Rhode Island

Department of Health

DECISION

Proposed Affiliation of St. Joseph Health Services of Rhode Island, Roger Williams Hospital, Roger Williams Medical Center, and CharterCARE Health Partners Under the Hospital Conversions Act of Rhode Island

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STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

RHODE ISLAND DEPARTMENT OF HEALTH

3 CAPITOL HILL, ROOM 401

PROVIDENCE, RHODE ISLAND 02908

July 17, 2009

In the Matter of:

Proposed Affiliation of St. Joseph Health Services	**:**	
of Rhode Island, Roger Williams Hospital, Roger	**:**	
Williams Medical Center, and CharterCARE	**:**	**DECISION**
Health Partners (the "Transacting Parties")	**:**	
Under the Hospital Conversions Act of Rhode Island	**:**	

I. Introduction and Background

The above entitled matter came before the Rhode Island Department of Health (hereinafter referred to as the "Department") on February 2, 2009 in the form of an initial Application of the Transacting Parties, made jointly to Department and the Rhode Island Department of Attorney General ("RIAG") pursuant to Section 23-17.14-6 of the Rhode Island Hospital Conversions Act[1] (the "Act"). Upon receiving the initial Application, the Department and RIAG reviewed the Application for completeness. On March 6, 2009, the Department and RIAG sent a joint letter notifying the Transacting Parties that the Application was incomplete and specified all the additional information the Transacting Parties were required to submit to complete the Application. Following a review of additional information submitted by the Transacting Parties on April 17, 2009, the Department and RIAG sent a joint letter on May 1, 2009, within the statutorily required timeframe, notifying the Transacting Parties that the Application had been accepted for review (the combined submissions are hereafter referred to

[1] Chapter 23-17.14 of the Rhode Island General Laws

as the "Application"). In addition, the Transacting Parties and the Department entered into an agreement on February 13, 2009 pursuant to § 23-17.14-13 of the Act, which provides that no Application may be considered complete unless an agreement has been executed for the payment of costs of experts and consultants engaged by the Department or RIAG to effectuate the purposes of the Act.

Beginning on May 2, 2009, the Department and RIAG began concurrent substantive reviews of the Application pursuant to Sections 23-17.14-5 and 23-17.14-9 of the Act. At the same time, RIAG was completing its determination pursuant to Sections 23-17.14-6(c) and 23-17.14-32 of the Act as to whether certain information contained in the Application was confidential and/or proprietary and, accordingly, not a public record under Rhode Island law. On May 19, 2009, the RIAG issued its letter identifying the documents that were deemed confidential and/or proprietary pursuant to the Act. Upon this determination, and upon receipt of a Certification from the Transacting Parties that the electronic disc submitted as part of the filing contained only public information, the Department posted the public records' portion of the Application on the Department's website in order to make the Application available for inspection by the public, as consistent with the Act.

a. The Transacting Parties

Roger Williams Hospital ("RWH") is a 220 bed, not for profit, tax exempt, general, acute-care hospital in Providence, Rhode Island that provides secondary and tertiary care, is engaged in medical research and is a community-based teaching hospital affiliated with the Boston University School of Medicine. RWH also provides homecare services through Roger Williams Homecare, a home health agency operated under RWH's license. RWH is also a party to Roger Williams Radiation Therapy, LLC, a for profit joint venture with RTSI, Inc. providing radiation therapy services.

Roger Williams Medical Center ("RWMC") is a member, shareholder, partner or is otherwise affiliated with: Roger Williams Hospital (through common directors), Roger Williams Realty Corporation, Roger Williams Medical Center Physicians Office Building, Inc., Rosebank Corporation, Elmhurst Health Associates, Inc., Elmhurst Extended Care Facilities, Inc., and Roger Williams Medical Associates, Inc. (the "RW Affiliates").

St. Joseph's Health Services of Rhode Island ("SJHSRI") is a not for profit, tax exempt organization which, through its unincorporated divisions, operates an integrated delivery system providing a range of services including, but not limited to, a 359 bed non-profit, tax exempt general acute-care hospital. SJHSRI provides acute care services at its Our Lady of Fatima Hospital division, assisted living facility services through its St. Joseph Living Center division, and specialty care services through St. Joseph Hospital for Specialty Care. SJHSRI also operates a pediatric dental residency program affiliated with Lutheran Medical Center in New York, as well as a school of nursing education through its St. Joseph School of Nursing division. SJHSRI is the member or shareholder of a number of nonprofit and for profit entities ("SJHSRI Affiliates"), including Our Lady of Fatima Ancillary Services, Inc., St. Joseph Health Services Foundation, and SJH Energy LLC. SJHSRI is also a party to Northwestern Rhode Island Imaging Center, LLC, an MRI center in Johnston, Rhode Island, which is a for profit joint venture through Our Lady of Fatima Ancillary Services, Inc. SJHSRI is also a party to a Market Participation Service Agreement for SJH Energy, LLC with ISO New England, Inc. In addition, SJHSRI is also a party to Southern New England Rehabilitation Services, which provides rehabilitation services through a joint venture of SJHSRI with Rhode Island Hospital.

CharterCARE Health Partners (CCHP) is a nonprofit corporation formed for the purposes of affiliating RWH, RWMC and SJHSRI as described below.

Collectively, CCHP, RWH, RWMC and SJHSRI may be referred to herein as the "Transacting Parties" or "Applicants."

b. Description of Proposed Affiliation

The Transacting Parties have determined that by joining the RWH, RWMC and SJHSRI together to create a new health care system, they can enhance their respective charitable purposes and missions and better serve the health care needs of the communities they serve in a manner that will preserve the Catholicity of SJHSRI and enhance RWH's historic mission of medical research and education.

The two existing hospitals will remain as two separately licensed acute care hospitals following the proposed affiliation. The Transacting Parties propose that CCHP will become:

a) the sole member of RWH,

b) the sole member of each RW Affiliate,

c) the Class A Member of SJHSRI and

d) the member or shareholder of each SJHSRI Affiliate.

At the same time, the Bishop of the Diocese of Providence will become the Class B Member of SJHSRI, with certain reserved powers relating to the continued Catholicity of SJHSRI. RWMC will merge into RWH or otherwise transfer all of its assets and liabilities to RWH, and RWH will change its name to Roger Williams Medical Center. Throughout Section III of this document, Roger Williams Hospital will be referred to as "RWH." When RWMC is used it will be considered the entity described above under Section I.a.

CCHP will have a fifteen (15) member Board of Trustees. The Initial Board shall consist of eight (8) Trustees designated by the Bishop and seven (7) trustees designated by the Board of Trustees of RWMC/RWH. The Initial Board members shall serve for a term of three (3) years (the "Initial Term"). Upon the expiration of the Initial Term, the Trustees shall elect their successors to staggered terms such that five (5) individuals shall be elected to two (2) year terms, five (5) individuals shall be elected to three (3) year terms and five (5) individuals shall be elected to four (4) year terms.

The Transacting Parties represent that CCHP will employ a Chief Medical Officer ("CMO") and that, with the exception of the CMO, other leadership positions will be funded and transitioned from existing executive positions. Kenneth Belcher would hold two offices after the affiliation: Chief Executive Officer of CCHP and Chief Executive Officer of RWMC (formerly RWH). Further, John Fogarty would hold two offices after the affiliation: Executive Vice President and Chief Operating Officer of CCHP and Chief Executive Officer of SJHSRI.

c. Jurisdiction

Section 23-17.14-4(6) of the Act defines a "Conversion" to include:

"any transfer by a person or persons of an ownership or membership interest or authority in a hospital, or the assets of a hospital, whether by purchase, merger, consolidation, lease, gift, joint venture, sale, or other disposition which results in a change of ownership or control or possession of twenty percent (20%) or greater of the members or voting rights or interests of the hospital or of the assets of the hospital or pursuant to which, by virtue of the transfer, a person, together with all persons affiliated with the person, holds or owns, in the aggregate, twenty percent (20%) or greater of the membership or voting rights or interests of

the hospital or of the assets of the hospital, or the removal, addition or substitution of a partner which results in a new partner gaining or acquiring a controlling interest in the hospital, or any change in membership which results in a new person gaining or acquiring a controlling vote in the hospital."

The proposed affiliation satisfies the definition of a conversion under the Act and is therefore subject to the prior review and approval of both the Department and the RIAG. Pursuant to Section 23-17.14-5 of the Act, the review by the two departments shall occur concurrently, and neither department shall delay its review or determination because the other department has not completed its review or issued its determination. Separate statutory review criteria are established under the Act for the Department and the RIAG.

d. The Department's Standards for Review under the Act

While the Act requires the Department's consideration of certain statutory criteria set forth below, it also contemplates that the Director may consider matters related to the viability of a safe, accessible and affordable health care system that is available to all the citizens of the State and matters otherwise related to protecting the public health and welfare[2].

The Department's additional statutory criteria include:

- Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed Transacting Parties are satisfactory;
- Whether sufficient safeguards are included to assure the affected community continued access to affordable care;
- Whether the Transacting Parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community;
- Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;

[2] § 23-17.14-3; and R23-17.14-HCA subsection 5.3 (h)

- Whether the Transacting Parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workplace;
- Whether the Transacting Parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring; and
- Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

In addition, under the *Rules and Regulations Pertaining to Hospital Conversions* (R23-17.14-HCA, Section 5.3(h)), the Director shall also consider issues of market issues, including market share, especially as they quality, access, and affordability of services.

e. Other State Regulatory Process

Health Services Council ("Council") Review under the Health Care Facility Licensing Act of Rhode Island[3].

On May 15, 2009, in accordance with the requirements of RIGL 23-17, Applications submitted by CCHP for changes in effective control of SJHSRI, RWH and Elmhurst Extended Care Facilities Inc. were deemed complete for processing before the Council. The Council reviewed these Applications at six meetings held between May 19 and June 30, 2009, including one meeting that was held to provide an opportunity for the public to comment on the proposal. At the meeting of June 30, 2009, the Council unanimously recommended that the Applications be approved subject to conditions. The written report of the Council, including all findings and recommendations, was transmitted to the Director of Health. The entirety of the record of the Council review, including but not limited to Applications, written information provided by the Applicant, representations made by the Applicant both in writing and verbally before the Council, third party advisories and recordings of meetings of the Council and the Council's written report to the Director are hereby incorporated within the record of the

[3] Chapter 23-17, Rhode Island General Laws, as amended

Department's review under the Hospital Conversion Act. The entire record of the Council review is also available to the public.

RIAG Review under the Hospital Conversion Act.

As previously indicated, the Act requires both the Department and RIAG to review and approve a hospital conversion. The review criteria for each department are separately set forth in the Act and each department independently and separately issues its determination under the Act.

II. Description of the Department's Review Process under the Act

a. Application and Other Documents Supplied by Transacting Parties

The Transacting Parties submitted documents in response to an application form that gathers information for the review by the Department and the RIAG. The application form consists of 113 questions and requests for information (42 required by the Act) and 4 required appendices, including, but not limited to: requests for a detailed description of each of the Transacting Parties and their affiliates; the planning process and resulting consolidation proposal; the proposed governance and organization of the proposed affiliation; consultant reports concerning the affiliation, including due diligence reports; agreements, contracts, and conflict of interest policies and statements related to the proposed affiliation; plans for use of charitable assets and restricted funds; licensure status and related performance reviews of the Transacting Parties; recent or pending citations or lawsuits; description of the type, amount, and location of services provided by the Transacting Parties and the population currently served; proposed changes to the type, amount or location of services, and population served, including services to be eliminated, reduced, expanded, or consolidated; staffing plans; information on current and planned quality and performance improvement initiatives and related measurements, including patient satisfaction, quality of care, and health outcomes; plans for electronic medical records and health information interfaces; relationships with medical schools and other teaching programs; a description of efficiencies planned as a result of the consolidation; past financial information for each Transacting Party and future financial projections under the proposed affiliation; impact of the proposed affiliation on the hospital's market share and on the cost of health care; history of and proposed provision of charity care and community benefits; and the impact of the proposed affiliation on access to care, including primary care.

All documents and information submitted by the Transacting Parties has been reviewed and analyzed by the Department. Information detailing how the proposed affiliation will improve access and quality of care, and will achieve efficiencies as a result of consolidation of services and functions was particularly important to the Department's consideration of the Application under the Department's statutory review criteria.

b. Public Process

Particularly important to the Department was seeking and obtaining input from the communities and populations affected by the proposed affiliation. In pursuit of this objective, the Department strove to make the process as open and transparent as possible and to provide the public with as much information about the proposed affiliation as possible.

i. Public Record

The Act contemplates that the Department and RIAG maintain both a public and a confidential record to support the Department's decision on the conversion Application. On May 19, 2009, the RIAG made its determination, as required by the Act, as to what portions of the Application were confidential and/or proprietary. Upon this determination, the Department posted the entire public record portion of the Application on the Department website in order to provide public access to the non-confidential portions of the Application.

ii. Public Meetings

The Department is required under statute to hold an informational public meeting. The Department and RIAG agreed to jointly hold two public informational meetings jointly to provide opportunity for public comment on the Application. A notice of these public informational meetings appeared in the Providence Journal on May 21, 2009. In addition, the Department sent notice of these meeting by email to hundreds of community-based agencies and a press release was issued just prior to each of the meetings. The first meeting was held on May 27, from 6:00 to 8:00 PM at Rhode Island College, which is in the center of the two hospitals' service area. The second meeting was held on June 3, 2009, from 10:00 AM to noon, also at Rhode Island College. The Department and RIAG jointly moderated each of these meetings. At each of these meetings, the Transacting Parties were provided an opportunity to present a summary of the key points of the proposed affiliation for the attendees. The public was invited to participate and provide comment at the conclusion of the presentation. The

meetings generated only a moderate attendance, but at each meeting, public comment was presented. The majority of the public comment was favorable to and supportive of the proposed affiliation and some comments were received requesting consideration of particular issues.

iii. Public Comment

In addition to providing opportunities for comment at the public meetings, the Department and RIAG established a written public comment period, where the public and interested parties were invited to submit written comments until June 17, 2009. This opportunity to provide comment was advertised in the *Providence Journal* and e-mail along with the notice of the public meetings. The Department received and considered eight (8) written public comments.

c. Investigations and Other Testimony

The Department conducted a number of investigatory meetings in order to obtain information to inform the Department's review and decision. Investigatory meetings were held with the Transacting Parties, several health plans doing business in Rhode Island, and several state offices with health facility or health insurance regulatory oversight responsibility. In addition, the Department requested additional written information from the Transacting parties to assist the Department in its review.

d. Use of Experts / Recognition of Reports, Studies and Other Publications

The Department engaged three firms to provide expertise to assist in the Department's review. The Department asked these firms to provide expertise in the following areas:

i. To provide legal consultation,

ii. To conduct a literature review of recent hospital affiliations, in particular noting if these affiliations had an impact on the review criteria to be considered by the Department,

iii. To conduct a market share analysis of SJHSRI and RWH in the context of the market area of the proposed affiliated entity,

iv. To conduct a financial analysis of the proposed affiliation, with a focus on financial viability as it may impact access to care and affordability of care, and

v. To conduct an analysis of the proposed affiliation in the context of the experience of other similar affiliations, both successful and unsuccessful.

III. Discussion, Analysis and Findings Relative to Statutory Criteria and Other Considerations

As indicated in the previous section, the Department reviewed and considered: the completed Application; written information received subsequently from the Transacting Parties in response to the Departments' request; information received by the Department as part of the Application for Change in Effective Control (CEC) for the affiliation; public comment provided in writing or within the context of the two public informational meetings; other information gathered by the Department; and other publicly available information and reports.

A variety of factors have been taken into consideration in rendering this Decision, which include, but are not limited by, the criteria set forth in the statute. Following is a discussion and analysis of each of the statutory and regulatory criterion, including, for each criterion: (a) a background discussion, (b) factors considered in the review, (c) summary analysis.

Review Criterion 1: Whether the character, commitment, competence, and standing in the community, or any other communities served by the proposed Transacting Parties are satisfactory.

a. Background Discussion:

The Transacting Parties will be evaluated by considering their reputations and performance as "good corporate citizens." Good corporate citizens can be identified by the following characteristics:[4]

i. Maintaining a high standard of business ethics. It is vital to show that the hospital provides a fair and impartial set of standards to all, and maintains integrity, honesty, ethics and compassion in all of its activities.

ii. Working as Part of the Community. There are very many ways in which a hospital can give back to the community. This may be judged by the provision of community

[4] Modified from www.goodcorporatecitizen.com/top5ways.html

benefits and charity care at a level in keeping with the needs of the community and the other hospitals in the area. This may also be measured by opportunities the hospital provides for community input into strategic direction, such as community forums and community representatives on Boards.

iii. Providing good corporate governance. It is a prerequisite that all hospitals provide a satisfactory procedure for governance of their corporate affairs. This governance should be adequate enough to ensure that all their affairs are legally and morally above board.

iv. Engaging in fair trade and business practices, as well as fair workplace relations. One of the most important factors in maintaining any business is being fair and equitable to consumers, payers, employees and the provider community.

Competence can be measured by status and performance as evaluated by licensing and accrediting agencies, and by a hospital's performance as measured by access, quality, patient satisfaction, and outcome measures compared to the performance of other hospitals.

A hospital's character, commitment, competence, and standing in the community can be evidenced by its standing with the following agencies and groups:

- The State & Federal legal systems
- The licensing & certifying agencies
- JCAHO and other accrediting organizations
- Payors and purchasers of services
- Employees
- Medical Staff
- Patients and family members
- Community Members

b. Factors Considered

To evaluate whether the Applicants' character, commitment, and competence are satisfactory, among the factors that the Department considered were: accreditation status and survey reports of the Joint Commission on Hospitals; other accreditations and certifications; performance under each of the Applicants' hospital licenses issued and overseen by the Department and satisfactory compliance with any conditions imposed in association with approvals of Applications for Certificate of Need (CON) or Change in Effective Control (CEC)

that have been imposed in the past three years. The Department also considered any state or federal legal actions against the Applicants in the past 5 years, including malpractice cases, consent orders and evidence of correction. The Department also reviewed the proposed governance structure as well as policies and procedures related to corporate compliance and ethics.

To evaluate whether the Applicants' standing in community is satisfactory, among the factors that the Department considered were: patient satisfaction with services provided by the institutions benchmarked against other hospitals; public comment on the affiliation request; evidence of the Applicants' efforts to include input of providers and community members in the hospital strategic planning process which establishes hospital priorities; and efforts to include input of providers and community members in the hospital strategic planning process regarding the current affiliation request.

c. Summary Analysis

The Department determined that both RWH and SJHSRI have full accreditation status with the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). The Office of Facilities Regulation within the Department licenses each hospital. In addition, RWH is accredited by the College of American Pathologists (CAP), the Accreditation Council for Graduate Medical Education (ACGME), the American College of Radiology (ACR), and the American College of Surgeons (ACoS) Commission on Cancer. SJHSRI is accredited by CAP, ACoS, and the Intersocietal Commission on the Accreditation for Vascular Laboratories (ICAVL).

In September 2007, SJHSRI received an official reprimand from the Department concerning an August 2007 incident. The reprimand was related to information not provided to surveyors when requested. Since that time, when SJHSRI receives advisories and compliance orders from the Department they respond in a positive and constructive manner, with a willingness to take prompt corrective action.

SJHSRI has recently received CON approval to move inpatient psychiatric and inpatient rehabilitation from the Providence Campus to the Fatima Campus. There is no evidence that they are not in compliance with any CON of CEC approvals.

In January 2006, RWMC was indicted by a United States Grand Jury of the U.S. District Court, District of Rhode Island, for violations of federal criminal law. In January 2006, RWMC entered into a Deferred Prosecution Agreement with RI's United States Attorney (USAO-RI) that contained specific terms and provisions. In February 2006, the Department issued an Amended Show Cause Order to RWMC related to this indictment concerning activities of the Boards of Trustees in 2001 – 2005. This Order was a notice to show cause why the director should not impose conditions upon the hospital's license or take other appropriate action as circumstances require. The Department conditionally discontinued this Order on April 13, 2006 and the Consent Agreement was entered into with RWH whose sole member was RWMC. RWMC made significant changes, including changes to its Board of Directors. The CEO had already been replaced in February 2006. On April 13, 2007, the Department notified RWMC that the Consent Agreement/Order was expired. On November 17, 2007, the USAO-RI informed RWMC that they had fully complied with the requirements of the Deferred Prosecution Agreement, and terminated the corrective action plan resulting from the Deferred Prosecution Agreement effective December 2007. The USAO-RI commended Kenneth Belcher, the new CEO, for the successful efforts made by the hospital in complying with the agreement.

The Applicants' proposed governance structure for the affiliation appears to be consistent with the structure of other similar affiliations between a secular and Catholic hospital. The proposed structure will allow RWH to continue to provide some services which SJHSRI does not provide, including offering and providing emergency contraception in the emergency department as appropriate.

The Applicants propose to develop, under CCHP, consistent, system wide policies, procedures and protocols across all affiliates in areas including administration, compliance, finance, human resources, information systems, facilities and equipment, patient care services, performance improvement, universal protocols, clinical services and programs.

The Department found written corporate compliance and ethics policies at SJHSRI to be comprehensive. RWH's policies in this area were found to be adequate, but lacking the structure and detail of SJHSRI policies. Such policies for CCHP are yet to be developed. The Applicants stated their intention to create uniform policies across the affiliation in these areas, recognizing SJHSRI expertise in this area, and building on the policies in place at SJHSRI. It

should be noted that in actual practice, it appears that both hospitals are fully compliant with standard corporate compliance and ethics rules.

Results of patient satisfaction surveys of Medicare patients are publicly reported for individual hospitals by the Centers for Medicare and Medicaid Services (CMS), such that a hospital's performance can be compared to other hospitals. In answer to the question of how patients rate each hospital overall, for all hospitals in the U.S., an average of 64 percent of patients gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest) in surveys conducted from October 2007 to September 2008, the most recent available data. This is also the average for all hospitals in Rhode Island on this question. The result for RWH was slightly lower at 59%, and the result for SJHSRI was lower at 52%. The results for other patient satisfaction measures were similar, with RWH usually only slightly lower than the national and state average, and SJHSRI somewhat lower. This includes questions in the following areas: would the patient recommend the hospital to friends or family, communication of doctors and nurses with the patient, nighttime quietness, cleanliness of patient rooms, effective pain control, and how quickly staff responds to patients[5].

Unmet needs in the community are identified through community benefit opportunities, from employees, from medical staff in particular, from board members, through community meetings and from many other sources. These and other opportunities were used by the Applicants to solicit input from the communities about the proposed affiliation. The Applicants report that input from the community and staff has been very positive concerning the proposed affiliation. Information about unmet community needs will continue to be identified through such means and will be used by the CharterCARE (CCHP) Strategic Planning Committee, to set direction for hospital services and community benefits. The CCHP Strategic Planning Committee will combine two current committees at SJHSRI and RWH.

A small number of current and former patients and family members provided public comment on the Application in writing or at public meetings. All but one comment received were positive about each hospital, many pointing out valuable services provided by each, commending the caring manner of clinical staff, and expressing support for the affiliation.

[5] http://www.hospitalcompare.hhs.gov

In summary, both RWH and SJHSRI have had past inadequacies, as noted above. Each has recognized the need for and made significant improvements in their areas of deficiency. Each can benefit from the others strengths in certain areas.

Review Criterion 2: Whether sufficient safeguards are included to assure the affected community continued access to affordable care

a. Background Discussion.

A major safeguard to assure access to affordable care is the continued availability of a strong system of community based hospitals to serve as an appropriate first choice for care that can be delivered safely and most appropriately by such organizations. In this way, community hospitals are an important and valuable component of a health care market, providing an appropriate alternative to tertiary care institutions. Appropriately supporting and strengthening community hospitals is critical, so that they remain not only financially viable to remain in existence, but also remain sufficiently financially strong to provide medical services within an environment which has adequate resources to provide safe, high quality care. The continued financial viability of community hospitals is critical to assuring access to affordable care. Should community hospitals close due to financial or market share constraints, medical services that could have been provided safely and more affordably in a lower cost community-based setting will be provided in larger, more costly tertiary care hospital systems. The general nature of such tertiary care hospital systems is the more appropriate clinical environment for certain specialty care procedures, as they can centralize the performance of less common or more complex procedures in order to maintain adequate volume levels to assure clinical competence and the best patient outcomes. Larger hospital systems have more market leverage, which enables them to negotiate payment rates that ensure their continued financial strength. The affiliation of community-based hospitals will improve their ability to negotiate payment rates that will support them financially to assure their continued existence and their ability to provide safe, high quality care. This improved ability will enable such hospitals to compete more effectively with larger hospital systems.

Strengthening and supporting community hospitals by assuring their financial viability and financial strength is therefore a critical safeguard to assuring access to safe, affordable health care delivery system.

The experience of past affiliations has shown that the closer the affiliation is to a total consolidation of hospitals, the more efficiencies and cost savings result. Some studies have reported that combinations in which hospitals operate under a single license generate substantial savings, while system formation in which hospitals retain their individual licenses do not. Dranove and Lindrooth looked at all single hospital consolidations between 1989 and 1996 in the U.S. Of the 122 consolidations, 81 involved merging the two hospitals into a single hospital with consolidated financial reporting and operating under a single license. The other 41 consolidations involved the two separate hospitals remaining distinct but forming a system. In the well-controlled study, the authors selected 10 control hospitals having similar characteristics for each consolidating hospital. Hospital costs were followed for one year pre-consolidation and 2, 3, and 4 years after consolidation. Consolidation into systems did not generate savings, even after 4 years. On the other hand, merged hospitals operating under one license generated savings of approximately 14% at 2, 3, and 4 years after the merger. A more recent study on hospital consolidations also concluded that consolidations that include full integration of facilities and clinical programs are more likely to report significant cost savings.[6]

b. Factors Considered

To evaluate whether the Application includes sufficient safeguards to assure the affected community continued access to affordable care, the Department evaluated the past and current financial status of the Applicants, the Applicants' projections of financial status with the affiliation, and the Applicants' specific plans, including efficiencies, reductions, consolidations and other methods, which the Applicants will use to achieve their financial goals, and the reasonableness of these assumptions and the basis thereof.

In addition, the Department considered the Applicants' description of short and long term plans to assure access to health care services to the community, including: the Applicants' description of specific initiatives which CCHP will undertake to assure/improve access to care in the communities to be served; the current and planned communities to be served and any proposed changes pre and post conversion; any proposed changes in services to be provided by the Applicants pre and post affiliation, including the type and quantity of

[6] Zimmerman, H., "Review of the Literature of Hospital Mergers", 2009

services, location(s) of services, and the population served. This information was used to evaluate the proposal's potential or likely impact on availability and accessibility of services pre and post affiliation, including geographic access to specific services.

c. Summary Analysis

The Department engaged a team of experts with extensive experience in hospital operations and financial management, hospital affiliations, and acute care payment rates. This team has experience in these areas in RI as well as several other similar healthcare markets. The team reviewed the current financial status and recent financial history for RWH and SJHSRI as presented in the submitted documents. They also reviewed the Applicants' financial projections under the affiliation, and the underlying assumptions for the projections. They determined that while the affiliation has the potential to strengthen both hospitals, financially and in other areas, they also found that the financial viability of both hospitals, as well as the affiliation is concerning.

Both hospitals experienced poorer financial performance than budgeted for the current fiscal year. This experience is not limited to RWH and SJHSRI. The current national economic downturn, the increase in the number of uninsured, and other negative factors are exerting severe financial pressure on virtually all hospitals.

In response to their poor financial performance in the current fiscal year, SJHSRI responded aggressively by initiating a major cost reduction initiative in March 2009. While still anticipating to end the year with a net loss $3.5 million, this action served to somewhat stabilize an otherwise continuing downward financial trend for the current year. It appears that RWH has taken some actions to improve their current financial performance as well.

With regard to the Applicants' revenue projections for the affiliation, these projections appear to be based on optimistic assumptions:

- Financial projections assume that the hospitals will maintain or increase patient service volume. This may not be reasonable given recent decreases in volume of both inpatient and outpatient services at both hospitals.
- It could not be clearly determined from the data provided by the Applicants whether projected assumptions of rate increases for Medicare reimbursement were adjusted

for recent reductions to Medicare hospital reimbursement trend rates; thus the projected reimbursement rates overall may be overstated.

- It could not be clearly determined from the data provided by the Applicants whether the projected revenues for the first five years of the affiliation were estimated using a hospital-specific breakdown by payor mix, or if it has been adjusted for recent and projected changes to the hospitals' payor mix.

With regard to expenditure projections under the affiliation, there are multiple anticipated contributions to the projected decreased expenditure trends. The March 2009 cost reduction action by SJHSRI contributes significantly to improving the current year's financial performance as well as stabilizing the future years' projections. This conclusion assumes such cost reductions are maintained and remain permanent savings to the combined CCHP operation. The Applicants are estimating a savings of $15M over the first 5 years of the affiliation through the affiliations' plan of efficiencies. This contributes significantly to the projected reduction in expenditure trends. The Applicants estimate that this expenditure reduction represents 4.3% of the combined operating expense budgets of the Applicants. Projected expenditure reductions of $7M of the $15M are detailed through a combination of primarily administrative and support services over the first several years. The Applicants are estimating that the additional $8M in savings will be achieved through a combination of department-level consolidations, supply chain economies, clinical service integrations, and other contracted service costs. The Application did not provide sufficient detail for the Department's financial consultants to determine if the $8M savings projection is reasonable and attainable.

Given that the revenue estimates may potentially be overly optimistic, as discussed previously, the successful and timely implementation of all planned initiatives to reduce expenditures by $15M will be critical to the financial viability and success of the affiliation. In addition, if the actual revenue stream is less than these projections, not only will it be necessary to continue to implement the $15M planned savings initiatives to maintain a positive bottom line, but it will also be critical for the Applicants to quickly implement contingency plans to achieve additional cost savings initiatives.

The Applicants project a cost of approximately $2M to implement the $15M cost reductions, thus the net savings over 5 years is approximately $13M. This net cost reduction in year one is less than 1% of the combined hospitals' operating budget. This projected reduction

may not be aggressive enough to maintain satisfactory financial performance of the hospitals in the first year. The Application did not provide sufficient detail to determine if the Applicants have developed specific contingency plans for various potential revenue scenarios, or have carried out "sensitivity analyses" of expected performance levels. This sensitivity analysis would entail developing several versions of expense and revenue projections by utilizing best and worst-case variations for major assumptions involving service volume, reimbursement, and payor mix. A variety of contingency plans would be developed, focused primarily on reductions in costs. Such contingency plans would ideally detail various options, timelines, and savings estimates for further expenditure reductions beyond the original $15M, for use in the event that actual revenues were lower than budget.

The Applicants state that RWH key specialties include oncology, neurosurgery, orthopedics, behavioral health, geriatrics, dermatology and bariatric surgery. The Applicants state that SJHSRI key specialties include neurosurgery, orthopedics, behavioral health, wound healing, and urology. Neither hospital plans to eliminate any clinical programs or services that are duplicative across the two hospitals. The Applicants state that clinical consolidation will be limited in the near term (first several years) to coordination and collaboration. The Applicants have presented no plans to hire clinical staff, such as occupational therapists, physical therapists, speech therapists, and nutritionists, to work across the CCHP system including both SJHSRI and RWH.

The Department's expert consultants noted that clinical consolidation and integration through co-location or reduction of duplicative services have been critical elements of other similar hospital affiliations in achieving significant efficiencies and savings. Similar hospital consolidations that did not include full mergers of hospital systems were not successful in generating savings even after four years.[7] The Applicants do not anticipate clinical service integration until three to five years beyond the initial affiliation. "However, since the short-term outlook for these hospitals and the market is in itself not very promising, the proposed merger plan must address more aggressive savings from well- planned integration and

[7] Dranove D., Lindrooth R., "Hospital Consolidation and Costs: Another Look at the Evidence," Journal of Health Economics 22:983-97,2003.

consolidation of services and operations over the first 3 year period."[8] The Applicants propose to maintain duplicative clinical services at the two hospitals over the first several years of the affiliation. They plan to achieve Centers of Excellence for these overlapping services through the creation of unified policies and procedures, consistent with industry best practice. Although this is the initial step toward Centers of Excellence, the Applicants did not provide a plan to create single programs on one campus.

The Department's expert consultants as well as published literature indicates that it is not reasonable to assume that coordination of services across hospitals through unified policies and procedures will achieve the same level and timing of savings that would be experienced as a result of full clinical service integration and consolidation.[9] The Department is concerned that expenditure reductions necessary to maintain financial viability, may not be achieved given that:

1. There is a lack of specificity in materials provided to the Department of how the affiliation will achieve $8M of the $15M savings;
2. There is a lack of specificity in materials provided to the Department regarding whether the Applicants have developed sensitivity analyses and specific contingency plans in accordance with these analyses to ensure the savings are achieved and thereby financial viability is maintained and improved.
3. The Applicants do not anticipate clinical service integration until three to five years beyond the affiliation.

RWH and SJHSRI currently serve similar communities, with a large number of patients at both hospitals primarily coming from Providence and North Providence, and a lesser volume of patients coming from surrounding communities and several outlying communities in the East Bay area. CCHP is not planning to eliminate or significantly reduce any services RWH and SJHSRI currently provide to their community. Furthermore, they propose to serve the same communities they serve currently, with no anticipated changes.

[8] Kamien, K., Kraten,M and Atoyan, M., "Report for the Review and Assessment of the Conversion Application Submitted by Roger Williams Hospital, St. Joseph Health Services of RI and Roger Williams Medial Center" prepared for the RI Department of Health, June 2009.

[9] Dranove and Lindrooth, 2003

Both SJHSRI and RWH currently provide primary care services in medically underserved areas. SJHSRI has historically supported a major primary and specialty care Health Center in a very low-income neighborhood in Providence's south side. The Applicants assert their strong, unwavering commitment to this Health Center, and all services offered through this Health Center will continue. The Applicants' plan is that if the St. Joseph Providence campus building is sold, the Health Center will be relocated to a nearby location with the same services accessible to the same community.

Similarly, RWH offers primary care and internal medicine services through its medical residency program, affiliated with Boston University School of Medicine. Patients are seen one afternoon each week at a site on the RWH Campus by RWH resident physicians, who provide care for the same patients for three years. A faculty of academic general internists supervises this service. The Senior Centers in Greenville, West Warwick, North Providence and Providence, which are currently operated by RWH, will continue under the affiliation.

The Applicants anticipate that the efficiencies resulting from the consolidation and coordination of services will provide the financial support necessary to allow these important community services to continue as well as the support for the potential future expansion of community-based services and affiliations. The CCHP Board of Directors will have the responsibility to provide safeguards to maintain such community services, in that the reduction, elimination or relocation of any of its services will require Board approval. As well, elimination or reduction of the Health Center services would require approval by the Department of Health under *R.I.G.L. Section 23-17.14-18. The Hospital Conversions Act*.

In summary, the affiliation proposed by the Applicants will offer an appropriate, lower cost alternative to more costly tertiary care hospitals systems. The financial viability and improved financial strength of the affiliated combined organization is critical to maintaining a community based hospital system as a first choice option for services appropriately provided in a community hospital setting in this healthcare market. Maintaining financial viability and improving financial strength of the new affiliation may require more aggressive planning and action than has been proposed by the Applicants. The continued existence of these hospitals through the proposed affiliation is, in itself, a critical safeguard to assure the affected community continued access to affordable care.

<u>Review Criterion 3</u>: Whether the Transacting Parties have provided satisfactory evidence that the new hospital will provide health care and appropriate access with respect to traditionally underserved populations in the affected community

a. Background Discussion.

The culture of hospitals should be welcoming to all who seek care at the hospital, actively and promptly minimizing any barriers to care, and promptly facilitating access.

Access to health care traditionally means accessibility in terms of scope of services,[10] location, hours of operation and waiting times for appointment, to meet the needs of the community served by the hospital. However, access to care also includes the responsibility of hospitals to provide services to meet the needs of underserved populations in the hospital's service area, including low income and uninsured populations, by setting sliding scale rates for the uninsured and providing charity care for the low-income uninsured. In addition, access includes making every effort to provide services that are otherwise inaccessible in the hospital's service area due to short supply.

In addition, access to care includes a hospital's responsibility to be truly accessible to all in the community by being sensitive to the culture of individuals and families who seek care at the hospital, by providing prompt translation services when needed for individuals who need an interpreter, and by providing appropriate supports and accommodations for individuals with disabilities.

b. Factors Considered.

To evaluate whether the Applicants have provided satisfactory evidence that the new affiliation will provide health care and appropriate access with respect to traditionally underserved populations in the affected community, among the factors that the Department considered were: the Applicants' history of providing care to underserved populations; provision of charity care; identification of any services provided by the Applicant which are considered critical due to short supply or uniqueness; evidence that the Applicants provide and will continue to provide care that welcomes and accommodates multilingual and multicultural populations and individuals with disabilities; the Applicants' compliance with National

[10] Emergency/acute care, Primary/preventive care, Urgent care, Specialty/tertiary care, Oral health care and Behavioral health care/Substance Abuse treatment

Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) including any complaints received by the Department related to these standards; and the Applicant's history of and plan for providing community benefits.

c. Summary Analysis

The Department notes the long history of care that is provided by SJHSRI to underserved populations. SJHSRI has a unique culture in serving underserved populations, including low income families, minorities, and individuals and families who are homeless. SJHSRI provides critical and unique services that are not available elsewhere in the hospital's service area.

SJHSRI operates an adult and geriatric bed adult psychiatric inpatient unit, as well as an outpatient psychiatric service, that are critical components of Rhode Island's behavioral health care delivery system. SJHSRI appears willing to admit the most difficult psychiatric patients that other hospitals are often reticent to admit. SJHSRI is reported to have good discharge planning in close coordination with community mental health centers. SJHSRI has demonstrated its willingness to admit the most difficult psychiatric patients, regardless of insurance status or ability to pay, including admitting difficult patients referred from other emergency departments.

St Joseph's Health Center is located in the heart of Providence's inner city, providing 58,000 patient visits annually. The Health Center includes a walk-in clinic that provides a more appropriate and cost effective alternative to emergency department use for non-emergent urgent care needs. The Health Center also provides primary care to a low income, multicultural, traditionally underserved population. In addition to pediatric care, adult primary care, women's health care, and chronic disease clinics, St Joseph Health Center has a number of unique services that are not replicated elsewhere in the state. They operate the only pediatric dental residency program in the state, graduating four pediatric dentists each year in partnership with Lutheran Medical Center's Dental School in Brooklyn, NY. The pediatric dental clinic provides critical dental services to thousands of underserved children. In addition, St Joseph Health Services operates a lead clinic, a unique service providing comprehensive care and treatment to children who have been diagnosed with lead poisoning.

SJHSRI describes itself as mission–driven, committed to providing quality health care to underserved populations. They are struggling financially to maintain critical services to an underserved community, despite the increasing financial pressures resulting from a worsening economy, the rising number of uninsured and other factors. SJHSRI has assured the Department that even as they move their inpatient services from the Providence campus to the Fatima campus (previously approved under a separate application to the Department of Health), they will maintain the Health Center in its current location or in another location in the same neighborhood. The plan for both RWH and SJHSRI is to maintain all the direct patient services they currently provide.

RWH was also noted as providing critical services not available elsewhere in the state. RWH operates the states the only inpatient detoxification unit. This Level 4 unit has the expertise and capacity to provide drug and alcohol detoxification for the most clinically complex cases.

RWH also has gerontology program that offers a broad continuum of hospital and community-based geriatric services provided by gerontologists in partnership with other primary care physicians, resident physicians, psychiatrists, other physician specialists, nurses, physical therapists, occupational therapists, speech therapists, and other caregivers. RWH has an extensive network to provide for seniors' medical needs from the hospital to home, including critical care, intensive care, specialized inpatient geri-psychiatric care for seniors with mental illness, sub-acute care, skilled nursing facility care, home care services, and care in senior living and senior activity locations.

- Critical care, intensive care, inpatient geri-psychiatric care and sub-acute care are provided in RWH's hospital setting.
- Elmhurst Extended Care, a RWH affiliate provides 24-hour skilled nursing facility care at three levels of care: short term rehabilitation, long-term care, and a specialized dementia care unit. Elmhurst Extended Care is the only nursing home in the state affiliated with a hospital, and is the only nursing home in RI designated as an Eden Alternative facility.
- Through RWH's ContinuCare Program, seniors have access to gerontologists in senior centers and living complexes throughout the state.

- Residents in RWH's internal medicine program staff outpatient primary care clinics on the hospital campus, supervised by academic internal medicine physician faculty.
- RWH offers home care services, staffed by teams of nurses, physical therapists, occupational therapists, speech therapists and social workers who provide care to an average of 5,000 patients each month

This specialized program in gerontology is a unique, critical and a needed component of RI's health care delivery system.

Both RWH and SJHSRI offer free and reduced price care. The Department recognizes SJHSRI's efforts and achievements in the delivery of charity care. RWH is noted for their willingness to provide free services post-discharge, such as prescription medication and home IV therapy, for uninsured patients who have no means to pay and would otherwise require further hospitalization.

Although both hospitals receive payments from both Medicaid and Medicare to offset actual unreimbursed costs and for any Medicare and Medicaid shortfalls, both hospitals still ended 2007 with net unreimbursed uncompensated care:

- For RWH: $ 1,848,000 in net charity care costs and $2,168,000 in net bad debt costs for a total of $4,016,000 in net uncompensated care costs, representing 2.98% of revenue;
- For SJHSRI: $ 755,000 in net charity care costs and $470,000 in net bad debt costs for a total of $1,225,000 in net uncompensated care costs, representing 0.78% of revenue.

RWH and SJHSRI intend to coordinate their reporting of uncompensated care, including charity care and bad debt, to assure the reporting is consistent across CCHP and that the basis of such reporting is well documented. Beginning in 2009, there are new federal reporting guidelines and forms for all not-for-profit hospitals to report charity care, bad debt, unreimbursed costs for Medicaid and Medicare, and other community benefits using consistent definitions, methodology and reporting formats. This will assist the hospitals in their goal of consistent, accurate reporting. (IRS revised Form 990, Schedule H).

Under the CCHP affiliation, both hospitals assert that they will continue their established practices of providing care that accommodates individuals and families of many cultures, as well as individuals with disabilities. Each hospital maintains language and sign

language interpreter services, through a combination of in-house staff and outside contracts, as well as access to a "language line" at all times. Physical access for individuals with disabilities is also assured. The Department has received no complaints of difficulties in accessing such services as interpreter services at the two hospitals. The Department has no reason to assume that the hospitals are not in compliance with federal CLAS standards.

Both hospitals will continue their established practices of providing a broad array of community benefits, under the CCHP affiliation, including free health screenings for breast and prostate cancer, health fairs, a "Mini Medical School", various support groups, community blood drives, free flu shot clinics, and many other community outreach, screening, education and support activities.

In summary, SJHSRI has a notable history and culture of serving underserved, low income and minority populations. Both hospitals provided descriptions of how they provide accessible services to multi-lingual and disabled populations in accordance with CLAS standards. Both hospitals provide particular, unique services, which are critical to RI's health care delivery system.

Review Criterion 4: Whether procedures or safeguards are assured to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital;

a. Background Discussion

"The physician referral law (section 1877 of the Social Security Act)[11] prohibits a physician from referring patients to an entity for a designated health service (DHS), if the physician or a member of his or her immediate family has a financial relationship with the entity, unless an exception applies. (The exceptions are specified in 42 CFR Part 411, Subpart J.) The law also prohibits an entity from presenting a claim to Medicare or to any person or other entity for DHS provided under a prohibited referral. No Medicare payment may be made for a DHS rendered as a result of a prohibited referral, and an entity must refund any amounts

[11] http://www.socialsecurity.gov/OP_Home/ssact/title18/1877.htm

collected for a DHS performed under a prohibited referral on a timely basis. Civil monetary penalties and other remedies may also apply under some circumstances. [12]

b. Factors Considered

To evaluate whether the Applicants have provided satisfactory evidence that the affiliated entity will have satisfactory procedures or safeguards to insure that ownership interests will not be used as incentives for hospital employees or physicians to refer patients to the hospital, among the factors that the Department considered were: evidence of such written policies in the current entities, as well as any such proposed policies and procedures for the new affiliation.

c. Summary Analysis

The Application includes SJHSRI's policies and procedures that set forth minimum standards related to corporate compliance, code of conduct, conflict of interest, and referrals and kickbacks. Policies in place address the federal Stark and Anti-kickback laws. SJHSRI specifically prohibits employees from offering or granting any benefit to a referring physician or other referral source on the condition that such physician or referral source refer or agree to refer any patients to a person or medical facility.

With respect to RWH, the Application includes a code of ethics policy that sets forth standards and illustrates principals of conduct intended to cover the actions of individuals employed by or associated with RWH. According to this policy, RWH specifically requires adherence to fraud and abuse laws that prohibit direct, indirect, or disguised payments in exchange for the referral of patients.

Although each hospital has implemented policies and procedures that sufficiently meet this criterion, CCHP does not maintain such policies and procedures, since it is not a licensed health care provider and does not provide medical services.

[12] http://starklaw.org

In summary, based on the Department's review, there is no evidence of any arrangement between either of the hospitals and any physician or physician group or other provider that contemplates the use of ownership interests as incentives for the referral of patients to either hospital. Strengthening of policies and procedures for certain of the Transacting Parties in this area will provide greater assurance that no inappropriate or illegal incentive arrangements will arise in the future.

<u>Review Criterion 5</u>. Whether the Transacting Parties have made a commitment to assure the continuation of collective bargaining rights, if applicable, and retention of the workplace

a. Background Discussion

Through the conversion process, consolidations are expected in order to achieve efficiencies, and services and jobs may therefore be transferred or eliminated from an existing hospital. Such changes are acceptable and expected. The intention of this criterion is to assure that the collective bargaining rights of employees of the entities proposing to affiliate are maintained through any reconfiguration or consolidation and, to the extent possible, the existing workplace and workforce be maintained. Affiliating hospitals should take steps to minimize the any negative impacts of such changes, and should take active steps to come to agreement with any collective bargaining units to specify changes to the current agreements that will maintain any existing collective bargaining rights of employees.

b. Factors Considered

To evaluate whether the Applicants have provided satisfactory evidence of their commitment to assure the continuation of collective bargaining rights, among the factors the Department considered were the Applicants' description of collective bargaining issues that may be raised by the proposed affiliation, the Applicants' plan to address these issues, evaluation of the commitment demonstrated in the Applicants' plan to assure continued collective bargaining rights of employees, and evidence that the Applicants sought and considered the input of employees and employee union representatives in such plans. The Department also considered any comments provided to the Department from employees and employee union representatives on this issue.

To evaluate whether the Applicants have provided satisfactory evidence of their commitment to assure retention of the workplace, among the factors the Department considered were the Applicants' description of the planned consolidation, elimination, or expansion of functions/positions as a result of the affiliation; the impact of such changes on the workplace and workforce; and evidence of that the Applicants demonstrate a commitment to retaining the existing workplace and workforce where feasible.

c. Summary Analysis

At present SJHSRI currently maintains bargaining agreements with the United Nurses and Allied Professionals (UNAP) covering RNs working at the Fatima Campus. In addition, SJHSRI maintains bargaining agreements with the Federation for Nurses and Health Professionals (FNHP), i.e., one bargaining unit covering RNs and one bargaining unit covering technical workers at the SJHSRI Providence Campus. RWH has no unionized employees at this time.

UNAP has indicated in a written public comment that they are in the final stages of negotiating an additional amendment to the agreement concerning the affiliation, and have expressed their support for the affiliation.

The Applicants state that the staffing levels will remain consistent with current levels at both hospitals following the conversion. Under the proposed affiliation, CCHP indicated that it would employ approximately 2500 FTEs. During the first three years of operation, it is projected that 90 FTEs will be added due to increased volume and 39.8 FTEs will be eliminated due to planned efficiencies. Thus a net increase of 50.2 FTEs is expected. (See response to question 46)

The Applicants have stated that in cases where employees may be affected by job restructuring, the opportunity to apply for other positions within the system for which they are qualified will be made readily available.

In summary, the Applicants have stated their commitment to preserve and strengthen the workforce whenever possible, including continuation of collective bargaining rights.

<u>Review Criterion 6:</u> Whether the Transacting Parties have appropriately accounted for employment needs at the facility and addressed workforce retraining needed as a consequence of any proposed restructuring

a. Background Discussion

Hospitals that are affiliating should make reasonable efforts to retrain employees for new positions if their job is eliminated, with a goal of minimizing disruption of employment as a result of the conversion to the extent possible

To evaluate whether the Applicants have provided satisfactory evidence that they have appropriately accounted for employment needs at the facilities, among the factors the Department considered were the Applicants' description of the planned consolidation, elimination, or expansion of functions/positions as a result of the affiliation and the Applicants' demonstration that current and planned staffing levels are adequate, in particular in direct patient care areas.

b. Factors Considered

To evaluate whether the Applicants have provided satisfactory evidence that they have addressed workforce retraining needed as a consequence of any proposed restructuring, among the factors the Department considered was the Applicants' description of the methods they currently use and intend to use to retain the existing workforce where feasible, including plans to offer retraining to employees in areas to be consolidated for positions in areas of current shortage or planned expansion.

c. Summary Analysis

As stated in comments above, post-conversion CCHP will employ approximately 2500 FTEs. During the first three years of operation, it is projected that 90 FTEs will be added due to increased volume and 39.8 FTEs will be eliminated due to planned efficiencies. Thus a net increase of 50.2 FTEs is expected. The Applicants have stated their intention to use attrition whenever possible to accomplish job eliminations, in order to minimize impact on the workforce.

The Applicants have expressed their commitment under CCHP to preserve and strengthen the organization's workforce. In cases where an employee may be affected by job

restructuring, the opportunity to apply for other positions within the entire CCHP system will be made readily available to the employee. In instances where a job restructuring involves an employee changing to a job that requires additional skills, appropriate training and education will be provided. Under CCHP, both hospitals will continue to offer in-service training for new employees and for employees who may be transferring to a new Department among the RWH and SJHSRI campuses. As well, both hospitals will continue to provide on site training with CEU credits, as well as tuition reimbursement for employees who wish to pursue longer-term career development.

In summary, the Applicants have presented estimates of their future employment needs, with goals of retaining a significant number of jobs, and minimizing any negative impact of restructuring on employees. They project a long- term net increase in jobs based on a projected increase in patient volume. They have also stated their intent to retrain employees affected by any job restructuring for other appropriate positions that may be available within the CCHP.

Review Criterion 7: Whether the conversion demonstrates that the public interest will be served considering the essential medical services needed to provide safe and adequate treatment, appropriate access and balanced health care delivery to the residents of the state.

a. Background Discussion:

The consideration of safe and adequate treatment provides the department with an opportunity to consider the important issue of quality improvement in a hospital conversion request. Quality is defined in the Department's regulations R-23-27.27 Section 1.0, as follows:

> "Quality of care means the result or outcomes of health care efforts and is also measured using the framework and structure and process"

Various studies have analyzed the impact of hospital consolidations on quality of care:

> "Although the results in the literature are mixed, a narrow balance of evidence and evidence from the best studies indicates that hospital consolidation more than likely decreases quality than increases it." [13]

[13] Zimmerman H., Review of the Literature on Hospital Mergers, 2009, Prepared for the RI Department of Health, June 2009.

Cuellar and Gertier conducted a study examining hospital consolidations.[14] They concluded that the evidence suggests that hospital consolidations have primarily served to increase market power, not improve quality of care or efficiency, at least in the short run.

A February 2006 policy brief and report from the RWJF Synthesis Project concludes that the wave of hospital mergers and acquisitions in the 1990s raised hospital inpatient prices and likely lowered the quality of inpatient care. [15]

Hospital consolidations in RI should improve rather than decrease quality, by fostering the use of clinically related structures and processes such as hospital quality improvement programs, health information systems accessible to both providers and patients, clinical standards and procedures, patient safety programs, physician credentialing and peer review, medical home certification for outpatient primary care, and the like. It will be critical to ensure that under hospital consolidations in Rhode Island, integrated quality structures and processes are in place and health outcomes are routinely measured and reported.

There are many aspects to achieving a balanced health care delivery system, but the core concept is a system that promotes and rewards "higher value primary care, including preventive medicine and management of chronic illness"[16] over "higher-cost, intensive medical intervention." Such a balance can be achieved by:

- Assuring and rewarding access to primary care, including chronic care management, which are effective in reducing the need for higher cost medical interventions such as preventable hospitalization, ambulatory sensitive emergency department visits, and high cost medical procedures.
- "The underuse of effective care is a missed opportunity to limit the progression of illness and the need for more expensive services later on."[17]

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[14] Cuellar AE, Gertier PJ, "How expansion of Hospital Systems has Affected Consumers: Hospital Consolidation has resulted in more Negative than Positives so far," Health Affairs 24:213-19,2005

[15] RWJF, Synthesis Report, 2006

[16] A. Shih, K. Davis, S. Schoenbaum, A. Gauthier, R. Nuzum, and D. McCarthy, Organizing the U.S. Health Care Delivery System for High Performance, The Commonwealth Fund, August 2008

[17] . R. Singh, R. Seifert, Getting What We Pay for: Reducing Wasteful Medical Spending, Community Catalyst Report, December 2008

- Assuring and rewarding the provision of services in the least restrictive setting, including promoting the delivery of services in community settings rather than institutional settings. Examples are: promoting access and availability of, as well as redirecting non-emergent care to, community based primary care providers, urgent care sites, and health clinics, as more appropriate alternatives to hospital emergency rooms; [18]

- Assuring that institutional services, when necessary, are used most efficiently by entering into payment arrangements which reward higher value care and promotes accountability for the patient's entire episode of care both in and out of hospital. Examples of this are bundled payment approaches to paying for care over a period of time or for the duration of an illness, with rewards for quality, outcomes, and efficiency, as well as other payment approaches to better align payment with performance and value. (Reforming Provider Payment: Essential building Blocks for Health Reform, Commission on a High Performance Health System, March, 2009 report) Key expected improvements include decreased hospital admissions, fewer complications during hospital stays, efficient management of length of stay; and reduced readmissions.
- Assuring that patients move from institutional settings, such as inpatient care, to the most appropriate, least restrictive setting. Important to this is a system for collaborative cross system planning for the patient's care both in and out of hospital, including: active care coordination and care transition support; a system for hospital discharge planning which has accountability for the total care of the patient; and active collaboration and teamwork among hospital and community providers. This necessitates hospitals actively collaborating with home care, assisted living, and other community providers which can be appropriate, lower cost alternatives to discharge to a nursing home.
- Promoting patient incentives and easy access to information to promote patients choice of high quality, high value care.

[18] K. Davis, You Can Get There from Here: Mapping the Way to a Transformed U.S. Health System, The Commonwealth Fund, January 2009

The *July 2007RI Community Hospital Report* included the following statements regarding provider collaboration and hospital mergers:

"Through collaboration, hospitals should aim to reduce costs and increase quality, not solely enhance revenue through increased bargaining power. The state's regulatory and reimbursement framework should support this.

Effective collaboration would address hospitals' stated need to ensure that their own capacity is used most frequently. For example, this could be achieved by working with providers so that patients who seek hospital services but would be better served elsewhere can receive the right care in the most appropriate setting."[19]

As well, the Task Force Report made the following statement regarding community hospitals:

> " The role of {hospitals} must change if the future context of the health care system is one that rewards improved health outcomes as well as pays for individual episodes of acute and specialty care."[20]

Among the principles the Task Force agreed to for payment reforms to encourage efficient, high quality care are the following:[21]

- The new payment methodology should include pay-for-performance provisions.
- Payment should support primary care infrastructure and realign incentives to remove any reimbursement bias for complex services. Changes in payment should ensure that incentives are sufficient to support low-complexity and preventive services that are effective contributors to health. and
- Changes in payment should be used to align financially the interests of hospitals and physicians and thus eliminate some of the competition between them.

The Commission on a High Performance Health System states that "Our fragmented health system rewards high-cost, intensive medical intervention over higher-value primary care, including preventive medicine and the management of chronic illness." [22]

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[19] Report of the Community Hospital Task Force, July 2007

[20] Ibid.

[21] Ibid.

The report further identified six attributes for an ideal health care delivery system:

- Information flow to providers and patients through electronic health records systems,
- Care coordination and care transition support
- Peer accountability and teamwork among providers
- Easy access to appropriate care
- Accountability for the total care of the patient, and
- Continuous innovation to improve quality, value, and patient experiences. [23]

Among the recommendations of the Commission to move our fragmented delivery system toward this ideal, were:

- Payment reforms: bundled payment systems that reward coordinated, high-value care and expansion of pay-for-performance programs to reward high-quality, patient-centered care;
- Patient incentives to choose to receive care from high quality, high value systems; and
- An acceleration in the adoption of health information technology.[24]

In a more recent report, The Commission on a High Performance Health System concludes, "by increasing emphasis on primary care, improving coordination, and eliminating duplicative and unnecessary services, payment reforms could significantly slow growth in health care spending..…Payment reforms offer significant opportunities for health care providers to benefit from improving care and making prudent use of resources…. New payment methods reward value rather than volume… While embarking on payment reform may be daunting for [providers], given the large investment they have in the current system, new and innovative strategies are needed to align incentives to encourage and reward more effective and efficient care."[25]

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[22] The Commission on High Performing Health Systems, "Organizing the US Health Care Delivery System for High Performance," August 2008.

[23] Ibid

[24] Ibid

[25] The Commission on a High Performance Health System, "Reforming Provider Payment: Essential Building Blocks for Health Reform" March 2009.

Certainly hospital conversions present an unprecedented opportunity to foster an alignment between hospitals and payors in order to pursue transformational changes to RI's health care delivery system.

b. Factors considered

To evaluate whether the Applicants have demonstrated that the proposed conversion will assure and improve access to safe and adequate treatment by providing access to essential medical services to communities served, among the factors the Department considered were the Applicants' description of short and long term plans to assure the provision of safe, high quality health care services to the community; description of changes to quality structures and processes, including the organizational structure that will be used clinical and quality management, oversight and enforcement; plans and timeline for development and implementation of consistent clinical, quality, and patient safety policies and procedures across the new entity. Among the specific clinical, quality, and patient safety areas the Department reviewed were: plans and timelines for joint physician credentialing, peer review, quality improvement activities, patient safety and associated reporting, and descriptions of outpatient primary care clinics and affiliated physician offices with regard to NCQA medical home criteria.

The Department also considered the proposal's potential impact on concentrating specialty tertiary services within large volume centers – either consolidating such services within the proposed entity or by closing such services that may have adequate capacity and higher volume in other nearby facilities unrelated to the affiliation.

In addition, the Department considered the Applicants' description of plans to improve quality and patient safety through the further development of health information systems, including but not limited to plans and timeline for an integrated electronic medical record system and e prescribing across hospitals, other affiliates, and affiliated physician offices. The Department considered current and planned access to electronic medical information by affiliated physicians, and for patients, as well as the affiliations efforts and plans for participation in the statewide health information exchange.

With respect to quality of care, the Department considered findings by the Office of Facilities Regulation including past and current reviews, compliance orders, corrective action

taken and performance in providing inpatient psychiatric services under the facility status certification of the Department of Mental Health, Retardation and Hospitals ("MHRH"). The Department reviewed reports provided on the U.S. Department of Health and Human Services' *Hospital Compare* website concerning the hospitals' standing in areas of clinical performance, patient safety and quality, benchmarked against other hospitals in the state and in the country.

To evaluate whether the Applicants have demonstrated that the proposed conversion will promote a balanced system of health care service delivery and efficient use of services in the community, among the factors the department considered were national best-practice recommendations for a balanced, efficient health care delivery system, as discussed in the Background Discussion section of this criterion. Among the specific factors the department considered was the Applicants' specific plans and methods to assure health care services in the communities served are delivered in the least restrictive setting. The Department considered the Applicants' description of specific plans and methods, as well as the Applicants' history of efforts and successes, in the following areas that are critical to achieving a balanced health care delivery system:

1. to promote the alignment of payor, hospital, and related provider payment incentives to decrease or remove any reimbursement bias which may promote the use of institutional settings or tertiary services in lieu of less restrictive or community-based services;
2. to promote/include provisions in contracts with payors and/or providers, which reward the hospital and/or providers for providing higher value care;
3. to move toward an integrated health system across the community where the hospital partners with community-based providers to be accountable for care of the patient both in and out of the institution,
4. to improve access and capacity for primary care and chronic care management by promoting and supporting community based primary care services
5. to assure, promote and support the availability community based urgent care services, especially evenings and weekends, as an alternative to more costly emergency department use for non-emergent care;

6. to reduce preventable hospital admissions, readmissions and emergency department use within the communities served by the new entity;
7. to prevent, track and reduce complications during hospital visits and stays;
8. to appropriately manage length of inpatient stay;
9. to assure and promote a well-developed system for collaborative cross-system care coordination , care transition, and discharge planning and support from the emergency department, including collaboration with community providers or other partners to assure that discharge emergency department services is to least restrictive setting, such as with family and community supports, with home based services, to hospital diversion facilities or other appropriate settings in lieu of inpatient hospital;
10. to promote and assure a well-developed system for collaborative cross-system care coordination, care transition, and discharge planning and support from inpatient stays, including collaboration with community providers or other partners to assure that discharge from hospital inpatient services is to least restrictive community setting, such as with family and community supports; with home based services; to short-term step-down facilities, or to assisted living, in lieu of other institutional settings such as nursing homes;
11. to promote and support the capacity for community based long term care service s in least restrictive settings such as home based supports;
12. to promote the acceleration in the adoption of health information technology, including Electronic Medical Records (EMR), Computerized Physician Order Entry (CPOE), e-prescribing and participation in CurrentCare, the statewide Health Information Exchange (HIE).
13. to promote patient, provider, and hospital incentives, which promote access to and use of information by patients about the quality and cost of care.

c. Summary Analysis:

Both RWMC and SJHSRI have well-established quality improvement programs integrated throughout each institution. Quality is monitored internally through Performance Improvement Departments at both hospitals. Through the affiliation, the Application states that

the hospitals' quality improvement programs will be strengthened through several initiatives, which are described as follows.

The Applicants state that CCHP will create and recruit for a new position of Chief Medical Officer (CMO). The CMO will be a member of the CCHP senior management team, reporting to the CEO of CCHP, and have a lead role in quality improvement, and will be responsible for clinical program collaboration across the two affiliating entities. The CMO's responsibilities will also include physician credentialing across the new organization. The Application does not provide a timeline for recruitment and hiring a CMO.

The Applicants state that the affiliation will standardize clinical practice guidelines and protocols, as well as quality oversight and credentialing standards and practice, across the two hospitals within 3 to 5 years. The Applicants state that their goal is uniform physician credentialing policies and cross-credentialing in place within that same time period. The Applicants state that the development of central oversight in the emergency departments of both hospitals (total 60,000 visits per year) will provide a foundation for standardizing best practices, assuring clinical quality improvement and achieving operational efficiencies.

The Applicants state that CCHP will achieve continuous quality improvement through the creation of Centers of Excellence in the following areas: orthopedics, urology, neurosurgery, behavioral health, wound healing, oncology, geriatrics, rehabilitation, gastroenterology, laboratory, and bariatric surgery. The Applicants state that the Centers will improve quality from both a clinical and customer service perspective. However, the Applicants have not provided specific plans and timelines for development and implementation of Centers of Excellence.

Both hospitals use the same system for their respective health information systems. The Applicants state that this will assist them in integrating these systems, which is their intent through the affiliation. Both hospitals have electronic medical records, which store information that is accessible remotely to credentialed physicians. SJHSRI is an active participant in the enrollment efforts of the statewide health information exchange.

The Office of Facilities Regulation has noted a pattern of issues and failures in communication systems and implementations of policies and procedures in the inpatient psychiatric service at SJHSRI related to four specific incidents occurring in August 2007, December 2007, August 2008 and in December 2008.

In September 2007, the Department issued a Compliance Order to SJHSRI to engage the services of a consultant to review and make recommendations regarding safety and security for all psychiatric units/services. The orders imposed in the Compliance Order were satisfied in November 2007 by the submitting the expert report to the Department. From 2007 to June 2009, the Department has made seventeen (17) onsite unannounced inspection visits to investigate and ensure compliance with the September 2007 Compliance Order. In December 2008, a new consent agreement was signed and the hospital agreed to review certain policies and procedures (e.g., seclusion, constant observation and restraint use). It was also noted that SJHSRI receives advisories and compliance orders from the Department in a positive and constructive manner, with a willingness to take prompt corrective action

Quality of care measures for SJHSRI and RWH are reported through the Hospital Compare program. Hospital Compare was created through the efforts of the CMS and the U.S. Department of Health and Human Services and is a tool providing information on how well hospitals care for patients with certain medical conditions and/or surgical procedures. The information on the website http://www.hospitalcompare.hhs.gov/Hospital comes from hospitals that have agreed to submit quality information for Hospital Compare to make public.

For SJHSRI and RWH specific measures were reviewed. These included outcome of care measures, which focus on death rates, specifically on whether patients died within 30 days of their hospitalization and on rates of readmission specifically on whether patients were hospitalized again within 30 days. Death rates and rates of readmission show whether a hospital is doing its best to prevent complications, teach patients at discharge, and ensure patients make a smooth transition to their home or another setting such as a nursing home. Process of care measures (there are 25 measures for adults) show how often hospitals give recommended treatments known to get the best results for patients with certain medical conditions or surgical procedures.

In reviewing the outcome of care measures for both SJHSRI and RWH, rates were “no different than the national rate” for all measures, including:

- Pneumonia 30-day mortality
- Heart failure 30-day mortality
- Heart attack 30-day mortality
- Rate of readmission for pneumonia patients

- Rate of readmission for heart failure patients
- Rate of readmission for heart attack patients

For process of care measures, comparisons are made to the national and Rhode Island averages for each measure during the period July 2007 to June 2008. For most measures, both hospitals are within range of the averages or the number of cases was too small to determine reliably how well a hospital was performing. On one measure, percent of heart failure patients given discharge instructions, SJHSRI's rate is 15-18 percentage points below the averages, but the significance of this difference is not stated. In at least two measures, both hospitals are among the Top Hospitals nationwide, i.e.:

- Percent of heart attack patients give beta blocker at discharge
- Percent of pneumonia patients given oxygenation assessment

The Department evaluated the Applicant's plans to achieve a balanced health care system. The Applicants stated their expectation that third party payors will be moving to establish pay-for-performance contracts with providers. However, the Applicants did not provide any specific plans regarding this expectation.

The Applicants provided information about the outpatient primary care services offered currently by both hospitals. The Applicants stated their strong commitment to continue these services, which provide needed services to the community. SJHSRI operates a walk-in clinic for primary and urgent care needs in Providence's south side. In addition, the Application states CCHP's intent to work collaboratively with community providers to enhance access to primary care services; however no further details were provided.

Both hospitals have current initiatives in place to reduce average hospital inpatient length of stay (LOS). SJHSRI plans to reduce average LOS from 7.35 days in 2008 to 6.60 days by 2011. And RWH plans to reduce average surgical LOS from 5.2 to 4.2 days.

The Application states that an increase in patients with multiple chronic conditions is expected, but no plan was provided to improve patient management for the purpose of avoiding readmissions.

The hospitals do not provide plans to change discharge processes for patients being discharged from the emergency department or from inpatient stays. The proposed affiliation provides the opportunity to create a full continuum to meet the needs of individuals in need of long term care supports, from hospital to rehabilitation, to nursing home, to assisted living, to

home care, with geriatric specialty physicians available as needed. However, the Applicants have stated that they do not have plans at this time to create an integrated long-term care continuum.

The Applicants state their expectation that transparency of price and quality information will become more and more prevalent. However, no specific plans were provided to increase transparency of price and quality information to patients.

In summary, it appears that the affiliation will provide the opportunity to improve quality, as well as position the two hospitals towards a more balanced delivery system.

With respect to quality, the Department notes several areas that will provide opportunities for improvement, including: (1) integrating clinical policies and procedures, credentialing, and quality improvement processes across the CCHP under the leadership of a new system wide Chief Medical Officer, (2) building on each others' strengths in the area of quality improvement and measurement, and (3) building on common HIT platforms to accelerate the expansion and integration of Health Information Systems.

With respect to moving towards a more balanced delivery system, The Department also notes several opportunities for progress, including (1) moving from institutional to home and community-based care (2) increasing the capacity for primary care and chronic care management, and (3) promoting the alignment of payment incentives and performance-based contracts that reward the hospitals for providing higher value care, through partnerships with health plans and community providers.

<u>Review Criterion 8</u>: Market Share. In the review of hospital consolidations, the HCA statute directs the Department to consider issues of market share in its review, especially as they affect quality, access, and affordability of services.

a. Background Discussion:

For the purposes of the review of this criteria, market share refers to percent of the population that is served by the hospital. In a hospital consolidation, the market share of the affiliating hospitals is combined, increasing the new entity's market share, or increasing "market concentration", in that same geographic area. In both of these calculations, the definition of the geographic area, or "market area" is key: the larger the market area is defined, the less market share a hospital or hospital system will be calculated to have.

Market power is the ability of the merged hospitals, or of the hospitals remaining in the market after the merger, to use their increased market share to raise prices significantly above competitive levels (or otherwise to reduce rivalry).

Hospital consolidations can have two contradictory effects on consumers. Some may help consumers by generating efficiencies that allow hospitals to lower prices which may be passed on to consumers in the form of lower insurance premiums. Others may increase the hospitals market power allowing hospitals to raise prices which will increase the cost of health insurance in turn. More accurately, market power increases the price-cost margin [26]

Since 1982, the U.S. Department of Justice, the Federal Trade Commission, and state attorneys general have used the Herfindahl-Hirschman Index (HHI) to measure market concentration for purposes of antitrust enforcement. According to the DOJ-FTC 1992 Horizontal Merger Guidelines, markets in which post-merger HHI is below 1000 is considered "unconcentrated", between 1000 and 1800 are considered "moderately concentrated" and those above 1800 are considered "highly concentrated." A merger potentially raises "significant competitive concerns" if it produces an increase in the HHI of more than 100 points in a moderately concentrated market or more than 50 points in a highly concentrated market. A merger is presumed "likely to create or enhance market power or facilitate its exercise" if it produces an increase in the HHI of more than 100 points in a highly concentrated market.[27]

Appropriate use of this statistic depends on proper definition of the market (a question of substitutability of services) and on the appropriate geographic scope of the market. Geopolitical boundaries are a convenient, but sometimes meaningless, basis for defining the market for hospital services. Geographic markets are limited to a greater or lesser extent by 1.) the cost of transportation and 2.) legal barriers, such as those imposed by entry regulation that may regulate trade between areas. On the conceptual level, Department of Justice (DoJ) Guidelines define a market for antitrust purposes as the smallest geographic area, and group of

[26] Gaynor M., " Is Vertical Integration Anticompetitive? Definitely Maybe (But That's Not Final)," Journal of Health Economics, 25:175-80, 2006

[27] Zimmerman, H., " Hospital Market Concentration and Market Share" June 2009

producers that, if combined could profitably exercise monopoly power (i.e., set prices at levels above the competitive prices). [28]

During the 1990s, hospitals consolidations were widespread in the U.S. leading to an increased concentration of hospitals as is measured by the HHI. Between 1990 and 2003, the population-weighted HHI increased from 1623 to 2323. This is roughly equivalent to moving from 6 equal-sized organizations to 4 equal-sized organizations.[29] Hospital consolidation was national in scope, but varied significantly by geographical region.

Measuring the effects of hospital consolidation on prices is difficult because hospital prices paid by private insurance companies are generally considered proprietary trade secrets and this accounts for the largest source of revenue that is negotiable. A recent study concealed the identity of insurers and obtained price data from four areas that had hospital consolidations. Before and after consolidation prices were determined for inpatient services adjusted for case mix complexity. Three of the areas had significant price increases after consolidation and the other had constant prices. A 10% increase in the HHI was estimated to result in a 6% increase in prices.[30]

A recent Research Synthesis Report for the Robert Wood Johnson Foundation looked at three approaches to price competition research: the structure-conduct-performance (SCP) approach, the event study approach, and the simulation approach. The SCP approach does not analyze actual mergers, but investigates the relationship between price and HHI and uses that to predict how the merger will affect price. The event studies investigate the effects of actual mergers. The synthesis report found that the best event studies concluded that prices for merged hospitals, relative to controls, rose 10% or more after mergers. One recent event study found that consolidation raised prices by 40%. The strongest simulation studies found that mergers of hospitals close together generate greater price increases than mergers of distant hospitals. The most recent study reviewed found that consolidated hospitals have prices 15% higher than independent counterparts. The study concludes that research on hospital

[28] ibid

[29] ibid

[30] Ibid

consolidation in the 1990s raised prices by at least 5% and likely significantly more.[31] An objective of the Department's regulatory review of market share, in consideration of whether a proposed affiliation will impact access and affordability, is to determine whether the proposed consolidation will have an increase in market share to such a degree to result in a significant increase in market dominance or power, and, the degree to which this market power will result in an increase of the price, or cost, of care in the market. The decision regarding a proposed hospital consolidation should favor consolidations which are likely to achieve efficiencies and savings without a significant increase in market power, price and the cost of care in the market and to not favor consolidations which are likely to result in an increase in market power which is likely to increase the price or cost of care in the hospital's health care market.

b. Factors Considered:

In the Department's review of the Application in consideration of issues of market share, among the factors the Department considered were the Applicants' demonstration that the proposed conversion will not adversely impact the market share of facilities in the area if such impact would be likely to adversely impact access to care; the Applicants' description of current and proposed market share by type of service; the Applicants' description and analysis of the proposal's potential or planned impact on changes to market share of other entities and the potential impact of such; and the Applicants' description of any anticipated changes in physician referral patterns as a result of the proposal. The Department also considered a detailed analysis on market share conducted by an expert consultant specific to this proposal, including an analysis of the potential of the proposed affiliation on market concentration in an already highly concentrated market, and the potential impact of such on access, quality and affordability of health care.

In the Department's review of the Application in consideration of issues of market share, the Department considered whether the proposal demonstrates that the affiliation will improve and promote affordability of care. Among the factors the Department considered in this review was the Applicants' specific plans to improve efficiency of care as a result of the

[31] Ibid

affiliation, including the Applicant's description of efficiencies and improvements in affordability of care delivered to the community as a result of the proposal. The Department also analyzed and considered the potential impact of the proposed affiliation on the financial viability of the proposed affiliated entity, including review and analysis by expert consultants of the proposal's business plan/Pro Forma; and an analysis of the assumptions and potential for increases in hospital financial trend rates, such as hospital cost trends, charges, payor mix, and third party payment rates.

c. Summary Analysis

RWH and SJHSRI are medium sized hospitals located less than five miles apart. There is significant overlap of service areas of the two hospitals given their closeness in proximity. The two hospitals combined will represent an inpatient market share of approximately 24% in Providence County and about 15% of the entire state. The affiliation of these two community hospitals is not expected to impact the market share of other hospitals in the state.

The Application indicates that the affiliation should not impact the market share of other Rhode Island hospitals. Although Butler Hospital provides similar adult psychiatric/behavioral services, RWH and SJHSRI do not plan to expand their licensed or operating bed capacity as a result of the proposed affiliation; therefore, market share for these services should have no negative impact. The Applicants do not expect to gain additional marketshare from other independent community hospitals that may somewhat overlap their service areas (e.g., Landmark and Memorial hospitals).

The market share analysis provided by the consultant engaged by the Department found that the two hospitals affiliating to form CCHP have a combined market penetration exceeding 5% for all the cities and towns of Providence County, Kent County and Bristol County. For the cities and towns of Washington County and Newport County, their combined market penetration is less than 5% with two exceptions (North Kingstown 5.3% and Tiverton 5.7%). It is notable that the combined market penetration for CCHP is greater than 50% in Smithfield; greater than 40% in Johnston and North Providence; greater than 30% in Glocester; greater than 20% in Burrillville, Cranston and Providence; and greater than 10% in Bristol, East Providence, Foster, Lincoln, North Smithfield, Situate and Warren. A comparison of market distribution of discharges for RWH and SJHSRI showed that the percentage of inpatients that each hospital draws from corresponding cities and towns differ by 2% or less with the

exceptions that SJHSRI gets relatively more of its patients from North Providence and Johnston while RWH gets relatively more of its patients from Providence. Based on their combined market penetration, discharges from eight (8) cities and towns (Cranston, East Providence, Johnston, North Providence, North Smithfield, Providence, Smithfield and Warwick) account for 75% of their total discharges.

The consultant analyzed Rhode Island market share and the HHI for private non-governmental hospitals in calendar years 2006 and 2007. If all hospitals in Rhode Island were independent in 2007, the HHI for all short term general hospital discharges (excluding newborns) would have been equal to 1268. This implies that the market for these services would be considered moderately concentrated if all hospitals were independent. Given the existing system hospitals, the HHI is increased to 2600; thus the market may be characterized as highly concentrated. DOJ-FTC guidelines indicate that a merger that produces an increase in the HHI of more than 50 points in a highly concentrated market raises "significant competitive concerns." In the case of the proposed affiliation of RWMC and SJHS, the HHI is increased by 103 points. Such an affiliation is presumed "likely to create or enhance market power or facilitate its exercise." Comparing the hospital concentration in Rhode Island (as is measured by the HHI) to the other geographical regions shows that Rhode Island hospitals are more highly concentrated than the average for New England as well as other regions in the U.S. except the South.

The consultant also looked at services for which the market share may be affected by the affiliation of RWH and SJHSRI for five services: medicine, cardiology, psychiatry, general surgery, and orthopedics. The HHI indicates highly concentrated (greater than 1800) HHI for all of the major services. General surgery is the most concentrated. However, psychiatry service would be affected the most—increasing by more than 300 points whether output is measured by discharges or inpatient days. For this service in particular, the analysis looked at only non-governmental hospitals.

The tertiary/specialty care services market share of CCHP for fiscal year 2007 is as follows: Cardiac Catheterization -0%, Radiation Therapy – 5.1% and Positron Emission Tomography – 19% (exhibit 63). It is expected that, since SJHSRI does not have a Cardiac Catheterization Lab or Radiation Therapy Facility, referrals from SJHSRI would go to RWH for those services, thereby increasing RWH market share for such services. Given the

extremely low market share for these tertiary services, the effect of the affiliation is expected to be minimal on the current statewide market share for these services. Neither SJHSRI nor RWH provide open-heart surgery, neonatal services and organ transplant services therefore no change in market share for these services are expected.

Notwithstanding the consultants' conclusions based on the HHI index that the proposals may increase the concentration of Rhode Island's already concentrated marketplace, the proposal for an affiliation appears to preserve the existing market share for the two licensed hospitals. It also appears that such affiliation would have little change in the existing market share of the affiliating hospitals or other hospitals in the state.

In summary, although the market leverage resulting from the affiliation is expected to increase reimbursement slightly, the affiliation serves as an appropriate, lower cost viable alternative to other dominant system hospitals. The Department also found that any such increase in price is likely to be more than offset by the continued availability of these community hospitals as an appropriate, cost effective alternative to urban tertiary care hospitals.

IV. Conclusions

In the Rhode Island Hospital Conversions Act, the first purpose in defining the purpose of the chapter is to "assure the viability of a safe, accessible and affordable healthcare system that is available to all citizens of the state (Section 23-17.14-3 (1)). In the review of the proposed partnership of SJHSRI and RWMC into a new affiliation to be called CharterCARE Health Partners, the Director of Health considered this purpose, as well as the eight criteria specified in the statute and associated regulations for the review of proposed conversions of not-for-profit hospitals.

In the course of this review, the Department found that the financial viability of both hospitals is tenuous, SJHSRI in particular. The Department also found that the proposed affiliation is likely to strengthen the financial viability of both hospitals, and that the proposed affiliation appears to be critical to the continued survival of these hospitals., which overrode other concerns raised in the review.

The Department also found that both SJHSRI and RWMC provide critical services that are essential to the health of the citizens of Rhode Island, and to the communities primarily served by the hospitals in particular. The continued survival of these hospitals through this

proposed affiliation is necessary for continued access and availability of the critical services these hospitals provide to the primary communities they serve and to all citizens of the state. Furthermore, the improved financial strength of these hospitals is necessary for the hospitals to have sufficient resources to continue to provide safe, high quality services.

The Department also found in the course of its review that SJHSRI and RWMC together provide the only community hospital system in their primary service areas. This community hospital system serves as an accessible and more affordable alternative to more costly tertiary care hospital systems for services appropriately provided in a community hospital. The continued presence of these hospitals through this affiliation will support the viability of an affordable healthcare system available to Rhode Island's citizens.

The Department's review also found that there could be a increase in the price of services provided by the hospitals as a result of the increased market leverage which may result from the affiliation. The Department also found that that any such increase in costs is likely to be more than offset by the continued availability of these community hospitals as an appropriate, more affordable alternative to urban tertiary care hospitals. The financial viability and improved financial strength of the affiliated combined organization is critical to maintaining this community based hospital system as a first choice option for services appropriately provided in a community hospital setting in this healthcare market. The continued existence of these hospitals through the proposed affiliation is, in itself, a critical safeguard to assure the affected community continued access to affordable care.

Both RWH and SJHSRI have had past inadequacies, as noted in this decision. Each has recognized the need for and made significant improvements in their areas of deficiency. Each can benefit from the other's strengths in these areas, as well as the affiliation will provide the opportunity for the hospitals to build on core competencies of each institution, and to consolidate services where appropriate, improving the strength and efficiency of each hospital in the areas of patient safety, quality improvement, administrative services and clinical excellence.

Rhode Island's health care delivery system will strive to continue to progress to meet the challenges and expectations of a high performance health system. Essential to this will be payment reforms which will create incentives to transform hospitals as they are today to institutions with fewer beds and more outpatient services, and with critically important ties to

community providers in the care of each patient. This affiliation will position these two hospitals to take the aggressive actions needed to define their place and new role as a combined, modern, high quality and efficient delivery system.

V. Decision and Conditions

The Hospital Conversion proposed by the Transacting Parties is approved by the Department, subject to the conditions that follow. Within the following conditions, Roger Williams Medical Center (RWMC) refers to the newly approved hospital, which has been referred to as Roger Williams Hospital throughout **Section III.**

1. <u>Pre affiliation actions required:</u>

1.1. Prior to the affiliation, CCHP shall develop and establish, and RWMC shall revise, corporate compliance and ethics policies to be similar to, and consistent with, SJHSRI Corporate Compliance and Ethics Policies. Such policies shall include, but not be limited to, policies for compliance with the federal Stark law and similar state and federal laws regarding illegal referrals or self dealing, and shall include procedures for implementing and assuring compliance. Such policies and procedures shall be provided to the Department prior to implementation of the affiliation.

1.2. Prior to the affiliation, CCHP will engage the services of an outside financial consultant who is acceptable to the Department. CCHP's financial consultant will, in partnership with the affiliated entities, provide reports to the CCHP Board of Directors and the Department, as specified in condition 3.1 below.

2. <u>Post affiliation actions required:</u>

2.1. CCHP will work with the state certified Regional Health Information Organization (RHIO) to offer CurrentCare (HIE) enrollment to RWMC and

SJSHRI patients beginning with the outpatient Departments, emergency Departments, and the Elmhurst Extended Care Facilities, Inc.:

2. 1. 1. SJHSRI will continue to expand their enrollment activities to other Departments;

2. 1. 2. RWMC will begin offering enrollment in at least one Department by six months following the implementation of the affiliation.

2.2. By ninety (90) days following the implementation of the affiliation, a detailed plan to standardize all clinical policies and procedures between SJHSRI and RWMC within three years following the implementation of the affiliation. A copy of this plan and quarterly progress reports shall be provided to the Department.

2.3. By six (6) months following the implementation of the affiliation, CCHP shall conduct and submit to the Department a study analyzing the option of qualifying the South Providence Health Center as a FQHC "look-alike," to potentially enhance reimbursement and sustainability.

2.4. By three (3) months following the implementation of the affiliation, both hospitals shall enter into a contract with a state certified Patient Safety Organization (PSO) to implement a "near-miss" reporting program for medical errors. CCHP will provide attestation to the Department of such contracting arrangement when completed.

2.5. By six (6) months following the implementation of the affiliation, both hospitals shall have procedures in place to inform patients being discharged from an inpatient stay or from the emergency Department of the availability of follow up care. Such follow up care will be available at both hospitals on an outpatient basis and charity care will be available for these services. Copies of such procedures shall be provided to the Department.

2.6. By one year following the implementation of the affiliation, all outpatient clinics operated by the hospitals or by other entities providing primary care that are controlled by CharterCARE (specifically, Roger Williams Medical Associates and Elmhurst Health Associates, Inc) shall be NCQA Medical Home Certified at Level 1, and progressing to Levels 2 and 3 over the following 3 years.

2.7. By one year following the implementation of the affiliation, RWMC and SJHSRI shall adopt joint policies and procedures for physician credentialing and for authorizing admitting privileges to the hospitals. Such policies and procedures shall be submitted to the Department.

2.8. By two years following the implementation of the affiliation, all physicians on staff at either hospital shall have joint credentials at both hospitals. Attestation of such shall be submitted to the Department.

2.9. By two years following the implementation of the affiliation, both hospitals shall publish, on a website that uses a searchable capability, a schedule of hospital rates that are used to charge uninsured and self-pay patients for services.

2.10. By two years following the implementation of the affiliation, SJHSRI and RWMC and any other entities providing primary care that are controlled by CharterCARE (specifically, Roger Williams Medical Associates and Elmhurst Health Associates, Inc) shall implement e-prescribing in their outpatient and emergency departments.

2.11. By three years following the implementation of the affiliation, all patients shall have electronic access to their medical information, including lab and

imaging reports, allergies, prescriptions, and dictated notes (admission and discharge summaries, operating notes, and consult notes).

3. <u>Monitoring and reporting required:</u>

3.1. CCHP's state-approved financial consultant (see condition 1.3) shall, in partnership with the affiliated entities, provide reports to the CCHP Board of Directors and the Department. Such reports shall, at a minimum, include the following:

3. 1. 1. Beginning thirty (30) days after implementation of the affiliation, and on a quarterly basis thereafter, financial statements (income statement, balance sheet, statement of changes in cash position, patient statistics both inpatient and outpatient) shall be provided, as would be presented to the Board of Directors in regular quarterlyly financial presentations. Detailed back-up schedules as prepared for Management's internal review should also be included.

3. 1. 2. Beginning thirty (30) days after implementation of the affiliation, and on a quarterly basis thereafter, specific plans of correction and immediate action plans shall be provided that address any budgetary shortfalls and/or if financial performance is unfavorable to the budget plan as approved by the Board;

3. 1. 3. Beginning thirty (30) days after implementation of the affiliation, and on a quarterly basis thereafter, sensitivity analyses and specific contingency plans, in accordance with these analyses, shall be prepared and provided to ensure the savings are achieved and thereby financial viability is maintained and improved.

3. 1. 4. Beginning thirty (30) days after implementation of the affiliation and on a quarterly basis thereafter, updated short and long term forecast shall be provided that use agreed upon accounting procedures, as established for non-profit hospital organizations. These forecasts shall contain specific financial objectives with timelines and analysis of profit and loss by service line (cost center) for those areas being consolidated. These forecasts should incorporate staffing and other operational costs, as well as reimbursement and other revenue detail by cost center.

3.2. By ninety (90) days following the implementation of the affiliation, a fully detailed plan, including timelines, for the $15M in savings, as projected in the Application. Reports shall be provided to the Department on a quarterly basis identifying achieved savings.

3.3. CCHP shall provide to the Department the following reports informing the Department of updates to the affiliation's implementation plans and progress:

3. 3. 1. by thirty (30) days after implementation of the affiliation, an updated Comprehensive Strategic Plan that includes updated assumptions used in the strategic plan;

3. 3. 2. by sixty (60) days after implementation of the affiliation, specific timelines for implementing operational, clinical and financial objectives;

3. 3. 3. by ninety (90) days after implementation of the affiliation, a detailed plan for integration and consolidation of services and operations over the first three years, including plans for:

a. implementation of Centers of Excellence;

b. clinical integration/consolidation in areas of redundancy or with excess capacity.

3.4. By one year following the implementation of the affiliation and thereafter on an annual basis, CCHP shall provide an Annual Report to the Department, describing progress related to rebalancing efforts described on pages 37 and 38 of this document.

3.5. By one year following the implementation of the affiliation and thereafter on an annual basis, SJHSRI and RWMC shall report quality metrics, specified by the Department, to the Department.

4. Ongoing Conditions

4.1. SJHSRI, RWMC and all affiliates shall provide services to all patients without discrimination including payment source or ability to pay.

4.2. CCHP, SJHSRI and RWMC shall implement the Application as approved.

4.3. Data, including but not limited to finances, utilization and demographic patient information shall be furnished to the Department upon request,

4.4. Services at the facilities shall be provided in conformance with the requirements of the Rules and Regulations for Licensing of Hospitals (R23-17-HOSP) and Rules and Regulations Pertaining to Hospital Conversions (R23-17.14-HCA);

The conditions imposed with respect to the approval of this Application are deemed to be directly related to the proposed conversion. Said conditions and each of them severally are deemed to be related to Health Department criteria as set forth in R.I.G.L. 23-17.14-11 and 23-

17.14-28. The conditions aforesaid shall be enforceable and have the same force and effect as if imposed as a licensure condition in connection with or related to R.I.G.L. 23-17-6, 23-17-7, 23-17-8 and 23-17-8.1.

The Director of the Department of Health (Director) shall have the authority to enforce compliance with these conditions and each of them in accordance with any provision of Chapter 23-17, which is applicable and pursuant to the authority granted pursuant to R.I.G.L. Chapter 23-17.14. The Director may take appropriate action to enforce compliance with these conditions and each of them as the circumstance may require, provided that such action is directly related to the proposed conversion.

If any of the aforesaid conditions or the Application thereof to any person or circumstances is held invalid, that invalidity shall not affect any other condition or Application of any other condition which can be given affect without the invalid provision, condition or Application and to this end the conditions and each of them severally are declared to be severable.

RHODE ISLAND DEPARTMENT OF HEALTH

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Director of Health
Rhode Island Department of Health