are so important to population health improvement.

Within the relatively narrow view of population health management that is used, the Advisory Board report concludes that Ballad Health would have the “[b]uilding [b]locks”²⁷ to compete in a value-based health care economy but it does not offer any new²⁸ or defined plans for how the suggested benefits might be achieved using the building blocks, nor does it demonstrate why granting the COPA is necessary to achieve the benefits. The report only opines on what it thinks Ballad Health might be able to do. It does not discuss what the applicants are currently doing to improve population health or to pursue value-based initiatives, or what they are capable of doing as independent entities going forward. Further, it does not show by clear and convincing evidence that Ballad Health can or will effectively do what the report opines it may be capable of doing, nor that Ballad Health will do these things materially better than the applicants could do as independent entities or with alternative partners.

The report also fails to discuss the ways in which Mountain States and Wellmont could cooperate with each other as independent entities to improve population health absent the COPA. For example, no reasons are given why the applicants could not cooperate as independent entities on community-based obesity-reduction, tobacco use cessation, health literacy improvement, or teen pregnancy prevention strategies, to name some potentially verdant areas for strategic cooperation.

Importantly, the report does not suggest that Ballad Health, should the COPA be granted, will do anything to reduce the number of uninsured persons in the region, nor does it address how Ballad Health will provide better coverage to the substantial number of uninsured persons through any risk-based coverage arrangements or through other strategies it might pursue. Insofar as lack of health insurance is a significant root cause of some of the population health problems in the region, it seems apparent that the merger will not yield any material benefit in this regard.

Finally, the report discusses potential benefits to the common information technology (IT) platform that the applicants say they plan to develop,²⁹ but it fails to point out that the relevant benefit is only the increment by which the common platform is better than what each system is capable of doing on its own through its current EHR systems and through the existing health information exchange. As integrated delivery systems, the applicants are well positioned to individually realize many of the purported IT-related benefits on their own. Indeed, many of the purported benefits are available now – e.g., each system can use its existing IT system to standardize procedures and other care among current providers.

²⁷ Advisory Board report at 10, 13-14.

²⁸ Relative to what the applicants have offered in their COPA application.

²⁹ Advisory Board report at 23-24.

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Surprisingly, the report criticizes Mountain States for using multiple IT systems,³⁰ but then fails to acknowledge that the health system, if it thought it were important to do so, could go to a single IT system on its own. Furthermore, as noted in my prior report, Mountain States' current IT system has met meaningful use requirements and has received various accolades for its effectiveness.³¹

B. Ballard Health Population Health Improvement Plan – Capacity and Preparedness Assessment and Recommendations, Conduent Community Health Solutions; 2017

The Conduent Community Health Solutions report purports “to assess the capacity of Ballard Health to develop and implement an effective population health [improvement] strategy” and achieve quantifiable improvements in community health in the region.³² This report uses a broader and more appropriate definition of population health than does the Advisory Board report, but it also suffers from multiple limitations. For example, the report offers only a quite limited view of how the applicants might work to improve population health in the region. It fails to adequately discuss why the applicants cannot now work together as independent entities on community-based population health initiatives (e.g., on obesity reduction, tobacco use cessation, or teen pregnancy prevention strategies, to name a few), or what could be done through alternative merger arrangements and strategic collaborations with each other (as briefly discussed with regard to the Advisory Board report).

The report suggests that Ballard Health will have the basic building blocks to pursue population health improvement initiatives, but it does not provide clear and convincing evidence that they will actually do these things, nor does it provide any new or detailed strategies or formal plans by which the likelihood of success of such efforts can be judged.

The report demonstrates that the applicants already participate in partnerships and collaborations intended to benefit population health, and it asserts that population health initiatives will improve due to enhanced access to current programs.³³ However, while the report suggests that the COPA will allow the applicants to extend the reach of some of their current programs, it fails to provide sufficient information to determine, among other things: (1) how users presently access these programs and the current capacity or reach of the programs (e.g., Are they offered only to patients of the sponsoring entity? Is there a limit to the number of participants?); (2) the beneficial outcomes or net impact of the current programs – or even whether the applicants are objectively evaluating the outcomes of the programs; and (3) the extent to which the current programs are capable of being expanded or enhanced (either with or without the merger). Failing to provide such basic information about current programs precludes one from predicting or judging whether the merger would meaningfully increase the capacity or breadth of the programs over what the applicants currently do.

³⁰ Advisory Board report at 23.

³¹ Kizer Independent Assessment at 27.

³² Conduent report at 3, 24-25.

³³ Conduent report at 15-19.

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Overall, this report fails to provide clear and convincing evidence that the merger will yield material improvements in population health that could not be achieved through the systems collaborating as independent entities or that could be achieved through a merger with a non-competitor.

APPENDIX 1

A lauded health care reformer moves on

Knight Ridder/Tribune Business News/Washington Bureau

By Frank Greve

Sunday, November 27, 2005

WASHINGTON -- Dr. Kenneth Kizer's been saving lives wholesale for most of his professional life, and if his latest ideas work out he might save yours.

Chances are you've already encountered his approach. Kizer, one of America's leading health care reformers, is a big fan of such strategies as:

- Electronic medical recordkeeping to aid and speed patient care.
- Bar codes to unfailingly match hospital and nursing home patients to their medicines.
- Computer-aided medical records research to determine which treatments and drugs -- and which doctors and hospitals -- perform best.
- Public release of care quality report cards.

Kizer, 54, a burly and brilliant workaholic -- driven, some colleagues say, by being orphaned at age 12 and surviving in a succession of foster homes -- isn't alone in pushing these initiatives.

But in the vanguard of medical reformers, Kizer's got a unique credential: He's already delivered in one big arena.

Moreover, Kizer did it in the '90s in what was then the most widely disparaged hospital chain in the United States: the 173-hospital system run by the Department of Veterans Affairs. It now provides veterans with "significantly better" health care than Medicare's fee-for-service program, according to a comparison published in the *New England Journal of Medicine* in 2003.

That success came two professional lives ago for Kizer. More recently, he's created and run a Washington group of more than 300 physician, hospital, insurer and consumer representatives whose purpose is to agree on specific standards to measure medical care quality.

Some standards are as simple as whether a hospitalized heart attack victim gets a beta-blocker drug to ward off the harmful effects of stress hormones on the heart. Heart patients who don't get beta-blockers after heart attacks are 40 percent more likely to be dead a year later.

The blocker criterion is one of 68 hospital care quality measures endorsed by Kizer's National Quality Forum. Such standards are the essential first step to making telling comparisons in health care, according to the dean of U.S. medical care reformers, Dr. Donald Berwick, president of the Institute for Healthcare Improvement, based in Cambridge, Mass.

In the long run, well-applied quality measures, by driving out bad care, will help to deliver more good care at lower cost, reformers such as Kizer and Berwick believe. Ultimately, the U.S. health care system would pay doctors to keep patients healthy -- a system called pay-for-performance -- rather than to treat their illnesses.

Kizer's success in getting competing health care interests to agree on hundreds of measures of quality care was "a massive political achievement," and "a major win for the country," according to Berwick.

Kizer announced earlier this month that he'd be leaving the National Quality Forum in December to take over Medsphere Systems Corp., of Aliso Viejo, Calif., a small health information-technology company whose goal is to cut the price of electronic patient recordkeeping by using the free, publicly available open-source system that the VA devised.

About 10 percent of U.S. hospitals currently keep patient records electronically in a dynamic form that enables doctors to diagnose, monitor and manage their patients.

The difference that sophisticated health IT can make is clear in VA hospitals. When laptop-bearing personnel enter a patient's room, they can review not just the patient's latest data but the medical record of every VA medical encounter the patient's had since the mid-80s.

If the patient's been stricken while traveling, records can be transmitted instantly to or from the VA hospital the patient normally uses. Records can also be shipped to consulting VA physicians or downloaded by care-monitoring loved ones if the patient agrees.

VA doctors also enter drug orders on their computers. If they've missed a potential allergic reaction or a dangerous drug combination, the computer flags a warning. When the hospital pharmacist fills the prescription, the system spits out a strip of bar code that goes on the medicine, saying what it is, who it's for, when it's to be given, at what dose, and by whom.

G. Sue Kinnick, a VA hospital nurse from Topeka, Kan., who died last year, came up with the VA's bar code system while returning a rental car in Seattle. Drug-related mistakes contribute heavily to the medical errors that kill an estimated 44,000 and 98,000 Americans annually.

Why not use the same hand-held reader with which attendants matched cars and renters to help nurses match bar-coded drugs with a bar-coded ID on the patient's wrist?

Kizer, while the VA's undersecretary for health in 1994-99, loved the idea. "It wouldn't have gone anywhere without upper management's leadership," said Russell Carlson, the nurse-consultant for the bar code system now in place in every VA hospital.

For turning around VA health care, Kizer earned kudos from lawmakers such as Sen. John Kerry, D-Mass. But he also antagonized them by reducing in-patient beds and hospital staff. After several senators put holds on Kizer's renomination to pressure him to restore some of those cuts, Kizer resigned.

Nancy-Ann DeParle, a quality forum board member, attributes Kizer's tough-minded confidence to the dire straits he grew up in.

Kizer's first daylong job was at age 5 or 6, he recalled in an interview, when he earned three cents a quart for picking strawberries. He also ironed for his mother, who took in laundry.

His father, a factory worker in Boring, Ore., outside Portland, died of a heart attack when Kizer was 6 and the two were shopping. His mother committed suicide when he was 12, leaving five children wards of the state.

In the eighth grade, Kizer attended five schools in Oregon, California and Nevada, he recalled.

He settled in Reno, Nev., for three years of high school, where he proved a successful, popular student and ultimately was class president. He learned what he called "helpful" ideals and attitudes from football and track.

The early loss of his parents and some nasty aspects of foster care, Kizer said, "made me more serious ... made me want to be successful."

Kizer won honors as a pre-med student at Stanford, where he supplemented his scholarship with jobs as an emergency room orderly, library clerk and fireman. He graduated from UCLA medical school and, facing the draft, served a stint as group medical officer for Navy ordnance disposal units headquartered in Hawaii.

Then-California Gov. George Deukmejian named Kizer to head the state's emergency medical care authority in 1983 and, later, to direct the state's Department of Health Services. There, Kizer led the most successful anti-smoking campaign in any state's history, cracked down on nursing home abuses and, at age 33, suffered the nickname "Baby Doc."

Kizer's wife and high school sweetheart, Suzanne, lives in Sacramento, to which he's commuted from Washington on weekends, often writing medical journal articles on the plane. They have two grown daughters.

For recreation, Kizer likes to dive in the South Pacific. Friends who've gone along say he relishes swimming with sharks.

Harold Gracey, Jr., the VA's chief of staff in Kizer's era, who's now re-tired, offered Kizer the highest of praise. "The things that are attributed to him, he really did," Gracey said. "He wasn't one of those appointees who shine other people's work up, advertise it and take credit for it