STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH CARE ACCESS

EASTERN CONNECTICUT HEALTH NETWORK, INC. (ECHN)
AND PROSPECT MEDICAL HOLDINGS, INC. (PMH)

PURCHASE ECHN ASSETS BY PMH

DOCKET NO. 15-32016-486 AND 15-486-01

MARCH 30, 2016

2:00 P.M.

ELKS LODGE
9 N. PARK STREET
VERNON, CONNECTICUT

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1 . . .Verbatim proceedings of a hearing
2 before the State of Connecticut, Department of Public
3 Health, Office of Health Care Access, in the matter of
4 Eastern Connecticut Health Network, Inc. (ECHN) and
5 Prospect Medical Holdings, Inc. (PMH), Purchase ECHN
6 Assets by PMH, held at the Elks Lodge, 9 N. Park Street,
7 Vernon, Connecticut, on March 30, 2016 at 2:00 p.m. . . .
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11 HEARING OFFICER KEVIN HANSTED: Good
12 afternoon, everyone. This public hearing before the
13 Office of the Attorney General and Office of Health Care
14 Access, identified by Docket Nos. 15-32016-486 and 15-
15 486-01-CON, is being held on March 30, 2016 to consider
16 Eastern Connecticut Health Network and Prospect Medical
17 Holdings application for the purchase of the assets of
18 Eastern Connecticut Health Network by Prospect Medical
19 Holdings.
20 This hearing is part of the procedure
21 under what is commonly referred to as the Conversion
22 Statute, which requires the Commissioner of the
23 Department of Public Health and the Attorney General to
24 evaluate any proposal, which would convert a non-profit

1 Connecticut hospital to a for-profit entity.
2 For OHCA's purposes, this public hearing
3 is being held pursuant to Connecticut General Statutes,
4 Section 19a-639a and 19a-486e, and will be conducted as a
5 contested case, in accordance with the provisions of
6 Chapter 54 of the Connecticut General Statutes.
7 My name is Kevin Hansted, and I have been
8 designated as the Hearing Officer on behalf of the Office
9 of Health Care Access for this hearing.
10 The staff members assigned to assist me in
11 this case are Kimberly Martone, Steven Lazarus and Carmen
12 Cotto. The hearing is being recorded by Post Reporting
13 Services.
14 OHCA will make its determination on this
15 application pursuant to Sections 19a-486d and 19a-639 of
16 the Connecticut General Statutes.
17 Eastern Connecticut Health Network and
18 Prospect Medical Holdings have been designated as parties
19 in this proceeding.
20 At this time, I'll turn it over to the
21 Office of the Attorney General for a few opening remarks.
22 MR. PERRY ZINN ROWTHORN: Thank you,
23 Kevin.
24 HEARING OFFICER HANSTED: You're welcome.

1 MR. ZINN ROWTHORN: Good afternoon,
2 everybody. My name is Perry Zinn Rowthorn. I'm the
3 Deputy Attorney General. I've been designated by
4 Attorney General George Jepsen as the Hearing Officer in
5 this matter for the Office of the Attorney General.
6 I want to thank the Applicants for being
7 here today, the witnesses, and public officials that we
8 will hear from, and a special thank you to the members of
9 the public, who are here.
10 We recognize that this transaction is
11 important to your community, to all the communities that
12 ECHN serves. That's why we're here. We're happy to see
13 so many of you here.
14 We recognize that we have some tight
15 quarters, but we are happy to have you with us today.
16 We're conducting this hearing jointly with
17 OHCA, but the Attorney General's criteria in evaluating
18 this transaction and his focus are slightly different.
19 I'll say a few words about that.
20 The Attorney General's role is defined and
21 limited by statute, the Conversion Act that Attorney
22 Hansted referred to, Section 19a-486 of the Connecticut
23 General Statutes.
24 That Act reflects the Attorney General's

1 traditional role in protecting the public interest and
2 charitable assets and insuring that monies and properties
3 committed to a charitable purpose are safeguarded and
4 used appropriately.
5 Non-profit hospitals and hospital systems,
6 like ECHN, hold their assets for essentially a charitable
7 purpose, providing health care, not for generating
8 profits for shareholders or owners, and, in that way,
9 they are different from for-profit hospitals.
10 The administrators of a non-profit
11 hospital are the stewards of its charitable assets with a
12 responsibility to take good care of those assets.
13 The law does not prohibit non-profit
14 hospitals from converting to for-profit status. When one
15 seeks to do so, as here, the Attorney General's job is to
16 ensure that the non-profit hospital is meeting its
17 obligations of good care for charitable assets.
18 We make sure three things, that the
19 process leading to the sale was responsible. Were the
20 hospital administrators careful in deciding to sell and
21 choosing a buyer and negotiating a transaction?
22 Second, that the terms of the sale are
23 fair. Will the hospital get fair market value for its
24 assets? And, third, that the proceeds of the transaction

1 will continue to be used for charitable health-related
2 purposes, those proceeds remain charitable assets after
3 the transaction, and we need to ensure that the assets of
4 the sale are protected from being used for the for-profit
5 purposes of the new hospital system.
6 Because the Attorney General must remain
7 focused throughout on the charitable assets, his review
8 and our decision for the most part does not focus on the
9 running of the for-profit hospital after the transaction.
10 Issues relating to the operation of the
11 new hospital entity, as it relates to access to health
12 care services, are within OHCA's purview.
13 Today's hearing is a very important part,
14 but just one part of a review that has been ongoing for
15 months. We'll take testimony and evidence, and we'll
16 hear public input. We'll ask some questions.
17 Don't assume, if we don't ask a question
18 on a topic, that the topic is unimportant to us. Before
19 today, we have received and reviewed thousands of pages
20 of documents, we've asked questions and follow-up
21 questions, and all of the materials that have been
22 generated as part of our review are available on the
23 Attorney General's website. That is www.ct.gov/ag.
24 Your input is particularly important to

1 our review. All the information we receive today and in
2 the hearing that we held yesterday in Manchester will
3 become part of the official record of our review.
4 We'll also take comments in writing, and
5 those comments, if we receive any, will be included in
6 the official record.
7 We have sheets available at the door, I
8 believe, that discuss the process to sign up to speak, as
9 well as the process for submitting written comments.
10 Please take copies of those sheets for yourself or for
11 anyone you know, who might be interested in submitting a
12 written comment.
13 We are on track to complete our review
14 under the current schedule as early as June 10th of this
15 year. A word about what our decision might entail.
16 Under our statute, the Attorney General
17 must approve the transaction as is, deny it, or approve
18 it with conditions that relate to the purposes of the
19 Conversion Act. For the Attorney General, that means
20 conditions that relate to the Attorney General's focus on
21 charitable assets and their future protection.
22 This is a joint hearing. Kevin and I are
23 going to work together to move this along to cover as
24 much business as we can. You can assume that if either

1 of us makes a ruling on an objection or a point of
2 evidence, that that ruling applies to both of our
3 offices, unless we otherwise state it, and, if we ask a
4 question, that that question and its answer are part of
5 each of our office's review.
6 The agenda for today is going to be
7 slightly different than it was yesterday. We received
8 some feedback from the public, that they wanted to be
9 heard earlier in our proceeding, so we'll proceed as
10 follows.
11 We'll take opening statements from the
12 Applicants. After that, we'll have an opportunity for
13 public comment. It's traditional to hear from public
14 officials first, then we will have questions from OHCA,
15 and, if the Attorney General's Office has questions after
16 OHCA finishes its questions, we'll ask questions, and
17 then we will reopen it for public comment after that.
18 I'm going to turn it back over to Kevin
19 for some additional important business notes. Before I
20 do that, I want to recognize and thank the staff from the
21 Attorney General's Office, who is here with me today.
22 To my immediate left is Assistant Attorney
23 General Henry Salton, who is providing legal advice to
24 the Attorney General and to OHCA in this proceeding, and

1 to his left is Assistant Attorney General Gary Hawes, who
2 is coordinating this review for the Attorney General's
3 Office, and with us somewhere here is paralegal
4 specialist Cheryl Turner. Thank you for your attention.
5 HEARING OFFICER HANSTED: Thank you,
6 Perry. At this time, I will ask staff to read into the
7 record those documents already appearing in the Table of
8 the Record in this matter. All documents have been
9 identified in the Table of the Record for reference
10 purposes. Mr. Lazarus?
11 MR. STEVEN LAZARUS: Good afternoon.
12 Steven Lazarus. As of yesterday, we had entered into the
13 record Exhibits A through BB. We also had some
14 additional exhibits added since yesterday, so the Table
15 of Record has been extended to include Exhibit GG.
16 There were some notes, edits that were
17 brought up by Attorney Matthews. Those are not being
18 included at this point, however, they will be done prior
19 to the close of the hearing, and we will provide you with
20 an updated, revised Table of Record prior to the closing.
21 MS. REBECCA MATTHEWS: Thank you. This is
22 Rebecca Matthews, counsel for ECHN.
23 We also made one request about the
24 administrative notice taken regarding the Greater

1 Waterbury Health Network application. I know that's
2 already on the record. I just wanted to note it again,
3 if that's okay. Thank you.
4 MR. ZINN ROWTHORN: Can speakers be
5 careful to speak into their microphones and make sure
6 that our audience, which extends into the second room,
7 can hear us? Thank you.
8 HEARING OFFICER HANSTED: Thank you. Any
9 objections to the exhibits, Attorney Matthews?
10 MS. MATTHEWS: No.
11 HEARING OFFICER HANSTED: No? Okay.
12 MS. MATTHEWS: No objection.
13 HEARING OFFICER HANSTED: Thank you. And
14 now I'd like all those individuals, who are going to
15 testify here today, to please stand, raise your right
16 hand, and be sworn in by the court reporter. You have to
17 turn around, folks. She's behind you.
18 (Whereupon, the parties were duly sworn
19 in.)
20 HEARING OFFICER HANSTED: Okay, thank you,
21 everyone, for doing that. Now, as we did last night,
22 would you just please each identify yourselves for the
23 record, whoever wants to start?
24 MS. MATTHEWS: Rebecca Matthews, counsel

1 for ECHN.
2 MR. PETER KARL: Peter Karl, CEO of ECHN.
3 DR. DENNIS O'NEILL: Dennis O'Neill, Chair
4 of ECHN.
5 MS. JOY DORIN: Joy Dorin, Board of
6 Trustees, ECHN.
7 DR. MITCHELL LEW: Mitchell Lew,
8 President, Prospect Medical Holdings.
9 MR. VON CROCKETT: Von Crockett, Senior
10 Vice President for Prospect Medical Holdings.
11 MR. JONATHAN SPEES: Jonathan Spees,
12 Senior Vice President for Prospect Medical Holdings.
13 MR. STEVEN ALEMAN: Steve Aleman, Chief
14 Financial Officer, Prospect Medical Holdings.
15 MR. TOM REARDON: Tom Reardon, President
16 of Prospect East.
17 MS. MICHELE VOLPE: Michele Volpe, Legal
18 Counsel for Prospect Medical Holdings.
19 HEARING OFFICER HANSTED: And we had a
20 couple of folks in the audience, who were sworn in.
21 Would you just please identify yourselves for the record?
22 I believe the public comment microphone is on behind you.
23 MR. DENNIS McCONVILLE: Dennis McConville,
24 Senior Vice President for ECHN.

1 MS. LINDA QUIRICI: Linda Quirici, Vice
2 President for Patient Safety and Quality.
3 MS. NINA KRUSE: Nina Kruse, Vice
4 President of Communications.
5 MR. MICHAEL VEILLETTE: Michael Veillette,
6 Chief Financial Officer of ECHN.
7 MS. JOYCE TICHY: Joyce Tichy, General
8 Counsel, ECHN.
9 HEARING OFFICER HANSTED: Thank you,
10 everyone. Attorney Matthews, you may proceed with your
11 opening.
12 MS. MATTHEWS: Thank you. I’m going to
13 actually just turn it over directly to Dr. Dennis
14 O’Neill.
15 DR. O'NEILL: Thank you, Rebecca. Good
16 afternoon, Mr. Hansted, Mr. Zinn Rowthorn, members of the
17 Office of the Attorney General and members of the Office
18 of Health Care Access.
19 My name is Dennis G. O’Neill. I’m the
20 Chair of the Board of Trustees of Eastern Connecticut
21 Health Network.
22 I’m also a physician in private practice
23 working in the Manchester and Vernon communities for the
24 past 33 years.

1 Thank you for providing us with the
2 opportunity to submit testimony in support of ECHN's
3 proposal to transfer its assets to Prospect Medical
4 Holdings.
5 First, I would like to adopt my pre-filed
6 testimony, then I'd like to explain that, after my
7 introductory comments, Peter J. Karl, ECHN's President
8 and CEO, is going to make a brief presentation on our
9 financial situation.
10 Joy Dorin to my left, one of our Trustees
11 and Chair of the Board's Transaction Committee, will then
12 present information on the transaction, itself, and
13 ECHN's quality program, after which representatives of
14 Prospect Medical Holdings will offer information on their
15 organization.
16 Manchester Memorial Hospital and Rockville
17 General Hospital, the flagship hospitals of ECHN, were
18 built about 95 years ago by members of their respective
19 communities in response to the influenza pandemic of 1918
20 and, also, as memorials to those community members, who
21 died in World War I.
22 For many decades, these hospitals
23 functioned as separate community hospitals, and then,
24 about 20 years ago, they joined together to form ECHN.

1 They were both in good financial shape at
2 the time, but pursued a merger, in order to provide more
3 efficient and better integrated hospital care for their
4 citizens.
5 Over the last two decades, ECHN has grown,
6 as the communities have grown, beyond the two hospitals
7 into a health care network with 13 wholly-owned
8 subsidiaries, 12 joint venture companies, and dozens of
9 facilities serving the needs of our communities.
10 ECHN now employs 3,000 people in eastern
11 Connecticut, and the hospitals in Manchester and Vernon
12 are the largest employers in their communities.
13 In just this last year, 2015,
14 approximately 115,000 people were treated in our
15 hospitals, 61,000 were examined in our emergency
16 departments, 5,000 folks were cared for by our visiting
17 nurses, and we delivered about 1,400 babies.
18 Needless to say, the citizens of eastern
19 Connecticut need and use our facilities, but the American
20 people, in general, and the members of our communities,
21 more specifically, have told us that they want and need
22 care that is even more integrated than the care they
23 receive today, care that is higher in quality and lower
24 in cost.

1 In an attempt to respond to these needs
2 and in anticipation of worsening financial conditions,
3 the trustees of ECHN formed, about four and a half years
4 ago, a work group to evaluate whether or not ECHN should
5 pursue a partnership with another organization.
6 At that time, we thought we had about five
7 years before our circumstances became dire, due to
8 changes in the health care landscape that we thought were
9 going to have a negative effect on our organization.
10 The first year was spent deciding that we
11 should partner, as opposed to going it alone. In the
12 second year, we selected as our best option an asset
13 purchase agreement offered by Vanguard Health System and
14 Yale-New Haven Health System.
15 In the middle of that second year,
16 Vanguard was acquired by Tenet, and we spent the
17 remainder of the year getting to know them.
18 During year number three, we negotiated a
19 deal with Tenet that would have preserved our hospitals,
20 the jobs of our employees, and the pensions of our
21 retirees, and provided capital for future growth, but, at
22 the end of 2014, Tenet abruptly left the state, citing
23 what it perceived as overly restrictive conditions placed
24 on its acquisitions by state regulatory agencies.

1 That was a great disappointment to us,
2 because it essentially scuttled three years of work, and
3 because, more importantly, we were three years closer to
4 2016 with still no deal in hand.
5 But then, in 2015, our fourth year, we
6 were fortunate enough to find Prospect Medical Holdings
7 and spent most of that year negotiating a deal with them
8 and resubmitting our application for regulatory review.
9 Prospect is a health care company based in
10 California that, through the business acumen of its
11 founders, the perspicacity of its senior management team,
12 and the perseverance of its staff, has in the last two
13 decades become an industry leader in what is referred to
14 as population health management.
15 That is managing all aspects of a health
16 system, inpatient care, outpatient care, physician office
17 care and home health care for a large group of people, in
18 this case eastern Connecticut, with higher quality and
19 lower cost.
20 Like all health care companies, though,
21 Prospect is not a perfect hospital company. Last year,
22 during inspections at two of its California hospitals,
23 the Centers for Medicare and Medicaid Services, CMS, made
24 determinations that required correction. You'll hear

1 more about this from Joy Dorin and the folks from
2 Prospect.
3 It's important to note, though, that our
4 trustees and corporators chose overwhelmingly, the
5 trustees voted unanimously, and the Corporators voted
6 with 98 percent in favor to transfer our assets to
7 Prospect for at least three important reasons.
8 First, Prospect is not Tenet. They're
9 smaller in size, less threatening as a newcomer within
10 the state of Connecticut, and because they're not
11 affiliated with Yale or Hartford HealthCare, they would
12 actually increase, rather than reduce, competition within
13 our state.
14 Secondly, the deal we negotiated with
15 Prospect is essentially the same deal we negotiated with
16 Tenet, with preservation of our hospitals, employees and
17 retirees and capital for our future.
18 And, thirdly, Prospect is a recognized
19 expert in what they refer to as and what you'll hear more
20 about in a couple of minutes coordinated regional care,
21 taking to a new level what began with the creation of our
22 two hospitals many years ago and continued with the
23 formation of ECHN.
24 Now, for more detailed information on

1 ECHN's financial condition, I'd like to pass the
2 microphone to Peter J. Karl, ECHN's President and CEO.
3 MR. KARL: Thank you, Dr. O'Neill. If you
4 can think back this far, 2010 was a milestone year for
5 the country. The Affordable Care Act legislation was
6 passed by the federal government, and what that meant was
7 there was going to be a change in the way health care is
8 provided. Hospitals, health systems, positions will be
9 rewarded for value of care.
10 A lot of the reimbursement risk will fall
11 on the hospital providers, themselves, and the
12 physicians, themselves.
13 This fee for service methodology that we
14 have lived under for many, many years, as far back as
15 many of us can even think, is going away.
16 That's when we made the decision to think
17 about partnering. We recognize remaining independent was
18 essentially the kiss of death.
19 I would ask that the regulators in front
20 of us please take my next three slides and put them side-
21 by-side, as we did yesterday. It helps to follow along
22 for me to tell the story. That would be slide seven,
23 slide eight and slide nine.
24 I began at ECHN as CEO at the end of 2004.

1 As you can see by the top chart, ECHN suffered
2 significant losses prior to me coming here. A lot of
3 this had to do with the merger of the two institutions
4 and some of the difficulties associated with the past
5 merger.
6 As you can see, though, in the earlier
7 years, fiscal year '08, '09 and '10, you could see that
8 the organization was performing relatively well, not
9 great. Two to three percent margin, two percent margin.
10 But as you can see below, the situation
11 that we've all had to deal with, one is pension funding
12 reform, and then, of course, the market crash. All of
13 that happened between 2008 and 2009, so the liability,
14 our pension liability, jumped significantly, and what
15 that really meant was that we had to begin funding our
16 pension significantly.
17 In the past, because of the performance of
18 the stock market, the pension funded itself, so that was
19 not a concern.
20 We, then, of course, had our debt
21 payments, as you can see on the bottom graph in dark
22 blue. Our debt payments were taken into account, and we
23 pay approximately $12 million a year to pay down our
24 debt.

1 As you can see, we really did not increase
2 our debt very much, except for one year in 2009, where we
3 took out additional debt to replace our Critical Care
4 Unit at Manchester Memorial Hospital.
5 Back in the earlier years, in 2004, you
6 could see there was a jump. That money was used to
7 upgrade the Rockville General Hospital facility.
8 What we found during these years is that
9 reimbursement was declining, pension liability was
10 increasing, and then, as you can see in 2015, the
11 government updated the mortality tables for a very good
12 reason.
13 Everyone was living longer, therefore, the
14 mortality tables had another effect on our pension, which
15 our liabilities then grew significantly.
16 If you look at the next page, you can see
17 that, in 2014, ’15 and ’16, the hospital tax was put into
18 play by the most recent state government. There was also
19 sequestration that was put in place by the federal
20 government, because they were unable to balance their
21 budget, and then, of course, there were other reductions
22 in reimbursement.
23 So, if you tie back the second page to the
24 first page, you can see why our income had dropped

1 significantly. You may even wonder how we were able to
2 survive with these significant reductions in
3 reimbursement, and we were still able to either break
4 even or just barely have a loss, but what that has
5 created is an issue that is explained on the next page,
6 and that is our inability to reinvest in our facility.
7 We can no longer -- we no longer have free
8 cash flow to reimburse, to reinvest in our facilities,
9 and our facilities have aged significantly.
10 As you can see at the top, the age of
11 plant is 21 years. What that means is it's about twice
12 as old as the average hospital plant is nationally.
13 The age of the plant that you'd like to
14 have is around between eight and 10 years old, and what
15 that means is replacing equipment, replacing the
16 infrastructure of the organization, keeping it up-to-
17 date. Ours is very, very old.
18 How are we able to still barely get by in
19 '13, '14, '15, even though we weren't making any type of
20 income, especially with these cuts?
21 Well we had to reduce our labor costs,
22 and, therefore, 60 percent of our operating budget is
23 labor. We had to reduce employees. We had to reduce
24 jobs to the tune of 200 positions were eliminated.

1 We also, as I mention on this slide, we
2 did not reinvest in the facility, so we are limping
3 along. Unfortunately, we are at the end of our rope, and
4 the rope is beginning to fray.
5 So, more or less, to wrap up our
6 condition, our financial condition, there is continued
7 payment erosion, as I've mentioned, declining levels of
8 payment from the state government, payment reforms with
9 more financial risk, increased pension obligations and
10 rising costs. This is just simply unsustainable.
11 Now, again, we saw this coming four, four
12 and a half years ago. Not to this great extent, thank
13 you. I just lost my mind for a second. But we did see
14 it coming.
15 So we went through an RFP process. Dr.
16 O'Neill mentioned that we selected Prospect Medical. The
17 RFP process included several other suitors.
18 We felt, clearly, that Prospect was the
19 best. Prospect stepped into the shoes of Tenet Health
20 Care. We'll be paying $105 million to satisfy our debts
21 and obligations and have agreed to invest $75 million of
22 capital.
23 They will maintain Manchester Memorial
24 Hospital and Rockville General Hospital, Woodlake at

1 Tolland and VNHSC, our Visiting Nurse of Connecticut.
2 They'll continue with the brand, and they will still
3 install a Community Advisory Board.
4 And just to expand on that a little bit to
5 answer one of the questions that Mr. Salton had
6 yesterday, the local Board will have primary
7 responsibility for the quality program and are delegated
8 to make changes, as necessary.
9 Corporate provides checks and balances.
10 That will be covered more in the PMH presentation, but we
11 did have a little bit of clarification, because I know
12 there was some confusion yesterday. We wanted to make
13 sure we responded from both parties to that.
14 There will be a continued commitment to
15 charity care, employment for all eligible ECHN employees,
16 and establishment of a community foundation to oversee
17 the charitable funds that are leftover from the deal.
18 This community foundation will be an arm's
19 length, independent foundation, not controlled by the new
20 ECHN.
21 We feel the culture fit between ECHN and
22 Prospect is there. We did our site visits. We visited
23 their organizations, as compared to other suitors. There
24 are always questions about why a for-profit, and my

1 answer is this. For-profits are able to go to the equity
2 markets. We are unable to do that.
3 I wanted to make a statement, because I
4 think it's very important. People, some people in the
5 community think that there's a benefit for
6 administration, myself, to sell this organization and
7 that I will be making and reaping in a lot of money for
8 this sale.
9 This is not a leverage buyout. This is
10 not a hostile takeover. This is a sale of the
11 organization that's been agreed upon by both parties.
12 There is no financial benefit or bonuses for me or for
13 any of the administrators that are on my team. I just
14 wanted to make that very clear.
15 Thank you very much. I will pass the
16 baton over to Joy Dorin, who is the Vice Chair of the
17 Board of Trustees.
18 MR. ZINN ROWTHORN: Mr. Karl, before you
19 do that, can I ask for one clarification for the benefit
20 of the audience?
21 You mentioned that for-profits have access
22 to equity markets, which may not mean a lot to some in
23 the audience, but what is the significance of that, based
24 on the condition of the hospital that you just described

1 to us?
2 MR. KARL: Okay. Thank you to help me
3 clarify that. Not-for-profits can only go to borrow
4 money through a bond process, so they go out, and they
5 seek loans, bonds, float bonds.
6 For-profits are able to go out and raise
7 money through the stock market, and PMH can explain that
8 more clearly.
9 For instance, PMH, 55 percent of its
10 ownership is Leonard Green. Leonard Green is an equity
11 company, and they are able to go out and raise capital by
12 going, as I said clearly, and, Steve, you can -- Steve
13 can explain that a little bit better.
14 MR. ALEMAN: Sure. The alternative
15 methods that we have as a for-profit, as Peter was
16 stating, is private equity groups, who ultimately become
17 shareholders and can invest money into the company for
18 growth and operations.
19 In addition to that, we have access to the
20 open markets, whether it's additional shareholders or
21 investment banks, who look to provide alternative forms
22 of debt, to raise capital for future acquisitions in
23 growth within the company.
24 All of those are avenues that we have at

1 our disposal, we have used in the past, and look forward
2 to using in the future for the growth of kind of our --
3 Prospect, as it stands in future acquisitions.
4 MR. REARDON: I wonder if I might just add
5 something, Peter. For a long time, tax exempts had a
6 tremendous advantage, in that they could go out and get
7 taxes and financing through bonds, but do you know what
8 taxes and financing can be used for? Bricks and mortar,
9 and that's not where the action is anymore.
10 You can't use it for purposes of IT
11 systems. You can't use it for purposes of population
12 management infrastructure. Bricks and mortar is not
13 where the action is anymore, and, so, now it's a huge
14 shortcoming for non-profit tax exempt organizations.
15 MS. DORIN: Thank you and good afternoon.
16 My name is Joy Dorin, and I adopt my pre-filed testimony.
17 I've been a member of the ECHN Board of
18 Trustees since 2004 and currently serve as the Vice Chair
19 and Chair of the Transaction Committee.
20 In my professional life, I've held
21 positions in health care organizations, including Cigna
22 Health Plan, Athena Health Care and Qualidigm, the
23 state's quality improvement organization that works with
24 the Centers for Medicare and Medicaid.

1 Throughout my career, I've been involved
2 in and responsible for quality, patient satisfaction and
3 compliance matters across the health care continuum.
4 In addition to my professional background,
5 I'm a longtime resident of Manchester, nearly 40 years.
6 While I was born and raised in New Jersey, I consider
7 Manchester my home.
8 This is where my friends live, my son and
9 his young family live, and my husband owns a small
10 business on Main Street.
11 I mentioned my Manchester roots, because
12 insuring ECHN's future is important to me, and it's
13 important to every other individual and family, who lives
14 east of the river.
15 In evaluating our options, we established
16 four goals, that high-quality health care services are
17 accessible, affordable and delivered safely to the people
18 in this part of Connecticut, that clinical services are
19 expanded, that employees continue to have jobs, and that
20 facilities and technology are upgraded.
21 Dr. O'Neill talked about the importance of
22 preserving ECHN to serve the public need, and Mr. Karl
23 covered the financial challenges and how the Prospect
24 transaction will allow ECHN to meet these challenges.

1 I'd like to spend a few minutes focusing
2 on the importance of quality and safety. We are proud of
3 the efforts our staff and physicians have taken.
4 Of note, ECHN was one of the first
5 networks in Connecticut to become a high-reliability
6 organization.
7 HROs understand that they operate in an
8 environment of high risk. Industry examples are health
9 care, aviation and nuclear power.
10 These organizations work hard to manage
11 risk and strive to reduce accidents, but, if they do,
12 HROs will work to learn from these accidents to minimize
13 their reoccurrence.
14 This decision and journey has changed our
15 culture to the benefit of our patients. It has resulted
16 in process improvements and a reduction in serious safety
17 events.
18 Our focus on quality has resulted in the
19 Joint Commission recognizing our two hospitals as top
20 performers.
21 At Manchester Memorial Hospital, we were
22 recognized for heart failure, pneumonia, surgical care,
23 immunization and perinatal care and at Rockville General
24 Hospital for pneumonia, surgical care and immunization.

1 Because of these accomplishments, it was
2 important that our potential acquirer share our
3 commitment to quality and safety.
4 As part of our initial due diligence, ECHN
5 requested quality information from all potential
6 acquirers and did a side-by-side comparison of the CMS
7 quality indicators.
8 We also visited hospitals owned by the
9 potential acquirers and met with staff members involved
10 in quality and performance improvement.
11 More specifically, visits were made to
12 Prospect hospitals in California and in Rhode Island to
13 obtain additional information and to learn more about the
14 Prospect coordinated regional care model.
15 When ECHN learned of the immediate
16 jeopardy determinations identified at the Los Angeles
17 Community Hospital and the Southern California hospitals,
18 the Board determined that it needed more information and
19 appointed a quality evaluation team to research and
20 report back to the Transaction Committee and the Board.
21 I was appointed to the team, along with
22 Dr. Michelle Conlin, the Chair of the Performance
23 Assessment and Improvement Committee and a practicing
24 physician, and three members of ECHN's Quality

1 Department, the Vice President of Quality and Safety and
2 two Quality Improvement Managers.
3 The team was charged with determining
4 whether Prospect's experiences in California could
5 threaten or diminish ECHN's current quality and safety
6 standards and its ongoing performance improvement
7 initiatives.
8 To complete our charge, the team first
9 focused on the immediate jeopardy issues and deficiencies
10 and Prospect's plans for correction.
11 The team found the remediation plans to be
12 comprehensive and appropriate, and, in several minutes, a
13 representative from Prospect will provide more
14 information on these issues, their root causes and the
15 corrective action plans.
16 The evaluation team, however, didn't stop
17 here. We decided to go broader and deeper, and, over the
18 last four and a half weeks, we requested, received and
19 reviewed extensive amounts of information from Prospect
20 about its hospitals in California, Texas and Rhode
21 Island.
22 This information included past regulatory
23 surveys, remediation plans and year-over-year quality
24 metrics. The quality reviewers focused, in particular,

1 on the most recent surveys, as they would be most likely
2 to reveal any issues or patterns of concern with how
3 Prospect currently conducts its hospital business in the
4 areas of quality and safety.
5 The team also looked retrospectively at
6 quality assessment and performance improvement indicators
7 and prospectively at the 2016 Quality Assessment and
8 Performance Improvement Plans.
9 Additionally, we reviewed employee
10 turnover statistics and, in a parallel activity,
11 collected and discussed updated financial information.
12 Given that regulatory standards are
13 applied differently among regions, the evaluation team
14 paid special attention to Prospect’s CharterCARE
15 hospitals in Rhode Island.
16 The evaluation team sent its Quality
17 Department team members to those hospitals for a day-long
18 visit to observe and evaluate the aspects of the quality
19 and safety programs in person.
20 The ECHN reviewers found not only that the
21 programs were of high quality, but they had been
22 enhanced, rather than scaled back, after Prospect’s
23 acquisition.
24 Throughout this review, Prospect made its

1 information and personnel fully available to assist us.
2 As we discussed their plans and approach to quality and
3 safety, Prospect was asked specifically whether or not
4 they expected to receive any additional survey
5 deficiencies.
6 Prospect responded that, while immediate
7 jeopardy findings were not expected, because of the new
8 quality controls, structure and processes it had
9 implemented, it was likely that additional deficiencies
10 would be noted. This, in fact, did happen.
11 In the March 23rd CMS response to the Los
12 Angeles Community Hospital resurvey, the hospital was
13 cited for deficiencies.
14 Prospect communicated this to us on the
15 same day they were notified, and we have since had
16 several follow-up communications with them about these
17 results.
18 Quality improvement, by definition, is a
19 continuous process. We all know hospitals are complex
20 regulated organizations with many moving parts, and
21 sometimes, despite the best intentions and focus on care,
22 issues do arise.
23 After the review just outlined, the
24 evaluation team concluded the immediate jeopardy issues

1 were isolated, that Prospect took the California survey
2 results seriously and responded swiftly with corrective
3 actions.
4 The evaluation team also collaborated with
5 the Transaction Committee and ECHN Council to evaluate
6 Prospect's continued appropriateness as a transaction
7 partner. The Transaction Committee recommended that ECHN
8 seek a quality commitment letter to ensure ECHN's patient
9 quality, patient experience and safety programs retain
10 their forward momentum for a period of time post-closing.
11 Prospect has agreed to execute such a
12 letter, which also contains a provision for ECHN to
13 benefit from the quality improvement programs observed at
14 the CharterCARE hospitals and to maintain these programs
15 consistent with industry best practices.
16 Based on the findings presented by the
17 evaluation team and the protections gained under the
18 quality commitment letter, the Transaction Committee
19 recommended and the Board confirmed ECHN's commitment to
20 proceed with the transaction.
21 With the Prospect acquisition, ECHN will
22 have responsibility for quality and safety. This means
23 the current ECHN quality team will continue its good work
24 in eastern Connecticut.

1 In addition, it is anticipated that
2 Prospect’s eastern region, which includes Prospect’s
3 hospitals in Connecticut and Rhode Island, will
4 collaborate on quality and safety measures that are
5 expected to be implemented in Prospect’s hospitals across
6 the country.
7 ECHN looks forward to this collaboration.
8 Thank you for your time.
9 MR. ZINN ROWTHORN: Thank you. Can I ask
10 for some signal from the back about whether folks can
11 hear what’s being said up here? Okay, thank you.
12 DR. O'NEILL: That concludes ECHN’s
13 initial presentation. Next, I’d like to pass the
14 microphone to Dr. Mitchell Lew, the President and CEO of
15 Prospect Medical Holdings.
16 DR. LEW: Good afternoon. ECHN and
17 Prospect, committed to this community. Who is Prospect?
18 We are a health care services company that operates local
19 community hospitals. We utilize local governance and
20 local physician leadership.
21 We make investments in our hospitals and
22 in our communities. Some examples of this would be in
23 Rhode Island. We recently completed a beautification
24 project at the hospital, where we redid the entry, we’ve

1 enhanced the GI lab, and we're looking to possibly open a
2 cardiac heart lab.
3 As far as investments in the communities,
4 in California, we identified two community needs that
5 needed to have some facilities, so we opened two new
6 hospitals, one in Bellflower, it's a psych hospital, and
7 one in Orange County, California, which is an acute med
8 surg.
9 The stability that we offer communities
10 are continued employment and creation of new jobs. We
11 expand programs and services to improve access and
12 quality.
13 Some examples of this would be, in our
14 hospitals in Texas, we opened up an emergency room. In
15 California, we've opened several urgent cares and
16 wellness clinics, and, also, in Rhode Island, we've
17 opened several urgent cares in and around the community.
18 Our hospitals. We have 14 community
19 hospitals, seven in California, four in Texas, and we've
20 owned those for about four years, two in Rhode Island,
21 and it's been coming up on two years, and one recently in
22 New Jersey.
23 We serve many different communities. I'd
24 like to point out that many of the hospitals that we have

1 are in underserved communities, and we accept all health
2 plans. To us, a patient is a patient.
3 We provide medical, surgical, in some
4 cases tertiary, psychiatric and long-term services. We
5 have a lot of experience in proving multiple services at
6 our facilities.
7 We have over 40 outpatient clinics and
8 centers. A lot of the care in our model is delivered
9 outside of a hospital, because we want care to be
10 appropriate in the right setting.
11 We're not just a hospital company. We
12 also own and operate medical groups. We've been doing
13 this for quite some time in California. You can think of
14 our physician groups as multi-specialty health care
15 provider groups without walls, and our physicians are
16 linked into what we call Independent Practice
17 Associations, or IPAs, and these are just networks of
18 doctors that work very closely together, and, in these
19 networks, the physician can be independent, on their own,
20 or they can be employed.
21 Either way, it works for us, and important
22 to note that we are an open system.
23 As I've mentioned, we've been in Southern
24 California for quite some time, over 20 years. Also, in

1 Texas. We have over 500 doctors in our network, in Rhode
2 Island, over 350 physicians, and, even in New Jersey, we
3 have about 125 physicians.
4 We're contracted with all major health
5 plans. We have nearly 9,000 physicians under contract.
6 We take care of nearly 300,000 patients, and we provide
7 coordination of care across the entire continuum, so if a
8 patient is in a hospital or in a nursing facility,
9 clinic, physician office, we follow their care
10 throughout.
11 Our goal is to achieve better outcomes,
12 with higher patient satisfaction. We want patients to go
13 and tell their family and friends to come receive care
14 here.
15 Now through our experience of operating
16 hospitals and running physician groups, we've developed a
17 very unique model of care, and it's a delivery model that
18 we refer to as Coordinated Regional Care, or CRC.
19 And, so, the definition of CRC is the
20 integration hospitals, physicians and other medical and
21 community providers, and I want to emphasize community,
22 because we always work with the community and local
23 agencies, whether it be a home health agency, or a DME,
24 Durable Medical Equipment company, or a palliative

1 company. We always create the network with the
2 surrounding community providers, but we work very closely
3 with the health plans and the government payers in a very
4 strategic way, because we want to achieve the best
5 patient care and the best outcomes.
6 We've implemented this model in seven
7 regions, in California, Texas and Rhode Island and
8 currently in development in New Jersey, Connecticut and
9 Pennsylvania, and we've already made great strides here
10 in Connecticut, in terms of setting up our model.
11 We practice population health management,
12 which is a very popular buzz word, but, to us, what that
13 simply means is that we value the care of every person in
14 the community, and we want to make sure that we take the
15 best care of everyone.
16 With this unique model of care provides
17 higher value, because, in our opinion, better care does
18 not need to cost more.
19 So what is our secret? How do we do this?
20 How do we improve care and outcomes? We use a patient-
21 centered and a physician-led approach.
22 We have multi-disciplinary care teams that
23 take care of high-risk patients 24/7. We have the
24 ability to stratify the sickest patients in the

1 population and really focus with these teams. The teams
2 consist of nurse practitioners, social workers and
3 pharmacists that follow a patient and are available
4 around the clock, and, if necessary, we will go to the
5 house to evaluate a patient and provide care.
6 We engage the patient and the family. I
7 spoke already to the homebound program. We take care of
8 specific diseases with specific care plans, such as
9 diabetes and heart disease.
10 We integrate behavioral health, because
11 we've learned that many patients have coexisting
12 diagnoses. Some are medical diagnoses, some are
13 behavioral health, and, in order to really appropriately
14 and efficiently take care of one's health, you've got to
15 approach both, the behavioral health and the medical
16 health, so we've implemented that into our model.
17 We have Quality Care Coordinators, who are
18 people that just work the phones. They get patients in
19 to see their physician. They make sure they come in for
20 their screening, their wellness, because those are
21 important, obviously, in taking care of a patient and
22 providing the preventive health measures.
23 We follow patients in the hospital,
24 skilled nursing facilities, long-term care. Again, this

1 speaks to our care across the continuum, and, of course,
2 this is a physician-led network.
3 We are absolutely committed to quality,
4 and we've achieved the highest quality scores across our
5 medical groups.
6 In California, the largest, actually CAPG,
7 California Association of Physician Group, is the largest
8 trade association in the country. We've reached the
9 highest level of quality, it's elite status, and it's
10 been for four straight years.
11 Another respected trade association, IHA,
12 has recognized us for things, such as clinical quality,
13 and, in California, the Department of Managed Health Care
14 has recognized us for treating cardiovascular disease,
15 diabetes, and this is some of the disease-specific care
16 plans that I spoke to on an earlier slide.
17 Out of a five STAR rating, we are four to
18 five STAR on our Medicare Health Plan Quality and
19 Performance Ratings.
20 MR. ZINN ROWTHORN: Dr. Lew, if I could
21 just ask, by way of clarification? What I'm going to try
22 to do here, I know that you've gone to pains to translate
23 your presentation into lay terms, which I appreciate.
24 It's vital that we make sure that the key concepts being

1 discussed are understood by our audience.
2 With respect to your comments on
3 coordinated regional care, can you talk a little bit
4 about what that would mean for a patient at an ECHN
5 hospital, how that experience might appear different from
6 what exists, whether that is a model that, if this
7 transaction were to be approved, would be moved to
8 immediately, or is there a transitional period first?
9 Thank you.
10 DR. LEW: Sure. Thanks, Perry. So,
11 Perry, traditionally, patients will go to their doctor.
12 They may get admitted. They'll get treated at the
13 physician's office. They get sick, they call 9-1-1, they
14 go to the emergency room, they get admitted to the
15 hospital, they have a lot of whole host of tests done,
16 they're released from the hospital on seven different
17 medications.
18 They go home, they don't really remember
19 how they're supposed to take their medication, when
20 they're supposed to see the doctor, the primary care, the
21 cardiologist. You've got multiple specialists that see a
22 patient in the hospital.
23 Family members don't always get the
24 directions and the instructions, because they are at

1 work, and, so, the patient is not sure exactly what's the
2 follow-up. How do I take my medications? They may call
3 their doctor. They go see their doctor within a week or
4 two, and the doctor says, oh, I didn't know you were in
5 the hospital.
6 What did they do? Let's get some tests.
7 Let's get the records. Let me look at them. Meanwhile,
8 the patient may -- their condition may deteriorate, and
9 you've lost a lot of time, and you've lost the continuity
10 and the coordination of care between what happened in the
11 hospital and what's supposed to happen at the physician's
12 office, and, so, often, the patient will get readmitted.
13 Maybe they took their medications the
14 wrong way, or they forgot, the family member didn't
15 remind them, and the patient goes back to the hospital,
16 or the patient may go home and get dizzy, may fall and
17 fracture their hip, then they get taken back to the
18 hospital.
19 This is very common. I'm pointing these
20 things out, because we see these things happen, and, so,
21 in lay terms, the reason why I want to give this example
22 is because I want to illustrate how within our model the
23 likelihood of something like that would be very low.
24 So the patient gets admitted to a

1 hospital. Rather than call 9-1-1, we would probably, if
2 this is a patient that we've identified to be at risk,
3 the patient will likely call our nurse practitioner, who
4 would make an evaluation either by phone or go to the
5 house, the patient's house and say, okay, Mrs. Smith may
6 be in a little bit a congestive failure, a little bit of
7 fluid in the lungs, and we should admit her to the
8 hospital, so we would arrange to have Mrs. Smith brought
9 to the hospital and immediately transfer the care to a
10 hospitalist, a physician, who works in the hospital, to
11 take over the care.
12 Once the patient is admitted, we begin to
13 start planning, okay, what are going to be the needs
14 post-discharge? And, so, we'll get the appropriate tests
15 in the hospital and the appropriate specialist
16 consultants to come and evaluate the patient and do the
17 tests, and then, whether it's a couple of days, we'll
18 transfer Mrs. Smith to a lower level of care. That might
19 be a skilled nursing facility.
20 And then our multi-disciplinary team of
21 the nurse practitioner and the pharmacist may go to the
22 skilled nursing facility and say, Mrs. Smith, you have
23 these seven medications. Do you know how to take them?
24 Let me explain to you how to take these medications, so

1 that you don't get readmitted.
2 So, again, that's the handoff. That's the
3 continuum of care that these Care Plus. We've branded
4 our programs, and we've called it Care Plus.
5 And, so, we'll go skilled nursing
6 facility, and then we'll evaluate the home. Is she ready
7 to go home? Does she have the proper support and the
8 proper care taking at home, and then we'll transfer,
9 we'll have the patient transferred from skilled nursing
10 to home.
11 All throughout this, we're letting the
12 primary care physician know what's going on, that your
13 patient has been admitted to the hospital and is now in
14 skilled nursing, and we'll send the records
15 electronically to the primary care, and then, once the
16 patient goes home, our rule of thumb is, when the patient
17 goes home, got to be seen post-discharge clinic or in the
18 primary care within 24 hours.
19 So we want her to be seen in the
20 physician's office. If the doc is closed, not available,
21 we setup wellness clinics within the community, and our
22 wellness clinics have multiple purposes. One of them
23 would be to evaluate our patients post-discharge, and,
24 so, Mrs. Smith could go to the post-discharge clinic to

1 be evaluated, or go to the physician's office, and if
2 Mrs. Smith requires transportation, we'll arrange for the
3 transportation, but now she is locked into our system, if
4 she wasn't already.
5 She's going to have an assigned case
6 manager that will make sure and follow her care
7 throughout. We've learned that, if you can identify
8 really those sickest patients, it's around five, 10
9 percent, that's a majority of the spending, and you
10 really got to do a good job of focusing on taking care of
11 those patients.
12 Perry, that's just an example of within
13 our model, a very simplistic way for the audience to
14 understand how it could work, but, obviously, there are a
15 lot more complexities that we could add to it, in terms
16 of, you know, more complex issues, besides congestive
17 heart failure.
18 We could talk about how we would, when
19 Mrs. Smith is feeling great and needs her wellness exam,
20 or needs to have the quality measures done, we'll make
21 sure and coordinate that with her, with the physician's
22 office, and help make the appointment, so that she can go
23 back for her other types of screenings. We build that
24 into our model, also. Does that help?

1 MR. ZINN ROWTHORN: It does. Thank you.
2 So I have just one follow-up. It's a model that relies
3 on interaction and relationships with physicians in the
4 community.
5 Is it anticipated that the physicians, who
6 currently have relationships with -- privileges or other
7 relationships with ECHN hospitals would continue to have
8 those relationships under Prospect?
9 DR. LEW: Yes. They would still continue
10 to have admitting privileges, and what we found is it
11 tends to be more efficient to have a designated
12 hospitalist group see the patient, but that's just a
13 general rule.
14 I mean I think that what's important is
15 that the physician adheres to our standards of how
16 quickly you need to see the patient and make sure and
17 stay on top of it and coordinate with the specialist.
18 It's not something magical that a
19 practicing physician can't see a patient in the hospital
20 and has to be a hospitalist, but it's more that they do -
21 - the hospitalists tend to do this every day, seven days
22 a week, but we have examples in various markets, where
23 groups of primary care physicians said I want to be part
24 of that panel.

1 And, so, as long as they can adhere to our
2 programs and work closely with our medical directors, who
3 are all local doctors, right, the physician leaders are
4 all local, as long as they can adhere to the policies and
5 procedures that we've established, I could see a
6 scenario, where we could have local physicians
7 participate.
8 MR. ZINN ROWTHORN: Thank you.
9 MR. CROCKETT: My name is Von Crockett,
10 and I adopt my pre-filed testimony.
11 Dr. Lew had just previously mentioned
12 several of our awards that we've won. I wanted to take a
13 few moments to discuss the issues that Mrs. Dorin brought
14 forward regarding the recent events that have occurred in
15 California and some of the mistakes that were made and
16 the corrective actions that this organization is taking
17 to resolve them and to improve our quality program.
18 Specifically, in late 2005, during a visit
19 by CMS to do surveys at two of our licensed facilities --
20 MR. ZINN ROWTHORN: Mr. Crockett, do you
21 mean 2015?
22 MR. CROCKETT: 2015. Thank you. 2015,
23 CMS, during a survey process, had identified areas where
24 the care that was being provided was not meeting the

1 standards of conditions for Medicare, the CMS conditions
2 of participation, and they had given the two facilities
3 what's called a deficiency notice of immediate jeopardy.
4 By definition, immediate jeopardy means
5 that the care and the processes that are currently being
6 provided to a patient could cause harm to a patient.
7 The deficiencies were specific in the one
8 facility at LA Community Hospital for an allegation of
9 physician misconduct, and then there were two immediate
10 jeopardies at the Southern California Hospital license.
11 The first one had to do with the
12 temperature and humidity in the operating room, and the
13 cath lab was not being maintained consistently, and then
14 the second immediate jeopardy was the infection control
15 specifically for the washing of sterilization of surgical
16 instruments.
17 In the three situations, there was no
18 specific patient harm that did occur, that, once again,
19 it was for that the processes could potentially cause
20 harm.
21 When we received the notifications,
22 Prospect took the allegations very seriously and began
23 steps to do remediation of all three.
24 From a process perspective, once you

1 receive a notification of immediate jeopardy by CMS, it’s
2 expected to be resolved immediately, and they actually
3 don’t leave the facility until the allegation has been
4 abated.
5 Once it’s been abated, then they will
6 issue a report, and included in the report will be other
7 deficiencies that they identify, in addition to the
8 immediate jeopardies.
9 In each of those cases, there were
10 additional deficiencies that were identified, and they
11 were specific to infection control, patient care, the
12 quality program and governance.
13 Specifically to the quality program, what
14 the found in the organization was that the quality
15 program was a kind of a static program that was
16 continuing to collect data and information and that it
17 wasn’t being adapted in a real time fashion to address
18 the issues that were occurring at the facility, and they
19 saw that the quality program was marching off to one
20 degree and that the quality -- I mean the quality program
21 was marching off to one side, and the organization had
22 issues that weren’t being addressed, and, so, there was a
23 deficiency from the quality program.
24 Once the issues were identified, there

1 were immediate steps and issues taken to resolve them.
2 One of the first things that was done was that Prospect
3 engaged a national consulting firm that has a track
4 record of assisting hospitals and addressing these type
5 of issues, then they were brought on site for both of the
6 locations.
7 MR. HENRY SALTON: Excuse me. Could you
8 say when that occurred?
9 MR. CROCKETT: We received reports in
10 January. I don't have the exact date, but it was
11 approximately January. I don't have the exact date in
12 January.
13 MR. SALTON: And when you brought on this
14 consulting group?
15 MR. CROCKETT: Oh, I didn't understand the
16 first question, when you say it occurred.
17 MR. SALTON: Okay, so, when did you bring
18 on the consulting group?
19 MR. CROCKETT: It was in January of 2016.
20 MR. SALTON: Okay and the statement you
21 made about the quality program being static, when was
22 that identified to Prospect?
23 MR. CROCKETT: Well we didn't get the
24 details of the report until approximately January, as

1 well, for both situations.
2 MR. SALTON: Was there a verbal conveyance
3 of the concerns on the quality?
4 MR. CROCKETT: Not at the time. We
5 actually didn't receive that deficiency until January.
6 MR. SALTON: Okay.
7 MR. CROCKETT: When they were on site,
8 they were really focused on the immediate jeopardy issue
9 and making sure that that was resolved, in addition to
10 some other patient care concerns.
11 The role, in addition to that, the
12 corporate office had started the process of providing
13 additional resources, so that the organization could
14 correct the issues that were identified.
15 In terms of a root cause analysis and
16 lessons learned, and there were several lessons learned
17 there that are applicable as we move forward, the first
18 one had to do -- in terms of some of the causes, first,
19 before we get into lessons learned, on the cause issue is
20 the one facility, Southern California Hospital, is an
21 organization that is needing -- had previously gone
22 through a bankruptcy and had a substantial amount of
23 deferred maintenance, and we were in the process of doing
24 construction up on the roof, when one of the contractors

1 had a small localized fire that caught fire and ended up
2 damaging our air conditioning system throughout the
3 facility.
4 Throughout that process, the organization
5 did not have the appropriate response in resolving it to
6 the degree it should have been resolved, as well as from
7 a timing perspective.
8 Part of the issue, as well, from -- and
9 that caused multiple issues, in addition to the HVAC
10 system. Secondarily, though, as an organization, we had
11 delegated the role of the quality program to a local
12 level, and, with that, as the organization was dealing
13 with these issues, it was being dealt with at a local
14 level, without the proper oversight at a corporate level.
15 Lastly, as the organization was needing
16 additional resources, those issues weren't brought
17 forward in a timely fashion, as well.
18 So in terms of steps to resolve, as it
19 relates to the immediate issue, of the immediate jeopardy
20 issues and getting them resolved, is that the national
21 consulting firm was brought in, and they have several
22 roles that they're actually doing.
23 The first role is to help us prepare the
24 response, what's called a plan of correction, back to

1 CMS. From a status perspective, we have, on the LA
2 community, we have prepared a plan of correction. CMS
3 had come out and done a resurvey, based upon that plan of
4 correction. That resurvey occurred in the middle of
5 February.
6 When they were on site, the issues
7 associated with immediate jeopardy, the quality program
8 and several of the other original deficiencies were
9 resolved, but, during the site visit that they did, did
10 identify two issues still outstanding or new issues.
11 One had to do with nursing services or
12 patient care, and the second one had to do with infection
13 control. That plan of correction on that one is in the
14 process of being written and prepared, and it should be
15 completed approximately by April the 8th.
16 For the Southern California Hospital, we
17 have submitted our plan of correction to CMS, and that
18 plan of correction has been shared with ECHN, as well as
19 the regulatory officials, and we're awaiting at this
20 point for CMS to come out and do the resurvey associated
21 with Southern California Hospital.
22 I should mention, as well, that, as part
23 of this process, CMS has put us on what's called a
24 termination track, and, currently, the termination track

1 for the LA community license has currently now been
2 extended to approximately June 13th.
3 For the Southern California Hospital,
4 that's currently on a track for I believe it's May 23rd,
5 and our expectation is that we are taking every step
6 associated that's needed to resolve these issues.
7 Getting back to our engagement with a
8 consulting firm --
9 MR. ZINN ROWTHORN: Mr. Crockett, if you
10 don't mind breaking there for some points of
11 clarification? We had a very extensive discussion on
12 this subject yesterday in Manchester, and I want to make
13 sure that our audience today has received a similar level
14 of clarity or at least information around what this CMS
15 process means and entails and looks like going forward,
16 so, just by way of terminology first, CMS is the federal
17 regulator that manages the Medicare and Medicaid
18 programs, is that correct?
19 MR. CROCKETT: That's correct.
20 MR. ZINN ROWTHORN: And when we talk about
21 immediate jeopardy, you mentioned conditions that might
22 pose patient harm, but the immediate jeopardy referenced
23 is not immediate jeopardy to a patient, but it is
24 immediate jeopardy -- you've been notified with respect

1 to your hospitals that they are in immediate jeopardy of
2 being terminated from participation in the CMS programs,
3 is that right?
4 MR. CROCKETT: Well you can actually
5 receive an immediate jeopardy and not be terminated from
6 the program. I don't think that actually how you've
7 articulated it is actually accurate. The immediate
8 jeopardy is actually a level -- it's a deficiency level,
9 and it basically is stating that your care processes are
10 not consistent to the point of immediate jeopardy of
11 concern, as it relates to the patient.
12 MR. ZINN ROWTHORN: Okay, so, let me say
13 it differently. The threat, that you have been notified
14 by CMS, is that, if these conditions aren't corrected to
15 CMS's satisfaction, that the hospitals will be terminated
16 from participation in the CMS programs, is that correct?
17 MR. CROCKETT: It is correct, and I think,
18 just in terms of from a context perspective, I want to
19 spend just a second on that.
20 From a context perspective is that the
21 federal government has what's called conditions of
22 participation, what are basically expectations of how
23 care is provided for patients throughout the United
24 States for hospitals to abide by.

1 From an administrative process, the
2 federal government does not have a way of imposing
3 penalties or fines, in terms of when organizations either
4 are not -- are not failing to adhere to them, and, so, as
5 a process perspective, in the event that organizations
6 find themselves in the unfortunate situation of not
7 adhering to them, then their only possible recourse is to
8 the threat of removing a hospital license.
9 There is no other administrative process
10 or penalty associated with that, and, so, by default, it
11 is a way to make sure organizations take this very
12 seriously and to provide every recourse necessary for it
13 to be resolved and appropriately so.
14 CMS has every intent, when these do occur,
15 is to get the organizations back to the level of
16 participation, and it does happen, but it’s pretty rare,
17 for CMS to actually close a hospital down or terminate
18 the license for it, and they usually do it for two
19 reasons.
20 One, if a hospital is in the process of
21 bankruptcy or they don’t have the cash to correct the
22 issues that are needing to be corrected, or, two, if they
23 just don’t have the desire to adhere to the rules and the
24 policies going forward.

1 Most often, the time or the circumstance
2 is that they will continue to work with organizations to
3 the point that they believe that the organizations are no
4 longer improving.
5 There are many hospitals that have
6 actually received immediate jeopardy and/or terminations,
7 and they're everything from community-based hospitals to
8 large teaching organizations with well-known reputations.
9 Two of those that come to mind is UCLA Medical Center,
10 and, actually, the Cleveland Clinic was in the past
11 recent history put onto a termination track, so we have
12 every intention of moving forward.
13 MR. ZINN ROWTHORN: Thank you. That's
14 helpful. And just one further clarification. We have
15 been talking about immediate jeopardies with respect to
16 two individual hospitals in California, but the way those
17 hospital licenses are structured the immediate jeopardy
18 notices actually pertain to six hospitals, is that
19 correct?
20 MR. CROCKETT: That is correct. There's
21 seven hospitals in California, and the Los Angeles
22 community license is a three-campus system, and the
23 Southern California Hospital license is also a three-
24 campus license, and, so, from an administrative

1 perspective, when CMS does its process, it's on the
2 license.
3 And, so, even though the issues are
4 predominately two of the six, that all six hospital
5 licenses are impacted by the actions that are being
6 undertaken.
7 MR. ZINN ROWTHORN: Understood. And, so,
8 you know this, but I'll clarify it for our audience. We
9 have asked you and you have agreed that we will keep the
10 record open in our proceeding, so that we can receive all
11 the communications between Prospect and CMS with respect
12 to these immediate jeopardies.
13 MR. CROCKETT: That's accurate. Moving
14 forward, in terms of our investment in quality, so, in
15 addition to helping them address the plan of correction,
16 the other aspect that they are working on or that they
17 have completed is to revise our quality program,
18 specifically, making sure that the program at each
19 license is specific to each facility, and that it is
20 addressing from a monitoring perspective the areas of
21 concern that have been identified by CMS, so that not
22 only do we correct these immediately, but there's going
23 to be ongoing compliance with the plan of correction and
24 a monitoring associated with that.

1 The other thing that they have done is
2 they have gone through our process of looking at our
3 policies and making recommendations to them to making
4 sure that all of our policies are adhering to the
5 Medicare conditions of participation and making them
6 workable from the facility, as well.
7 From an oversight perspective and getting
8 back to kind of the lessons learned, the quality program
9 at these two facilities, as well as our other facilities,
10 have been predominately delegated down to the facility
11 level.
12 With that, we are now adding additional
13 corporate quality leadership oversight to these two
14 facilities, as well as to our other hospitals, as well.
15 Specifically, we have created four additional positions.
16 One will be a Chief Quality Officer, the
17 second will be a Chief Clinical Officer, the third is a
18 Chief Corporate Nursing Officer, and the fourth is a Vice
19 President of Regulatory Affairs and Patient Safety.
20 The role of these four individuals are
21 going to ensure that we have an active quality program at
22 each of the hospitals, that the program is reflective of
23 the individual issues that are being raised and are being
24 monitored and adapted, as appropriate, that the quality

1 programs are consistent with the industry standards and
2 national patient safety goals, and that when
3 organizations are not -- when each of these facilities
4 are not meeting the components of the quality program,
5 that they identify the resources and a review of the
6 policies and procedures, in order for the facilities to
7 get back on track and meet those objectives.
8 These positions are relatively new, and
9 we've got three of the four in place, and the fourth one
10 will be on board shortly.
11 The third issue is we've established
12 regional hospital quality oversight, and the point of
13 that is that we don't intend to have everything running
14 through California, so, for our east coast facilities, we
15 will have an individual on the east coast to assist with
16 what I've said the four individuals will do, but more on
17 a real time basis on the east coast, as well.
18 And, lastly, this is something that we
19 have learned in conjunction with our work with
20 CharterCARE, and that, recently, CharterCARE has adopted
21 what's called a high-reliability process organization.
22 MR. ZINN ROWTHORN: CharterCARE is your
23 Rhode Island?
24 MR. CROCKETT: Correct. And what we've

1 seen is that, within the first year of them adopting it,
2 we have seen areas on their quality plan that have
3 started to show improvement, and, with that, we have also
4 reviewed the quality program for ECHN, and they have been
5 a long-time member of the HRO process, as well.
6 As part of the process that we have
7 recently gone through, in conjunction with working with
8 ECHN, what we have agreed to do, and ECHN has a great
9 quality program, it's very thorough, and it's an adaptive
10 quality program that they are achieving high marks on, is
11 that Prospect has agreed for us to adopt the current
12 quality program that's currently at ECHN, as well as
13 that, from a local Advisory Board perspective, is that
14 the local Advisory Board will be responsible for setting
15 the goals and the components of the quality program, and
16 that the role of the corporate oversight will be really a
17 check and a balance, and what does that exactly mean?
18 A check and a balance is specifically are
19 they on track, or are they on target? Are the goals
20 consistent with hospital and industry best standards?
21 And in the event that they're not meeting the goals, what
22 resources need to be brought in from a policy perspective
23 and/or from a resource perspective, so that would be the
24 role of the corporate oversight. We have agreed this for

1 a two-year period.
2 I want to switch gears for just a second
3 now and talk a little bit now in regards to what do we
4 expect of kind of a post-transaction for ECHN? To do
5 that, I wanted to spend just a moment regarding the
6 operations in Rhode Island, CharterCARE.
7 We have -- the acquisition is a little
8 over almost a year and a half now, and, after a year and
9 a half, there's been some substantial improvements, in
10 terms of the health care delivery model in Rhode Island,
11 and we're hopeful in expecting the same progress to be
12 made in Connecticut.
13 First of all, is that the Rhode Island
14 market was made up of predominately a lot of independent
15 physician groups, either ones, or twos, or small groups
16 that were not in an organized fashion.
17 We have come in, and we have organized it
18 into a multi-specialty IPA, with over 100 primary care
19 providers that now have the ability to contract with
20 health plans as a single entity going forward.
21 We've increased the employed physicians by
22 over 50. Previously, they had around 18, and we're now
23 over 50 employed physicians.
24 As part of our population management,

1 we've expanded the outpatient clinics outside of the
2 service area, as well as an investment in an outpatient
3 oncology center.
4 From a quality perspective, the
5 organization, the cancer centers achieved academic
6 certification from the Joint Commission, and we have
7 expanded a significant strategic capital, in order for
8 this organization to move forward.
9 They were in a similar situation, where
10 they had deferred maintenance and weren't able to invest
11 in the equipment and technology they needed to care for
12 their patients.
13 And then, lastly, Rhode Island, like
14 Connecticut, is a Medicaid expansion state, and, as part
15 of the expansion state, the Rhode Island budget, as they
16 expanded Medicaid, has increased their deficit on the
17 state budget through all the fee for service activity
18 that was occurring for Medicaid.
19 In working with the legislative bodies up
20 there, Prospect is in the process of implementing a
21 Medicaid managed care pilot project, and the goal of this
22 is to, as Dr. Lew was alluding to, is to have the
23 Medicaid population into an environment, where their care
24 is coordinated, and, with that, we believe that this will

1 save the state of Rhode Island over $6 million on an
2 annual basis through the pilot project.
3 As part of our expansion outside of the
4 state of California, in addition to Rhode Island and now
5 in New Jersey, when we looked at Connecticut, there were
6 several favorable things that we found that we believed
7 that, when you looked at our model of working with the
8 health plans, as well as the physicians, would be very
9 favorable for the citizens of Connecticut, in conjunction
10 with us.
11 The first one is that Connecticut is a
12 Medicaid expansion state and, as such, is going to be
13 needing to have a different way or model of how the care
14 is delivered, in order for it to be remaining affordable
15 to the citizens of Connecticut, as well as the state
16 budget.
17 The health plans within Connecticut, and
18 this is important to us, are actually very receptive to
19 our types of model and changing from a fee for service
20 into a value-based care.
21 Later on, Dr. Lew can go into some of the
22 work we've already done in engaging the health plans in
23 Connecticut, and it's been significant.
24 ECHN, as an organization, already has

1 high-quality physicians with a great reputation, and it's
2 an organization that is looking for value-based health
3 care knowledge and expertise, and, so, lining up what
4 their needs were with us, it looks like a perfect fit.
5 When we get on a post-acquisition basis,
6 one of the things that Dr. Lew alluded to is that we
7 don't go out of network with the insurers. That's
8 actually part of our business, and, so, what you see is a
9 different type of relationship, where you see the health
10 plans, the physicians and the hospital actually working
11 together, and it's all focused on the patient.
12 With that coordination of care, we believe
13 that there will be better care for the patients, as well
14 as higher satisfaction.
15 Through this, ECHN will have improved
16 access to capital and greater financial strength to
17 insure its long-term financial viability.
18 MR. ZINN ROWTHORN: Let me take a moment
19 there. Thank you for that. I notice we've been joined
20 by State Representative Srinivasan, and our understanding
21 is you have a difficult schedule today, sir, so we'd be
22 happy to hear from you now, if you'd like to be heard.
23 MR. PRASAD SRINIVASAN: Good afternoon,
24 Mr. Zinn Rowthorn, Mr. Hansted, and members of the Board.

1 I want to thank you very much for giving
2 me this opportunity to be here this afternoon and very,
3 very grateful to you for accommodating my schedule and
4 letting me get back to the LOB. I appreciate that very
5 much.
6 I'm Prasad Srinivasan. I'm a State
7 Representative from Glastonbury, and this is my third
8 term. I'm the State Representative. I'm also a
9 practitioner. I'm an allergist in private practice in
10 the Hartford area.
11 I haven't come here to drum up business
12 during allergy season, so that's not why I'm coming here,
13 to do that, but we do have an office here, incidentally.
14 (Laughter) My partner comes to Ellington, so we're very
15 much here.
16 The reason I'm here is for you to consider
17 this partnership between ECHN and Prospect Holdings. As
18 you know, the entire landscape in health care has
19 changed, and it's constantly changing, and, in this
20 landscape, where we are at this point, we really don't
21 know what's coming down the pike for us tomorrow and,
22 obviously, months and years to come.
23 With that in mind, when you look at the
24 needs of the hospital and you look at the needs of the

1 patients, it is a changing playing field, and we hope to
2 be able to accommodate the needs of our patients.
3 Patients, for them, access is very, very
4 critical. Thirty-five years ago, I opened my practice in
5 the Hartford area, and my first satellite was on the
6 other side of the river, and I would always ask my senior
7 partner, whom I joined, what is the big difference? Why
8 cannot these people from Manchester, Rockville and
9 Glastonbury cross the river and come to Hartford?
10 He says, no, Prasad, you don't get it.
11 There is a mental block about that. People do not like
12 to cross and come over, and I've seen that in my 35 years
13 of practice, so the access is my biggest concern with
14 these hospitals.
15 ECHN, the two hospitals that form ECHN,
16 are so critical in the services that they provide to the
17 area, and, looking at where we are, and I'm sure, between
18 yesterday and already, you've heard the financial story,
19 so I'm not going to go over that at all, that's not my
20 intent, to talk about the finances of the hospitals, but
21 that is of concern, because unless we have the viability,
22 the financial viability, my concern is for our patients,
23 is what's going to happen to these patients, who live
24 here, and this is their home?

1 Just the end of last year, late last year,
2 my employee's husband got extremely ill, extremely ill,
3 and to the point that it perhaps may have been
4 appropriate for him to go down to either Yale or to
5 Hartford, because of the severity of his illness, but he
6 chose no.
7 He said I do not want to go there. This
8 is the hospital that I've been to. This is where my kids
9 were born. This is where I belong, and, whatever happens
10 to me, it's going to happen in this hospital.
11 Fortunately, he did extremely well. He
12 recovered, and he's back home, and that's the mindset of
13 people that we need to be able to realize and recognize
14 how important it is.
15 So when you look at the needs for the
16 patient, that's what I'm most worried about, that if
17 these doors were to be closed, or partially closed, or
18 whatever happens, because, obviously, because of
19 financial reasons, what will happen to their services,
20 whether it be primary care services or it be specialty
21 services?
22 All of them are needed right here in the
23 area, and when we have somebody that it is possible for
24 us to have in this day and age a very, very difficult

1 landscape here in the best of both worlds, I hope you
2 will give that the utmost consideration.
3 I know you will. I'm well aware of that,
4 but I hope, at the end of the day, it will be that we can
5 go ahead with this merger.
6 When we look at this, at the hospitals
7 now, as you're well aware of, the needs of the hospital
8 from a patient point of view have increased tremendously.
9 Medicine is just outpacing itself, in
10 terms of its technology, and we need to keep track of
11 that. We need to provide the top services. We cannot
12 say that, in this hospital, an MRI cannot be done, or a
13 third degree CAT scan, or all of those procedures cannot
14 be done here, and you need to go somewhere else.
15 We need to be able to provide all of that,
16 so we can take proper care of our patients, and for that
17 message, that we are state-of-the-art, we will continue
18 to be state-of-the-art, and we will continue to stay
19 here, is very critical.
20 Equally important, rather than being here
21 only, which is obviously very important, is for us to
22 recruit physicians, to recruit health care providers into
23 the area.
24 I'm sure you're well aware of the

1 financial state that our state is in, and, given where we
2 are, it is difficult to recruit people. It is very
3 difficult to get people to come to our state, and
4 physicians and health care providers are no exception.
5 Six years ago, when I ran for my office
6 for the first time, I needed help in my office. I have
7 advertised left, right and center to get another
8 allergist to join me. Long story short, I haven't got
9 one yet, so that's the climate that we are in,
10 unfortunately. That's the message we have been given for
11 small businesses.
12 So to recruit physicians for us, to
13 recruit top class technicians, health care providers, the
14 PAs and the APRNs, the message to them has to be very
15 clear. This is a viable organization. This hospital is
16 here to stay. The system is here to stay for years to
17 come, and this is a place you could call home.
18 So I hope, when you look at it from a
19 financial point of view, which you already heard about,
20 but, more importantly, appeals of our patients, that they
21 need to get their access here, and I fully agree, I fully
22 agree we need to have oversight. No question at all
23 about that.
24 The labor contracts, we need to look at

1 them carefully. We need to make sure that physicians and
2 other health care providers don't feel that their jobs
3 are at risk, so should there be oversight? Absolutely,
4 yes, but in the right mix.
5 When you drive a car, you have an
6 accelerator, you have a brake. You need both of them to
7 go from Place A to Place B, so, similarly here, I hope
8 the oversight will be not be so burdensome, so burdensome
9 that nobody is willing to come to Connecticut. We need
10 to find the right balance for you, me, and, more
11 important, for our patients.
12 Thank you very much for giving me this
13 opportunity today. I appreciate that.
14 MR. ZINN ROWTHORN: Thank you very much,
15 Representative.
16 HEARING OFFICER HANSTED: Thank you.
17 MR. ZINN ROWTHORN: Can I ask, while we're
18 taking this break for comment, do we have Mayor Champagne
19 in the audience? Do we? Oh, I'm sorry. Thank you.
20 We'd be happy to hear from you, as well, sir.
21 MAYOR DANIEL CHAMPAGNE: Thank you. First
22 of all, I'd like to take the opportunity to thank you for
23 letting me speak today.
24 My name is Mayor Daniel Champagne of

1 Vernon, and Rockville General Hospital is here in my
2 town, and Rockville General Hospital means a lot to me.
3 Both my kids were born there. I met my wife there,
4 because I work there. It's very important to me that
5 Rockville stays open.
6 I'd like to thank the Office of the
7 Attorney General and the Office of Health Care Access for
8 their work in reviewing the proposal to ensure that
9 residents throughout the service area, including those
10 who reside here in Vernon, will continue to have quality,
11 affordable, and, most importantly, accessible health
12 care.
13 I'd like to begin by saying Rockville
14 General Hospital is our hospital. It has served as a
15 pillar of our community for nearly 100 years. When it
16 was first established on Prospect Street in 1921, our
17 community donations built it.
18 When it relocated to its current location
19 on Union Street in 1945, the Tolland County region
20 supported it.
21 For nearly a century, each time the
22 hospital has faced trouble, the community has pulled
23 together, turning it around with our donations and our
24 hard work.

1 In return, Rockville General Hospital has
2 been a place where generations of our residents have
3 received accessible quality health care. Today,
4 Rockville General Hospital and the Visiting Nurse and
5 Health Services of Connecticut are Vernon's second and
6 third largest employers, respectively.
7 My largest concern about this proposed
8 sale is that Prospect is only required to state its
9 intentions for Rockville General Hospital for the next
10 three years.
11 One reassurance was that Prospect had
12 stated they are not in the business of closing hospitals,
13 but I would like a longer commitment just on paper,
14 because that would make me feel better.
15 I also requested the Attorney General's
16 Office to ensure that all charitable trusts in the
17 foundation funded from prior donations remain true to the
18 goals of the original donors. The trust should continue
19 to be applied for the good of the patients and the
20 community.
21 In summary, during these tough economic
22 times, it's important to save our local hospitals to
23 ensure every citizen has affordable accessible care at
24 the highest quality right here in our community.

1 I don’t want to leave Rockville. I don’t
2 want to leave the Vernon area for health care when we
3 have it here. We’ve had it here for a century.
4 Rockville General Hospital provides
5 medical services to all our residents, including many
6 seniors and those, who live in low-income housing.
7 These services are offered right in our
8 neighborhoods and backyards, so there’s no need to travel
9 long distances, especially if the medical needs are a
10 critically urgent matter.
11 I vow to do everything in my power to make
12 sure Rockville General Hospital remains a vital part of
13 this community.
14 Vernon and the surrounding communities
15 rely on both medically and financially for the numerous
16 jobs it provides.
17 Again, I want to stress that Rockville
18 General Hospital is our hospital. We started it. It
19 began here with the generosity of our residents. It has
20 remained here with their continued support and patronage,
21 and we eternally consider -- and will eternally be
22 considered a community asset for the medical care it
23 provides to Tolland County.
24 And when I refer to Rockville Hospital,

1 I've had procedures done at Manchester, too, because some
2 were offered there. I think one of the big losses was
3 when we got rid of the maternity ward, and, having both
4 my daughters born there, it was quite a loss to me. I
5 understand why it was done. It just hurt. I think it
6 hurt our community.
7 I was very surprised with, not unexpected,
8 but when Mr. Karl stated that he realized that, if we
9 don't do something, it's the kiss of death for our
10 hospital. Taxes are on the rise from the State. We're
11 losing money federally. We need to do something, and
12 looking for a partner to come in and save our hospital is
13 something that is necessary.
14 Thank you for the opportunity to speak
15 today.
16 HEARING OFFICER HANSTED: Thank you.
17 MR. ZINN ROWTHORN: Thank you, Mayor.
18 MR. SPEES: Thank you and good afternoon.
19 I'd like to say a few things just about the commitments
20 that Prospect is making to the community as part of the
21 transaction, and some of these have been mentioned by Mr.
22 Karl in his presentation, but the first couple of points
23 relate to the key financial terms of the transaction and
24 the purchase price of $105 million.

1 It's significant not just because it
2 represents fair market value for the assets of ECHN, but,
3 also, as Peter mentioned, it eliminates, together with
4 the existing assets of ECHN, it allows the hospital and
5 the health system to pay off all of its debt, so, upon
6 closing of the transaction, the health system at ECHN
7 will be debt-free, and that eliminates in excess of $9
8 million worth of capital that has been previously
9 required to pay down debt, as opposed to becoming
10 available for investment in the health system.
11 In addition to the purchase price, we've
12 committed to make a minimum of $75 million in capital
13 expenditures to be spent or committed to be spent within
14 five years of the closing.
15 A couple of things of significance related
16 to the $75 million capital commitment. It is an
17 investment in the system, so don't think of it as
18 exclusively investment capital for bricks and mortar and
19 equipment.
20 It really is intended to develop the
21 coordinated regional care model and increase access
22 points in the system, so while the strategic and capital
23 plan has yet to be developed, it's likely to include
24 increasing access points, particularly on the ambulatory

1 care side in such things as urgent care centers or
2 additional physician locations.
3 It’s also available for service line
4 development in developing new service lines for the
5 community hospitals, as well as the more traditional
6 capital investments in facilities and equipment.
7 I wanted to mention a couple of things in
8 follow-up to our conversation yesterday regarding the $75
9 million capital commitment, and I wanted to point out,
10 after having had a chance to review the language in the
11 purchase agreement, that the $75 million is, in fact, not
12 conditional.
13 There are provisions that merely call for
14 the potential deferral from the five-year capital
15 commitment, but not the $75 million, and that deferral
16 has to occur in consultation with local community members
17 and with the local Advisory Board, and it’s limited to
18 the isolated case, where there is a state action that is
19 discriminatory towards for-profit hospital and health
20 system operators.
21 In addition to the capital expenditures --
22 MR. ZINN ROWTHORN: Is there an outside
23 time limitation on how long that commitment could be
24 differed, in the event that the --

1 MR. SPEES: Yeah, that's not specified in
2 the purchase agreement, so the language in the purchase
3 agreement says with consultation with the Board and the
4 community.
5 MR. ZINN ROWTHORN: I should say, just for
6 the benefit of our audience here, we did have a
7 discussion yesterday about some concerns that we have
8 about any conditions on the capital commitment as part of
9 our charge here.
10 A significant part of our charge is to
11 evaluate whether the assets are receiving fair market
12 value, and part of, a substantial part of the value of
13 this transaction, as you've highlighted, is the capital
14 commitment, so any conditions, no matter how attenuated,
15 that suggest that that capital commitment could be
16 altered in some substantial fashion, would be of some
17 concern to us.
18 MR. SPEES: Understood.
19 MR. ZINN ROWTHORN: Thank you.
20 MR. SPEES: In addition to the financial
21 terms, the straight financial terms of the transaction,
22 as has been mentioned, we have committed to maintain
23 ECHN's current charity care policies, or, if we make
24 changes, they will result in policies that are at least

1 as favorable as the existing charity care policies.
2 Again, Prospect is about access, and we
3 want to assure the community that that access will
4 remain.
5 While we are a California-based company,
6 we're very strong believers that health care is local,
7 and the key decisions regarding strategy and operations
8 needs to be made locally, so we are committed to our
9 local management team here at ECHN.
10 We've called for the establishment of a
11 local Advisory Board, which I'll talk a little bit more
12 about in a minute.
13 And with respect to the existing medical
14 staffs, they will remain, and, as of the closing of the
15 transaction, they will all become members of the Prospect
16 medical staff.
17 We've also committed, as part of the
18 transaction, to maintain the hospital services, as has
19 been mentioned, for a period of three years.
20 Obviously, should we make any changes in
21 there, that would be in consultation with the local
22 Board.
23 In addition, we've committed to hire all
24 3,000 employees of ECHN, and you'll note on the slide it

1 says in good standing, so that begs the question what
2 does good standing mean? In the case of ECHN, really, we
3 do one single pre-employment screen, and that is to make
4 sure no employee is on the Office of Inspector General's
5 exclusion list for participation in the Medicare program.
6 And, lastly, as has been previously
7 mentioned, at the request of ECHN's Board, we entered
8 into a quality commitment letter to provide that we will
9 maintain their existing quality programs for a period of
10 at least two years.
11 MR. ZINN ROWTHORN: Mr. Spees, was there a
12 commitment to honor the Collective Bargaining Agreements
13 that are in place?
14 MR. REARDON: May I answer that?
15 MR. ZINN ROWTHORN: Sure.
16 MR. REARDON: There is. There is such a
17 commitment.
18 MR. ZINN ROWTHORN: And I guess, while
19 we're paused, the three-year commitment that you
20 mentioned and the Mayor referenced is a commitment to
21 maintain the hospital as an acute care hospital or the
22 hospitals, I should say?
23 MR. REARDON: That's correct.
24 MR. ZINN ROWTHORN: Okay.

1 MR. SPEES. So I want to talk a little bit
2 about the Advisory Board, and it actually should be more
3 correctly labeled as Advisory Boards, because each of the
4 two ECHN hospitals will have its own local Advisory
5 Board.
6 This is a key partnership for Prospect and
7 for our local management teams here. This local Advisory
8 Board really serves as a resource for both Prospect, as
9 well as our local management team, regarding our capital
10 commitment and how those funds should be invested in the
11 health system and with respect to our strategic planning
12 process, which will begin almost immediately upon
13 closing.
14 It's, also, these Boards will be one of
15 many opportunities for our community members to engage in
16 conversations with both the local teams here locally, as
17 well as with Prospect executives.
18 In addition to its advisory role with
19 respect to the capital commitment and strategic planning
20 of Prospect and ECHN, the Advisory Board will be
21 principally responsible for medical staff credentialing,
22 and will maintain and oversee our quality assurance
23 program, and, also, will be principally responsible and
24 oversee and manage the accreditation process, so those

1 activities at the Board level will be principally the
2 responsibility of the local Advisory Boards.
3 Over time, we expect that the Boards will
4 also support us in our physician recruitment efforts, not
5 only providing input into physician needs in the
6 community, but support our efforts to bring new
7 physicians into the community, recognizing that this
8 commitment that we're making in this partnership with
9 ECHN is not just a one or two-year commitment. It is a
10 very long-term commitment.
11 In the event that at some point in the
12 future there is a leadership change at the hospital, we
13 would look to the local Advisory Board for input into any
14 leadership change.
15 MR. REARDON: I was delighted to hear
16 Mayor Champagne mention that Rockville Hospital started
17 on Prospect Street. We're hoping that we'll be able to
18 bring that full circle on there.
19 Prospect offers a unique health care
20 delivery model. I'd like to emphasize the words health
21 care delivery model. It has been mentioned previously,
22 but we are not a hospital-centered company. We are a
23 physician-centered company, but it's about putting
24 together a coordinated regional care model, which

1 includes all kinds of components in the community.
2 It may be surgery centers, it's home
3 health agencies, it's community mental health. We need
4 to have the entire network. We don't have to own
5 everything, but we need that entire network, in order to
6 provide coordinated care to our patients.
7 Think about that for a second. Mitchell
8 was talking about an example, and the fee for service
9 system we have now is so fragmented. It's so fragmented.
10 You can have a situation, where the primary care doc
11 doesn't even know that their patient is in the hospital.
12 Under our system, we coordinate care.
13 Somebody knows where our patients, where our members are
14 at all times. We will follow them into the home. We'll
15 make sure that they get better care, and, frankly, it is
16 better care.
17 In terms of cost, think about that for a
18 minute. I'm going to over-simplify this, but think about
19 it. You go to a primary care doc and you get some tests.
20 Nothing wrong with that.
21 The primary care doc is doing everything
22 they think he or she should do, and then you go to a
23 specialist and you get some tests. Again, nothing wrong
24 with that. They're trying to do the best they can do.

1 And then you go to a hospital and you get
2 some tests, and some pundits will suggest to you that at
3 least 30 percent of the fee for service dollar is wasted,
4 and you can see how it could be wasted.
5 With coordination of care, you actually
6 can squeeze dollars out of the system and reduce cost.
7 ECHN hospitals are low-cost hospitals. We like community
8 hospitals.
9 No disrespect meant to the academic
10 medical centers. They're the crowned jewel of American
11 medicine, but if you compare the cost at ECHN to a Yale
12 or to a Hartford, frankly, the costs are about $5,000 a
13 discharge more at the academic medical centers, and not
14 everything has to be done there.
15 And, so, we think it really does promote
16 better community care. We think it really does provide
17 lower cost.
18 In terms of empowering local physicians, I
19 mentioned yesterday, and I'll say it again, at
20 CharterCARE, with our IPA there, I think as much as a
21 third of the physicians have been attracted to the IPA,
22 even though they had nothing to do with CharterCARE
23 hospitals, simply because they feel empowered, and they
24 feel empowered, because, under the current system, fee

1 for service doesn't provide the monies, in order to
2 develop coordination of care.
3 And with the monies provided with risk
4 contracts, you can actually build the infrastructure,
5 like we have developed, in terms of population
6 management, to do real population management, and the
7 physicians are in charge.
8 No disrespect meant to the managed care
9 companies. We work with them, but the physicians are in
10 charge, and they feel empowered, and they actually get
11 better results. Point blank, they get better results.
12 In terms of maintaining and creating local
13 jobs, I'll say it again. We are a company, we're a
14 growth company. We're not a contraction company.
15 In terms of extensive corporate resources,
16 I mentioned population management infrastructure. We
17 have hundreds of people, who will do analytics, will even
18 do claims processing, not because we think it's a sexy
19 business, but that's how we get data. When we medical
20 management, we assist the IPAs, and we assist the
21 hospitals in both respects.
22 In terms of local leadership, all health
23 care is local, and, so, we really do support the local
24 leadership with regional oversight, and Von and others

1 have alluded to the fact that, with our quality program
2 at this point, we will have checks and balances at the
3 corporate level.
4 Investing significant capital, again,
5 others have emphasized this, but it’s in the system.
6 It’s in the network. It’s not just about hospitals.
7 Yes, the hospitals will get investment,
8 but development of networks will get investment, other
9 things will get investment, as well, because we want to
10 develop a network.
11 In terms of charity care policies, yes,
12 we’re going to preserve those policies. I think I
13 mentioned yesterday and I’ll say it again, many of our
14 hospitals are safety net hospitals. We embrace Medicaid
15 and indigent populations.
16 In terms of Medicaid pilots already
17 alluded to in Rhode Island, we’ve embarked on a Medicaid
18 pilot project. We’d love to do the same thing in
19 Connecticut.
20 If I could move to the next slide? We
21 like Connecticut. Let me tell you why we like
22 Connecticut, and we like Rhode Island, and we like New
23 England, and there are a variety of reasons for that.
24 First of all, there’s very little

1 penetration from a managed care standpoint, in terms of
2 real risk contracting. Prospect has been awarded one of
3 21 organizations in the entire nation that CMS has said
4 you are a next generation ACO, where you can do downside,
5 as well as upside risk.
6 There's been very little risk management
7 or risk contracting in the state of Connecticut, and if
8 you look at the SIM program, the State Innovation Model,
9 they're talking about moving as many as 80 percent of all
10 patients in Connecticut to a value-based payment in just
11 a couple of years. We know how to do that. We've been
12 doing that for 29 years. We think we can help achieve
13 that.
14 When we look at the metrics in
15 Connecticut, in Connecticut, if you take 1,000 patients,
16 Medicare patients, and you talk about how many days you
17 expect them to spend in a hospital, I don't remember the
18 exact numbers, but I think it was 1,400, in aggregate,
19 days in a hospital.
20 We try to keep patients out of a hospital.
21 In our hospitals in California, we've got the days down
22 to about 700, as opposed to 1,400, and that doesn't mean
23 it hurts the hospitals. To the contrary.
24 We have a saying; more and better for

1 less. If we do a better job and we do it for less money,
2 we're going to get more patients, and that's what we've
3 seen as volume increases.
4 There are other things that really --
5 there's still a fragmented physician market. We work
6 very well with independent physicians, and, in terms of
7 attracting physicians to a marketplace, we've had
8 tremendous success up at CharterCARE.
9 We've got a whole new vascular surgery
10 group that came in from Massachusetts. We've attracted
11 general surgeons when we've been told, oh, you can't
12 attract those folks. We have, because they feel
13 empowered.
14 And, so, we think that Connecticut is a
15 tremendous opportunity to really transform the way health
16 care is delivered in the state. Again, our model is
17 disruptive innovation, is what it is.
18 Last slide, whoever has it. Oh, thanks.
19 So our goal, our goal really is the triple aim. We
20 really do think with our model, and I mentioned yesterday
21 I've been around for a couple of years, but I was
22 attracted to Prospect, because I really do believe they
23 have the special sauce to do this; higher quality care,
24 higher patient satisfaction, highest value, lower cost.

1 We're very excited about the possibility
2 of working with ECHN in Connecticut. And, with that,
3 that concludes our Direct testimony from Prospect.
4 MR. ZINN ROWTHORN: So let me ask one
5 question, by way of clarification. Again, for the
6 purpose of making sure we're talking in terms that people
7 can understand, you've mentioned risk or value-based
8 contracting a few times, and I think you're making a
9 contrast to fee for service.
10 For example, in the Medicaid case, you
11 might, under a fee for service contract, you had paid per
12 procedure that you provide, but am I right in
13 understanding risk base? You would get paid a certain
14 fixed amount per patient or per number of patients, and
15 whatever care they get, you're only going to get paid
16 that one amount?
17 MR. REARDON: I will defer to Dr. Lew on
18 that, but essentially correct. What we do with these
19 risk contracts, like in California, where it's very
20 advanced, is the managed care companies will pay us 90
21 cents or 88 cents on the dollar, they will do the
22 marketing, we'll do everything else, and we're basically
23 responsible for the care of that patient completely.
24 It has to come out of the budget we have,

1 and we've developed systems to do exactly that.
2 Mitchell, do you want to elaborate?
3 DR. LEW: Yeah, Perry, that's correct.
4 Traditional fee for service physician, the hospital gets
5 paid per unit, so more volume, more money they make.
6 We're evolving into a more value-based
7 type contracting system, where I guess the first step
8 would be physicians, hospitals would get rewarded if they
9 are able to save on total cost of care, and then a more
10 mature level beyond that would be to take what we call
11 global capitation, which is, again, a fixed amount to
12 take care of a population, whether they pay for the
13 hospital care, pay for the physician care.
14 And Tom referenced the ACO, and, so, CMS
15 has come out with ACOs as a way to really move health
16 care delivery models into the direction of coordinating
17 and managing care quality, but, also, cost, so the
18 leaders that are doing this have started and moved along,
19 and, as Tom referenced, our company is fortunate to be
20 one of only 21 health systems in this entire country to
21 be approved as a next generation ACO, which is the most
22 mature model so far that's put out there by the
23 government.
24 We've been far ahead of the curve in

1 California, and it’s just a matter of time before other
2 states adopt these models, and, so, the sooner that we
3 can come and implement the model I think ECHN will be
4 well ahead, and we will be leaders, leaders in
5 transforming the delivery model in the state, and then be
6 able to go to the Governor and propose Medicaid pilots to
7 provide a better quality of care, but, also, save the
8 state and their Medicaid spending, and that’s what we do
9 with the commercial health plans, also, and they get it,
10 but, again, it’s a step-wise process.
11 I don’t think we’ll go directly to global
12 cap on day one, but it takes time to get there. The
13 initial stages of just setting up the structure, setting
14 up the network, and we talked a little bit about this
15 yesterday, establishing a risk-taking entity and the
16 necessary licenses, we’ve already done that here in
17 Connecticut, and we’ve engaged the plan.
18 Our goal is to hopefully be approved and,
19 when the deal closes, to have our structure established
20 and have engaged in signed contracts with the health
21 plans.
22 And I think, over the next several years,
23 we’ll be all staring at capitation, which is great. It’s
24 a good way to do it. The docs love it, and I think the

1 patients will see the results of it, in terms of better
2 care and higher patient satisfaction.
3 MR. ZINN ROWTHORN: Thank you. At this
4 time, we’ll take a 10-minute break, and, then, when we
5 resume, we’ll have public commentary. I don’t know where
6 the sign-up sheets are, but this would be a good time to
7 get your name on it, if you want to. Thank you.
8 (Off the record)
9 (Whereupon, the public spoke.)
10 HEARING OFFICER HANSTED: We are going to
11 continue with today’s hearing, and we’ll turn to OHCA’s
12 questioning. Mr. Lazarus, if you want to begin? Just
13 give him a couple of minutes.
14 MR. ZINN ROWTHORN: Before we lose members
15 of the public, who may be leaving, I’d invite you to stay
16 for this portion of the discussion, because what I’d like
17 to do, with the consent of our friends from OHCA, is ask
18 the Applicants to address some of the concerns that we’ve
19 heard articulated by members of the public.
20 And, so, I’ll point you to, I think, some
21 concerns that stood out to me as themes, and I know we
22 heard this from Mrs. Fisher when she spoke, and she
23 wanted to know why we ought not wait until the CMS
24 concerns are resolved before you proceed with this

1 transaction, so I'll open that up to you and be
2 interested in your thoughts in response to that question,
3 and anyone can take that.
4 MR. KARL: This is Peter Karl, CEO of
5 ECHN. I thought the testimony that was presented by us
6 was quite clear. The burden of the additional taxes, the
7 burden of some of the federal reductions in reimbursement
8 has led to the demise of the independent hospital as we
9 know it, and for us to delay any longer would put the
10 organization as a whole in total jeopardy, as it relates
11 to survival for the long-term.
12 There are bond covenants that need to be
13 met, and what that means is, with the amount of debt that
14 we currently carry and have carried for many, many, many
15 years, there's certain measures that we have to meet.
16 With these most recent taxes that were put
17 on by the state of Connecticut, we will no longer be able
18 to meet those bond covenants, and, if that happens, the
19 bond insurers will come in and strip down the
20 organizations and most probably make a significant
21 recommendation to consolidate all services at one
22 institution.
23 There isn't time to wait, and, very quite
24 honestly, we've done a very deep dive into the quality

1 issues that occurred out in California.
2 We spent many hours, day and night,
3 looking into them. We are confident that Prospect is the
4 right partner, and waiting any longer is too dangerous
5 for the survival of the organization.
6 DR. O'NEILL: This is Dennis O'Neill,
7 Chair of the ECHN Board.
8 To be perfectly honest, we did entertain
9 that idea. The trustees and the Transaction Committee
10 did discuss at great length whether it would be prudent,
11 more prudent to wait until these issues were resolved,
12 reconciled, and then come back to the bargaining table,
13 so to speak, but the short answer is we're running out of
14 time.
15 As Peter stated, within months, if not
16 before, we will trip our bond covenants, which will set
17 into motion a number of deleterious effects for the
18 organization from a financial standpoint, so we felt, I'm
19 talking about the trustees, we felt it was better to
20 proceed with the transaction working with Prospect to
21 assure that the quality programs that we have in
22 Connecticut remain intact and are, if anything, enhanced,
23 rather than table the deal for some time period and allow
24 the organization to continue into financial jeopardy.

1 We thought it was basically better to
2 proceed and work with Prospect to maintain our quality,
3 rather than continue into financial jeopardy.
4 MR. ZINN ROWTHORN: Dr. Lew?
5 DR. LEW: Yes, thank you. Again, to
6 review what the agreement and the understanding, as it
7 relates to quality in California and the quality program
8 with ECHN, you know, what happened in California
9 certainly is concerning, and Mr. Crockett went over what
10 we're doing to address it, and we're very proud of what
11 ECHN has developed in the area of quality and being a
12 high-reliability organization.
13 And, so, we did reach an agreement, and
14 it's in writing and signed, that we will support that
15 program, and, so, we're not bringing California's quality
16 program to Connecticut.
17 We're going to support the existing
18 program that Connecticut has, as we have done in Rhode
19 Island. Rhode Island has their program, and we let them
20 control locally what that plan is, and they manage it,
21 and we just serve as a check and balance system.
22 And to use the nice lady's analogy on
23 being an educator and a student, you know, if you want to
24 look at us as performing an F on the test in California,

1 that student is not coming here to tutor Connecticut on
2 quality, okay?
3 We're going to tutor that student in
4 California to become an A, and that California student is
5 going to continue to be an A student with our support.
6 MR. ZINN ROWTHORN: Anybody else want to
7 address that, that point?
8 MS. MARTONE: I would like to ask
9 Prospect, specifically, if you can address three things
10 that the public brought up last night and tonight, today,
11 and that would be the independent monitor, the
12 independent ombudsman, and the submission of some type of
13 form of the contents of a 990 Form.
14 HEARING OFFICER HANSTED: We'll take a
15 two-minute break, just so you can converse on that.
16 (Off the record)
17 HEARING OFFICER HANSTED: We're back on
18 the record. Thank you.
19 DR. LEW: Kim, I'm going to have Tom
20 Reardon answer questions one and two.
21 MS. MARTONE: Sure.
22 DR. LEW: And Steve Aleman will answer
23 question three.
24 MS. MARTONE: Thank you.

1 MR. REARDON: In terms of an independent
2 monitor, we're absolutely open to that for a period of
3 time.
4 MS. MARTONE: Okay
5 MR. REARDON: What was the second
6 question?
7 MS. MARTONE: The ombudsman.
8 MR. REARDON: Oh, ombudsman.
9 MS. MARTONE: The independent ombudsman.
10 MR. REARDON: We think the independent
11 ombudsman would be duplicative of what we have the
12 Advisory Board doing. Furthermore, as Peter will point
13 out to you, we have all kinds of patient advocates within
14 the system, itself, so we think it would be duplicative.
15 MS. MARTONE: I think the concern that was
16 addressed yesterday was the fact that they wanted to make
17 sure that he was an independent ombudsman that wasn't
18 directly picked from hospital management that people
19 could go to. Is that what will be part of the local
20 Advisory Board?
21 MR. REARDON: Well the local Advisory
22 Board is independent. Those community members, who will
23 be there to listen, and, as Peter said, there's been a
24 process, whereby the corporators, 300 of them, elect a

1 Board, and it's constantly rejuvenated, and, so, I think
2 there will be independent folks on that Advisory Board,
3 and, again, we think it would be duplicative to have
4 additional requirements.
5 MS. MARTONE: Okay.
6 MR. ALEMAN: And related to the request
7 for disclosure, such as the information, the 990,
8 Prospect has supported transparency in Connecticut, as we
9 have worked through this process and transactions in
10 other states.
11 This isn't the first time that we've
12 encountered it, and we've worked very closely, for
13 instance, with the Department of Health in New Jersey on
14 transparency and disclosures, and, actually, they moved
15 forward to ensure that for-profits had similar
16 disclosures as the not-for-profits, and we've supported
17 that, worked directly with the Department of Health, and
18 we support that here in Connecticut, as well.
19 MS. MARTONE: Okay, thank you. And, going
20 to that, do other states, or have other states required
21 you to have independent monitors, or ombudsman, or any
22 type of individual?
23 MR. REARDON: In Rhode Island, there were
24 conditions of approval, and there was an independent

1 monitor, my recollection is for three years, to make sure
2 that those conditions were upheld and implemented.
3 MS. MARTONE: Okay, but not an ombudsman
4 or any type of individual?
5 MR. REARDON: No. Not to my knowledge,
6 no.
7 MS. MARTONE: And then Steve had questions
8 about it, but since we're here at this point, in terms of
9 the community health needs assessment, you know, we
10 discussed that last night, and the importance that OHCA
11 puts on that, in terms of not just evaluating Certificate
12 of Need and looking at clear public need, but ensuring
13 that there's access to high quality and affordable
14 services in underserved areas most of the time, so we do
15 require hospitals to participate in community health
16 needs assessments.
17 All hospitals in Connecticut submit their
18 implementation plans, as well as any data, sometimes that
19 we need in order to evaluate that, and you had confirmed
20 that there was a willingness to participate, correct, and
21 involve the community and its members and other providers
22 in conducting a needs assessment of the area to determine
23 needs, and you also explained how you also have metrics
24 and analytics that are exceptional and enhanced, if you

1 can talk to that.
2 DR. LEW: Correct, so everything you said
3 can, in terms of the needs assessment, local input, local
4 advisory, but we certainly want to make sure within our
5 model that there is access to care within the community,
6 whether it be through a physician’s office, a community
7 clinic, an urgent care.
8 I spoke earlier about having these clinic
9 sites for post-discharge patients recently discharged
10 from the hospital. Very important for us to make sure
11 there is access and primary care driven and central
12 around -- primary care being central.
13 We would look, and we often work with
14 health plans, and in states, where we have pilots, we
15 have to make sure that there is adequate access. There
16 are very strict requirements on that.
17 And we don’t want our patients having to
18 travel far for their care, because, if they have to, they
19 won’t go seek care, so it’s just part of our overall
20 analysis that we undertake to make sure that it’s
21 convenient and comprehensive.
22 MS. MARTONE: Now, again, the same
23 question. Are you required in other states to
24 participate in a community health needs assessment? Have

1 you conducted any yourselves, or with other partners?
2 MR. CROCKETT: Yeah. In the states that
3 we're currently operating in, the answer is, no, we're
4 not required to, and, so, the community needs assessment
5 we do is mostly working through with our physicians and
6 our Advisory Boards, in terms of accessing the
7 information that's needed.
8 MS. MARTONE: Okay, so, it's not like a
9 community health needs assessment that's required by the
10 federal government, per se, every three years?
11 MR. CROCKETT: Yeah, not as how you're
12 defining it or how it's currently being operated in
13 Connecticut, no.
14 MS. MARTONE: Okay.
15 HEARING OFFICER HANSTED: Is there a
16 specific document that's created by PMH with respect to
17 those findings?
18 MR. CROCKETT: No. It's going to be a
19 local, I mean it's going to be done at the local level as
20 part of the strategic planning process.
21 HEARING OFFICER HANSTED: Okay and what is
22 typically done in the other states on the local level, in
23 terms of a, quote, unquote, "community health needs
24 assessment?"

1 MR. CROCKETT: Well, I mean, by
2 definition, we don't do a community health needs
3 assessment. The issue is, you know, from a community
4 perspective, the issue is are the services being
5 provided, and are they appropriate, and what are the gaps
6 associated with it?
7 It actually really starts with a process
8 of us moving away from a fee for service environment into
9 a population management program.
10 When Dr. Lew was mentioning the data
11 analytics associated with it, as we start the process of
12 taking over the total responsibility of care for the
13 patient, it's looking at the outpatient services that are
14 currently being provided, as well as the inpatient
15 services and the tertiary care.
16 And, so, when community members are having
17 to leave their community to get those services elsewhere,
18 because the hospitals can't provide it or they don't have
19 the outpatient resources for it, then we look at, if it's
20 onesie, twosie, the answer is no, but if there's a
21 substantial amount of the community that needs to go
22 outside of the community and travel outside of the
23 community, then that's a, from our perspective, a need
24 within the community that's currently not being provided

1 by -- it may be even not even just us, even our
2 competitors, if they're having to leave the community.
3 From our perspective, it starts off with
4 this. What does it need to do to coordinate, actively
5 coordinate the care of the patient and have the community
6 members not having to leave the community, and that's,
7 from a data analytics perspective, that's where really we
8 start the work at.
9 DR. LEW: Kevin, let me give you a
10 practical example. Again, we talked about local
11 physician Boards, and they have respective committees.
12 We will look at -- we have data, and we
13 can look at where patients are going for their care.
14 They're showing up in certain emergency rooms, and then,
15 as we migrate to these value-based contracts and you get
16 more data, you can see that -- let's say you have 10
17 primary care physicians and 1,000 patients attributed to
18 those 10 doctors. That may be only a small percentage of
19 those patients are actually staying locally for their
20 care, and they're having to go further away for their
21 care.
22 We have the ability to look at that data,
23 and, so, we have to create better ways to make sure that
24 they can come in and stay in their towns and not have to

1 cross this river that everybody is talking about, and,
2 so, that, again, is look to see should we open an urgent
3 care? Should we be reaching out to these patients and
4 let them know that we can offer transportation, so it
5 really starts grass roots a lot of times, but supported
6 by data, so the local docs are hearing that their
7 patients are ending up elsewhere, so we come in and
8 support them and figure out the solutions to keep
9 everybody in the community and not have to cross that
10 river.
11 HEARING OFFICER HANSTED: Okay, thank you
12 for that, Dr. Lew. I appreciate that. What I'm getting
13 at is, yesterday, there was testimony that PMH will
14 support ECHN with respect to community health needs
15 assessments for I think it was through 2018. Correct me
16 if I'm wrong.
17 What happens after that point? What is
18 submitted to OHCA, if this were to be approved, in terms
19 of a community health needs assessment? And there may
20 very well be you'll continue to support them, and they
21 will continue to submit a community health needs
22 assessment.
23 Absent a formal community health needs
24 assessment, what does OHCA look at to ensure that the

1 needs of the community are being met and planned out?
2 DR. LEW: Well I would say, you know, OHCA
3 should look at making sure that the care is staying local
4 and it's not leaking to other states or other towns
5 within the state.
6 I would say that OHCA should look at the
7 level of patient satisfaction, look at the outcomes, look
8 at the quality measures within the population that's
9 being managed.
10 HEARING OFFICER HANSTED: Okay. All
11 right, thank you.
12 DR. LEW: Sure.
13 MR. LAZARUS: I have a follow-up. Now
14 you've been in Rhode Island for two years, right?
15 DR. LEW: Two years in June, yes.
16 MR. LAZARUS: Have you conducted a CHNA
17 there? Has PMH been involved in doing CHNA there yet?
18 DR. LEW: A community needs --
19 MS. VOLPE: Yeah.
20 MR. CROCKETT: Not a formal one, as it's
21 being defined here.
22 MR. LAZARUS: Okay. The way you've
23 defined it, has one been done, conducted there?
24 DR. LEW: Oh, yes. Absolutely. Yeah.

1 When I spoke to the percentage of leakage outside of the
2 service area, a lot of business and patients were going
3 out of network and going to other systems, and now that
4 we have data and figuring out a way to reach out to
5 patients, we've actually doubled the amount of patients
6 that are coming now to our system and not having to go
7 outside for their care.
8 And as part of the pilot that we're doing
9 with the state of Rhode Island, very closely, as the
10 population gets mapped through the health plans and
11 assigned to our network, we have to absolutely make sure
12 that there's the behavioral health, the medical health
13 components, and we have to work with the community
14 clinics. That's being looked at very closely.
15 MR. LAZARUS: Would you be able to provide
16 us a copy of an example, say, from Rhode Island that we
17 could perhaps look at to get an idea of what you're
18 talking about, the analytics?
19 DR. LEW: Sure.
20 MR. LAZARUS: Because we understand the
21 community health needs assessment, as it's performed in
22 Connecticut, and we're trying to understand PMH's
23 definition of the community needs health assessment.
24 DR. LEW: Steven, when you want the

1 report, what information, like what questions would you
2 want answered, so I can try to get the right --
3 MR. LAZARUS: Well is there a report
4 that's created, generated that tells you the needs of the
5 community?
6 MS. MARTONE: Because like what we
7 typically see, say, in the community health needs
8 assessment filed by the hospitals, you know, they hire a
9 consultant, and they have partners and community
10 providers that are part of this big work group, and they
11 may do phone surveys, they may consult with different
12 partners, and they assess the needs of the area, and, so,
13 then they make a list of what they're recommending, in
14 terms of what needs to be done in the area that's not
15 certainly being done, in terms of unmet need.
16 MR. CROCKETT: In addition to what Dr. Lew
17 was mentioning, and this was done in conjunction with
18 some of the work that the IPA part of our division was
19 doing, as well as our local Advisory Board, that two
20 additional areas that were being underserved within the
21 area was OB services, as well as cardiac care.
22 And, so, as part of that analysis,
23 CharterCARE has recently submitted applications to the
24 Department of Health in Rhode Island for those services

1 to be performed at CharterCARE, and, as part of that
2 process, there was a needs assessment that was completed
3 that would be consistent with how you've outlined it, so,
4 from that perspective, we would be willing to provide you
5 with the application that shows the needs assessments for
6 those services.
7 The needs assessment, from our
8 perspective, is an ongoing issue. We don't do it, you
9 know, once every three years, do it once every four
10 years. It's kind of more of a living, breathing process
11 as we go through population management, so what I would
12 consider for this first two-year process, this would be
13 kind of our first step in looking at those needs, but I
14 think it's substantial when you look at it.
15 MS. MARTONE: We want to ensure that the
16 community is involved. We want to make sure that
17 physicians, providers, other providers in the community
18 are involved. That's all we're looking for really, in
19 terms of this assessment, so it's not just your
20 assessment, but it's the community's assessment, and
21 that's what we're trying to ensure here, that we want to
22 see an implementation plan that actually shows what
23 you're going to do, how you're going to implement it, who
24 is going to be involved in it, and when it's going to be

1 done.

2 So if you're identifying behavioral health
3 as a need, then we want to see a detailed plan, in terms
4 of how you're going to do that. Okay.

5 MR. LAZARUS: So that's something you have
6 an example of.

7 HEARING OFFICER HANSTED: Yeah. The Rhode
8 Island application you mentioned that you're willing to
9 submit, why don't you provide that?

10 MS. VOLPE: To be responsive to you, we
11 will look at that. It may be a needs assessment, like
12 we've seen with other CON applications from consultants,
13 and that isn't what you want.

14 MS. MARTONE: Thank you.

15 MS. VOLPE: So I think, just so there's no
16 miscommunication, let us go back and look and see if
17 there have been an assessment, based on the description
18 you've provided, and we will research that.

19 As has been stated in testimony, as a for-
20 profit, they're not required to do a traditional
21 community health needs assessment, because that is a
22 creature of tax exempt hospitals and a compliance issue,
23 and it's expected that OHCA would get that response,
24 because it's required of tax exempt hospitals.

1 So let us go back and see if, in fact,
2 we've done an assessment similar, along the lines that
3 you're looking for, okay? Because I think, and I don't
4 know this for sure, but if we were to produce the Rhode
5 Island one, I don't think it's what you'd be interested
6 in, because it could be more of a consultant needs
7 assessment that we all are familiar with that many of the
8 hospitals here use to support a service they want to
9 implement, so it's not different, but I think it is
10 different, in terms of what you're asking for.
11 MS. MARTONE: Okay, thank you.
12 HEARING OFFICER HANSTED: Thank you,
13 Attorney Volpe. And if you do have something that you're
14 going to submit, that will be Late File No. 9.
15 MS. VOLPE: Correct. Yes.
16 HEARING OFFICER HANSTED: If you do not
17 have one, please send us a letter to that effect.
18 MS. VOLPE: Yes.
19 HEARING OFFICER HANSTED: Thank you.
20 MR. ZINN ROWTHORN: I had a couple more
21 issues I wanted to touch on out of the public commentary,
22 and I know you may feel that like you've addressed this
23 issue in some detail in your materials and last night and
24 perhaps some today, but, clearly, there remains a

1 question the mind, at least to some of the people in this
2 room, who spoke to us, Mrs. Burke and others, about why
3 ECHN did not partner with one of the local health
4 systems, who are all non-profit.
5 I'd be interested, maybe Dr. O'Neill or
6 Ms. Dorin, to hear. Perhaps you could address that.
7 MS. DORIN: So, as mentioned, we've been
8 involved in this process since December 2011. When we
9 first undertook the decision to seek out a partner, we
10 actually established five criteria.
11 The criteria that we were looking for in a
12 partner was whether or not that partner would bring
13 organizational strength and capability, whether they had
14 a strategic vision for serving the health care needs of
15 our market, Manchester, Rockville, Vernon and the
16 surrounding towns, whether or not they had the financial
17 strength to be able to help us with our debt, and whether
18 or not they would actually be able to implement the deal.
19 It's probably not a surprise. I mean we
20 got proposals from two of the larger hospital systems
21 within the state, and, for a variety of reasons, those
22 didn't fit the criteria.
23 Two of them we would have significant
24 implementation risks, because of anti-trust issues. We

1 felt, considering the five criteria, in conjunction with
2 the visits that we made to California and to Rhode Island
3 and the culture that we could actually see and feel in
4 those facilities and from talking to Prospect, that
5 Prospect was, by far, the best fit for us.
6 The process that we went through was
7 extensive. It took a long time, and I feel very
8 comfortable that we've made the right decision.
9 As I mentioned last night and today, I
10 live in Manchester. I've lived there for 40 years. I
11 want to be able to look my friends and family in the eye
12 when I see them in the local supermarket, which is right
13 around the corner from where I live, that we have made
14 the right decision, and I feel that we have. I have no
15 qualms, whatsoever.
16 MR. ZINN ROWTHORN: I appreciate that, and
17 I think, in fairness, it is worth probably pointing out
18 that, originally, the transaction that you initially
19 sought was with Vanguard, which became Tenet, which did
20 have, as a participant in that transaction, the Yale-New
21 Haven health system, is that correct?
22 MS. DORIN: Right.
23 MR. ZINN ROWTHORN: And then, to the point
24 that you make about anti-trust concern, I think, to

1 clarify that reference, I think what you're suggesting,
2 and you can correct me if I'm wrong, is that were you to
3 partner with an existing health care system in
4 Connecticut, you would be reducing the number of
5 competitor health systems in the state, as opposed to
6 partnering with a system that doesn't currently have a
7 presence in the state. Is that your point?
8 MS. DORIN: Correct.
9 MR. ZINN ROWTHORN: Dr. O'Neill, did you
10 want to answer?
11 DR. O'NEILL: If I can just add, in the
12 latest round, we had offers from Hartford HealthCare and
13 Trinity, the for-profit entity that has recently acquired
14 St. Francis.
15 In the case of Hartford HealthCare, it was
16 not an acquisition of ECHN. Their most recent offer was
17 a partial purchase of some of our most profitable lines,
18 namely, our VNA, and they didn't offer to diffuse our
19 debt or take on our pension liability, so it was an offer
20 that we thought was financially not feasible.
21 Added to that was the anti-trust issue.
22 We were advised by legal counsel and Hartford was advised
23 by their legal counsel that the likeliness of an
24 acquisition deal would be very low from an anti-trust

1 standpoint.
2 In other words, we would be requested by
3 the FTC to have a second opinion, which would delay it
4 another year, and the likelihood of it being denied was
5 relatively high, so we felt we didn't have enough time to
6 go through that process, even if we wanted to go the
7 Hartford Health route.
8 In the case of Trinity and St. Francis, it
9 was based on two issues that we felt that it was not
10 feasible. The first was women's health issue. We felt,
11 being part of a Catholic system, would significantly
12 reduce access to women's health for residents in our
13 market, in our 19 towns east of the river, and we heard
14 strenuous objections from our obstetrical department and
15 from a number of community members, that that was not a
16 good alternative for eastern Connecticut.
17 Added to that was we had an issue with the
18 way Trinity's management would manage ECHN east of the
19 river. We've requested, but we did not get the
20 assurances that we needed, that the management of our
21 health system would be in the best interest of eastern
22 Connecticut, as opposed to the best interest of Trinity
23 corporate and St. Francis in Hartford.
24 So those are the reasons, basically, that

1 we decided that Prospect was the best option for us.
2 MS. DORIN: And if I could just add one
3 other thing to that? Again, when we set out on this
4 selection process, what we wanted to make sure was that
5 care was accessible, affordable to this part of
6 Connecticut.
7 As many of the individuals, who commented
8 today, maintaining health care locally is very important,
9 and our feeling on the Transaction Committee and, also,
10 on the Board was that, if we were to partner with
11 Hartford HealthCare or Trinity, St. Francis, that, bit-
12 by-bit, year-over-year, services would be taken out of
13 this market and brought into Hartford, so our goal in
14 selecting a partner would not have been satisfied by
15 seeking one of those as our ultimate partner.
16 MR. ZINN ROWTHORN: Thank you for that.
17 I'll ask a question that I asked last night, and it
18 reflects some of the commentary that we received here
19 this evening, about the continuing engagement of the
20 hospital system with the communities beyond perhaps the
21 Advisory Board, and I think what that question reflects
22 is what you already know and what you're here again
23 tonight, which is that there's a real sense of value in
24 the communities for these hospitals, almost a proprietary

1 sense that the hospitals are a community asset.
2 What I'd love to hear you address is, and
3 maybe the way to address that is both to talk about what
4 the local Advisory Board will -- how it will be empowered
5 and constituted, but, also, other thoughts that you would
6 like to share with the folks here tonight, about how the
7 communities will be able to continue to have that sense
8 of engagement with the hospital going forward.
9 MR. KARL: Thank you. Perry, we had the
10 discussion this morning about that exactly, because I
11 know that was brought up.
12 So how it works twice per year, and we're
13 happy to go forward, actually, and open it up more, is we
14 do semi-annual updates to our corporators.
15 We bring them in, 300 people, feed them
16 dinner. That way, we know they'd come, and we give the
17 state of the onion, State of the Union. We speak about
18 truly, you know, what the organization is going through.
19 We've educated them over the past four and a half years
20 about where -- what struggles we're having.
21 We educate them on, obviously, on the
22 Affordable Care Act, the detail of the Affordable Care
23 Act, really moving towards value care, so on and so
24 forth.

1 What I see going forward and what I'm very
2 comfortable doing is holding two open forums, community
3 forums per year, perhaps one in Manchester, one in
4 Rockville, inviting the public to come to them, to give
5 them a State of the Union on how the organization is
6 performing, review what's new in the organization, what's
7 happening, what's been invested in the communities, and,
8 you know, truly educate them and educate them on how
9 rapidly health care is changing, and let me just add one
10 thing to that, and we spoke about this this morning.
11 I hear the community loud and clear.
12 Health care 10 years ago, 60 percent of our revenue and
13 our volume was inpatient. Forty percent was outpatient.
14 Seventy percent of the revenue that comes
15 into the organization now, ECHN, is ambulatory, is
16 outpatient, so the way we think of hospitals of the past
17 is completely different than how they truly function
18 today.
19 If you look at a Rockville hospital and
20 you look at a Manchester hospital, 10 years ago our
21 census -- we have licensed beds of 300 at Manchester.
22 Ten years ago, you know, we're running 200 and something
23 beds over there. We have a 100-bed hospital here. Ten
24 years ago, we were running 80 patients. We now run about

1 36 here, and we run about 110, 115 at Manchester.
2 There’s nothing wrong with that. It’s
3 because, 10 years ago, you were admitting patients when
4 they didn’t need to be admitted. Technology has changed,
5 has changed dramatically, and I think that’s what’s
6 getting lost in the public, and shame on us for not being
7 able to educate them well enough, so they better
8 understand that, and, so, you know, I would commit to
9 doing that on an ongoing basis.
10 MR. ZINN ROWTHORN: Thank you.
11 DR. O'NEILL: Just to build on that, we
12 have, in our not-for-profit, governance structure right
13 now. We have 300 corporators, and I think we do actually
14 a pretty good job of educating them.
15 MR. ZINN ROWTHORN: Could you just explain
16 what a corporator is?
17 DR. O'NEILL: Well a corporator in our
18 governance structure is the body of people that governs
19 the organization, that elects the trustees and approves
20 any major decisions, such as a sale of the organization.
21 The corporators historically were the ones
22 who gave money to build the hospitals, and, from a
23 governance standpoint, that’s how they’ve been worked
24 into the system, so, as Peter said, we meet with them on

1 a regular basis. Many of them serve on our committee
2 structure, and I think we do a pretty good job of
3 educating them, as evidenced by the fact that, when we
4 went through this process of explaining to them why we
5 needed to be acquired, and then we went through the whole
6 thing with Tenet, and then we went through the most
7 recent iteration with Prospect, 98 percent of them
8 approved the acquisition, and they're independently-
9 minded people, just like the folks, who have come in
10 today to talk to us.
11 You can't please everyone. You can't
12 please all 300 of them, but a 98 percent approval rating
13 I think is a testament to the fact that we have educated
14 them over time, and that they do see the wisdom in our
15 course of action.
16 So going forward, even though, in a for-
17 profit governance structure, we wouldn't have 300
18 corporators, we would still see the value in meeting with
19 community members on a semi-annual basis to do basically
20 the same process.
21 MR. REARDON: If I could just make a quick
22 comment, Peter and Dennis? I've had the privilege of
23 attending two of these corporator meetings, and although
24 you're right, there's education that goes on in one

1 direction, believe me, there are no bashful people at
2 these meetings. There's education that goes both ways.
3 And I said yesterday, and I'll say it
4 again today, as much as we at Prospect want to be part of
5 this community, we will never know this community as well
6 as the community members do, and, so, we want your input,
7 and the idea of a Town Hall meeting a couple of times a
8 year and open it up to more than just corporators is a
9 terrific idea, I think, so I think we would support that.
10 MR. ZINN ROWTHORN: Thank you, Tom. Tom,
11 I appreciate that, and I think what I'll ask to hear from
12 you guys on the Prospect side of the table is the
13 community does, as you say, know the folks on this side
14 of the table. They don't know you, just like you don't
15 know them.
16 Were this transaction to be approved, do
17 you have a commitment to have national leadership from
18 the organization participate in some of these events or
19 other opportunities to hear directly from the community?
20 DR. LEW: Perry, similar to what we talked
21 about yesterday, in terms of the multiple touches through
22 the model that our network managers would have with the
23 community, that's one way that we would do it, to hear
24 the concerns of the community, as it relates to their

1 care, but, to specifically answer your question, national
2 presence coming to these meetings, that would be fine.
3 I'd love to.
4 MR. ZINN ROWTHORN: Okay, thank you,
5 Doctor. I'll raise it here, because you heard it, and
6 it's the issue about local taxation. Now it's not part
7 of our review. It's beyond the scope of our review,
8 obviously, and, currently, as a non-profit, that your
9 organization is not locally taxed, I'll give you the
10 opportunity to address what Prospect's plans are with
11 regard to tax abatement issues.
12 MR. REARDON: Shall I respond to that,
13 Mitchell? First of all, I heard the comments last night,
14 and I heard them again today.
15 I think there's, frankly, a complete
16 misconception, as to what we have in mind here, and I've
17 read it in the press, too, and I just think there's a
18 misconception.
19 Right now, ECHN does not pay taxes.
20 They're a non-profit. On day one, ECHN is a for-profit
21 organization and will pay taxes. It will pay sales
22 taxes, it will pay personal property taxes, and they will
23 pay real property taxes.
24 We have approached both Vernon and

1 Manchester, and they're awaiting a proposal from us, and
2 we will submit a proposal. I can't get into the details
3 of what that proposal will be, but what I can tell you
4 is, in Rhode Island, what we did there was we looked at
5 the pilot payments.
6 The pilot payments are the payments that
7 the state makes when you have a lot of non-profits in
8 your town, and it's not 100 percent of what the property
9 taxes would be.
10 And what we've done in Rhode Island is we
11 started out with both Providence and North Providence
12 with the pilot payments being a floor for what we would
13 do.
14 And, by the way, pilot payments, from
15 everything I've heard, they're not guaranteed next year,
16 or the year after that in this state, because everything
17 we've heard is it's not a question of whether, but when
18 there will be cuts to cities and towns.
19 MR. ZINN ROWTHORN: And, by the way, pilot
20 payments is a payment in lieu of taxes that a
21 municipality would receive --
22 MR. REARDON: Right.
23 MR. ZINN ROWTHORN: -- and some
24 compensation for having non-taxed property within its

1 Board.
2 MR. REARDON: Right. So what we did in
3 Rhode Island with respect to property taxes was to make
4 sure that the cities and town were made whole, and then
5 we ramped up from there, and the idea was that, to add a
6 huge tax burden on top of an organization that's already
7 in trouble is a tremendous struggle, and, so, what we've
8 asked for is breathing space to make the organization get
9 healthy again, so that we can ramp up to full property
10 taxes, as well as sales taxes and personal property
11 taxes.
12 MR. ZINN ROWTHORN: Thank you for that.
13 We heard a statistic, and I can't -- I'm not familiar
14 with its source and I can't vouch for it, but there was a
15 statistic that 49 of the 50 (coughing) health care
16 systems are for-profit.
17 I'll give you the opportunity to talk
18 about costs within your system. I think you've touched
19 on it some tonight. Maybe, Dr. Lew, if you want to?
20 DR. LEW: Yeah. I'll just add to that.
21 In the markets that we are in, we are considered the
22 lower cost hospital systems.
23 As I shared earlier, you know, we serve a
24 lot of underserved areas, but even in communities, where

1 they're not considered underserved, we're considered a
2 lower cost hospital, and we see ourselves, because we
3 think we are able to produce better outcomes, as very
4 high value, because you have competing health systems
5 that will cost double, and it's probably similar here, so
6 you're paying double, but we think we can get as good or
7 better outcomes, so I don't think we're in that 49 out of
8 50, Perry.
9 MR. ZINN ROWTHORN: I appreciate that.
10 That's all I have, specifically. I want to, while we're
11 gathered here, give you the opportunity. I know you're
12 paying attention to what the public reaction is, both in
13 our comments that we received, but in coverage in the
14 media.
15 If there's anything else you want to take
16 the opportunity to address, I think, in fairness, I'm
17 happy to give you that.
18 DR. LEW: I would just like -- is this the
19 final thing, Perry?
20 MR. ZINN ROWTHORN: I'm sorry to say to
21 the folks in the back that there was a headshake in
22 response to that question. (Multiple conversations) If
23 you want to save wrap-up commentary for the end, you can
24 do that. I'm all set. Thank you.

1 HEARING OFFICER HANSTED: Okay, now we're
2 going to move to OHCA's questions. Mr. Lazarus?
3 MR. SALTON: Hold on. Are you going to
4 let the AG finish their questions?
5 HEARING OFFICER HANSTED: Sure.
6 MR. SALTON: Okay.
7 MR. ZINN ROWTHORN: I may have indicated
8 we were all set, Henry. (Laughter)
9 HEARING OFFICER HANSTED: We'll go back to
10 the Attorney General's Office for more questioning.
11 MR. SALTON: One observation I just want
12 to make is that folks should understand that, yesterday,
13 we had almost six hours of hearing, of which about five
14 hours was presentation and questions from this panel, so
15 there were a lot of detailed questions that we covered
16 yesterday, and some of those detailed questions we're not
17 repeating today, so that we don't use all of the time of
18 people here and test their patience.
19 I do have just a handful of things that I
20 want to ask for. Yesterday, you spoke about, in response
21 to the quality issues in California, that you've brought
22 in this new corporate leadership, the four new corporate
23 officers, and you indicated that's not the sum total,
24 that those individuals will have staff and resources to

1 support their work and oversight of quality of care.
2 And you indicated, I think, that you're
3 going to provide us some CVs for those individuals. We'd
4 also like details on the supporting staff and resources
5 budget money, whatever, that you have allocated to that
6 part of your corporate office.
7 MR. ZINN ROWTHORN: Is that a late file?
8 MR. SALTON: As a late file.
9 HEARING OFFICER HANSTED: That will be
10 Late File No. 10.
11 MR. SALTON: You also indicated that,
12 after the closing, I mean after the approval and the sale
13 is completed, there's going to be a strategic planning
14 process for how the $75 million in capital improvements
15 that serve the hospitals and the larger community are
16 going to be expended over the next five years.
17 If you have, I assume you've done this in
18 your other acquisitions, give us a detailed description
19 of how that strategic health planning process will take
20 place.
21 Who is involved? Who is at the table?
22 What input you're going to get, and who exercises
23 authority, or has a vote on how that plan will be done?
24 I understand that you can't tell us

1 specifics of where every dollar is going to be spent, but
2 at least, right now, we'd like to know what that process
3 is, so we understand how decisions are going to be made.
4 Of particular concern is that we know,
5 from the hospital yesterday, there are substantial,
6 millions and millions of dollars in needs on the campus
7 that need to be addressed, so we would like to know -- I
8 would recommend that you submit as a late file, also, a
9 description of that process.
10 HEARING OFFICER HANSTED: That will be
11 Late File No. 11.
12 MR. SALTON: I'm trying to go through this
13 real quick. Number three is we'd ask ECHN if you could
14 give us also a list of those capital improvements on the
15 campus that you think are critical to be done in the next
16 two to three years that would affect patient care if
17 they're not done.
18 I understand there's always a desire to
19 improve the cosmetics of a hospital to attract patients,
20 but I think what we're really talking about are capital
21 improvements over the next two to three years that are
22 critical to patient care.
23 MR. KARL: We will do that.
24 HEARING OFFICER HANSTED: That will be

1 Late File No. 12.
2 MR. SALTON: Okay, so, then I want to ask
3 just a couple more questions. One is, Prospect and the
4 hospitals gave sort of a little bit more detailed
5 description or variation on this side letter that says
6 that the ECHN quality program is going to be maintained
7 over the next two years, and it was a little bit
8 different description than we heard last night, and we
9 understood that you guys wanted to kind of regroup and
10 provide us a little bit more thorough description, but I
11 just want to make sure that -- my understanding is that
12 the side letter, as written, still governs, and there
13 hasn't been any change to that, based on what you said
14 today.
15 MS. DORIN: Correct.
16 MR. SALTON: Okay, now, the other question
17 I have is I understand there are going to be two Boards,
18 and, first, I'd like to know, and I don't think it's been
19 very clear, exactly, when you guys decide to create these
20 two Boards, how are members going to be selected and
21 placed on a local Board, and who is going to do the
22 selection?
23 DR. O'NEILL: I can answer that. Our
24 intent is to follow the current process, whereas we have

1 one Board that acts as a mirrored Board, because there's
2 two hospitals, so we open the book for Rockville
3 Hospital, open the book for Manchester Hospital, and
4 that's how we carry this through, so it's two Boards, but
5 it's truly one, okay, because that's what we currently
6 have now. If not, you'd be having Board meeting after
7 Board meeting, so we streamline that, because we've been
8 consolidated for 20 years, so that's one.
9 How we would pick the new Board and what
10 our plans were was to go out to our corporators, look at
11 our active corporators, look at the diversity of the
12 towns that we currently live in or they currently serve,
13 and then make sure that we have a balance of not only
14 cultural diversity, but diversity in their careers;
15 someone from Highland Park Market, someone from
16 Manchester Community College, and so on and so forth, and
17 we would select that through our corporators, but we
18 would be open to other ways to do it. That's how we've
19 done it in the past, and that's how we plan on continuing
20 doing it.
21 And the way Prospect sets up their Boards
22 that I mentioned yesterday, there will be five physicians
23 and five community members, and what I would recommend is
24 that we would keep two of the current Board members on

1 the new Board, just for continuity, but bring on three
2 brand new community member Board members, and then five
3 physicians would come from the community, again, diverse,
4 that would come from the IPA that currently practice in
5 town.
6 MR. SALTON: Okay and, so, is that also
7 Prospect’s understanding?
8 MR. CROCKETT: It is.
9 MR. SALTON: And who makes the selection
10 of the physicians?
11 MR. CROCKETT: The selection of the
12 physicians will come from a recommendation from the CEO
13 and then would be approved by corporate.
14 MR. SALTON: Okay and as far as the
15 community members go?
16 MR. CROCKETT: Recommendation, once again,
17 from the CEO, and then approved by corporate.
18 MR. SALTON: And what would be the
19 criteria for corporate approval of Board members?
20 MR. CROCKETT: Making sure that it’s
21 diverse and well-represented and not overloaded. It’s
22 just a check and a balance, nothing, other than that.
23 It’s the same criteria that they go through their
24 selection, as well, and just a validation that it was

1 diverse and it’s appropriate.

2 MR. KARL: If I just might add, also, when
3 you commit, as you are probably aware, I just want this
4 for the record, if you commit as a Board member, you’re
5 committing not only to a monthly meeting, but you’re
6 committing to being on call when issues arise.

7 You also commit to serving on several
8 committees, so it is a significant, significant time
9 commitment that is a volunteer time commitment, which
10 will continue, so it isn’t easy finding Board members,
11 simply because they spent mornings, evenings at the
12 hospitals, at VNHSC, at Woodlake, and, so, we are very,
13 very careful when we look at our corporators to see,
14 again, to make sure they’re diverse, but also can afford
15 the time to volunteer, because if you miss a meeting or
16 two, you’re completely out of it, and, so, it’s a very
17 focused process.

18 MS. MARTONE: Do the Board of Trustees
19 also weigh in on the community members that are chosen?

20 DR. O'NEILL: Yes. Currently, the Board
21 of Trustees has a Governance Committee.

22 MS. MARTONE: Okay.

23 DR. O'NEILL: Made up of trustees, and the
24 Governance Committee goes through an iterative process

1 every year adding corporators, letting corporators cycle
2 off, and then selecting trustees, and then selecting the
3 committee Chairs and then the committee members, so it's
4 a process.
5 The Governance Committee does all this
6 work, and then sends it to the full corporate Board for
7 approval, for review and approval.
8 MS. MARTONE: Okay, thank you. Sorry,
9 Henry.
10 MR. SALTON: Okay, so, if you would also,
11 then -- I appreciate your description on the record, but
12 if you have something and produce something in writing
13 that would be the defined process for the local Board
14 after the acquisition, we'd like that as a late filing,
15 also.
16 HEARING OFFICER HANSTED: And that will be
17 Late File No. 13.
18 MR. SALTON: That's all I have. Thank you
19 for your patience. Thanks, Perry.
20 MR. ZINN ROWTHORN: Good questions. All
21 good questions. Now that definitively concludes the
22 Office of the Attorney General's questions.
23 HEARING OFFICER HANSTED: Okay. I'll take
24 a pause here. We have some questions. Mr. Lazarus?

1 MR. LAZARUS: Just a few questions today.
2 We're not going to have two hours' worth of questions.
3 What I'm going to do is summarize a couple
4 of the things we talked about yesterday and just make
5 clear that the understanding is correct on both sides.
6 First of all, PMH said it has hired four
7 individuals at the corporate level to address the quality
8 of its 14 hospitals in the various states.
9 PMH has entered into a two-year assurance
10 agreement, quality assurance agreement with ECHN to
11 preserve ECHN's quality assurance programs and enhance it
12 as it sees fit for two years, and you provided a copy of
13 that yesterday.
14 Also, the local ECHN Board will have
15 authority to revise, update and enhance the ECHN's
16 quality program as it sees fit.
17 To that effect, could you just kind of
18 clarify, when you talked about authority, does that mean
19 it's just simply a matter of recommendation, who will the
20 recommendation to be to, or do can they actually make any
21 changes?
22 For example, they need to improve the
23 quality of the OR and needs $50,000, is that something
24 that they can recommend, or is it something that they can

1 actually move forward with? That's just an example.
2 MR. CROCKETT: Let me best try to answer
3 that. The expectation that we had discussed today, this
4 morning, actually, with ECHN is that the role of the
5 Advisory Board is to have the responsibility for setting
6 the goals associated with it.
7 In conjunction with that, the role, then,
8 of the corporate team is to make sure that they're best
9 practices and that it's aligned with best practices and
10 national patient safety goals associated with that.
11 Underneath kind of that framework or that
12 umbrella, my expectation is the goals that you did of an
13 example of improving the quality in the OR would fit
14 within that criteria, then the answer is yes.
15 I mean I can't definitively say yes or no
16 on every example, but, underneath that umbrella of
17 example, then my answer would be of course we'd want to
18 improve the quality of the OR.
19 MR. LAZARUS: But they would recommend
20 something to the executive team, to the corporation?
21 MS. MARTONE: They couldn't just move
22 forward with what he's asking. The Board can't just
23 decide to do that and move forward.
24 MR. CROCKETT: Say that again?

1 MS. MARTONE: What he’s asking is if the
2 local Board, ECHN Board, would have the authority and
3 enforcement, say they decided something like that was
4 needed to be done to just move forward and do that and
5 spend the funds that they wanted to spend, so our
6 question is what kind of other approvals would they need,
7 if any?
8 MR. CROCKETT: So, to be clear, the role
9 of the Advisory Board is to set expectations. When you
10 think of quality, I think quality is a little bit of a
11 misnomer, because it means 20 different things to 20
12 people, and it’s a very broad brush associated with it.
13 When we think of quality, it starts off
14 with what are the outcomes of what is trying to be
15 achieved, and, at the end of the day, that’s really the
16 point of it, so, using your example, when we talk about
17 the outcomes that are looking for, I’m looking
18 specifically, then, for the outcomes that need to be
19 achieved within the operating room, and there’s various
20 ways of how outcome can be achieved that needs to be
21 achieved.
22 I don’t think it’s actually the
23 appropriate role for the Board to identify the pathway to
24 achieve it. That’s the role of the actual local

1 management team to say we want to improve whatever
2 standard, and there's multiple ways to actually improve
3 it, and here's, then, our recommendation back to the
4 Board on how we're going to achieve the outcome.
5 The point of it is is that it's not the
6 process of achieving it as achieving the outcome. It's
7 the local management team's responsibility to actually
8 figure out how to achieve it. It may be 30,000. It may
9 be 100. There's multiple ways to achieve it.
10 HEARING OFFICER HANSTED: But just a
11 follow-up on that. So if local management decided, like
12 in Steve's example, that the OR needed to be improved in
13 some manner, would the local management require PMH
14 corporate approval before they could go ahead and do
15 that, or does the decision to take that action stay
16 local?
17 MR. CROCKETT: Well there's multiple
18 levels of -- let me start off with, once again, when we
19 use the word quality, I think it's a very broad brush
20 that can be misinterpreted on multiple different ways,
21 starting off with issues associated with what's
22 considered patient safety, life safety, CMS requirements.
23 We don't actually require corporate level
24 of approval associated with that. In fact, we expect

1 local management to address and resolve any of the issues
2 that are specific to patient safety, life safety, and
3 that's a continuous level of readiness that we expect
4 24/7, 365, and doesn't need approval associated with
5 that.
6 As it talks about the process, then, so,
7 from that level, the answer is no.
8 HEARING OFFICER HANSTED: Okay, thank you.
9 MR. LAZARUS: That helps clarify. Thank
10 you. PMH also said that they will make every effort for
11 the new Chief Quality Officer to make him available for
12 OHCA and the AG after she begins her position on April
13 4th.
14 Considering that -- just be aware that,
15 for the administrative purposes, this docket has been
16 consolidated with PMH's other application, where they're
17 acquiring Greater Waterbury Health Network, so any
18 information that's collected in either one of these
19 records can be utilized towards any of the record.
20 Having said that, can PMH have the new
21 Chief Quality Officer available to testify in the
22 PMH/Greater Waterbury Health Network hearing that we're
23 in the process of scheduling, which I believe we're
24 looking to schedule on April 26th?

1 MS. VOLPE: I mean PMH is prepared, you
2 know, for purposes of late file, to provide detail on the
3 job descriptions, the CVs, you know, the qualifications
4 for all the representatives that are going to be in the
5 Quality Department, as well as an organizational chart,
6 you know, and I think Henry today asked for budgeting.
7 I guess a question we have is what a new
8 person on the job now, if you have their qualifications,
9 you know their job descriptions, you know the
10 organizational chart, you have the details that you need,
11 somebody, who is just hired, what are you hoping to
12 accomplish with speaking with them when they haven't been
13 with the organization?
14 MR. LAZARUS: I do believe that yesterday
15 it was made clear that this person/position was going to
16 be the person, who was going to be responsible within the
17 corporation for all the quality. The buck stops with
18 that person.
19 MS. VOLPE: I mean I'll turn it over to
20 Von, but, in terms of responsible for all the quality, we
21 want the local Boards and the local management to be
22 responsible for the quality, absolutely.
23 The corporate is there as a resource and
24 to make sure that the local hospitals are implementing

1 best practices, do have good quality plans and programs
2 in place, and are implementing them, so this person is
3 going to be responsible overseeing all of that, but we
4 want the responsibility for quality at the local level,
5 and we want the local management and local Boards to do
6 what they feel needs to be done for quality purposes.
7 MR. SALTON: I think that, if this group
8 at the corporate level -- I mean it sounds to me from
9 your presentations that the problems in California are a
10 manifestation of some failures at the local level and
11 that you've now decided to backstop the local level of
12 quality assurance by providing this corporate level
13 division on quality assurance.
14 MS. VOLPE: Correct.
15 MR. SALTON: And I think that it would be
16 very useful for us to have a sense of who this Chief
17 Quality Officer is, their judgment, her judgment, or his
18 judgment, the way she perceives what's happened in the
19 past, and her approach on a going-forward basis, as far
20 as being someone on the top of a pyramid, who has 14 to
21 18, 19 hospitals, and how she's going to approach the
22 job.
23 And even though we don't expect, I don't
24 think anyone expects her to say I've been on the job for

1 two weeks and I have all the answers, her approach and
2 her judgment, her sense of which way the compass pushes
3 is a useful thing for us in making some determinations
4 about the assurance of access and quality to care.
5 MR. ZINN ROWTHORN: And I'll just add one
6 further point, that I think this is a discussion, whether
7 through that way or another way, that's worth continuing,
8 because I'll confess that, even after today and
9 yesterday, there remains some uncertainty in my mind
10 about where the allocation of responsibility lies between
11 corporate and the local Board on quality issues.
12 We had a discussion yesterday that we
13 didn't hear about today, which was that there was some
14 authority delegated to the Rhode Island hospitals that
15 looked more than advisory, but looked actually like a
16 delegation of actual authority on quality issues, so I
17 think we need to -- I think, collectively up here, what
18 we're expressing to you is we need to have a very crisp
19 understanding, to the extent possible, of how quality
20 decisions are going to be allocated between national
21 leadership and local leadership.
22 MS. VOLPE: And we understand that, Perry,
23 and we want there to be a crisp understanding, so, in
24 order to give that to you, I mean do you want that

1 detailed in writing, in terms of how the hierarchy is
2 going to work and the organizational chart, or are you
3 saying that your preference would be to have a person new
4 on the job show up? I mean how can we give you that
5 crisp understanding?
6 MR. ZINN ROWTHORN: I think we should
7 order as a late-filed exhibit some further written
8 explanation on the allocation of quality responsibility,
9 and I'll defer to OHCA and others on the request for live
10 testimony at the Greater Waterbury Health Network
11 proceeding in a couple of weeks.
12 I think we would approach that, I think,
13 with some understanding that the person would be new to
14 the job, but she's going to be backstopped by a group of
15 folks, who know the organization well, so I think it
16 would be helpful to have both.
17 HEARING OFFICER HANSTED: Just for the
18 record, the allocation of the quality responsibilities
19 will be Late File No. 14.
20 MS. MARTONE: And is that going to include
21 the chart of organization you just brought up, Michele?
22 MS. VOLPE: The organizational chart?
23 MS. MARTONE: Correct.
24 MS. VOLPE: Sure. Yes.

1 MS. MARTONE: Thank you.
2 MR. CROCKETT: And in regards to the
3 question, yes, we will make her available for the
4 Waterbury hearing.
5 MR. ZINN ROWTHORN: Thank you.
6 MR. LAZARUS: Thank you.
7 MR. ZINN ROWTHORN: Appreciate that.
8 HEARING OFFICER HANSTED: Just a follow-up
9 on that. OHCA would request that this individual, this
10 new hire, attend the Waterbury hearing in person whenever
11 that is scheduled for. I believe that's the end of
12 April.
13 MR. CROCKETT: Correct.
14 HEARING OFFICER HANSTED: Thank you.
15 MS. VOLPE: Thank you.
16 MR. LAZARUS: Can you please provide us as
17 a late file copies of any and all deficiencies received
18 by PMH-owned hospitals in Rhode Island for the past three
19 years? And please include any plans of correction
20 related to those deficiencies.
21 HEARING OFFICER HANSTED: That will be
22 Late File No. 15.
23 MS. VOLPE: Just a point of clarification
24 on that late file. I mean they haven't owned the

1 hospitals for three years, so, for Rhode Island, for the
2 time period for which Prospect has owned --
3 MR. LAZARUS: Two years would be fine,
4 then, yes.
5 MS. VOLPE: Okay.
6 MR. LAZARUS: So I'm just confirming that,
7 yesterday, we had discussed the Quality Evaluation Team,
8 and they were going to provide documentation I believe on
9 either reports that were developed or generated by that
10 committee or any of the materials they had reviewed.
11 I believe we had talked about that
12 yesterday. Would you be handing those in as late files?
13 MS. VOLPE: I think there was a late file
14 number assigned to those.
15 HEARING OFFICER HANSTED: There is.
16 MR. LAZARUS: Okay. Okay, so, just
17 clarifying.
18 MS. VOLPE: And the last one you
19 requested, Mr. Lazarus, that would be Late File 15?
20 HEARING OFFICER HANSTED: That's correct.
21 MR. LAZARUS: Thank you. Yesterday, we
22 had discussed the eastern region quality I believe it was
23 initiative, or team, or something. It's our
24 understanding from yesterday that it's not something

1 that's been developed yet, but will get developed over
2 time. Do you have a time frame for that development? Is
3 it over the two-year period that you're looking, or is it
4 something relatively soon after the closing --
5 MS. DORIN: I'd defer to Von as the
6 President of the eastern region.
7 HEARING OFFICER HANSTED: Remember the
8 microphone, please.
9 MS. VOLPE: Can you repeat the question
10 for Mr. Crockett?
11 MR. LAZARUS: Yesterday, we were
12 discussing the eastern region either quality initiative
13 or team that's been put together, and we understand that
14 it's not put together yet, but will be, so I'm trying to
15 get an idea of what time frame would that be for that to
16 occur, and, also, what's the goal and vision for that
17 team or initiative?
18 MR. CROCKETT: Let me start off with the
19 goal and the vision first, and then we'll talk about
20 implementation.
21 The goal and the vision is that, as we
22 work with the four individuals, starting off with the
23 Chief Quality Officer, of identifying what resources and
24 best practice is to be shared, as well as policies to be

1 looked at, and it's really more at an umbrella level.
2 It's a resource for the local team here to
3 have someone to call upon and to look at a specific care
4 practice, specific policy and understanding, so the point
5 of the east coast regional team is to be an on-site
6 ability within hours in a, you know, in a same time zone
7 conversation to carry out the corporate initiatives, so
8 they're not doing anything independently. It's
9 underneath a corporate umbrella of the oversight and
10 check and a balance.
11 From a time perspective, I anticipate
12 that, at the time of the close, we will have a regional
13 Director of Quality at the time of the closure, and there
14 will be support staff shortly thereafter, within two to
15 three months, but I would expect to have the leadership
16 position filled.
17 MR. KARL: If I can just, if you don't
18 mind, just add to that? What we're currently doing now,
19 you heard from Linda Quirici yesterday, our quality
20 person.
21 What we're doing right now, what we found
22 is extremely helpful, is we're going to be moving onto
23 the same formatted score cards, so when you're looking at
24 them, you're looking at identical score cards, as it

1 relates to outcomes, whether it's hospital-acquired, so
2 on and so forth.
3 And what we learned from Rhode Island and
4 what they learned from us is there's certain things that
5 we present better, and there are certain visual
6 scorecards that they present better, and we're hoping to
7 do the same thing when Waterbury comes up, because,
8 currently at CHA, the Connecticut Hospital Association,
9 as you know, there are certain quality items, quality
10 measures that we share between hospitals, but we don't
11 like sharing that type of information with competitors.
12 Being that we're not going to be
13 competitors, this is going to be of great help for us to
14 see why are you doing so well with falls in the
15 institution? How come your falls are down so far? What
16 they heard from us is that we have a Red Slipper Program.
17 If the patient has red slippers on, that means that
18 they're at a fall risk, and, so, that's how we're going
19 to play this going forward.
20 MR. LAZARUS: Okay, thank you. Just to
21 clarify, when you talk about eastern region, you mean
22 it's northeast, so it will be Pennsylvania, New Jersey,
23 Rhode Island, Connecticut, or just specific to
24 Connecticut and Rhode Island?

1 MR. CROCKETT: It would include actually
2 New Jersey and Pennsylvania, so our east coast will be
3 true east coast.
4 MR. LAZARUS: Okay. I was just
5 confirming. And, just confirming, that yesterday you had
6 said regarding the community benefit that PMH on the
7 record said that they would fund ECHN's community benefit
8 at the current levels after the acquisitions?
9 MR. CROCKETT: That was correct.
10 MR. LAZARUS: Okay and as regarding the
11 capital projects plan, can you talk about some timeline
12 for that one after the closing? I know there was some
13 discussion, but I wasn't clear on that.
14 MR. SPEES: Sorry. Can you repeat the
15 question?
16 MR. LAZARUS: Sure. The capital project
17 plan that's to be developed after the closing, what's the
18 time frame for that?
19 MR. SPEES: Well, I mean, that's really
20 the responsibility of local management to implement, but
21 we would expect that the process would begin very quickly
22 after closing, and we'll work with the local leadership
23 team on timing of completion process-wise.
24 MR. KARL: Steve, in speaking with my

1 strategic planner and already having conversations about
2 how we would roll this out, I would say, you know, after
3 closing, it would be about a six-month period for us to
4 develop a comprehensive plan that would look out, again,
5 that would look out.
6 It's very difficult looking forward in
7 health care, as you all know, because of the changes, but
8 the strategic plan would probably look out two to three
9 years, and then, again, it would be updated on a regular
10 basis, as necessary.
11 MR. LAZARUS: Okay, thank you.
12 MR. ZINN ROWTHORN: I believe the
13 testimony was that the anticipation is that the money,
14 the $75 million, would be spent or committed within five
15 years.
16 MR. LAZARUS: Carmen?
17 MS. CARMEN COTTO: Hi. Carmen Cotto, OHCA
18 staff. I have some questions also related to the capital
19 projects, but more at the local level, so my question
20 will be addressed to you.
21 In the application on page 3224, indicated
22 that they intended to secure a loan for $5 million to be
23 spent exclusively on behavioral health expansion at
24 Rockville General Hospital as a capital project.

1 Was the loan secured, and, if so, will the
2 project be completed by closing to increase the
3 commitment amount?
4 MR. KARL: The answer is, yes, the loan
5 was secured. It falls under, obviously, our Behavioral
6 Health Department. It's an eating disorder center.
7 That's the only one in the State of Connecticut that
8 would specialize in bulimia and anorexia.
9 And, yes, the loan was secured, and the
10 construction, I can walk you over to Rockville, is
11 currently underway, and we expect it to be completed in
12 the late June -- first phase, meaning 20 beds, will open
13 in June, and then an additional 10 beds will open in
14 September, so it's a two-phased approach, and it has no
15 affect on the purchase price.
16 MS. COTTO: But on the capital commitment,
17 it does? No? Just confirming.
18 MR. SPEES: Well that's actually a
19 complicated answer that I can try. We've agreed to
20 assume the loan, the $5 million loan, but the expectation
21 is the loan is currently secured by cash collateral, and,
22 so, if ECHN at closing has the cash collateral available
23 and delivers it to Prospect, then it has no impact on the
24 capital commitment.

1 If, in fact, ECHN needs the cash to
2 satisfy its obligations or for other reasons and doesn't
3 deliver the cash collateral, the net difference would
4 actually reduce the capital commitment. In essence, we
5 would have pre-funded the capital commitment.
6 MS. COTTO: So, as you indicated, the
7 capital project is for a 30-bed eating disorder inpatient
8 unit for adolescents and adults. That was stated on our
9 page 2149, and, at page 2173, it was stated that
10 Rockville General Hospital has no other behavioral health
11 inpatient service.
12 How was that service determined to be a
13 need, as compared to a general psychiatric inpatient
14 unit?
15 MR. KARL: Approximately, and, Kim, I'd
16 have to go back to OHCA, but approximately five years
17 ago, we entered into a partnership, filed a Certificate
18 of Need, and received approval to open Walden Behavioral
19 Care East, which was an outpatient eating disorder office
20 or center in one of our South Windsor buildings.
21 We had always expected this to grow to a
22 point, because of the significant need that's out in the
23 community relating to these types of eating disorders.
24 What has happened in that five-year period

1 since they've moved in is they've expanded three times at
2 the outpatient unit, and they are at capacity up at their
3 two inpatient units in Massachusetts, so, as a result,
4 they will manage the department. It will be under our
5 license, and it will be our staff.
6 They will hire the physicians, but it will
7 be our staff taking care of these patients.
8 MS. COTTO: One more question related to
9 this issue. What inpatient behavioral health capacity
10 does ECHN currently have, and what relationships do both
11 of its hospitals currently have with community-based
12 organizations to maintain continuity of care/follow-up
13 care regarding behavioral health and substance abuse?
14 MR. KARL: Okay, so, ECHN has an extensive
15 behavioral care division. We have an inpatient adult and
16 adolescent locked unit at Manchester Memorial Hospital,
17 32 beds, 35 beds. I stand corrected.
18 We also have an extensive partial day
19 program, whereas those patients that graduate from the
20 inpatient unit go into partial day, until they are, then,
21 released back into the community, back into society.
22 We also have an extensive ambulatory
23 program at 150 North Main Street. We have over 60,000
24 visits that we see at that outpatient center.

1 We also have, believe it or not, we have a
2 day school in the basement of Manchester Memorial
3 Hospital, and let me define what the day school is.
4 It's those individuals, those sixth
5 graders to seniors in high school, that have behavioral
6 issues that they're unable to function at an everyday
7 high school.
8 They are taught, as they would be in the
9 school systems, but they are taught at our organization
10 in the basement, not because for any other reason than
11 that's where the space is, but they are taught, and they
12 graduate. They actually graduate from that program,
13 graduate with a degree, a high school degree.
14 Those patients, those students, most of
15 them are very active in our behavioral health programs,
16 outpatient programs, so that's the behavioral health
17 piece.
18 And, again, we just recently opened an 11-
19 station locked unit in our emergency department at
20 Manchester, because of the overflow of behavioral health
21 patients. We're in a crisis, as we all know, with
22 behavioral health. We just opened, and, again, it's
23 about $1.2 million behavioral health unit in our ED, to
24 hold those patients there while they are waiting for the

1 beds that are up on the unit to open up, and that was
2 done for patient safety, and, as important, it was done
3 for employee safety.
4 You can imagine, after midnight, holding
5 patients in the emergency department while you're getting
6 MIs and car accidents coming in, and then you have
7 behavioral health patients not being properly cared for,
8 so that was done.
9 MS. MARTONE: And can I just ask? Were
10 any of these initiatives or programs implemented because
11 of the recommendations of the community health needs
12 assessment?
13 MR. KARL: Absolutely.
14 MS. MARTONE: Okay.
15 MR. KARL: Absolutely.
16 MS. MARTONE: All right.
17 MR. KARL: And if I just may add, Kim,
18 because I think Carmen asked the second question, about
19 whether it's opiates, or drug abuse, or substance, I'm
20 sorry, substance abuse, yes, we, in fact, there's a lot
21 going on, but we also have volunteer programs at both
22 hospitals, as it relates to substance abuse, whether it's
23 alcohol, Alcoholics Anonymous, or Narcotics Anonymous,
24 and we are in the process of, at this point in time, Dr.

1 Carroll is in the back, he can speak better, that we're
2 going to be doing hopefully a pilot program with the Town
3 of Manchester, and then we'd like to involve the Town of
4 Rockville, as it relates to the heroin epidemic, mostly
5 because of the Fentanyl issue that's out there currently,
6 so, you know, so, that all, obviously, you don't need a
7 community needs assessment to recognize the problem we're
8 having with the opiates.
9 As you know, Connecticut has made the
10 decision, and correct me if I'm wrong, Dr. Carroll, that
11 we will no longer, at least in our hospital, be
12 prescribing opiates for any more than seven days, and
13 what that has created is a significant issue associated
14 with heroin abuse and Fentanyl abuse, because these
15 patients are addicted, and they can no longer get their
16 opiates, so now they are going after that high, which is
17 heroin, so what we've created, by not providing
18 additional scripts, because our physicians now review the
19 statewide panel for each patient that gets a
20 prescription, they go onto a panel, so we will not be
21 doing refills, which has now created our whole other
22 issue, which we are now going to begin dealing with at
23 this point in time. I hope that answered your question.
24 MS. COTTO: My next question is in

1 reference to the purchase price. I've seen through your
2 presentations that you're only referring to the $105
3 million. Through the application process, there were two
4 scenarios that were introduced to us.
5 There were two scenarios submitted to us,
6 and you're only introducing one. Can you explain that?
7 MR. SPEES: Yeah. At the time of the
8 original submission, there was the possibility that ECHN
9 was going to get an additional loan, which was the
10 genesis of the alternatives. With the passage of time,
11 it's now -- that additional loan is off the table, so it
12 actually makes it much less complicated, so we can deal
13 with just the $105 million scenario.
14 MR. KARL: Carmen, if I can answer that,
15 also?
16 MS. COTTO: Sure.
17 MR. KARL: We felt we may need a bridge,
18 because of the Connecticut state tax, so we were worried
19 about the operating cash, so we're going to go out,
20 borrow $10 million to carry us until this approval went
21 in place, but when we went to banks, they weren't all
22 that friendly about giving up some money, $10 million, so
23 it came back off the table again.
24 MS. COTTO: Okay. Page 3325, you stated

1 that all the joint ventures, in terms of ECHN, were to be
2 transferred to PMH as part of the asset purchase were on
3 schedule for transfer. Could you provide an update on
4 the issue associated with the joint venture, venture
5 transfers?
6 MR. KARL: I'll have Dennis McConville.
7 MS. COTTO: Yes. Okay.
8 MR. McCONVILLE: So, yes, we have 12 joint
9 venture companies, and we have obtained consents in hand
10 for all, but the four joint ventures related to real
11 estate that are under ECHN Enterprises, and those are in
12 process, and we should have those prior to closing. I
13 don't see any issue from our partners.
14 MS. COTTO: I'm going to ask some
15 questions related to the assumption of debt and the
16 pension obligations. Your pre-filed testimony indicated
17 that, and you also mentioned it today, that nearly $75
18 million of ECHN's outstanding debt will be paid through
19 this transaction, which will free up $9 million of debt
20 service annually for ECHN.
21 My question on the $9 million is, first of
22 all, how did you estimate that $9 million was the basis
23 for that? What was the basis for estimating the $9
24 million?

1 MR. SPEES: That information was given to
2 me by Mike Veillette, the hospital CFO.
3 MS. COTTO: Is he available?
4 MR. VEILLETTE: Okay, so, Carmen, the $9
5 million is a function of the long-term debt, primarily
6 the tax-exempt debt that we've had through CHFA and some
7 more recent direct placements with TD Bank, the energy
8 loan with Santander, there are a couple of other loans,
9 as well as the annual payment on the line of credit,
10 because we've been paying down on the line of credit with
11 TD Bank, so we've been paying that down at about $1.8
12 million last year and this year, so that $9 million is
13 1.8 related to the line of credit, 7.2 million of annual
14 debt service related to all the other debt.
15 The remaining annual debt is capitalized
16 lease payments, and that will be assumed by Prospect.
17 MS. COTTO: Which is? What's the total
18 now on that?
19 MR. VEILLETTE: The total number on that
20 is in the neighborhood of around -- it's around $3
21 million.
22 MS. COTTO: Now that $9 million you expect
23 to be free up of $9 million annually. For what extended
24 period of time are you expecting that after closing? The

1 first year? Two years?
2 MR. VEILLETTE: That's an average over in
3 like the next three years.
4 MS. COTTO: Three years? Okay. Now
5 there's been different amounts presented to us related to
6 the debt. In some testimony, I heard 75, through your
7 presentation, it was 78, and the audited financial
8 statements indicated a different amount.
9 I just need you to confirm what is the
10 actual amount for the outstanding debt.
11 MR. VEILLETTE: If you go to our audited
12 financial statement for 9/30/15, the total number between
13 what I would call traditional debt and then look at the
14 debt related to capitalized lease obligations and then
15 the line of credit, that total number is around $90
16 million, if you don't take into account the assets, whose
17 use is limited, so payments that we're making as we're
18 going through the year, so you'll record debt on a gross
19 basis and liabilities, but then you will also be making
20 payments on a monthly basis, and it will be going into
21 what we call assets, whose use is limited, and then you
22 also have a handful of asset accounts, debt service
23 reserve funds, and, so, that is netted.
24 Those funds would be part of the pay down

1 towards the overall gross debt.

2 MS. COTTO: Which I did see the audited
3 financial statements, and I saw, the total amount that I
4 saw was close to 90, as you explained.

5 MR. VEILLETTE: Right.

6 MS. COTTO: Now, based on that, could you
7 please -- what we're asking you to do is to reconcile
8 those numbers with the revised Table 8 that was requested
9 yesterday by the Attorney General's Office.

10 MR. VEILLETTE: So we're doing that on a
11 monthly basis, and, so, yeah, Gary and I spoke, and you
12 requested it yesterday.

13 MS. COTTO: Yes. He requested a late
14 file. I want to make sure that it's reconciled with
15 information --

16 MR. VEILLETTE: We have both of those
17 pieces of debt, if you will, broken out, so the long-term
18 debt, which gets paid down, is net of those other assets
19 I referred to, debt service reserve funds, assets, whose
20 use is limited, and then the capitalized lease
21 obligations are in the assumed liability cluster on the
22 net proceed schedule.

23 MS. COTTO: Okay. I have a question on
24 the funding pension obligations. Please explain PMH's

1 plan for funding the $64 million pension obligation.
2 When will that happen? Right after closing? How will
3 that be taking place, the funding of the $64 million on
4 the pension obligations?
5 MR. SPEES: Yeah, so, the funding on the
6 pension plan will continue post-closing, just as it does
7 now, and there are a host of very complicated IRS
8 formulas that deal with how and when the pension
9 obligations have to be satisfied, and it depends on the
10 return on the investments that have been mentioned, as
11 well as IRS guidelines for what level of funding
12 currently exists.
13 MS. COTTO: Okay. Now will you be able to
14 do the same for the pension, the $64 million calculated
15 cash flow associated with that, like you did with debt?
16 Did you come up with the $9 million that you'll free up
17 to use for capital projects? Could you provide us with a
18 calculation that shows the financial benefit coming out
19 of the $64 million cash flow and the cash flow that will
20 come out?
21 MR. SPEES: I don't know if I can answer
22 that question completely, as I'm not entirely sure if the
23 liability, the unfunded liability is still carried on the
24 post-closing balance sheet of ECHN, or if it has now

1 moved over to the corporate balance sheet of PMH, so it’s
2 difficult for me to say how that’s going to be funded
3 going forward, and part of that is because the current
4 asset portfolio, as it is today, is not what it would be
5 traditionally if it were under an entity that was let’s
6 just say not in our status right now.
7 So, in other words, what I mean by that is
8 our portfolio is entirely in fixed income, and that’s to
9 preserve any more growing of that pension liability in
10 our balance sheet and not exposing it to potential swings
11 in the equity market.
12 I would suspect that, post-closing, that
13 portfolio allocation would be re-examined, re-assessed,
14 and be converted to a more traditional portfolio, so that
15 you could benefit from a more diverse portfolio in the
16 long run and close that pension funding gap, and,
17 hopefully, there will be some improvement in interest
18 rates sometime in the near future, because that is the
19 most profound impact on the current status of that
20 funding gap.
21 We have estimates currently, based on our
22 current portfolio, on what that funding requirement is,
23 but for me to be able to say that there’s a -- those
24 numbers are concrete, so to speak, I don’t have the

1 ability to do that, because I don't know what's coming,
2 in terms of interest rate changes. I don't know what's
3 coming, in terms of potential future funding relief.
4 We've already gone through four measures
5 of pension funding relief just since 2009. It's possible
6 there could be even more funding relief in the future
7 that could change the outlook of pension funding
8 requirements, cash funding requirements for the years
9 2017 through 2021.
10 I can tell you that, if you look at that
11 right now, at this point in time, those numbers are
12 projected to be somewhere in the neighborhood of $17 to
13 $19 million when you get out four or five years.
14 I doubt that that would be the case in the
15 future, once that pension portfolio were reallocated in a
16 more traditional model.
17 That's a long answer, but that's what I
18 can tell you about potential pension funding.
19 MS. COTTO: I guess what I'm trying to get
20 at is what are you getting out of this benefit of PMH
21 relieving you of the $64 million?
22 MR. SPEES: Their ability to be able to
23 help us achieve a greater EBITDA cash flow performance,
24 so, like I said, I'm not sure if that funding requirement

1 comes from that cash flow or if it comes from another
2 source, but EBITDA performance would be the reason for
3 being able to absorb that potential funding requirement.
4 MS. COTTO: And you cannot project that
5 for the next --
6 MR. SPEES: I can only tell you what I
7 have today. I'm sorry. I can only tell you what I have
8 today, based on a projection on what our current model
9 is, based on our current portfolio.
10 MS. COTTO: Could you submit that
11 information to us?
12 MR. SPEES: We could submit that.
13 MS. COTTO: Yes, please.
14 HEARING OFFICER HANSTED: That will be
15 Late File No. 16.
16 MS. COTTO: I have a question for Mr.
17 Crockett. In your pre-filed testimony, you indicated
18 that one of the financial benefits for ECHN related to
19 this proposal would be that revenue collection will be
20 streamlined through PMH's system.
21 Could you please describe this revenue
22 collection process and elaborate how it will be
23 beneficial to both Manchester Hospital and Rockville
24 Hospital?

1 MS. VOLPE: I'm sorry. Can you --
2 MS. COTTO: The page?
3 MS. VOLPE: Yeah, the page. I just want
4 to make sure that was in Mr. Crockett's testimony.
5 MS. COTTO: Okay, sure.
6 MS. VOLPE: As opposed to maybe Mr. Spees.
7 MS. COTTO: Sure.
8 MS. VOLPE: But we'll want to get your
9 question answered, so go ahead and ask it.
10 MS. COTTO: It's page 3359.
11 MR. CROCKETT: So, from a revenue
12 streamline collection process, part of our efforts of
13 looking to assist ECHN, there's many things we're hoping
14 to bring to the table, but one of them is the revenue
15 cycle process.
16 For us, the revenue cycle process is
17 actually multi-faceted. It actually starts at the time
18 of admission. We look at, from an admission perspective,
19 in making sure that, as they're registering the patient,
20 they're collecting the right information, in order for us
21 to actually bill and collect correctly.
22 Part of that is going through and looking
23 at the various -- if they don't have insurance currently,
24 we go through an insurance verification process, where we

1 look to see if they actually -- if they're currently not
2 eligible, if they're currently not on Medicaid, that
3 they're eligible for Medicaid and they're uninsured, then
4 we will hook them up with an eligibility worker to get
5 them insured through the Medicaid program for the
6 uninsured population.
7 For those that do have insurance, we're
8 making sure that the information that is collected is
9 correct and verified and validated, so that, as we go
10 through the billing process, that they can collect from a
11 charging perspective.
12 We go through in making sure that the
13 coding is accurate and that it's correct, they're using
14 the right codes most often. Bills are either not paid or
15 denied, because people are using incorrect codes, or the
16 process for coding is incorrect, and, so, we will have a
17 team go through the validation, in terms of the coding
18 and making sure that that's accurate.
19 From a care perspective, it's not uncommon
20 for bills to be denied associated with eligibility and
21 making sure that, if they do have insurance and that the
22 care is being provided, that they don't do a pre-kind of
23 a verification of insurance, or that it's just not being
24 approved through whatever managed care company insurance

1 that they have, and, so, we'll have a process to making
2 sure that, as the patients are in the hospital and
3 they're receiving the care that they're having, that it's
4 being validated and verified, and, really, it's keeping
5 the managed care companies up-to-date, in terms of what's
6 happening.
7 On the back end of the process, from a
8 billing perspective, we do work with some vendors. We
9 always look to look for local vendors associated with it.
10 We usually look for either internally or externally the
11 expertise associated with making sure that the billing is
12 done timely, people don't wait six months to get a
13 hospital bill.
14 And I'm not saying any of these things are
15 applicable to ECHN. These are more national practices
16 that we look to go through and improve.
17 We won't be actually applying anything
18 that I've just said. Part of our process is we will go
19 through and do an evaluation with what they currently
20 have and really look in areas where we can improve upon
21 what they're currently doing.
22 MS. COTTO: Okay, thank you. Would you
23 like to add anything?
24 MR. ALEMAN: The only thing that I, and

1 Von was very thorough, the only thing I would emphasize
2 this is one area that we see as a core competency of
3 ours. We work very closely with all of our facilities,
4 and one item that I would want to emphasize is the
5 revenue cycle business office resides at the facility, so
6 that's not something that we do centralized or from
7 another location. It resides in the facilities, and we
8 believe it operates most effectively at the facilities.
9 We bring our best practices, our data-
10 driven tools for analytics to help them implement the
11 policies and practices, and make sure that we're
12 consistent, you know, company-wide on how we do it.
13 MS. COTTO: Okay, thank you. I just have
14 a couple of follow-up questions from what we talked about
15 yesterday.
16 MR. ALEMAN: Sure.
17 MS. COTTO: And the first one is related
18 to, when we talk about PMH's ability to continue funding
19 ECHN in the future, as you still continue to acquire
20 hospitals that are in poor financial health, including
21 the New Jersey hospital, as you just acquired, you
22 indicated that you'll still be able to and, also, that
23 New Jersey is actually doing better now.
24 MR. ALEMAN: That's correct.

1 MS. COTTO: Could you elaborate on that
2 statement? What are the financial gains?
3 MR. ALEMAN: Yeah, sure. It's been a
4 while, but when we first started being formally engaged
5 with East Orange General Hospital, it was February of
6 2014, and I believe, if my memory serves me, we signed
7 the APA June of 2014, and, so, we were in the regulatory
8 review process for well over a year and a half in New
9 Jersey.
10 Now when we signed the APA with East
11 Orange General Hospital, they were losing approximately
12 about a million/two a month, and we worked very closely
13 with the management team on some of the items that we've
14 touched base on, such as revenue cycle and the business
15 office, what Von went through in great detail.
16 We worked very closely with them to just
17 improve those practices to ultimately ensure that the
18 facility is collecting what they have ultimately earned
19 from operations, and, actually, over that period of time,
20 bridge that gap from the number that I highlighted to
21 basically break even up to the point of close, and then
22 we looked for further improvement, so, as we take a look
23 at and we focus on, as you stated, financially-troubled
24 facilities, we worked to improve processes, so all the

1 way up to the point of the close of the transaction and
2 beyond, that, certainly, the target is that they're all
3 break even, hopefully, even doing better, or, if they had
4 positive EBITDA, that we've even worked with them to
5 improve that performance.
6 That is basically kind of our strategy. I
7 think we've been fairly effective with that. I think we
8 have that same track record of turnaround in performance
9 at CharterCARE, certainly, East Orange, so that's part of
10 what I reference when I say, you know, I'm fairly
11 confident, as we move forward here, that none of those
12 acquisitions are going to put a drag on our operating
13 cash flow or free cash flow.
14 I feel very confident in our projections
15 for not only following through on our commitments to
16 ECHN, but every acquisition that we work through, and in
17 none of our cash projections do I embed what the
18 projected cash projections are from that target, so, in
19 other words, in none of my cash projections for the
20 commitments for ECHN do I have in there any cash that may
21 be generated from ECHN.
22 In other words, they're not paying for
23 their own commitments. It's the level of conservatism I
24 think that I have in putting together those projections.

1 MS. COTTO: Okay, so, the Pennsylvania
2 acquisition, what is the status of that?
3 MR. SPEES: So the Pennsylvania
4 acquisition is in the regulatory process. It's different
5 than in this state. There is no Certificate of Need, so
6 it's with the Attorney General's process currently, and
7 we expect that -- we're actually scheduling the public
8 hearing I think toward the end of this month, as well,
9 and we anticipate that that process, if it runs as
10 expected, will conclude around the same time as this
11 process.
12 MS. COTTO: Okay. Let's see.
13 MR. SPEES: I'm sorry. The end of April.
14 That would be tomorrow, wouldn't it? I'm reasonably sure
15 the hearing is not tomorrow.
16 MS. COTTO: You testified that the $75
17 million capital expenditures is not necessarily for just
18 brick and mortar, capital projects, but how much of that
19 75 do you expect to actually invest on bricks and mortar,
20 because now we do have information that you submitted
21 that indicated that ECHN has $40 million dollars already
22 identified as capital projects that it needs to address,
23 so will it be accurate to say that, out of the 75, at
24 least 40 million will be set aside for those that they

1 actually need?

2 MR. SPEES: I'll elaborate. I think that

3 we appreciate the nature of the question, but I'll answer

4 it in the same way I answered it previously, is that that

5 will be a product of the capital planning and strategic

6 planning process that we're going through, and, really,

7 to try to do it any other way would sub-optimize the

8 result, and, so, it really needs to be a comprehensive

9 analysis of all of the needs.

10 There are limitations on capital, and, so,

11 there's competition for capital, and unless it's done

12 thoughtfully and thoroughly and with a big picture in

13 mind, then it won't produce the best result.

14 MR. ALEMAN: Yeah, and I'll just

15 elaborate. I think it's been addressed a few times. We

16 look at those. We're here to invest in ECHN and invest

17 in Connecticut.

18 We believe in our model, we believe in the

19 state, we believe in the system, and we'll work very

20 closely with management on the best use of that capital

21 to grow the system.

22 I go back to our Nix acquisition in San

23 Antonio, Texas, that we acquired that from a for-profit,

24 and we actually had no capital commitment as part of that

1 transaction, but any capital commitment that we have we
2 look at at as a floor, and even though with the Nix in
3 San Antonio we had no capital commitment in first two
4 years, we invested over $20 million in the building out
5 of the ER and almost the doubling of the behavioral
6 health facilities in infrastructure within the core
7 building, building out other volume streams into the
8 hospital, I use that as an example of the investment that
9 we made into San Antonio, Texas to grow that system, that
10 is our intent here, also, being able to break that down
11 at this point into specific, whether it's bricks or
12 mortar.
13 The underlying theme is it's to grow the
14 system. It's to grow ECHN. It's to grow services and
15 allocate the capital to the best means to achieve that
16 end.
17 MS. COTTO: Okay, thank you. My question
18 now is related to the most recent data submitted to OHCA,
19 quarterly data that was submitted within the past week,
20 and I have some questions on the difference between what
21 was submitted these past few days and what was originally
22 submitted through completeness, and this for ECHN.
23 The submission, the regional submission
24 indicated, for cash flow operations, indicated that, for

1 fiscal year-to-date, 2014, ECHN generated $305 million.
2 The submission that we received past week,
3 past few days, yesterday, it has a difference of $200
4 million from that amount. I need someone to explain to
5 me why is that so different?
6 MR. VEILLETTE: So, Carmen, in all candor,
7 the quality review or quality control on those reports,
8 they just were shared with me it may have been two days
9 ago, and I found some things in there that didn't appear
10 to be appropriate, correct, and I asked for my team to
11 take another look at it, and we found some formula issues
12 in those reports, so I would rather not try to guess, as
13 to what changed, because I haven't compared the previous.
14 I just knew, when I looked at a few of
15 them, I knew there was an error, such as in days, days
16 and accounts receivable, for example, where you had
17 Manchester had an individual number, you had Rockville
18 had an individual number, and then the combined number
19 didn't make any sense, and then I asked a few other
20 questions, and then I compared it to the audited
21 financial statements, and I asked that we recheck every
22 number, so everything was re-checked, and there was some
23 other -- I was assured that everything had been
24 corrected, but, quite honestly, I can't tell you, because

1 I haven't done a full reconciliation of what was
2 submitted originally and what was submitted after, so it
3 would be my preference to respond to that as part of the
4 late filing.
5 MS. COTTO: The late file, yes. Yes, at
6 the late file.
7 HEARING OFFICER HANSTED: This will be No.
8 17.
9 MS. COTTO: Okay. I think we're almost
10 done here. I just have one more request or two more
11 requests and we can go.
12 HEARING OFFICER HANSTED: Well, to
13 clarify, she'll be finished.
14 MS. COTTO: For me. He's the one that
15 will decide that. Sorry. I apologize.
16 We talked about the $100 million available
17 funding.
18 MR. ALEMAN: Yes.
19 MS. COTTO: And you indicated that it's
20 now in excess of 60, not 110?
21 MR. ALEMAN: That's correct.
22 MS. COTTO: Okay and, also, that the cash
23 flow, the free cash flow has increased 210 to 15?
24 MR. ALEMAN: Correct.

1 MS. COTTO: Through the process, we asked,
2 when we first heard about the 110 million in the free
3 cash flow, we asked for supporting documentation for
4 those numbers. Now they have changed. Could you please
5 revise your form that you sent us, the schedule that you
6 sent us? And that is Schedule R of the December 11, 2015
7 completeness responses.
8 MR. ALEMAN: Yes.
9 MS. COTTO: Could you revise it, just to
10 make sure that it’s updated with the new correct amount?
11 MR. ALEMAN: Yes.
12 HEARING OFFICER HANSTED: That will be
13 Late File No. 18.
14 MS. COTTO: And then we have requested a
15 table that includes EBITDA, working capital,
16 stockholder’s equity for three earlier prior
17 acquisitions, Nix, Roger Williams Medical Center and Our
18 Lady of Fatima. That’s on page 3400.
19 I just have a question on one of your
20 footnotes. The footnote indicated that, it says that the
21 net benefit of government supplemental payments in 2014
22 was higher than average, while the net benefit of
23 government supplemental payments in 2015 was below
24 average.

1 From an operational perspective, the
2 performance of Nix was slightly better in 2015 and ’14.
3 Could you elaborate on those payments, supplemental
4 payments?
5 MR. ALEMAN: Sure. And this is related to
6 the Nix in San Antonio.
7 MS. COTTO: Yes.
8 MR. ALEMAN: Their supplemental program,
9 the 1115 waiver, has a few different pieces related to
10 it, an uncompensated care component and a DSRIP
11 component, of which they receive revenue.
12 The revenue component has been fairly
13 stable year-over-year. What happened in the 2014 period,
14 there is an unrelated expense, but it’s part of kind of
15 the program to be, and, for them, it’s called the
16 SOS(phonetic) expense, where they actually -- there are
17 costs associated with savings that they kind of carve out
18 of the system with some other systems that they work
19 with.
20 Bottom line is those costs, in general,
21 run about roughly about a million dollars a month. They
22 were significantly lower in 2014.
23 And it’s just by virtue of the costs
24 associated with their partners and, basically, what they

1 have to fund, so that one particular year the costs were
2 about $6 million lower than they normally are.
3 Once again, roughly, about a million
4 dollars a month or 12 million a year. If my memory
5 serves me, there was about $6 million in that given year,
6 so that's what really drove the increased performance on
7 a net basis in 2014 for the Nix.
8 MS. COTTO: Okay. That explanation leads
9 to your EBITDA?
10 MR. ALEMAN: Correct.
11 MS. COTTO: Because your EBITDA for Nix in
12 2014 actually decreased between 2014 and 2015.
13 MR. ALEMAN: It went down from '14 to '15.
14 MS. COTTO: Okay.
15 MR. ALEMAN: Right. '14 was good, and
16 then it went down to '15.
17 MS. COTTO: Okay, now, could you provide a
18 table with numbers, the same numbers for EBITDA, working
19 capital and stockholder's equity, related to New Jersey
20 as it is right now?
21 MR. ALEMAN: Sure. Update that for New
22 Jersey.
23 MS. COTTO: Yeah, for New Jersey. Include
24 one line that includes New Jersey.

1 MR. ALEMAN: Yes.
2 HEARING OFFICER HANSTED: That will be
3 Late File No. 19.
4 MS. COTTO: And that's it. Thank you.
5 HEARING OFFICER HANSTED: All set?
6 MS. COTTO: Yes.
7 HEARING OFFICER HANSTED: Do you have
8 anything? Okay. I just want to take a few more minutes
9 of your time and go back to the quality issue.
10 As you're aware, quality has been an issue
11 in this hearing, last night's hearing. It's been an
12 issue with us, and it's been an issue with the community
13 members.
14 It's also one of OHCA's criteria that we
15 need to look at in deciding on this application, and I
16 just want to -- I don't want to go into many specifics,
17 but I just want to highlight some of the quality issues
18 that we discussed.
19 Specifically, in April 2014, there was an
20 immediate jeopardy found at Southern California Hospital
21 at Hollywood. In August 2014, the surveyors found that
22 immediate jeopardy still existed at that hospital.
23 In September of 2015, Southern California
24 Hospital at Hollywood, Culver City and Hollywood, were

1 found to be in immediate jeopardy.
2 In December 2015, immediate jeopardy was
3 found at Southern California Hospital at Hollywood. In
4 November of 2015, deficiencies were found at Los Angeles
5 Community Hospital. And, in February of 2016, a resurvey
6 of Los Angeles Community Hospital found that the hospital
7 failed to address the November 2015 audit deficiencies.
8 And we've heard testimony about the
9 quality agreement that's in place for two years, and
10 we've heard other testimony about some of the steps you
11 took to rectify the deficiencies and the immediate
12 jeopardy.
13 I'd like you to take this opportunity to
14 expand upon with more specificity what actions you're
15 taking, not only at the local level, but at the corporate
16 level.
17 As Perry stated earlier today, there's
18 some confusion with respect to the allocation between
19 corporate and the local level, in terms of who is
20 responsible for quality assurance, so if you can take
21 this opportunity to address us and the community members,
22 I'd appreciate that.
23 MR. CROCKETT: You know, I think that the
24 way to start the conversation is that, you know, quality

1 starts and ends on a day-to-day basis, and what you do
2 for quality is interesting in what happened yesterday,
3 but every single day quality needs to occur.
4 From our perspective, that’s something
5 that we strive for and we’ll continue to strive for in
6 each of the facilities.
7 With that, it has always been and will
8 continue to be important for this organization, I mean
9 Prospect and ECHN, that the ability of a local team to be
10 able to resolve issues in real time fashion.
11 It’s not uncommon, when you talk about
12 quality, that it starts with not just a patient, but it
13 also encompasses a physician and what his needs are, in
14 order to provide safe care, as well as complaints from a
15 patient.
16 From those three areas, it’s important for
17 us to make sure that the local team is empowered and
18 remains empowered to resolve issues quickly and timely
19 and appropriately.
20 As we talk through this, that has always
21 been our mandate, and it continues to be our mandate, and
22 we look to hold our local teams accountable in real time
23 and not have to go through a corporate approval process
24 or off-site approval associated with that.

1 That being said, obviously, it didn’t
2 prevent certain issues arising within the hospitals that
3 you mentioned, and, as we went through and looked at what
4 was causing some of those issues, in particular, one of
5 the common threads that we’ve seen was a lack or a
6 turnover at the executive level, as well as some at the
7 nurse level.
8 Some of the challenges we have
9 specifically to this specific market, so this is not an
10 issue that’s within all of our California, I mean without
11 all of our Prospect hospitals, but within this specific
12 market, is that Los Angeles County has 73 hospitals just
13 within the county, and, with that, our hospitals are
14 safety net providers working as community-based hospitals
15 in underserved areas, and we are next door neighbors to
16 very large, well-respected, well-regarded organizations.
17 And, so, with that being said, the
18 competition within our marketplace at an executive level,
19 as well as at a nurse level, is tremendous, and, so, it’s
20 not uncommon for the large academic tertiary centers, in
21 order to get their nurses, they will go after the nurses
22 that are already employed and have the ability to do so.
23 And, so, our challenge within our
24 marketplace, and it continues to be a challenge and

1 something that we have now spent additional time and
2 energy to focus on, is maintaining consistent leadership
3 within a very, very competitive market, as well as nurse
4 leadership.
5 And, so, with that, we have multiple
6 initiatives to address those issues, including proper
7 career pathways for nurses, so they feel that they don't
8 have to leave our organization, specialty training for
9 the nurses. We're looking for a mentoring program, a
10 preceptorship program, and ongoing support.
11 Nursing, at the end of the day, when you
12 talk about quality, it's not 100 percent of the quality,
13 but it's usually a major part of it.
14 That's not the only cause, obviously,
15 associated with it. So going forward, a couple of
16 different things. One of them is that, as we mentioned
17 previously in our presentation, is, if the organizations
18 do have a lack of resource or expertise, that it's
19 important for us on a go-forward basis to be able to
20 provide leadership and that expertise to backfill as a
21 backstop to organizations that may have some of those
22 concerns, so that's number one.
23 And we look to have kind of a consistent,
24 high-level leadership expertise that can assist when the

1 organizations do have turnover, or gaps, or a knowledge
2 deficit associated with it.
3 On the turnover piece, we have engaged
4 with our corporate HR Department, with our local facility
5 HR Departments, to put in new additional programs to
6 address some of the issues associated with the turnover
7 and retention of the staff.
8 We believe and we're fully committed to
9 it, in terms of putting the resources that are needed to
10 address it in going forward.
11 Let's be clear. CMS doesn't enjoy coming
12 out, and they've said the same thing. They have a high
13 expectation, and they told us personally that being on a
14 rollercoaster ride and multiple visits is not what they
15 do, nor what they expect to do, and it's very disruptive
16 in our organization.
17 And, so, we're committed to resolving the
18 issues, and with some of the things I had outlined
19 beforehand, as well, I hope that you would see that, as
20 well.
21 DR. LEW: Kevin, let me just add --
22 HEARING OFFICER HANSTED: Sure.
23 DR. LEW: -- to what Von said, because I
24 think he probably answered most of your question, but I

1 think you wanted to hear like --

2 HEARING OFFICER HANSTED: No, go ahead.

3 Add what you'd like to add.

4 DR. LEW: Yeah. Quality is going to be of

5 the highest priority, okay, for this company. The silver

6 lining in going through what we're going through is it

7 points out areas that we need to improve, whether it be

8 to build out a corporate infrastructure, bringing the

9 Chief Quality Officer, and a lot more bandwidth in the

10 area of quality, but it's also in other areas related to

11 clinical and medical, and I'm one example, being in the

12 corporate office.

13 So I can tell you that it is a priority,

14 and it is a commitment at the very highest level, and,

15 so, you know, Von can tell you the details of what's

16 happening at the level of each local hospital, but I can

17 assure you, at the corporate level, it has our attention

18 daily and will continue to.

19 I'd love to be here in front of you at

20 some point or share with you how we turned it around and

21 how it's something that we're very, very proud of.

22 HEARING OFFICER HANSTED: Okay, thank you.

23 Does anyone else want to add anything? Okay. All right,

24 that concludes our -- did you want to add something,

1 Doctor? I see you reaching for the microphone.
2 DR. O'NEILL: I have a summary, summary
3 comment at the end.
4 HEARING OFFICER HANSTED: Okay. That
5 concludes our question and answer session. At this
6 point, if counsel or their clients want to give a closing
7 statement, they're welcome to do so.
8 DR. O'NEILL: Well I just wanted to say,
9 on behalf of ECHN, I wanted to thank all of you again for
10 the opportunity to provide support for this transaction.
11 We appreciate your insightful questions,
12 because they've served as guideposts for us along the
13 process, and we certainly appreciate your attention to
14 our application.
15 I'd also like to thank members of the
16 community, who have spoken at both hearings, because it's
17 only through their support that we exist.
18 Approving this transaction will allow the
19 physicians, nurses and hospitals of eastern Connecticut
20 to continue to provide the services that we think our
21 citizens need and deserve, so, on behalf of ECHN, I'd
22 like to thank you again.
23 DR. LEW: And, also, on behalf of Prospect
24 Medical Holdings, I also want to thank the communities of

1 Manchester and Rockville.
2 To hear the questions and the passion of
3 the people of the community it's very reassuring to us on
4 how the people of the community care, and that's
5 important to us, to come in to regions and communities,
6 where the people really do care about the health care
7 delivery system and how they're going to be impacted.
8 I also want to thank the AG's Office, Gary
9 and Henry and Perry and Kevin and OHCA, Kim and Steven
10 and Carmen, for your time.
11 I hope you've learned more about Prospect
12 as a company and, also importantly, learned a little bit
13 more about the senior management team.
14 We are good citizens, even though we are
15 from California, with the exception of Tom, but we do
16 care about what we're doing as a company.
17 And you've heard that we operate
18 hospitals, and we operate medical groups, and we've got
19 this unique delivery model, and we also feel like this is
20 a very good fit with ECHN, and I hope that you're
21 convinced that we are, both parties, very committed to
22 making this work in the long-term for both communities.
23 And I ask that you do approve this
24 conversion application, and just know that we -- that you

1 approve it in a way that you know that we are a very
2 innovative and an entrepreneurial company, and that we're
3 not your normal company, and I mean that in a good way.
4 And I understand that you have assets to
5 protect, but you heard Steve share that we use our
6 commitment as a floor, and that we haven't closed
7 hospitals, and we don't close services. We're a growth
8 company. We add services, and we add programs.
9 And I know that OHCA has a responsibility
10 to assure access, but I hope you understand that access
11 is part of our model, and a community needs type of
12 evaluation is part of the solution, but these things are
13 all very important for us to function and to be
14 successful.
15 And if this can go through, I am very
16 confident that not only will two hospitals be saved, but,
17 in fact, they will be far better, in terms of services
18 and quality, and we will build a delivery system that can
19 be a choice and another option for the state, and that we
20 can be seen as transformative in a delivery system that
21 Connecticut can be very proud of.
22 And we're in this for the long-term, okay?
23 This is not something that we're investing this kind of
24 money to, quote, "flip it," okay?

1 We are in this for the long-term. We've
2 all been in health care all of our careers, so I ask that
3 you just take that, but, again, thank you very much for
4 this opportunity.
5 MR. ZINN ROWTHORN: Thank you, Doctor, and
6 thank all of you. This is a long and detailed and maybe
7 it might seem laborious process, but it's an important
8 process, and I know we've benefitted from having this
9 exchange today.
10 I'll close with where I started this
11 morning, which is to emphasize our gratitude to the
12 members of the community, who were with us today and
13 shared their views today and last night, so we appreciate
14 it, and thank you very much.
15 HEARING OFFICER HANSTED: Thank you, all.
16 Before we leave, before we leave, one moment. I just
17 want to clarify for those folks that may have come in
18 late, is there anyone here that would like to give public
19 comment that did not have an opportunity to do so?
20 Okay. Thank you, all, again, and, with
21 that, I will adjourn this hearing.
22 (Whereupon, the hearing adjourned at 7:32
23 p.m.)

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MARCH 30, 2016

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