



March 28, 2016

Michael K. Dexter, Chief
Center for Health Systems Policy and Regulation
Rhode Island Department of Health
Three Capitol Hill, Room 410
Providence, Rhode Island 02908-5097

Dear Mr. Dexter:

On review of your letter of March 23, 2016, I wish to clarify the following points.

The Department's letter of March 7, 2016, related solely to the inpatient obstetrical services and not to all clinical services. We have complied with that directive and will continue to provide all primary care and emergency services, including inpatient obstetrics, until our pending reverse CON request to relocate inpatient obstetrics is approved by the Department.

This is also to make clear that the possibility of merging the licenses of Memorial and Kent Hospitals, which we had been studying for some time and which had been a topic of preliminary discussion between representatives of our two staffs, is no longer under consideration, as we are focusing on our efforts to improve Memorial's dire financial condition in an effort to preserve other primary care and emergency services at that location.

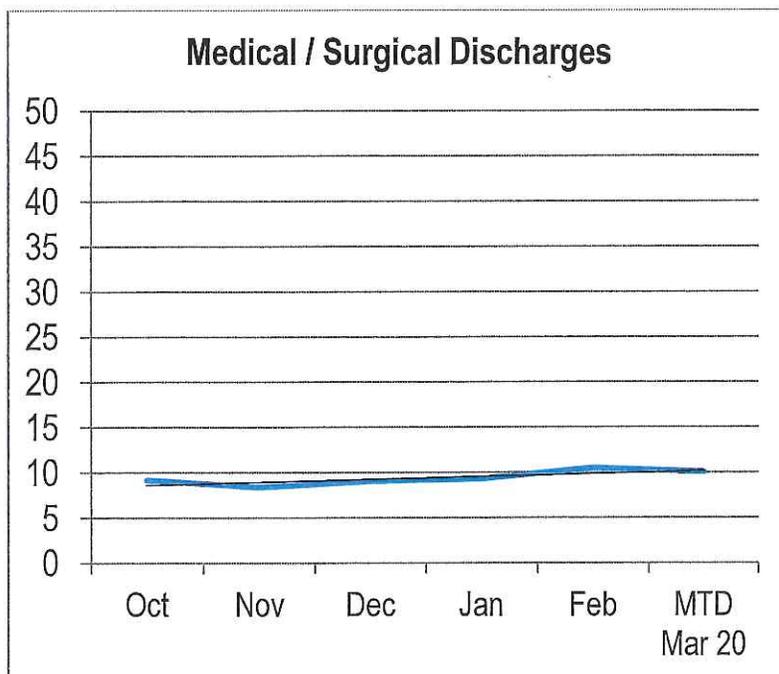
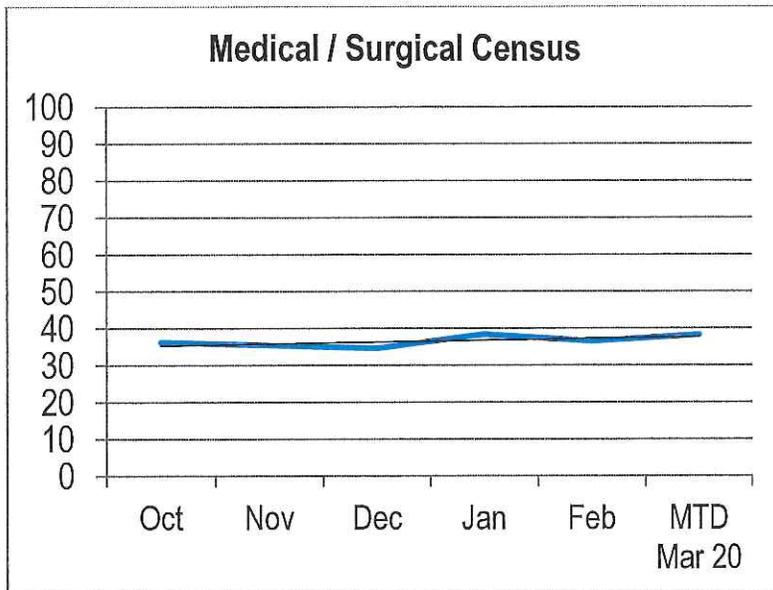
Moreover, while Care New England (CNE) is developing plans with respect to changes in other clinical services at Memorial as part of this effort, these plans do not involve changes to services offered at CNE's other hospitals.

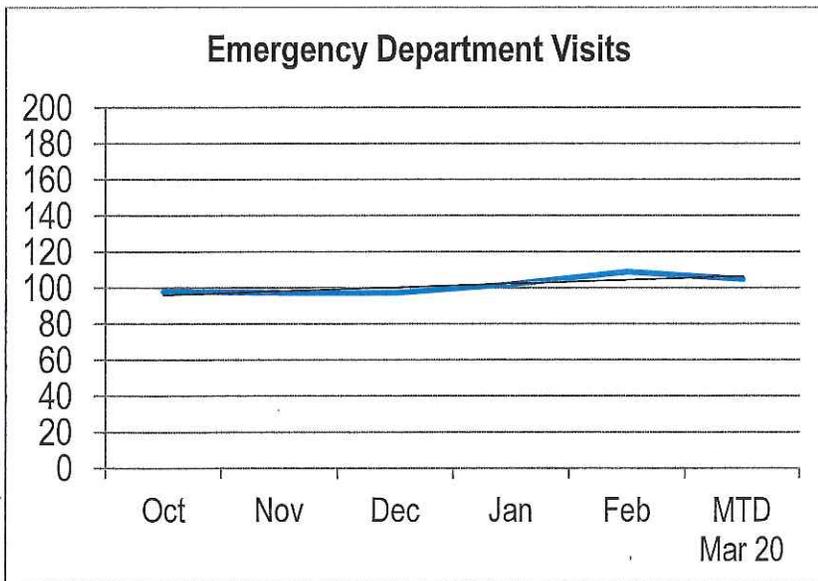
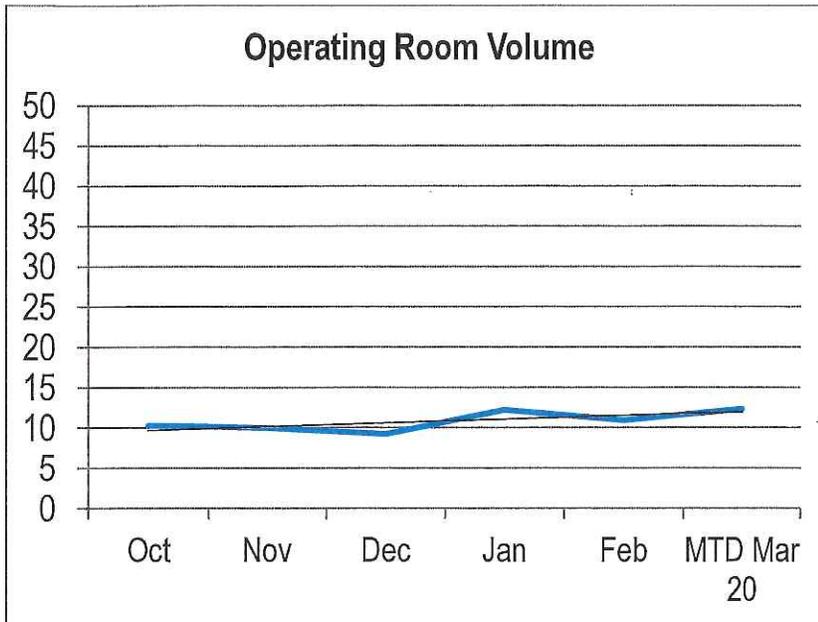
Finally, the additional changes anticipated at Memorial that are detailed in the body of this letter do not involve elimination or reduction of primary care or emergency services. Therefore, there is no expectation that regulatory applications will be required beyond those that have already been filed with respect to the inpatient obstetrics unit at Memorial.

Having made those clarifications, the response to your letter follows.

The Situation at Memorial Hospital

Memorial Hospital of Rhode Island is currently a full service hospital with a licensed bed capacity of 294 patients. The graphs below illustrate the average medical-surgical census at Memorial (averaging between 35 and 40 per day), as well as other key volume trends.





These very low volume and utilization statistics which we inherited and which we have striven to reverse have produced an unsustainable situation in terms of keeping Memorial operating as a full service hospital. As a result of this very low utilization, CNE undertook a careful planning process that analyzed what services the community required, and what CNE, as a system, could afford to provide without destabilizing its other hospitals. The plan consists of three major stages, over the next 12-18 months:

- I. Immediate cost reduction opportunities in the first 60 days and unrelated to restructuring, to include a reduction of 58 FTE positions on 29 March 2016.

- II. Major restructuring to re-purpose Memorial in order to meet essential community needs within CNE's economic means.
- III. Repurposing unoccupied portions of Memorial's campus for non-medical uses to provide income to offset continuing losses, even after phase II.

The Plan For Memorial Hospital

The model for restructuring that has now been put forward includes the following:

1. Continuation of the full service emergency department, operating 24/7
2. 10 bed observation unit to support that emergency department, for medical-surgical patients with short expected lengths of stay
3. 8 bed inpatient orthopedic surgery unit
4. Continuation of full outpatient surgery offerings
5. Continuation of all present outpatient primary care clinics, including primary care clinics in both family medicine and internal medicine
6. Continuation of all current outpatient specialty clinics, including cardiology and pulmonary medicine
7. Inpatient rehabilitation unit with capacity up to 20 beds
8. Continuation of the cancer center with both outpatient oncology clinics and infusion unit
9. Continuation of pre- and post- natal clinical care
10. Continuation of the neurodevelopmental center
11. Continuation of outpatient laboratory services
12. Continuation of diagnostic imaging services
13. Enhanced transportation services for patients requiring transport to and from the Memorial campus
14. Delicensure of up to 150 beds

The Sequencing of the OB Closure

The transfer of the Memorial obstetrical service to Women & Infants and Kent Hospital as the first step was not advanced lightly. It is essential in order for CNE to execute its transformation plan for Memorial. The changes proposed above cannot proceed if an OB service remains due to patient safety concerns should OB patients decompensate clinically. The continued presence of an OB service necessitates the continuation of the ICU and full inpatient medical services. However, the continuation of the status quo will continue to see Memorial on track to lose between \$2.5 and \$3.0 million per month vs. a targeted loss of \$1.5 million per month once the plan is fully implemented. Continuation of losses at those levels will further deplete CNE's already low cash on hand and will threaten the viability of the entire system.

Attached are the CNE financial statements for fiscal years 2013, 2014 and 2015, that are required to be submitted pursuant to RIGL section 23-17.14-12.1 (g) and at least the first two of which have been previously submitted to the Department. Also attached are projections for Memorial for fiscal years 2016-2018, assuming no changes are made.

We have given careful consideration to the transition of OB services from Memorial and provide a brief outline of our plans below:

Summary of OB Transition Plan to Date

In preparation for a decision from the RI Department of Health (DOH) regarding the transition of inpatient Obstetrical Services at Memorial Hospital, a task force was formed to identify and plan for the possible transition to Kent and Women & Infants Hospital (WIH). This task force includes leadership in the following functional domains: Nursing, Obstetrics, Emergency Medicine, MHRI Family Medicine, Legal, Marketing & Communications, Laboratory services, Pediatrics, Quality, Risk, and Anesthesia.

The comprehensive plan has considered the changes necessary if the request is approved by the DOH. Items with no direct impact to limiting the OB services at MHRI have been completed. Highlights are outlined below.

1. MHRI Family Medicine and Obstetrics providers
 - a. Credentialing and privileging at WIH: Providers desiring privileges at WIH submitted credentialing materials—applications have been processed and approved as appropriate
 - b. Credentialing and privileging at Kent: Providers desiring privileges at Kent submitted credentialing materials—applications are being processed
 - c. Meet and Greet held at WIH (Memorial residents and faculty attended along with WIH faculty, administration, nursing leadership and resident)
 - d. WIH Orientation developed and two sessions held to date with a third session planned. Material included Pediatrics, Labor and Delivery policies/ guidelines (attendees included residents and faculty)
 - e. Kent Orientation will be individualized (small volume of providers to date)
 - f. Plans are under development pertaining to transitioning Memorial Hospital Midwifery providers
2. Nursing
 - a. Plan for integration/orientation developed with Triage/ ED, Labor and Delivery, Mother Baby Unit nurse leadership at WIH
3. Communications
 - a. Individual communications with pregnant patients planning to deliver at MHRI—each patient contacted by phone. Follow up letters sent as appropriate.
 - b. Website set up to provide information regarding MHRI

- c. Patient packets and tours made available for patients at Kent and WIH
- 4. ED/ Triage
 - a. Policies and guidelines drafted for management of pregnant patients that present to MHRI post potential transition
 - b. Training programs in development for MHRI ED staff pertaining to above mentioned policies and guidelines
 - c. Changes necessary to accept MHRI patients at WIH and Kent ED/ Triage are completed
- 5. Transportation
 - a. Plan developed with EMS - ready to implement if/when request is approved
 - b. Multi-tiered emergency transportation plan in development considering level of acuity
- 6. Patient Registration/ HIM
 - a. Process developed to identify and register patients
 - b. Process in place to ensure proper transfer of prenatal records - ready to implement if/when request is approved
 - c. Information Systems security modifications to ensure appropriate access - ready to implement if/when request is approved
- 7. Residency training
 - a. Plan developed with Family Medicine and Obstetrics & Gynecology Residency Program Directors
 - b. Residents participated in orientation programs
 - c. On-boarding plan in place

We thank you for your careful consideration. We look forward to expeditiously addressing all questions that may be submitted with regard to our currently pending reverse CON request for relocation of the inpatient obstetrics unit at Memorial Hospital.

Sincerely,

Handwritten signature of Michael J. Dacey in black ink, appearing as 'Michael J. Dacey' with a stylized flourish.

Michael J. Dacey, M.D.
President
Memorial Hospital of Rhode Island

MJD/ms

Income Statement Projection - Memorial Hospital

	FY2014 Actual	FY2015 Actual	FY2016 No reductions	FY2016 Projected	FY2017 Projection	FY2018 Projection
Revenues and Gains						
Inpatient Gross Revenue	\$ 114,750,679	\$ 106,766,175	\$ 100,812,030	\$ 100,812,030	\$ 97,787,669	\$ 94,854,039
Outpatient Gross Revenue	\$ 200,703,000	\$ 232,964,569	\$ 203,568,818	\$ 203,568,818	\$ 203,568,818	\$ 203,568,818
Contractual Allowances	\$ (150,090,129)	\$ (190,748,585)	\$ (162,359,366)	\$ (162,359,366)	\$ (159,112,178)	\$ (155,929,935)
Discounts	\$ -	\$ (130,436)	\$ (191,872)	\$ (191,872)	\$ (191,872)	\$ (191,872)
Patient Service Revenue (Net of Cont Allow & Discounts)	\$ 165,363,549	\$ 148,851,723	\$ 141,829,610	\$ 141,829,610	\$ 142,052,436	\$ 142,301,050
Charity Care	\$ (9,569,716)	\$ (2,121,556)	\$ (1,571,882)	\$ (1,571,882)	\$ (1,571,882)	\$ (1,571,882)
Provision for Bad Debts	\$ (13,394,501)	\$ (11,915,283)	\$ (14,224,674)	\$ (14,224,674)	\$ (14,247,022)	\$ (14,271,957)
Patient Service Revenue Less Provision for Bad Debt	\$ 142,399,333	\$ 134,814,884	\$ 126,033,053	\$ 126,033,053	\$ 126,233,531	\$ 126,457,210
Net Assets Released from Restrictions	\$ -	\$ 289,688	\$ 250,075	\$ 250,075	\$ 250,075	\$ 250,075
Research Revenue	\$ 3,367,017	\$ 1,828,097	\$ 1,742,780	\$ 1,742,780	\$ 1,742,780	\$ 1,742,780
Other Revenue	\$ 4,399,344	\$ 3,148,186	\$ (3,794,323)	\$ (8,628,444)	\$ (12,081,387)	\$ (12,081,387)
Total Revenues and Gains	\$ 150,165,694	\$ 140,080,855	\$ 124,231,586	\$ 119,397,465	\$ 116,145,000	\$ 116,368,679
Operating Expenses						
Salaries & Wages	\$ 70,766,262	\$ 67,519,908	\$ 59,647,645	\$ 53,534,631	\$ 48,638,687	\$ 49,611,461
Fringe Benefits	\$ 22,182,249	\$ 20,976,592	\$ 21,383,571	\$ 17,514,255	\$ 14,591,606	\$ 14,883,438
Insurance	\$ 2,687,599	\$ 1,835,977	\$ 1,912,389	\$ 1,912,389	\$ 1,912,389	\$ 1,912,389
Medical Supplies and Drugs	\$ 15,613,421	\$ 17,966,137	\$ 16,829,760	\$ 16,829,760	\$ 16,829,760	\$ 16,829,760
Other Expenses	\$ 23,969,353	\$ 25,416,087	\$ 22,032,013	\$ 22,032,013	\$ 22,032,013	\$ 22,032,013
Research Expenses	\$ 3,367,017	\$ 1,847,605	\$ 1,734,533	\$ 1,734,533	\$ 1,734,533	\$ 1,734,533
Licensure Fee	\$ 6,984,804	\$ 6,008,811	\$ 8,076,893	\$ 8,076,893	\$ 8,076,893	\$ 8,076,893
Interest	\$ 591,355	\$ 572,430	\$ 601,302	\$ 601,302	\$ 601,302	\$ 601,302
Depreciation and Amortization ⁽¹⁾	\$ 4,818,613	\$ 5,077,797	\$ 5,303,354	\$ 5,303,354	\$ 5,303,354	\$ 5,303,354
Shared Services ⁽²⁾	\$ 8,764,001	\$ 20,499,888	\$ 18,979,865	\$ 18,979,865	\$ 17,816,333	\$ 18,004,527
Restructuring Costs	\$ -	\$ -	\$ 974,790	\$ 974,790	\$ -	\$ -
Total Operating Expenses	\$ 159,744,673	\$ 167,721,231	\$ 157,476,114	\$ 147,493,784	\$ 137,536,870	\$ 138,989,670
Income/(Loss) From Operations	\$ (9,578,979)	\$ (27,640,376)	\$ (33,244,529)	\$ (28,096,319)	\$ (21,391,871)	\$ (22,620,991)

Assumptions:

- No change in services
- Phase I staff reductions (58 FTEs) effective March 29, 2016
- Revised benefit structure effective January 1, 2016

⁽¹⁾ Does not include \$40m of facility improvements required to sustain operations

⁽²⁾ FY2014 did not include full allocation of corporate Shared Services