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 29, 2016

2:00 P.M.

MANCHESTER COUNTRY CLUB
305 SOUTH MAIN
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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 Manchester Country Club, 305
7 South Main, Manchester, Connecticut, on March 29, 2016 at
8 2:00 p.m. . . .
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10
11
12 HEARING OFFICER KEVIN HANSTED: Good
13 afternoon, everyone. This public hearing before the
14 Office of the Attorney General and Office of Health Care
15 Access, identified by Docket Nos. 15-32016-486 and 15-
16 486-01-CON, is being held on March 29, 2016 to consider
17 Eastern Connecticut Health Network and Prospect Medical
18 Holdings, Inc. application for the purchase of the assets
19 of Eastern Connecticut Health Network by Prospect Medical
20 Holdings.
21 This hearing is part of the procedure
22 under what is commonly referred to as the Conversion
23 Statute, which requires the Commissioner of the
24 Department of Public Health and the Attorney General to

1 evaluate any proposal, which would convert a non-profit
2 Connecticut hospital to a for-profit entity.
3 For OHCA's purposes, this public hearing
4 is being held pursuant to Connecticut General Statutes,
5 Section 19a-639a and 19a-486e, and will be conducted as a
6 contested case, in accordance with the provisions of
7 Chapter 54 of the Connecticut General Statutes.
8 My name is Kevin Hansted, and I have been
9 designated to serve as the Hearing Officer for the Office
10 of Health Care Access in this matter.
11 The staff members assigned to this case
12 are Kimberly Martone, Director of Operations, Steven
13 Lazarus and Carmen Cotto. The hearing is being recorded
14 by Post Reporting Services.
15 OHCA will make its determination on this
16 application pursuant to Sections 19a-486d and 19a-639 of
17 the Connecticut General Statutes.
18 Eastern Connecticut Health Network and
19 Prospect Medical Holdings, Inc. have been designated as
20 parties in this proceeding.
21 MR. PERRY ZINN ROWTHORN: Good afternoon.
22 My name is Perry Zinn Rowthorn. I'm the Deputy Attorney
23 General for the State of Connecticut. I've been
24 designated the Hearing Officer in this matter by Attorney

1 General George Jepsen.
2 I want to thank the Applicants, who are
3 here, the witnesses, any public officials we may hear
4 from, and a special thank you to the members of the
5 public, who are here today.
6 We recognize that this transaction is
7 important to your community, and it’s important to all of
8 the 19 communities that ECHN serves. That’s why we’re
9 here, and your presence here underscores the importance
10 of this transaction in our review.
11 We’re conducting this hearing jointly with
12 OHCA, but the Attorney General has a different role in
13 reviewing the transaction, a different focus and
14 different criteria, and I want to say a few words about
15 that before we get into the hearing.
16 The Attorney General’s role is defined and
17 limited by the Conversion Act, the statute that Attorney
18 Hansted referred to, Section 19a-486.
19 That Conversion Act reflects the Attorney
20 General’s traditional role in protecting the public
21 interest and charitable assets and insuring that monies
22 and properties committed to a charitable purpose are
23 safeguarded and used appropriately.
24 Non-profit hospitals and hospital systems,

1 like ECHN, hold their assets for essentially a charitable
2 purpose, providing health care, and not unlike for-profit
3 systems generating profits for shareholders or owners.
4 The administrators of a non-profit
5 hospital are stewards of its charitable assets with a
6 responsibility to take good care of those assets.
7 The law does not prohibit hospitals, non-
8 profit hospitals, from converting to for-profit status.
9 When one seeks to do so, as here, the Attorney General's
10 job is to ensure that the non-profit hospital is meeting
11 its obligations of care for charitable assets.
12 We make sure three things, that the
13 process leading to the sale was responsible, we look at
14 where hospital -- were the hospital administrators
15 careful in deciding to sell and choosing a buyer and
16 negotiating the transaction?
17 We look at the terms of the sale. Are
18 they fair? Will the hospital system get fair market
19 value for its assets? And we look at the proceeds of the
20 sale. Will they continue to be used for charitable
21 health-related purposes?
22 Those proceeds remain charitable assets,
23 and we need to ensure that the assets of the sale are
24 protected from being used for the for-profit making

1 purposes of the new hospital system.
2 Because the Attorney General must remain
3 focused throughout on the charitable assets, his review
4 and our decision for the most part does not focus on the
5 running of the for-profit hospital system after the
6 transaction.
7 Issues relating to the operation of the
8 new hospital entity, as it relates to access to health
9 care services, are within OHCA's purview.
10 Today's hearing is a very important part,
11 but just one part of a review that has been ongoing for
12 months. We'll take testimony and evidence, and we'll
13 hear public input today. We'll ask some questions.
14 Don't assume if we don't ask a question on
15 a topic that that topic is not important to us. Before
16 today, we have received and reviewed thousands of pages
17 of documents, and we've asked questions and received
18 answers in written form.
19 All of those materials, by the way, are
20 available for your review on the Attorney General's
21 website, www.ct.gov/ag.
22 The public's input is important to our
23 review. All the information we receive today and in the
24 hearing we'll hold on this transaction tomorrow in

1 Vernon, including all the public comments, will become
2 part of the official record of our review.
3 We'll do our best to accommodate
4 everybody, who wants to speak. We'll also take comments
5 in writing, and those comments will also be included in
6 the official record.
7 We have sheets at the door that you
8 probably saw when you came in to sign up if you want to
9 speak. We urge you to do that, and we're anxious to hear
10 your commentary.
11 You can also take sheets. We have
12 instruction sheets at the table for your own review or to
13 give to friends or acquaintances, who may wish to be
14 heard on this transaction, but couldn't be here today.
15 We are on track to review, to complete
16 this review and issue our decision as early as June 10th
17 of this year. I want to say a word about what that
18 decision might entail.
19 Under our statute, the Attorney General
20 either must approve the transaction as it is, deny it, or
21 approve it with conditions, and those conditions for our
22 purposes would relate to the purpose of the Conversion
23 Act. That is, they would relate to the Attorney
24 General's focus on protection of charitable assets.

1 This is a joint hearing. Kevin and I are
2 going to work together to move this along to cover as
3 much business as we can. You can assume that if either
4 of us makes a ruling, that unless we state otherwise,
5 that ruling will apply for both offices, and you can
6 assume that, if either of us asks a question, because we
7 have a joint record, that the question and answer will be
8 applicable in both of our reviews and records.
9 I'll talk a little bit about how we see
10 this proceeding going forward today. We're going to hear
11 first the Applicant's Direct testimony. Next, OHCA will
12 ask questions. To the extent that we have additional
13 questions after OHCA's, we'll ask questions, then we'll
14 have opportunity for public comment, and then opportunity
15 for closing remarks.
16 Before I turn it back over to Kevin, who
17 has got some additional important business to discuss, I
18 want to introduce the Attorney General's staff, who is
19 here with me today.
20 Immediately to my left is Assistant
21 Attorney General Henry Salton, who is providing legal
22 advice to the Attorney General and to OHCA.
23 Next to him is Assistant Attorney General
24 Gary Hawes, who is coordinating this review for our

1 office. Soon to be with us is paralegal specialist
2 Cheryl Turner, who has returned to our office to get our
3 name plates, because we see that OHCA has theirs, and
4 we're anonymous to this point at least, so thank you for
5 your attention. I'll turn it back over to Kevin.
6 HEARING OFFICER HANSTED: Thank you,
7 Perry. At this time, I'll ask staff to read into the
8 record all those documents already appearing in the Table
9 of the Record, and those documents have been identified
10 in the Table of Record for reference purposes. Mr.
11 Lazarus?
12 MR. STEVEN LAZARUS: Good afternoon.
13 Steven Lazarus. For today's record, I would like to
14 enter into the record Exhibits A through CC.
15 I would like to note that, in item BB, the
16 presentation being provided today by Eastern Connecticut
17 Health Network is included in those documents.
18 Also, OHCA intends to add to the record
19 Exhibit DD, which will be the PowerPoint presentation
20 submitted by Prospect Medical Holding.
21 And, also, a new document that we received
22 today that we're in the process of reviewing, the Quality
23 Assurance Commitment, is being added as Exhibit EE.
24 HEARING OFFICER HANSTED: Thank you, Mr.

1 Lazarus. Counsel, are there any objections to any of the
2 exhibits?
3 MS. REBECCA MATTHEWS: No objection. This
4 is Rebecca Matthews from Wiggin and Dana here on behalf
5 of ECHN. There are no objections to the record. We just
6 had a few clarifications that we wanted to make if that's
7 okay.
8 HEARING OFFICER HANSTED: Sure.
9 Absolutely.
10 MS. MATTHEWS: The first is with respect
11 to Exhibit E.
12 HEARING OFFICER HANSTED: If you just
13 bring it closer to you, it might help.
14 MS. MATTHEWS: Can you hear me now? Is
15 that better? So the first is with respect to Exhibit E.
16 There's a reference to a two-page request for an
17 extension to file the original application. I think
18 there were two separate letters, both of which were two
19 pages, one from each of the Applicants, co-Applicants, so
20 I'm not sure if this is referring to the letter from PMH
21 or ECHN, but we just wanted to make sure that both
22 letters were included in the record since that was a
23 joint request, if possible.
24 HEARING OFFICER HANSTED: Thank you. Yes.

1 MS. MATTHEWS: The second is with respect
2 to Exhibit H. There's a reference to a one-page public
3 comment letter. It doesn't say in the Table of Record
4 who it's from or the date.
5 I think, from looking at the docket, it is
6 referring to an e-mail from a Mr. Tonerowicz(phonetic)
7 from last October. Again, no objection at all to it
8 being in the record.
9 We just wanted to make sure or to clarify
10 on the record that there are other letters of support
11 that have been filed. Some of them were filed with our
12 initial application. I think that's DD, was the filing,
13 and then additional letters have been filed with our most
14 recent submission or the submission on Monday, the 28th,
15 so I just wanted to note that for the record.
16 A very small point on Exhibit K, which it
17 says it's dated November 24th, and I think it's dated the
18 23rd, and you just may hear us reference that filing. I
19 just want to make sure there's no confusion.
20 Just a couple more. One is P, where the
21 agencies have taken administrative notice of the Greater
22 Waterbury Health Network application, and, again, no
23 objection at all.
24 As you mentioned, these applications are

1 very lengthy. They're thousands of pages, so we don't
2 actually have that application with us today, and we may
3 not know everything in it, and we would just ask, if it's
4 possible, if there's anything specific that might be used
5 from that application in this decision that we might not
6 otherwise know about, if you could, please, if we could
7 respectfully request to have some specific notice and an
8 opportunity to respond, because we do not have it with us
9 today.
10 And I think that is all. I know you've
11 added the quality commitment letter, which we submitted
12 today. Thank you very much.
13 HEARING OFFICER HANSTED: Thank you. Okay
14 and, at this point, would all the individuals, who are
15 going to testify, would you please stand, raise your
16 right hand and be sworn in by the court reporter?
17 (Whereupon, the parties were duly sworn
18 in.)
19 HEARING OFFICER HANSTED: Thank you,
20 everyone. Just a couple more points. First of all,
21 before each of you speaks today, if you've submitted pre-
22 filed testimony, please adopt that testimony for me on
23 the record today before you speak. Thank you.
24 And if everyone would like to go down the

1 line and just introduce yourselves, that would be
2 helpful. Start down here.
3 MS. MELINDA AGSTEN: I'm Melinda Agsten of
4 Wiggin and Dana, counsel to ECHN.
5 MS. MATTHEWS: Rebecca Matthews, Wiggin
6 and Dana, counsel to ECHN.
7 MR. PETER KARL: Peter Karl, CEO of ECHN.
8 MS. JOY DORIN: Joy Dorin, member of the
9 Board of Trustees.
10 DR. DENNIS O'NEILL: Dennis O'Neill, Chair
11 of the Board of ECHN.
12 DR. MITCHELL LEW: Dr. Mitchell Lew,
13 President, Prospect Medical Holdings.
14 MR. VON CROCKETT: Von Crockett, Senior
15 Vice President of Corporate Development for Prospect
16 Medical.
17 MR. JONATHAN SPEES: I'm Jonathan Spees.
18 I'm Senior Vice President with Prospect Medical Holdings.
19 MR. STEVEN ALEMAN: I'm Steve Aleman,
20 Chief Financial Officer, Prospect Medical Holdings.
21 MR. TOM REARDON: And I'm Tom Reardon,
22 President of Prospect East.
23 MS. MICHELE VOLPE: And I'm Michele Volpe,
24 Legal Counsel for Prospect Medical Holdings.

1 HEARING OFFICER HANSTED: Okay. Thank
2 you, all, and welcome. And, at this point, Attorney
3 Matthews, you may proceed with your presentation.
4 MS. MATTHEWS: Thank you, all, very much
5 for this opportunity. I'd like to introduce first Dr.
6 Dennis O'Neill, who is going to speak on behalf of ECHN.
7 DR. O'NEILL: Good afternoon.
8 HEARING OFFICER HANSTED: Good afternoon.
9 DR. O'NEILL: Mr. Hansted, Mr. Zinn
10 Rowthorn, members of the office of the Attorney General,
11 and members of the office of Health Care Access, my name
12 is Dennis G. O'Neill. I'm the Chair of the Board of
13 Trustees of Eastern Connecticut Health Network.
14 I'm also a physician in private practice
15 working in the Manchester and Vernon communities for the
16 past 33 years.
17 Thank you for providing us with the
18 opportunity to submit testimony in support of ECHN's
19 proposal to transfer its assets to Prospect Medical
20 Holdings.
21 First, I would like to adopt my pre-filed
22 testimony, then I'd like to explain that, after my
23 introductory comments, Peter J. Karl, ECHN's President
24 and CEO sitting to my left, is going to make a brief

1 presentation on our financial situation.
2 Joy Dorin to my immediate left, one of our
3 Trustees and Chair of the Board’s Transaction Committee,
4 will then present information on the transaction, itself,
5 and ECHN’s quality program, after which representatives
6 of Prospect Medical Holdings will offer information on
7 their organization.
8 Manchester Memorial Hospital and Rockville
9 General Hospital, the flagship hospitals of ECHN, were
10 built about 95 years ago by members of their respective
11 communities in response to the influenza pandemic of 1918
12 and, also, as memorials to those community members, who
13 died in World War I.
14 For many decades, these two hospitals
15 functioned as separate community hospitals, and then,
16 about 20 years ago, they joined together to form ECHN.
17 They were both in good financial shape at
18 the time, but pursued a merger, in order to provide more
19 efficient and better integrated hospital care for their
20 citizens.
21 Over the last two decades, ECHN has grown
22 beyond the two hospitals into a health care network with
23 13 wholly-owned subsidiaries, 12 joint venture companies,
24 and dozens of facilities serving the needs of our

1 communities.
2 ECHN now employs 3,000 people in eastern
3 Connecticut, and the hospitals in Manchester and Vernon
4 are the largest employers in their communities.
5 In just this last year, 2015,
6 approximately 115,000 people were treated in our
7 hospitals, 61,000 folks were examined in our emergency
8 departments, 5,000 patients were cared for by our
9 visiting nurses, and we delivered about 1,400 babies.
10 Needless to say, the citizens of eastern
11 Connecticut need and use our facilities, but the American
12 people, in general, and the members of our communities,
13 more specifically, have told us that they want and need
14 care that is even more integrated than the care they
15 receive today, care that is higher in quality and lower
16 in cost.
17 In an attempt to respond to these needs
18 and in anticipation of worsening financial conditions,
19 the trustees of ECHN about four and a half years ago
20 formed a work group to evaluate whether or not ECHN
21 should pursue a partnership with another organization.
22 At that time, we thought we had about five
23 years before our circumstances became dire, due to
24 changes in the health care landscape that we thought were

1 going to have a negative effect on our organization.
2 The first year was spent deciding that we
3 should partner, as opposed to going it alone. In the
4 second year, we selected as our best option an asset
5 purchase agreement offered by Vanguard Health System and
6 New Haven Health System.
7 In the middle of the second year, Vanguard
8 was acquired by Tenet, and we spent the remainder of that
9 year getting to know them.
10 During year number three, we negotiated a
11 deal with Tenet that would have preserved our hospitals,
12 the jobs of our employees, and the pensions of our
13 retirees, and provided capital for future growth, but, at
14 the end of 2014, Tenet abruptly left the state, citing
15 what it perceived as overly restrictive conditions placed
16 on its acquisitions by state regulatory agencies.
17 That was a great disappointment to us,
18 because it essentially scuttled three years of work, but,
19 more importantly, we were three years closer to 2016 with
20 still no deal in hand.
21 But then, in 2015, our fourth year, we
22 were fortunate enough to find Prospect Medical Holdings
23 and spent most of that year negotiating a deal with them
24 and resubmitting our application for regulatory review.

1 Prospect is a health care company based in
2 California that, through the business acumen of its
3 founders, the perspicacity of its senior management team,
4 and the perseverance of its staff, has in the last two
5 decades become an industry leader in what is referred to
6 as population health.
7 That is managing all aspects of a health
8 system, inpatient care, outpatient care, physician office
9 care, home health care for a large group of people, in
10 this case the people of eastern Connecticut, with higher
11 quality and lower cost.
12 Like all health care companies, though,
13 Prospect is not a perfect hospital company. Last year,
14 during inspections at two of its California hospitals,
15 the Centers for Medicare and Medicaid Services, CMS, made
16 determinations that required correction.
17 You'll hear more about this in a couple of
18 minutes from Joy Dorin, one of our Trustees, and the
19 folks from Prospect.
20 But it's important to note at this point
21 that our Trustees and Corporators chose overwhelmingly,
22 the Trustees voted unanimously and the Corporators voted
23 with 98 percent approval rate, to transfer our assets to
24 Prospect for at least three important reasons.

1 First, Prospect is not Tenet. They're
2 smaller in size, they're less threatening as a newcomer
3 within the state of Connecticut, and because they're not
4 affiliated with Yale or Hartford HealthCare, they would
5 actually increase, rather than reduce, competition within
6 our state.
7 Secondly, the deal we negotiated with
8 Prospect is essentially the same deal we had negotiated
9 with Tenet, with preservation of our hospitals, our
10 employees, our retirees and capital for our future.
11 And, thirdly, Prospect is a recognized
12 expert in what they refer to as coordinated regional
13 care, taking to a new level what began with the creation
14 of our two hospitals many years ago and continued with
15 the formation of ECHN.
16 Now, for more detailed information on
17 ECHN's financial condition, I'd like to pass the
18 microphone to Peter J. Karl, ECHN's President and CEO.
19 MR. KARL: Thank you, Dr. O'Neill. My
20 name is Peter Karl. I'm the CEO of ECHN, and I adopt my
21 pre-filed testimony.
22 My mandate today is to try to explain how
23 and why we came here today. It really all started back
24 in 2010, as we reflect back and think about the

1 Affordable Care Act, the thought of decreasing
2 governmental payments, focusing on value, lower cost, but
3 high-quality care.
4 I'd like to walk you through the story of
5 how we got here. What I would ask is that you take
6 slides seven, eight and nine and put them side-by-side in
7 front of you. That may make it easier for me to explain
8 to all of you. Thank you.
9 So I started as CEO in December of 2004
10 and began the leadership of ECHN then. Back in the
11 earlier days, about 11 years ago, you can see how the
12 organization was performing.
13 It began to find its way in the 2008/2009
14 time frame. At that same time, if you remember, there
15 was a significant issue with pensions, as it relates to
16 WorldCom and Enron, and organizations not being able to
17 fund their pensions, therefore, the PBGC had to pick up
18 their pensions.
19 What happened then was the Pension
20 Protection Act went into play, and that Pension
21 Protection Act took the actuarial projections from a 21-
22 year look forward down to a seven-year look forward.
23 Because of that, the pension liabilities
24 for all organizations grew significantly. To make

1 matters worse, the market crashed. We all remember 2008
2 and 2009.
3 Even though ECHN froze their pension, we
4 now had a pension liability, a pension payment annually
5 that went from zero dollars, because the pension used to
6 fund itself through the market performance, to a total of
7 $12 million per year we had to pay into our pension.
8 Our pension, because of the market crash,
9 grew significantly. If you follow our debt throughout
10 the years, you can see that we controlled our debt.
11 There was no way for us to take on much more debt, except
12 back in 2009, where we had to invest about $9 million
13 into a new critical care unit at Manchester Memorial
14 Hospital, because of the need of our patients.
15 On top of all of that, as we're going
16 through this difficulty right now, about $12 million went
17 to the pension, about $12 million went to our debt, so
18 the first $24 million went out the door to pay
19 liabilities. What that left was very little to invest
20 back into the organization.
21 If you look at the next page, on page
22 eight, you'll see that, at the exact same time, later on
23 in the years, in '14, '15 and '16, the federal government
24 and the state government began imposing certain

1 reductions in reimbursement and imposing a hospital tax.
2 The hospital tax began earlier, but, in
3 2014, it was about $4 million, and, if you all remember,
4 the federal government could not agree on a budget, so
5 there was a two percent cut across the board, called
6 sequestration. That affected us to the tune of $2.2
7 million per year.
8 In fiscal year ’16, this year, the
9 Connecticut hospital tax imposed on our organization is
10 nearly $10 million.
11 Most recently, and you may want to add
12 this to the 9.942, the additional $4.6 million that was
13 promised to our organization by the state government was
14 held back, due to the state’s budget woes, so that $9.9
15 million jumped an additional $4.6 million.
16 I would ask you now to reflect back to
17 page seven, please. You look at page seven, you can see
18 that the organization can no longer perform at a positive
19 cash flow or at a profit.
20 It has to take all of these reductions.
21 You add up about $25.1 million in reductions in
22 reimbursement or tax, and you add that to the current
23 organization, so then you must wonder why how did you get
24 at least the $2.2 million or a loss of only $.3 million?

1 Well there are only two ways to get to
2 that. One way is to reduce labor. Labor is 60 percent
3 of our operating costs. We reduced approximately 200
4 FTEs over the past two years, because of these
5 reductions.
6 And if you go to page nine, there's the
7 other side of the ledger. You look at the organization,
8 and how do you reinvest in the organization if you don't
9 have any money? Well you don't. You can't fund your
10 depreciation, so what happens then?
11 The age of your plan continues to age.
12 Facilities begin to breakdown, equipment begins to
13 breakdown, and, as Dr. O'Neill mentioned, we're talking
14 about 100-year-old buildings.
15 Our average age of our plant, as it's
16 measured nationally, is 21 years old. The national
17 average for the age of a plant is 10 years old. We are
18 twice that age.
19 If you flip to the next page, please, and
20 I'll wrap this up, we are looking at not only these
21 forces, but the continued negative forces into the
22 future; continued erosion from the federal government,
23 declining levels in payment from the state government,
24 payment reforms that include financial risk, these

1 continued pension obligations that just won't go away,
2 the state of Connecticut is struggling with that right
3 now themselves, all of you, and the continued rising
4 costs. We have to pay our employees. We have to pay for
5 supplies and increases. Cost of living continues to go
6 up.
7 I can't express enough the dire situation
8 we are in at this point in time. Next page, please.
9 Let me briefly explain the proposed
10 transaction. What this transaction will do for us it
11 will satisfy our debt and our pension liabilities.
12 ECHN will have a fresh start. There will
13 be no debt. The pension liabilities will be satisfied by
14 Prospect Medical. Not only that, $75 million in capital
15 will be reinvested in the health network, and what I mean
16 by the health network is what Dr. O'Neill mentioned.
17 Not only the two hospitals, or long-term
18 care facility, or VNHSC, but into the communities,
19 whether it's additional services, additional physicians,
20 specialists that we currently don't have.
21 We will continue to have the ECH brand and
22 mission. There will be an Advisory Board, and we will
23 employ all physicians, all employment, all employees.
24 Excuse me.

1 And my last slide. One of the reasons why
2 we chose Prospect, and as Dr. O'Neill mentioned, is
3 because they know how to survive and thrive in risk-based
4 markets. They've done it in California. You're going to
5 hear a lot more about that as we go forward, but another
6 reason why we wanted to step into the for-profit arena is
7 this.
8 For-profits can go to the equity markets
9 to raise capital. Not-for-profits can't. Many of the
10 not-for-profits in Connecticut that are interested or
11 were interested in us are cash poor. They cannot come
12 forward. Adding our woes onto their woes is just a
13 recipe in failure.
14 Thank you. I'll now pass this over to Joy
15 Dorin, Vice Chair of the Board of Trustees.
16 MS. DORIN: Can you hear me? Okay.
17 Louder? Can you hear me now?
18 MR. ZINN ROWTHORN: In the back, can you
19 hear the speakers? Thank you.
20 MS. DORIN: Great. Thank you and good
21 afternoon. My name is Joy Dorin, and I adopt my pre-
22 filed testimony.
23 I've been a member of the ECHN Board of
24 Trustees since 2004 and currently serve as the Vice Chair

1 and Chair of the Transaction Committee.
2 In my professional life, I've held
3 positions in health care organizations, including Cigna
4 Health Plan, Athena Health Care and Qualidigm, the
5 state's quality improvement organization that works with
6 the Centers for Medicare and Medicaid.
7 Throughout my career, I've been involved
8 in and responsible for quality, patient satisfaction and
9 compliance matters across the health care continuum.
10 In addition to my professional background,
11 I'm a longtime resident of Manchester, nearly 40 years.
12 While I was born and raised in New Jersey, I consider
13 Manchester my home.
14 This is where my friends live, my son and
15 his young family live, and my husband owns a small
16 business on Main Street.
17 I mentioned my Manchester roots, because
18 insuring ECHN's future is important to me, and it's
19 important to every other individual and family, who lives
20 east of the river.
21 In evaluating our options, we established
22 four goals, that high-quality health care services are
23 accessible, affordable and delivered safely to the people
24 in this part of Connecticut, that clinical services are

1 expanded, that employees continue to have jobs, and
2 facilities and technology are upgraded.
3 Dr. O'Neill talked about the importance of
4 preserving ECHN to serve the public need, and Mr. Karl
5 covered the financial challenges and how the Prospect
6 transaction will allow ECHN to meet these challenges.
7 I'd like to spend the next few minutes
8 focusing on the importance of quality and safety. We are
9 proud of the efforts our staff and physicians have taken.
10 Of note, ECHN was one of the first
11 networks in Connecticut to become a high-reliability
12 organization.
13 This decision and journey has changed our
14 culture to the benefit of our patients. It has resulted
15 in process improvements and a reduction in serious safety
16 events.
17 Our focus on quality has resulted in the
18 Joint Commission recognizing our two hospitals as top
19 performers.
20 At Manchester Memorial Hospital, we were
21 recognized for heart failure, pneumonia, surgical care,
22 immunization and perinatal care, and, at Rockville
23 Hospital, for pneumonia, surgical care and immunization.
24 Because of these accomplishments, it was

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

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

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

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

1 action plans.
2 The team also collaborated with the
3 Transaction Committee and ECHN Council to evaluate
4 Prospect's continued appropriateness as a transaction
5 partner. The Transaction Committee recommended that ECHN
6 seek a quality commitment letter to ensure ECHN's patient
7 quality, patient experience and safety programs retain
8 their forward momentum for a period of time post-closing.
9 Prospect has agreed to execute such a
10 letter, which also contains a provision for ECHN to
11 benefit from the quality improvement programs observed at
12 the CharterCARE hospitals.
13 Based on the findings presented by the
14 evaluation team and the protections gained under the
15 quality commitment letter, the Transaction Committee
16 recommended and the Board confirmed ECHN's commitment to
17 proceed with the transaction.
18 Prospect's business model depends on
19 significant local oversight for operations, including
20 quality and safety. This means the current ECHN quality
21 team will continue its good work in eastern Connecticut.
22 In summary, in addition, it is anticipated
23 that Prospect's eastern region, which includes Prospect's
24 hospitals in Connecticut and Rhode Island, will

1 collaborate on quality and safety measures that are
2 expected to be implemented in Prospect's hospitals across
3 the country.
4 ECHN looks forward to this collaboration.
5 Thank you very much.
6 DR. O'NEILL: Thank you, Joy. That
7 concludes ECHN's comments. Next, I'd like to pass the
8 microphone to Mitchell Lew, who is the President and
9 Chief Executive Officer of Prospect Medical Holdings.
10 MS. MATTHEWS: Before Mitchell talks, if
11 we can just make one clarification point? I know Joy
12 mentioned that the quality commitment letter PMH had
13 agreed to sign it. That is the letter that we have. It
14 has now been executed and signed, and it's been
15 submitted.
16 MR. ZINN ROWTHORN: Can I ask by way of
17 one clarification? That letter, does it have a duration?
18 Do the commitments in that letter have a duration?
19 MS. DORIN: Two years.
20 HEARING OFFICER HANSTED: Can you just
21 speak into the microphone? Thank you.
22 MS. DORIN: Two years.
23 MR. ZINN ROWTHORN: I don't want to get
24 ahead of anybody's presentation, and feel free to tell me

1 that I'm about to hear the answer to this in one of the
2 presentations we're going to hear, but, from a structural
3 perspective, to the extent there were personnel, who were
4 identifiable for quality control in Prospect in those
5 California hospitals that had the immediate jeopardies,
6 what role will those individuals have with respect to
7 quality control in the ECHN system going forward?
8 MR. CROCKETT: This is Von Crockett.
9 Actually, none of those individuals will have a role,
10 and, during my testimony, I'll go through the structure
11 that we will have for the eastern region new individuals.
12 MR. ZINN ROWTHORN: Okay. We'll look
13 forward to hearing that. Thank you.
14 DR. LEW: Good afternoon. My name is Dr.
15 Mitchell Lew. I'm President of Prospect Medical
16 Holdings, PMH. I adopt my pre-filed testimony.
17 I appreciate the opportunity to speak
18 today in support of the conversion application regarding
19 the proposed acquisition of assets of Eastern Connecticut
20 Health Network, including Manchester Memorial Hospital
21 and Rockville General Hospital by PMH.
22 I'd like to begin by reintroducing the PMH
23 representatives here with me, so that they can adopt
24 their pre-filed testimony.

1 First is John Spees. John is Vice
2 President of Mergers and Acquisitions at PMH. John will
3 discuss the transaction, as well as certain aspects of
4 PMH's operations. John?
5 MR. SPEES: I'm Jonathan Spees, and I
6 adopt my pre-filed testimony.
7 DR. LEW: Next, I would like to introduce
8 Steve Aleman, who is the Chief Financial Officer of PMH.
9 Steve will be available to answer any questions related
10 to the financial operations of PMH.
11 MR. ALEMAN: I'm Steve Aleman, and I adopt
12 my pre-filed testimony. Thank you.
13 DR. LEW: Von Crockett, Von is the Senior
14 Vice President of Corporate Development at PMH. Von will
15 discuss the health care quality matters at the various
16 PMH hospitals and be available to answer questions
17 related to our quality programs. Von?
18 MR. CROCKETT: Von Crockett, and I adopt
19 my pre-filed testimony.
20 DR. LEW: In addition, we have Tom
21 Reardon. Tom is President of Prospect East and has been
22 working closely with ECHN from the start of the process,
23 and Tom will speak later in our presentation.
24 So let's go to the first slide. ECHN and

1 Prospect, committed to this community. Who is Prospect?
2 We are a health care services company, and we operate
3 local community hospitals, local governance, local
4 physician leadership.
5 We invest in our hospitals and in our
6 communities. For example, in Rhode Island, we're just
7 finishing up a beautification project, rebuilding the
8 entrance of the hospital. We've enhanced the GI lab, and
9 we're looking to hopefully build a heart lab, also.
10 We've opened two hospitals in California
11 recently in areas that needed them, specifically, in
12 Bellflower, a psychiatric hospital, and in Orange County
13 a new medical surgical hospital.
14 And, so, the stability that we do bring to
15 communities are continued employment and creation of new
16 jobs. We also believe in expansion of programs and
17 services to improve access and quality.
18 For example, in Texas, we built a brand
19 new emergency room at the Nix Health System. We've
20 opened several urgent cares in Rhode Island and the
21 surrounding communities, and, in California, we've opened
22 a lot of urgent cares and, also, wellness clinics, again,
23 to promote access and for convenience for the population.
24 A little bit about our hospitals. We have

1 14 community hospitals. Seven are in California, four in
2 Texas, which we've owned for about four years, and two in
3 Rhode Island, which we've owned for roughly two years,
4 and then recently opened or acquired a hospital in New
5 Jersey.
6 We serve many different communities. In
7 fact, many of the hospitals that we operate are in
8 underserved communities, and we take all types of health
9 insurance. To us, a patient is a patient.
10 We provide medical, surgical, in some
11 cases tertiary, psychiatric and long-term care services.
12 We have a lot of experience in proving multiple services
13 across our hospitals.
14 We have over 40 outpatient clinics and
15 centers in our model. Not all of the care is delivered
16 in the hospital. A lot of the care is delivered on an
17 outpatient setting, because we want to be very cost
18 effective.
19 We don't just own and operate hospitals.
20 We also have a lot of experience at operating and
21 managing medical groups. We've been doing this for many
22 years, and you can think of our model as a multi-
23 specialty health care provider without walls.
24 They are structured in what we call

1 Independent Practice Associations, called IPAs, where
2 these are networks of doctors that are working to
3 coordinate care together.
4 And the beauty of this model is that
5 physicians can remain independent, if that's what their
6 wishes are, or they can be employed. Our IPA model can
7 utilize both, depending on what the doctor wants.
8 We've been doing this in Southern
9 California for over 20 years. We have quite a presence
10 in Southern California. We've also been growing our
11 physician networks in Texas.
12 We have over 500 doctors in our network.
13 In Providence, Rhode Island, we have over 350 physicians,
14 and, in New Jersey already, we have 125 physicians.
15 As I stated earlier, we contract with all
16 major health plans. We have nearly 9,000 physicians in
17 all of our networks taking care of nearly 300,000
18 patients, and we provide coordination of care across the
19 entire continuum.
20 And, so, what that means is whether a
21 patient is at home, in a hospital, a skilled nursing
22 facility, clinic, or physician office, we follow their
23 care throughout.
24 Our goal is to have better outcomes and

1 high patient satisfaction, so that patients can tell
2 their family and friends come get your care here at ECHN.
3 As a result of our company's experience of
4 owning and operating hospitals and managing physician
5 groups, we have developed what we think is a very unique
6 model of care, a very unique delivery model, which we
7 call Coordinated Regional Care, or CRC.
8 Coordinated Regional Care is where we
9 integrate hospitals and physicians and other providers in
10 the community. For example, the local home health
11 company, the local palliative company, the local DME,
12 Durable Medical Equipment company, and they work very
13 closely, we work very closely with the health plans, the
14 payers and the government, because we want to achieve
15 improved patient care and high patient satisfaction.
16 And this model we've implemented already
17 successfully in seven regions in California, Texas and
18 Rhode Island and currently in development in New Jersey,
19 already here in Connecticut, and soon to be in
20 Pennsylvania.
21 So you've heard this buzz word, population
22 health management. Let me just put this in simple terms
23 for those, who are not in health care.
24 We care about the health of everybody in

1 the community. That matters to us, and we have the
2 experience to ensure that everybody will get good health
3 care.
4 We have a unique model, which provides
5 higher value, and, so, you can achieve better care, and
6 it doesn't have to necessarily cost more.
7 So how do we do this? What is our secret
8 to improving care and outcomes? Well it really revolves
9 around patient-centered, yet physician-led approach.
10 We have multi-disciplinary care teams that
11 take care of our sickest patients, they're available
12 24/7, teams of providers, such as nurse practitioners,
13 pharmacists, social workers, that are available to be
14 called by these sickest patients that we use data to
15 stratify, to identify who those patients are, and we
16 engage the family, we engage the patient.
17 We have a homebound program, so we will go
18 to the patient's home if we need to. We have disease-
19 specific care plans to take care of conditions, such as
20 diabetes or heart disease, and we also integrate
21 behavioral health, because behavioral health exists in
22 all populations, and some patients have what we call
23 comorbidities.
24 They have medical problems, they have

1 behavioral health problems, and if you can take good care
2 of and address the behavioral health needs, that
3 sometimes is the key to taking care of the medical needs,
4 and that is something that we're working to perfect, is
5 to integrate the two.
6 We utilize quality care coordinators,
7 which call patients to remind them to go see their
8 doctor, to remind them to get their blood test or have
9 their screening tools.
10 And, again, we follow patients, hospital,
11 skilled nursing, long-term care, again, across the
12 continuum, and it's a physician-led network.
13 And, so, we absolutely have a commitment
14 to quality, and, certainly, in our medical groups,
15 quality is not just a word that we throw around. We've
16 actually achieved the highest level of quality.
17 A very respected trade association, called
18 the California Association of Physician Groups, the
19 largest in the country, has recognized us at the highest
20 level, achieving elite status four years in a row.
21 Another respected association, IHA, has
22 recognized us for our clinical quality. We've received
23 awards from the Department of Managed Health Care in
24 California, specifically, cardiovascular disease,

1 cholesterol control and diabetes, and these are some of
2 the disease-specific care plans that I spoke to on the
3 prior slide.
4 We've achieved four to five STAR out of a
5 possible five star on our Medicare Health Plan Quality
6 and Performance Ratings.
7 I'm going to turn it over to Von.
8 MR. CROCKETT: While we're very proud of
9 some of the quality achievements that we've done, I think
10 it's also important for us to pause for just a moment to
11 talk about some of the mistakes we've made, and,
12 specifically, what were the causes of those mistakes?
13 What corrective actions have we taken, and what have we
14 learned, in terms of how to make us a better organization
15 going forward?
16 Specifically, as you're aware, quality is
17 something that's being assessed on a daily basis, and it
18 is through one of those assessments by our regulatory
19 agencies in California that it was identified that within
20 two of our 13 hospitals in California that two of the
21 facilities had a deficiency, specifically as it related
22 to what's called the CMS Medicare Conditions of
23 Participation.
24 Specifically with that, there were

1 violations with what's called immediate jeopardy.
2 Specifically, those immediate jeopardy violations were in
3 one facility. We had an allegation of physician
4 misconduct and then the organization's response
5 associated with that, and then, in another facility, we
6 had immediate jeopardy associated with temperature and
7 humidity, specifically in the OR suites, and then, third,
8 the washing of sterilization of surgical instruments.
9 I wanted to spend just a second to talk
10 about the root cause associated, and in any event, where
11 there's a breakdown in process or failure, it's not
12 usually just one event.
13 Specifically, as it's been discussed
14 beforehand, we take great pride in making sure that each
15 of our hospitals have strong local leadership, and, with
16 that, we have delegated the quality programs at an
17 individual level down at the hospital level, and it was
18 being managed and run at the hospital level.
19 Within both of these facilities, part of
20 the issue that we had was that we had turnover at the
21 executive ranks, as well as within some of the department
22 managers.
23 When there was a patient complaint made
24 and CMS came in to do the survey, not only did they find

1 that in some instances were that the care that was being
2 provided was not consistent with the policies that we had
3 in place, care was somewhat inconsistent.
4 Additionally, when they reviewed the
5 quality program, what they found was a rigid program,
6 where the organization had adopted previously and
7 modified to the issues that were at hand.
8 At the one facility that had the issues
9 with the temperature and humidity and the washing of
10 sterilization, previously in the year there had been, as
11 we were doing construction within the building, there had
12 been an event, where there had been a small localized
13 fire from a contractor up on the roof, which caused
14 substantial issues with our HVAC system.
15 That, in itself, is not the issue. The
16 issue was was that our response associated with that was
17 not sufficient to address the needs in resolving the
18 issue.
19 And when CMS came in, they found that the
20 response should have been a stronger response in making
21 sure that the issues are addressed.
22 When we look back at the root cause
23 associated with it, there are several issues with that.
24 The first of them is is that, as we had delegated the

1 role of quality and the responses to the local
2 leadership, there could have been a stronger response
3 from Prospect Medical in making sure that as organization
4 -- that these two organizations had when they had the
5 turnover that they had, that the appropriate resources
6 were provided to them at an executive level, as well as,
7 also, at the director level in resolving these very
8 specific -- in these very specific complaints.
9 Once the deficiencies were identified by
10 CMS, and I wanted to point out one point, which is that,
11 on the immediate jeopardies that we got for all three, it
12 wasn't -- there was no patient harm that was actually
13 dealt with, but it was more of an issue that the care
14 that was being provided did not meet the conditions of
15 participation, and it wasn't also consistent with our
16 policies of what we had in place.
17 As soon as we had been notified by CMS, we
18 took immediate action to making sure that the issues were
19 resolved there, as well as developing a corrective plan
20 for any of the other issues that they identified, in
21 addition to the immediate jeopardy.
22 We have previously disclosed these
23 deficiencies in detail to ECHN, as well as the Attorney
24 General's Office and OHCA, previously to today's

1 testimony.
2 As part of that, we have discussed
3 extensively with ECHN and our quality counterparts to
4 review our corrective action plans to making sure that
5 they were appropriate and detailed.
6 At a more detailed level, when we talk
7 about the corrective actions, the first thing that we did
8 was we engaged a nationally-recognized consulting firm,
9 and the purpose of them was to do two things.
10 One of them is to come and look at the
11 quality plans that were in place at both of these
12 organizations and making them to be an organic and a
13 responsive quality plan to not only address the issues at
14 hand, but to make sure that the quality plan would be
15 responsive for any future issues that would arise within
16 the organization.
17 Secondly, we have provided additional
18 resources at the local level of the hospitals by adding
19 strong and experienced leaders, as well as additional
20 capital resources at the facility to making sure that the
21 issues are addressed.
22 At a corporate level, we have modified our
23 quality program by having additional oversight, not just
24 for these two facilities, but it will be for all

1 facilities within Prospect.
2 The new oversight is going to consist of
3 we've got four individuals that are already in place.
4 One of them is a Chief Quality Officer, a Chief Clinical
5 Officer, a Corporate Chief Nursing Officer, and an
6 Associate Vice President of Regulatory and Patient
7 Safety.
8 The roles of these four individuals is,
9 first of all, is to monitor the quality programs at all
10 hospitals, and the point being there is making sure that,
11 A, that they're on track and that they're responsive to
12 the issues that are being addressed in the organization
13 and that they're timely.
14 Secondarily is to provide additional
15 resources, if needed, to implement the program, so in the
16 event that a hospital is lacking the resources, they can
17 provide resources or identify what resources need to be
18 provided.
19 The third is making sure that, when the
20 quality goals are not being achieved within the
21 organization, is to help the organization to take
22 corrective actions in a timely fashion.
23 Going forward, one of the big things that
24 we anticipate happening is, instead of being reactive, we

1 want to be proactive, and, to do that, we're going to be
2 looking to have the facilities be survey ready for both
3 the accrediting agencies, as well as the Department of
4 Health.
5 And then, lastly, the corporate oversight
6 will assist in sharing the best practices among the
7 various hospitals, and what we found is that, as we've
8 got multiple hospitals that have done very well in
9 multiple areas, is to bring those strengths and
10 weaknesses across the entire organization, so that we
11 have an organization that's stronger within the whole.
12 Lastly, our Quality Assurance and
13 Performance Improvement Plan is being revamped by a
14 national consulting firm, and, with that, we believe it
15 is going to be a much stronger program for all.
16 One of the things that was important when
17 we looked at the transaction, specifically for ECHN, was
18 that they had a very strong quality program to begin
19 with, and they have achieved some great results, and it
20 was important for us, as well as for them, that they know
21 that we are going to continue on with their quality
22 program, and our role in the oversight of it is to
23 provide additional resources, if needed, the sharing of
24 best practices among the various hospitals, and to

1 provide them resources that they may be lacking in any of
2 the specific areas.
3 With that, ECHN is already -- is well on
4 the way for the high reliability organization, and that's
5 something that not only do we support, but we've started
6 the process in Rhode Island, and we look to roll that out
7 actually in our California hospitals, as well, going
8 forward.
9 We continue to work on the issues that
10 were raised by CMS, and we are confident that the
11 corrections that we have put into place not only will be
12 satisfactory, but that will be shortly corrected.
13 And with these changes, the organization
14 is going to be a much stronger organization as a result
15 of that, not only for Prospect, but, also, in combination
16 with ECHN.
17 Switching gears now for just a second, I
18 want to spend just a few moments on slide 10, and when
19 you look at what we hope to achieve in ECHN, it's
20 important to take a look at what has been achieved in the
21 past year in Rhode Island, and what exactly has Prospect
22 brought to the organization?
23 First of all, probably the most
24 substantial is that, as we've looked at the organization

1 and the affiliation of the physicians, is that we have
2 formed a multi-specialty IPA that's now over 100-plus
3 primary care physicians.
4 Part of that was through the employment of
5 physicians, and part of that was through bringing
6 additional independent physicians into the organization.
7 We've expanded outpatient services within
8 the area, which includes an investment in an outpatient
9 oncology center, and this was all done as a result of
10 providing additional significant capital to them.
11 The capital is partly being spent on
12 infrastructure needs and deferred maintenance, and the
13 other part of it is being through the development of our
14 relationship with the physicians.
15 All this is leading up to one of the
16 issues that's facing Rhode Island most substantially, is
17 they're a Medicaid expansion state, like Connecticut,
18 and, as such, their state budget is under substantial
19 pressure in adding on the fee for service Medicaid
20 population with that, as we've worked with the
21 legislation and we're implementing a Medicaid value-based
22 pilot program, in terms of the managing of the Medicaid
23 lives that will hopefully be a solution for the state of
24 Rhode Island.

1 When we looked at expansion to the east,
2 we looked at several factors that we felt would be
3 important of making sure that our model is going to be
4 one that could be easily adopted and appropriate, and,
5 with that, we looked at Connecticut, specifically, and
6 there are specific things that are attractive for what we
7 believe our model in Connecticut.
8 With that is a state that, first of all,
9 is a Medicaid expansion state, and, with that, we believe
10 that there's going to be a need for organizations to have
11 relationships with both the health plan and the
12 physicians that are non-adversarial and, instead, are
13 working for the better of the patient in providing care
14 and the outcomes associated with that.
15 And, lastly, a state that is able to deal
16 with the changing landscape from both a regulatory
17 perspective, as well as a leadership perspective, as we
18 go through those changes.
19 What will this lead to? It will lead to
20 an organization, where, instead of having adversarial
21 relationships that normally have existed traditionally in
22 health care, pitting players against players, health
23 plans and hospital and physicians, all working together,
24 in terms of providing better care to the patient.

1 With that, we believe the patient will
2 have higher satisfaction. We believe that this is going
3 to allow, then, for greater access for capital for ECHN,
4 and, lastly, a sustainable model for health care that
5 will allow for these two community-based hospitals to
6 continue on.
7 MR. ZINN ROWTHORN: Before we switch
8 gears, thank you, Mr. Crockett, for that, it would be
9 helpful, I know you have submitted some information
10 relating to the immediate jeopardy findings, it would be
11 helpful at some point to have a summary of the status of
12 those matters, whether additional findings have been
13 made, the time frame for resolution, where you are in
14 that process.
15 For my sake, at least, and perhaps for
16 others, it would be helpful to have a sense of
17 perspective about what those kinds of findings and that
18 process mean to a hospital, whether this is a unique
19 experience for the Prospect medical system.
20 I'm interested, also, to hear from ECHN
21 about its views about helping us put that process into
22 context, so we'll take that now or whenever, but, while
23 we're here today, it would be helpful to hear about that.
24 MR. CROCKETT: Let me start off with the

1 status and the timing. There's two, the two facilities
2 have got the two different immediate jeopardies, and, so,
3 it needs to be separated, because they're on a separate
4 track from a timing and a resolution.
5 The first hospital is LA Community
6 Hospital, and it had to originally start off with the
7 allegation of physician misconduct.
8 There was a -- we had put together our
9 plan of correction, and that plan of correction had been
10 submitted back in late January, and, with that, we were
11 resurveyed by the Department of Health, CMS, in the
12 middle of February.
13 When they came out to do the resurvey,
14 there were, I believe, approximately five or six
15 deficiencies that were in the original report, including
16 the immediate jeopardy, and the issues that were
17 identified in the original report were mostly found to be
18 in compliance, with the exception of two, and those two
19 were nursing care and infection control.
20 Specifically, on the infection control,
21 there was an issue, as related to the location of how the
22 instruments were being -- where they were being
23 sterilized, and there was a recommendation by one of the
24 surveyors to move the location of the sterilization of

1 the instruments, as well as what's called our utility
2 rooms, clean and dirty rooms.
3 As it relates to the issues of patient
4 care, there were several findings associated with it,
5 and, once again, it was an issue of being inconsistent
6 with our policies that had been put into place.
7 Specifically, there's what's called a plan
8 of care, and it's kind of like the roadmap nursing has
9 for when a patient comes in, in terms of what they hope
10 to achieve with the patient and what the goals of them
11 are, and what they found was is that the plan of cares
12 were inconsistent on a documentation basis associated
13 with that.
14 The plan of correction from the resurvey
15 is due on April the 7th. We believe we'll either --
16 we'll have it in by then or before then. Once the plan
17 of correction is ready to be submitted back to CMS, we
18 will be providing that additional response to the
19 regulatory agencies, as well as ECHN, and, so, I
20 anticipate that will be later next week that we'll have
21 that.
22 With that, we anticipate CMS to be out
23 shortly after that, and, currently, we've been extended,
24 in terms of from a timeline, and it's now the first part

1 of June, in terms of from the track that we're on with
2 CMS.
3 MR. ZINN ROWTHORN: Okay, so, by way of
4 clarification, so participation in the program will be
5 terminated by the first part of June, unless there is a
6 resolution before then to CMS's satisfaction?
7 MR. CROCKETT: Correct.
8 MR. ZINN ROWTHORN: Okay.
9 MR. CROCKETT: Originally, it was April
10 13th, and they have now extended it to the first part of
11 June.
12 For the Southern California Hospital, we
13 have, from the report that was previously given that was
14 the immediate -- well, there's two immediate jeopardies.
15 One had to do with the temperature and the humidity,
16 specifically in the surgical suite, as well as in the
17 cath lab, and the second one had to do with the washing
18 of sterilization of surgical instruments.
19 From when CMS is out there, when they give
20 out an immediate jeopardy, they actually don't leave the
21 facility until it's abated during the survey process, and
22 what they look for when you put together your plan of
23 correction is making sure that not only was it abated,
24 but there's a process to continually monitor it, and that

1 it doesn't reoccur and go forward, and, so, as part of
2 our plan of correction, it was making sure that whatever
3 policies and processes were put into place is to make
4 sure that they weren't to reoccur.
5 That plan of correction was submitted, and
6 it was submitted last week, and we have actually provided
7 a copy of that submission to the regulatory agencies, as
8 well as to ECHN, and each of you should have that.
9 It's detailed and very thorough and was
10 put together in conjunction and help with our national --
11 with our consulting firm to making sure that the response
12 was appropriate and met Medicare's expectations with
13 that.
14 We expect for them to be on site.
15 Currently, the track that that is on, as it relates to
16 meeting the Medicare conditions of participation, I
17 believe it's May 23rd, and, with that, we anticipate, now
18 that we have submitted the plan of correction, that they
19 will be on site shortly to look at our plan and making
20 sure that the corrections that have been put into place
21 were appropriate.
22 MR. KARL: Mr. Zinn Rowthorn, there's two
23 points that I'd like to make. One is the seriousness of
24 these events were put in a timeline document from the day

1 we found out through the day that we felt as though all
2 the answers were brought to us satisfactorily, and we'd
3 probably like to add that as Late File No. 1, so you can
4 see the intensity of this.
5 Number two, I would like to bring forward
6 Linda Quirici, who is the Vice President of Quality Care
7 for ECHN, just to give an update on what we've done and
8 what we've found.
9 MR. ZINN ROWTHORN: We'll be happy to take
10 that late file, and I'll request that other documents
11 submitted to CMS or received from CMS while our review is
12 pending we'd appreciate a copy of those being submitted.
13 I'm happy, also, to hear from Ms. Quirici.
14 She should be sworn, I think, if she hasn't already.
15 MS. LINDA QUIRICI: Good afternoon. My
16 name is Linda Quirici. I am the Vice President of
17 Quality and Safety for Eastern Connecticut Health
18 Network.
19 HEARING OFFICER HANSTED: Could you just
20 speak into the microphone?
21 MS. QUIRICI: Sure.
22 HEARING OFFICER HANSTED: Thank you.
23 MS. QUIRICI: Okay, is that better?
24 HEARING OFFICER HANSTED: That's better.

1 MS. QUIRICI: Okay, so, the Quality
2 Department was brought in on February 24th, told that
3 they meted jeopardies and of the need to review to give
4 our opinion on the quality process in the California
5 hospitals and the Rhode Island hospitals, so we were very
6 involved in reviewing all of the records.
7 So, initially, they were the immediate
8 jeopardies that Von talked about, and the initial one was
9 the physician misconduct, and that was already a plan of
10 action was in place, that was already taken care of, and
11 that plan of action was put in place, and the response to
12 that we just got, and he spoke about that, so we reviewed
13 that in detail, as a matter of fact, this weekend.
14 We looked at all of the elements of that
15 again. He mentioned several things that were still
16 involved in the conditions of participation.
17 When I reviewed that, really most of the
18 areas were deficiencies that might be seen in any
19 hospital, truthfully, and they are developing now their
20 plan of correction for those deficiencies.
21 The other immediate jeopardies that Von
22 talked about were in the Southern California hospitals.
23 We reviewed those in detail, as well, and we reviewed
24 their other areas that needed to have review.

1 We also just got their plan of correction,
2 which we reviewed in detail. It is very comprehensive,
3 as they stated. They had a consulting company that came
4 in, as well as legal assistance, to make sure that their
5 plan was comprehensive and thorough, and it was, and I
6 believe they have submitted that, so we reviewed that in
7 detail, as well.
8 So that was submitted, and, when that
9 comes back, the findings, we will also review that to
10 make sure that things are comprehensive and that there is
11 nothing still outstanding, so that was reviewed by myself
12 and two quality experts that are experts in the areas of
13 the immediate jeopardy, which were the physician, which
14 were infection control and environment of care safety, so
15 we made sure that we brought in our experts to review all
16 of that thoroughly.
17 MR. ZINN ROWTHORN: Thank you. And has
18 either ECHN hospital ever received an immediate jeopardy
19 notice?
20 MS. QUIRICI: Not in my tenure. And
21 something important to notice is that 25 percent of
22 hospitals in California receive immediate jeopardy
23 findings, but, in Connecticut, immediate jeopardies are
24 very rare.

1 So the hospital practices -- you know,
2 hospitals differ a little bit from one coast to the
3 other. Again, we went to Rhode Island to see something
4 that's analogous, and our practices are analogous, and,
5 in California hospitals, you know, function a little bit
6 differently, as well as their regulatory agencies
7 function a little bit differently.
8 As a matter of fact, you know, quite
9 differently, to be honest with you, so the differences,
10 as far as having an immediate jeopardy, is much more
11 likely if you're in California than if you were in our
12 areas.
13 MR. ZINN ROWTHORN: Were these the first
14 immediate jeopardies received by any Prospect hospitals?
15 MR. CROCKETT: No. There was an immediate
16 jeopardy in 2013, if I'm not mistaken, and, getting back
17 to the California legislative process, the oversight is a
18 little bit different, but, at one of our hospitals, we
19 received a retroactive immediate jeopardy from three
20 years previously, and it had to do with -- it's just a
21 different process in California, so it's not the first.
22 As she stated previously from a context
23 perspective, within California, you know, one out of four
24 hospitals either has received or is receiving an

1 immediate jeopardy, and, from a context perspective, it’s
2 all sorts of hospitals, everything from community-based
3 hospitals to very well-regarded academic centers, UCLA
4 for one, and then, you know, out on the east coast,
5 Cleveland Clinic was in a process, where they had an
6 extended period of time, where they had to deal with an
7 issue.
8 This is something, obviously, we take
9 extremely serious, and we have put forth the resources,
10 additional resources to resolve it, not just to resolve
11 this issue, but to put in process to making sure that we
12 don’t get into this situation again.
13 MR. ZINN ROWTHORN: I’ll ask one more. I
14 know Attorney Salton has a question. And I know this is
15 not what anybody at that table expects, but I assume
16 that, if, in fact, CMS participation was terminated, that
17 that would have a material impact on at least those
18 hospitals and maybe Prospect’s financial condition
19 generally. Am I right to make that assumption?
20 MR. CROCKETT: I think it would be right
21 to say on any hospital that that would have an impact on
22 it, not just Prospect, but any hospital.
23 It’s rare that it happens, and this is
24 really -- from a process perspective, CMS doesn’t have

1 any way of doing what's called administrative penalties,
2 so their only process of making sure that hospitals
3 comply with the Medicare conditions of participation is
4 it's all or nothing, and, so, from an all or nothing
5 approach, is that when hospitals don't apply, then they
6 issue what's called a termination track, in order to get
7 hospitals back on track.
8 When you look at hospitals that haven't
9 been able to resolve the issues, it's usually one of two
10 reasons.
11 One is usually because they're in a
12 process of going through a bankruptcy and actually don't
13 have the resources, in order to resolve the issues that
14 have been addressed, or, two, that they don't actually
15 have the ability, and, so, it's very rare to actually see
16 a termination, and we have 100 percent confidence that we
17 will be able to resolve these issues.
18 MR. ZINN ROWTHORN: I gather that the
19 quality issues identified by CMS are localized in two
20 facilities, but the way the licenses are structured in
21 California, that the immediate jeopardy is directed at
22 six hospitals. Am I correct about that?
23 MR. CROCKETT: That is correct. So the
24 license structure is that we have a consolidated license

1 for each of the two licenses in question, and there's
2 three hospitals within each license, and there's a
3 license process that what you have stated is accurate.
4 MR. ZINN ROWTHORN: Can you talk, and,
5 again, I know this is not your expectation, as you just
6 said, but can you talk about Prospect's ability to
7 consummate this transaction financially, if, in fact,
8 those immediate jeopardies were effectuated, given how
9 this transaction is intended to be financed?
10 MR. ALEMAN: We could absolutely finalize
11 this transaction. We're not looking for financing for
12 this transaction and certainly carry through with the
13 commitments as part of this transaction, including
14 capital investments and so forth.
15 MR. ZINN ROWTHORN: Thank you.
16 MR. HENRY SALTON: If I could ask, being
17 familiar with the findings in the two immediate
18 jeopardies and in the continued finding of March 23rd of
19 the immediate jeopardy and being familiar with the
20 regional oversight by regulators here, would you be
21 surprised that a regulator in this region would reach a
22 conclusion of immediate jeopardy, based on these same
23 findings?
24 MS. QUIRICI: I think so. I think so. I

1 think, again, we saw things that commonly we see in our
2 surveys, so they were nothing that stood out that would
3 be unusual, so I think that an immediate jeopardy related
4 to most of the things that we saw would not have occurred
5 here, and I haven't, again, seen that in my tenure.
6 MR. SALTON: And you're familiar, I think,
7 I would assume, with the quality programs that are being
8 done in ECHN, which now we understand are going to
9 continue by the seller on a going-forward basis?
10 MS. QUIRICI: Yes.
11 MR. SALTON: For at least two years?
12 MS. QUIRICI: Yes.
13 MR. SALTON: Would you expect that the
14 quality improvement programs that you have adopted would
15 have prevented or greatly lessened the likelihood of
16 these kind of violations at your two hospitals?
17 MS. QUIRICI: I think that we have a very
18 strong quality program and a very strong regulatory
19 program, so, again, I saw very similar things in the
20 Rhode Island hospital when we went and visited, so
21 whether they would help in California, is that what
22 you're asking me?
23 MR. SALTON: Well I'm really trying to
24 anticipate whether or not, and I think that Prospect has

1 acknowledged that the Los Angeles hospitals needed to
2 upgrade their quality improvement programming and
3 planning, I'm trying to say to you could we anticipate
4 that this is a meaningful remedy, the continuation of the
5 ECHN quality improvement programs, that it would most
6 likely preclude or lessen the likelihood of these
7 violations happening in our hospitals.
8 MS. QUIRICI: Absolutely. Absolutely.
9 And we are very strong in survey readiness, so that, in
10 and of itself, would preclude these things from happening
11 here and have precluded them from happening here.
12 MR. SALTON: And let me ask just one final
13 question.
14 MS. QUIRICI: Sure.
15 MR. SALTON: We're glad to hear whatever
16 you have to say. In the March 23rd finding, where there
17 were continued findings of problems with infection
18 control, nursing services, I think patient rights, they
19 had been identified in a prior survey.
20 Is your hospital's experience that you
21 would have, is it common or rare, that you'd have a
22 continued finding on a resurvey of the same types of non-
23 compliance and conditions of participation that were
24 identified in an earlier CMS survey?

1 MS. QUIRICI: In Connecticut, I have heard
2 that hospitals have that happen, sometimes once or twice.
3 It hasn't happened in my tenure that I've had that, and I
4 have heard that in other hospitals. Sometimes, they are
5 resurveyed several times if that is not corrected.
6 MR. SALTON: In the context of immediate
7 jeopardy?
8 MS. QUIRICI: No. I don't know about
9 that. I don't personally know about that, but as far as
10 conditions of participation.
11 MR. SALTON: Okay, thank you.
12 MS. QUIRICI: Okay.
13 MR. ZINN ROWTHORN: And, to clarify, and
14 then perhaps we can get off this topic and move on for
15 the moment, but when you talk about differences between
16 the regulatory environment in Connecticut versus
17 California, you are talking about the same regulator and
18 the same regulations, but talking about different
19 regional applications?
20 MS. QUIRICI: That's absolutely right,
21 yes. Different methodologies. There is a difference
22 between the two, as far as how they function and how they
23 run, so, yes, there are.
24 Again, I'm much more familiar with this

1 area of the country.
2 MR. ZINN ROWTHORN: Understood. Thank
3 you. And I'll just highlight, bookmark. We heard that a
4 concern in California was that there was perhaps too much
5 localized control over quality, and there's now a
6 commitment to backstop local hospital quality control.
7 We've also heard that there's a commitment
8 to retaining ECHN's control over, localized control over
9 quality, which, in light of this discussion, sounds like
10 a good idea, so if you have other comments about
11 reconciling those statements, I think we'd be pleased to
12 hear them.
13 MR. CROCKETT: I'll start off. First of
14 all, when we looked at -- one of the things that was
15 important for us, as well, is looking at what their
16 quality program was, and they provided us not only their
17 quality program, but they provided us, in terms of
18 patient satisfaction, risk management and multiple other
19 practices, and we put that through in comparisons to how
20 we have revised our quality program.
21 Getting back to your point, the program
22 that they have currently for ECHN I think is a very good
23 program, and I think that it would have prevented some of
24 the things associated with it, so, from our perspective

1 it was an easy decision for us to adopt what they
2 currently have and the commitment to maintain it.
3 Part of the reconciliation is quality is
4 an ongoing thing that is evolving and changing, as well,
5 and within our corporate oversight, there's two things
6 that we actually will be taking on as kind of a corporate
7 initiative, and it will be hospital-acquired infections
8 and then, also, fall prevention.
9 So when we talk about corporate oversight
10 and ensuring best practices, what we hope to do, not just
11 for our Prospect hospitals, but, also, for ECHN, is for,
12 in those specific areas, look to improve their
13 performance on a go-forward basis, as well, and that is
14 really kind of what the whole expectation is of the
15 oversight.
16 DR. LEW: Perry, I want to just add
17 another comment regarding separation and allowing the
18 local hospitals to maintain, whether it be through an
19 agreement, but, also, point to what we've done in
20 CharterCARE in Rhode Island in supporting their
21 initiative to become a high reliability organization.
22 I know Lester Schindel, the CEO of
23 CharterCARE, I believe he was going to be here today, and
24 we also brought in someone by the name of Kim Lumia from

1 Connecticut, who actually is supporting Les in this
2 effort, so that's just a live example of how we support
3 the local initiative to become a high reliability
4 organization. Agreement or no agreement, this is what
5 our model is going to be.
6 MR. ZINN ROWTHORN: Thank you. So we can
7 move on.
8 MR. SPEES: Thank you. Good afternoon. I
9 just want to make a few comments about some of the key
10 commitments as part of the transaction from a transaction
11 standpoint.
12 Some of these were touched on by Peter in
13 his remarks, but I'll just amplify a little bit. The
14 first two points are the key financial terms of the
15 transaction, purchase price of $105 million and capital
16 expenditures of $75 million.
17 What's significant about the purchase
18 price is not just that it represents fair market value,
19 but, as Peter mentioned, it really, when combined with
20 ECHN's existing resources, allows all of the long-term
21 debt of the health system to be paid off. That frees up
22 over $9 million worth of annual funds that used to go to
23 paying down debt and makes them available for
24 reinvestment in the health system.

1 And with respect to the capital
2 expenditure commitment, I think it's important to note
3 that this is a minimum capital commitment on the part of
4 Prospect.
5 We have access to capital, and we're in
6 the business of investing capital in our facilities to
7 help them grow and perform better, so while we've made
8 this minimum commitment to the extent that there's a need
9 and appropriate investment of additional capital, we have
10 the resources to do that.
11 In addition to the financial commitments,
12 we've made a commitment to maintain the current charity
13 care policy, so that, as Mitchell mentioned in his
14 presentation, Prospect really is about access and
15 providing access to people, and this was a way to assure
16 the community that the existing charity care policies
17 will remain unchanged, or, if we do make any
18 modifications, they will be at least as favorable, if
19 not, more favorable going forward.
20 One thing that's really important to
21 recognize in these transactions is that this is a very
22 long-term commitment, so we're not just talking about
23 what's going to happen in the next year or two years, but
24 we're talking about 10 and 20 years down the road, and,

1 so, this commitment gives assurance to the community.
2 We also, as has been mentioned several
3 times, while we're a California-based company, we're very
4 committed to and understand that health care is a local
5 business, and we provide corporate resources and support
6 to really help the local management team and Board of
7 Directors make the key decisions with respect to the day-
8 to-day operations, and, so, we've committed to maintain
9 management here locally and a local Board of Directors,
10 which I'll talk a little bit more about in a second, and
11 we've committed to the existing medical staff, so, as of
12 the close of the transaction, all of the existing members
13 of the medical staff will become members of the medical
14 staff of Prospect Medical Holdings.
15 In addition, we've also made the
16 commitment to maintain the services that are currently
17 provided in the community, and our final commitment is to
18 the employees, and we've committed that, as of the
19 closing, we'll hire all employees in good standing.
20 That begs the question, as to what does
21 good standing mean, which I will answer, and that is that
22 we actually perform a single screen on the employees, and
23 that's to make sure that none are on the Office of
24 Inspector General's excluded list from participation in

1 the Medicare. That's the only condition to becoming an
2 employee of Prospect Medical.
3 And then, as we've discussed earlier, we
4 have signed this quality commitment letter, which, again,
5 could be viewed as a very minimum commitment, and, as
6 we've discussed on several occasions, you know, we're
7 committed to grow and expand our quality care services.
8 A little bit about the local Advisory
9 Board. This is really key for Prospect. As the local
10 resource to assist our management team and our company in
11 being the best community member that we can, we really
12 partner with the local Board, and it serves as a resource
13 to the governing Board on a number of matters,
14 particularly providing input into the capital plan that
15 we'll develop post-closing.
16 I just wanted to mention, with respect to
17 the capital plan, that the $75 million, in addition to
18 being a minimum, it's not just, you know, bricks and
19 mortar and equipment that is part of that capital
20 investment, so it's not necessarily capital in the
21 traditional sense of accounting, but it's really an
22 investment in the health care system, in total, and it
23 will be likely, as part of our strategic plan, will be
24 invested in increasing access points in the community,

1 whether that's through new urgent care or ambulatory
2 centers, as Mitchell mentioned, or adding physician
3 prospects and growing the physician network, maybe an
4 investment in behavioral health resources, so that really
5 is an investment in developing the overall coordinated
6 regional care system in the community.
7 The local Advisory Board, in addition to
8 providing input into that capital plan and our overall
9 strategic plan, really will be responsible for much of
10 the day-to-day oversight of key hospital programs.
11 Those include, particularly, oversight of
12 all of the accreditation programs, so the Board will be,
13 the local Board will be principally responsible to
14 oversee the accreditation of the hospitals going forward.
15 It will be delegated authority on the
16 medical staff credentialing, so all issues of medical
17 staff credentialing will be handled by the local Board.
18 In addition, we will expect, you know,
19 input and communication from the local Board, in terms of
20 all of our growth initiatives, including physician
21 recruitment.
22 And, again, recognizing that this is a
23 long-term process, in the event there is any sort of
24 leadership succession down the road, then we would look

1 to the local Board for participation in that process, as
2 well.
3 MR. ZINN ROWTHORN: Can I ask one follow-
4 up there, which is if you could talk a little bit about
5 the process and time frame by which decisions will be
6 made, as to spending down that $75 million capital
7 commitment?
8 MR. REARDON: Hi. This is Tom Reardon.
9 Everything is local. Everything starts locally, I should
10 say, and, so, we will be consulting with the local Board
11 and with the local management team, and they will create
12 a strategic plan.
13 We'll push back. We'll have give and take
14 on it, but it's a process that we go through. So, in
15 Rhode Island, what we agreed to there, as I recall, and I
16 may be wrong on the exact numbers, but my recollection is
17 that we agreed that we would have a strategic plan within
18 six months of close, and then we would sit down with the
19 Attorney General's Office and orally present that plan,
20 rather than put it in the public record, and I think we
21 can make the same kind of commitment here.
22 MR. ZINN ROWTHORN: Do the transaction
23 documents talk about a time frame by which that $75
24 million will be expended?

1 MR. SPEES: They do. The actual
2 commitment in the purchase agreement is, within five
3 years following the closing, the $75 million has to be
4 invested or committed in some way to be invested.
5 MR. ZINN ROWTHORN: Thank you.
6 MR. REARDON: Again, I'm Tom Reardon. Let
7 me comment on this slide 15. Please note that it says
8 Health Care Delivery Model.
9 We are not a hospital-centered company.
10 We're actually a physician-centered company that thinks
11 about population management, and that's the way we
12 approach things.
13 We really truly believe that it's better
14 care for the community. We don't have to open
15 everything. We will do a coordinated regional care
16 program that includes community mental health, and
17 surgery centers, and all kinds of different community
18 providers to get the best care to a person at the lowest
19 cost at the appropriate time, and that is our motto, and
20 we think we do it very well.
21 Our model empowers local physicians. We
22 partner very well with managed care plans, but even when
23 managed care plans are trying to work with you, it's
24 difficult for them to get to you the right data, and, so,

1 we have an infrastructure with respect to population
2 management that does all kinds of things.
3 We even do claims processing, not because
4 we think it's a very sexy business, but that's how we get
5 the data, and when you get delegated functions from the
6 managed care plans and you do analytics and you do
7 medical management, the physicians actually know how to
8 do this.
9 As much as the MCOs try to do it, they
10 don't do it as well as the physicians and other community
11 providers do it, so that's our motto. That's the way we
12 approach it.
13 And the physicians really do feel
14 empowered. I did see, Mitchell, by the way, that Les
15 Schindel and Kim did come in. In Rhode Island, I would
16 say maybe a third of all the physicians, primary care
17 physicians that have joined the IPA there, have joined,
18 because they love the model. It empowers them.
19 Rather than have a managed care company
20 say, no, you have to have prior authorization, they're
21 making those decisions how to best expend monies.
22 And the trouble with fee for services
23 there's no money to do population management with real
24 risk contracts, which is what we're talking about. Is

1 there money to do the right thing? And the physicians
2 love it.
3 In terms of maintaining and creating local
4 jobs, we're a growth company. We've never closed a
5 hospital. We don't shrink hospitals. We grow hospitals.
6 Sam Lee, our CEO, has a wonderful mantra; more and better
7 for less. If we do a better job and we do it for less
8 money, we're going to get more patients, and that's what
9 we've seen over, and over, and over again. It really
10 does work.
11 In terms of extensive corporate resources,
12 John has touched on that, but we have all kinds of
13 things. Because we've worked with a lot of safety net
14 hospitals, we have really developed some very good data-
15 driven management tools.
16 We're not talking about slash and burn
17 here. We're talking about process reengineering, and
18 there's all kinds of other corporate support that we can
19 provide, in terms of savings on purchases of all kinds of
20 material and the like, so there's a whole host of things
21 we can bring.
22 Again, I'll go back to the CharterCARE
23 example. My recollection, and Les can correct me on
24 this, is, when we started at CharterCARE, all the

1 employees had a Blue Cross and Blue Shield contract.
2 When we took over, all the employees had a Blue Cross and
3 Blue Shield contract.
4 The difference was we're now self-insured,
5 and my recollection is that we dropped something like
6 $1.6 or $1.7 million to the bottom line, because of our
7 ability to fund a self-insurance program, so there's a
8 whole host of things we can bring to help the local
9 management.
10 Again, maintain local leadership with
11 regional oversight, all health care really is local, and
12 we really support that with regional oversight. Whether
13 it's quality or other issues, we will have input on these
14 things.
15 Investing in capital and facility services
16 and technologies, I'll go back to John's comments.
17 Again, we're talking about a health care delivery model
18 here, so it's not just about putting a new façade on a
19 hospital. It's a whole host of things, in terms of
20 creating this whole coordinated regional care network.
21 Charity care policies, yes, we've already
22 talked about preserving charity care policies.
23 Could you go to that last slide, John, for
24 me, please? Or second to last slide.

1 Why Prospect? Well we are committed to
2 Connecticut. We really are into the northeast in a big
3 way, and it's not just because I live in Boston and can
4 drive down to Connecticut more easily than fly somewhere.
5 We have the two hospitals in Rhode Island.
6 We're trying to acquire three hospitals in Connecticut.
7 We're close to, well, we've already signed an APA. We're
8 close to finalizing a deal in the Philadelphia region
9 with five hospitals.
10 And why do we like the northeast? We like
11 the northeast, because, frankly, there's very little
12 managed care penetration in the sense that we think of,
13 with real risk contracting and downside risk contracting
14 and delegated functions.
15 If you look at the SIM, the State
16 Innovation Model, and what Connecticut is trying to do,
17 they're trying to move, as I recall, 80 percent of
18 patients to value-based payments within two years.
19 Well we actually know how to do that.
20 We've been doing it for 30 years, and you can't convince
21 somebody overnight. With Blue Cross in Rhode Island,
22 they came out to see us a dozen times. Well I don't know
23 if it was a dozen times. They came out many times to see
24 what our infrastructure looked like and what we did, and

1 they became convinced.

2 And, so, in Rhode Island now, we do have
3 the first risk contract in the state. We do have a
4 Medicaid pilot project, which reduces cost. We even
5 committed to Blue Cross and Blue Shield, because the
6 office of its Health Insurance Commissioner asked for a
7 15 percent reduction of premium product.

8 We've come together with them on a product
9 that actually provides a 15 percent reduction in premiums
10 for small groups, for small employers, so we actually do
11 know how to save money by developing a coordinated
12 regional care program.

13 So we actually think that, when you take a
14 look at the metrics in Connecticut and Pennsylvania and
15 Rhode Island, again, for every thousand patients, how
16 many days will they spend in a hospital bed?

17 I don't recall the numbers in Connecticut,
18 but I think it's like 1,400 days, and some of our
19 hospitals were down in the 700s, so if you can keep a
20 patient out of a hospital, but you can take care of them
21 even better, with more dignity, in their home or in
22 another setting, it's better for everybody. It really
23 does work.

24 So we think we actually can help be

1 transformative in the way health care is delivered in
2 Connecticut, and we're really excited about the
3 opportunity.
4 The initial conversations with the
5 physicians and the development of the IPAs are going
6 swimmingly. We're pretty excited about it all.
7 So to the last slide, John? Again, we're
8 all about the triple aim. You probably can't guess this
9 from looking at me, but I've actually been around for a
10 couple of years, and I joined Prospect about three and a
11 half years ago, because I was so enamored with the model.
12 I actually do believe that this model can
13 help move us toward a triple aim of higher quality, lower
14 cost and higher patient satisfaction, so that's what
15 we're about, and that's what we'd love to work with ECHN
16 on, ECHN in developing here in Connecticut.
17 That concludes our Direct Testimony.
18 Thank you for your attention.
19 HEARING OFFICER HANSTED: Thank you.
20 Thank you, all. At this point, let's take a 15-minute
21 break, and we'll go back on the record 15 minutes from
22 now. Thank you.
23 (Off the record)
24 HEARING OFFICER HANSTED: Welcome back,

1 everyone. Thank you for that presentation. That was
2 wonderful. We're going to go to OHCA's questions at this
3 point, so I don't know who wants to start. Mr. Lazarus?
4 MR. LAZARUS: I will. Good afternoon.
5 Steven Lazarus. I'm going to address the questions
6 possibly to one or two people at a time, and you're
7 welcome to bring up anyone --
8 VOICES: Microphone.
9 MR. LAZARUS: Can you hear me now?
10 HEARING OFFICER HANSTED: Move this up a
11 little bit.
12 MR. LAZARUS: Is that better? All right.
13 Mr. Crockett, in your testimony, you say that PMH now has
14 hired a Chief Quality Officer, a Clinical Officer, Senior
15 Chief Nursing Officer and a VIP Regulatory and Patient
16 Safety person. When were these positions filled?
17 MR. CROCKETT: The Chief Quality Officer
18 position, actually, her first day is on April the 4th,
19 Monday, and the other three positions were filled
20 approximately about 45 to 60 days ago, and they're
21 currently working on the resolution at our two facilities
22 as we speak.
23 MR. LAZARUS: And how were these duties
24 and responsibilities covered before filling these

1 positions at PMH?
2 MR. CROCKETT: At the corporate level, we
3 really didn't have the positions, and, so, it was
4 delegated to the local entities to a certain degree, and,
5 so, what we're hoping to do with these positions is to
6 provide the additional oversight in making sure that, as
7 the goals are either being met or not met, that we look
8 at resources that are being expended and provide them as
9 necessary.
10 MR. LAZARUS: What will these positions
11 bring to mitigate an occurrence of immediate jeopardy in
12 our Connecticut hospitals?
13 MR. CROCKETT: Part of the issue that we
14 got cited on was that the Quality Assurance and
15 Performance Improvement Plan wasn't dynamic, and, as the
16 organizations were experiencing the difficulties that
17 they had, it wasn't modified to address those issues,
18 and, so, they came in and they saw the quality programs
19 off to the left, and the organization was moving in a
20 separate direction going forward.
21 As organizations go through their various
22 accreditation surveys or they have issues arise
23 associated with any type of other surveys, those findings
24 are inputted into a quality program, so that you can do

1 the monitoring and the compliance to those things on a
2 go-forward basis.
3 To be blunt, that's what did not occur
4 within our quality program at the facilities. They
5 continued to be monitoring things that were not outdated,
6 but just not completely as relevant, so lesson learned.
7 This is to make sure that the quality program is updated
8 not just once a year, but actually whenever the issues
9 need to be updated, and that's actually one of the things
10 that we're hoping to achieve with these individuals.
11 MS. KIM MARTONE: Kim Martone, OHCA staff.
12 You had stated in your testimony that you're currently
13 revamping the QI QA program?
14 MR. CROCKETT: Correct.
15 MS. MARTONE: Can you give us a summary at
16 all, in terms of what it contains, when it will be
17 available, who is involved in revamping it?
18 MR. CROCKETT: Yeah, sure. If we haven't
19 already provided you with the Quality Assurance and
20 Performance Improvement Plan, we can do so, and we will
21 be happy to do so.
22 It started off with two issues. First,
23 making sure that the 2016 national patient safety goals
24 are addressed associated within the quality program, and

1 that's more from just a kind of an oversight umbrella.
2 Specifically, each of the two
3 organizations within that, you know, the issues that have
4 been addressed or identified in the current CMS survey
5 are included in the program, so, for the one facility,
6 we're looking at temperature and humidity, we're looking
7 at infection control, we're looking at nursing services.
8 For the other facility, once again, we
9 want to make sure that the quality program is not a
10 cookie cutter, and, so, it's modified to the issues
11 specific that were at the LA Community facility.
12 The other aspect associated with the
13 quality program is making sure that each of the different
14 departments have a quality measure that they're
15 participating in, as well, and that was another
16 deficiency that we had, which is that we had -- that
17 wasn't seen as being completed from a house-wide
18 perspective, and, so, with that, you should see a
19 comprehensive program to monitor.
20 MS. MARTONE: Okay.
21 MR. LAZARUS: Can you please identify each
22 of the individuals, and tell us what experience do these
23 individuals have in working with large health care
24 systems and ensuring quality improvement, patient safety

1 issues of the hospital networks?
2 MR. CROCKETT: Sure. The Chief Quality
3 Officer has just previously held a position as a
4 divisional quality expert for HCA. I believe it was over
5 the western division for HCA. I don't know the exact
6 number of hospitals, but it was for about half of the
7 company.
8 With that, she had the responsibility for
9 the quality program, oversight, patient safety and
10 developing the policies and process and reporting tools
11 and kind of assuring of best practices within the HCA
12 division, and that will be the Chief Quality Officer.
13 The Chief Clinical Officer previously was
14 in a similar role for Kindred and was responsible for the
15 clinical effectiveness of nursing care for the Kindred
16 Corporation.
17 The background for the Corporate Chief
18 Nursing Officer, she's from the east coast and has held
19 multiple Chief Nursing Officer roles within various
20 companies, and I can provide further background
21 associated with her.
22 The position for the regulatory affairs
23 and patient safety has also extensive experience, and I
24 don't know it off the top of my head, but I can provide

1 that, as well.

2 MS. MARTONE: Yes. If you could provide

3 us a late file of their resumes, we'd appreciate it.

4 MR. CROCKETT: Yeah, I can do that. It's

5 not a problem.

6 HEARING OFFICER HANSTED: I just want to

7 clarify the record. The resumes will be Late File No. 3,

8 and Late File No. 2 will be the Quality Performance

9 Improvement Plan that you referenced earlier.

10 MR. CROCKETT: Actually, more than likely,

11 it would be 2, because, as I said, they're two different

12 plans; one for the LA community and one for the Southern

13 California hospital.

14 MS. MARTONE: Could you just make sure

15 they're dated, as well, so we know the date that they're

16 actually going into effect?

17 MR. CROCKETT: Sure.

18 MS. VOLPE: If we're numbering late files,

19 I believe ECHN wanted to submit an outline, as well, as

20 part of the late file.

21 HEARING OFFICER HANSTED: The time line is

22 No. 1.

23 MS. VOLPE: And 2 is the CMS?

24 HEARING OFFICER HANSTED: Two is the

1 Quality Performance Improvement plan or plans, and No. 3
2 are the resumes.
3 MS. VOLPE: Okay and we'd also like to
4 submit the Corrective Action Plan we mentioned that's due
5 on or about April 8th into the office regarding CMS's
6 corrective action.
7 MR. CROCKETT: And that's for the LA
8 community license resurvey.
9 HEARING OFFICER HANSTED: Okay, so, the
10 Corrective Action Plan will be Late File No. 4.
11 MS. VOLPE: Great. Thank you.
12 HEARING OFFICER HANSTED: Thank you.
13 MS. MARTONE: And just one more question.
14 Do you anticipate any changes to those quality assurance
15 plans, based on any -- these surveys, the results of any
16 of these surveys?
17 MR. CROCKETT: You mean in terms of the
18 ones that were just revised?
19 MS. MARTONE: Right.
20 MR. CROCKETT: Well that's actually one of
21 the things that we're going to do differently. As any
22 issues come up that are new, we're going to modify the
23 program, so the answer is that, in any hospital that we
24 have, as issues are identified from a CMS perspective,

1 the quality programs will be adjusted to make sure that
2 the monitoring goes, so the answer is yes.
3 MS. MARTONE: Okay and then, as Chief
4 Quality Officer, she obviously, or he, will have a say?
5 I'm assuming will be assessing the hospitals and the
6 quality of programs, and is there anything she's going to
7 be doing when she begins or he begins next week, in terms
8 of reevaluating these current issues and challenges?
9 MR. CROCKETT: Yeah, several things. The
10 first issue is that we're going to be asking her --
11 she'll be looking at -- her name is Debbie Barry, but
12 she'll be looking at any of the former either Joint
13 Commission and/or survey results that the facilities had
14 and looking at the responses that they had, and the
15 question is were the responses appropriate, and were they
16 compete, and, more importantly, are the facilities
17 continuing on with the work that they had said that they
18 were going to do with the correction of these facilities,
19 and that's, obviously, for all of them, all of the
20 Prospect hospitals.
21 Obviously, we've got the two that are the
22 most important at the moment. That it will be her role
23 of making sure the compliance with our plan of
24 corrections to CMS.

1 MS. MARTONE: Thank you.
2 MR. LAZARUS: What is PMH's plan to
3 contract with a patient safety organization if they
4 acquire ECHN?
5 MR. CROCKETT: At the moment, what we have
6 committed to is to continue to -- any quality programs
7 that they have currently in place we're going to maintain
8 that.
9 In terms of future plans, that will be
10 done in conjunction with the local Advisory Board and
11 with ECHN in consultation with direction from our Chief
12 Quality Officer.
13 MR. LAZARUS: As a result of the survey, I
14 think it was in your testimony that PMH hired a
15 consulting firm to review the operations and policies and
16 the procedures in California.
17 Based on the recommendations, PMH
18 implemented new ones. Can you please elaborate on
19 findings or recommendations of the consulting firm? What
20 new policies and procedures were implemented?
21 MR. CROCKETT: There's actually a couple
22 of things, and let me just talk about the process first
23 of all, then I'll get into some of the more specifics.
24 There were two things that were occurring.

1 The first one that was alluded to is that the hospitals
2 recently, in the past couple of years, have gone through
3 a license consolidation, and, as part of the license
4 consolidation, one of the things that's important is
5 making sure that the policies are consistent within that
6 license, and, so, the first thing that they were looking
7 for was making sure that the facilities not just only had
8 a consistent policy, but they were actually practicing
9 consistently to the policy, so that was number one.
10 The second thing that they looked for is
11 that they would take a look at the policy, specifically,
12 as it related to the Medicare conditions of
13 participation, and what had happened over a period of
14 years, we've gone through multiple surveys by various
15 regulatory agencies, is they had taken a base policy, and
16 whatever the issue at the moment was was that they would
17 add on top of it, and it became an unworkable policy that
18 was really kind of a configuration of multiple past
19 surveys that they thought there were doing right.
20 And what happened, specifically associated
21 with like our temperature and humidity issue, the intent
22 of what was put in our policy was, for the right reasons,
23 was unworkable.
24 Specifically, our policy stated on

1 temperature and humidity that the organization was to
2 check the temperature and humidity every hour and make
3 adjustments accordingly, and that's regardless if there
4 was a surgery being performed there or not. The practice
5 is is that that's actually not a CMS condition of
6 participation, nor is it a requirement, so when they
7 looked at our practice and saw that it wasn't consistent
8 with our policy, we got cited for it, in addition to
9 other things.
10 So they went through all of our policies
11 and looked at the operations of the organization,
12 streamlined the operations consistent with CMS
13 participation, so that, as we practice, that we're going
14 to be consistent with them, so using the temperature and
15 humidity as an example, it was revised to reflect that we
16 check the temperature and humidity at the start of the
17 day, which is about 4:30 in the morning, and make
18 adjustments, if it's necessary, associated with that, and
19 then we then check the temperature and humidity before
20 each case, making sure that there's proper versus what we
21 had in the past for checking every single hour.
22 They went through all of our policies
23 related to nursing care and made similar type of
24 adjustments. The total number of policies that were

1 changed, I don't have it off the top of my head, but I
2 believe it's over 45 of policy modifications that were
3 recently inputted.
4 MR. LAZARUS: Based off the 45 policies
5 that were modified, are any of these policies and
6 procedures that were specific to California are they
7 going to be implemented in other PMH hospitals that are
8 in Texas and Rhode Island?
9 MR. CROCKETT: At the moment, we're
10 actually focused just on California, and, once we have
11 our Chief Quality Officer and we get past our survey
12 status and we have the individual in place with her team,
13 the anticipation is then we take our revised policies and
14 take a look at, then, the policies at the other
15 facilities and identify if there's streamlining that
16 needs to occur and/or are they adherent to the policies,
17 and that would be kind of a step two that would happen
18 down the road.
19 MR. LAZARUS: Okay, now, who is the
20 consulting firm that you had hired?
21 MR. CROCKETT: We hired two. The
22 consultant firm is called the Greeley Company, and you
23 can either find them on the web or we can provide the
24 information, but it's a nationally-recognized firm that

1 works with CMS, and then we hired a local law firm,
2 called Hooper and Lundy, so, in tandem, the two of them
3 are assisting us in our response back to CMS.
4 MR. ZINN ROWTHORN: When you say work for
5 CMS, do you mean specialize on CMS-related issues?
6 MR. CROCKETT: Specialize in CMS, in
7 resolving issues when hospitals get sideways with CMS.
8 MR. ZINN ROWTHORN: Okay, thank you.
9 MR. SALTON: So is that the firm that did
10 the review, your comprehensive review, or are they just
11 doing the review for CMS purposes?
12 MR. CROCKETT: It is the same firm.
13 They're reviewing the policies, and they also were
14 responsible for the redefining and the development of a
15 quality program, the Quality Assurance Program, as well,
16 as well as in assisting us in our response back to CMS,
17 and they're still on site and will continue to be on site
18 until we resolve and pass the survey.
19 MR. LAZARUS: Now PMH has agreed to
20 maintain the respective quality programs that you just
21 stated for two years. Can you explain why two years?
22 MR. CROCKETT: Simply, there really isn't
23 actually a magic number to the two-year mark. It was
24 more of an issue of starting off with a transaction of

1 taking a look at their quality program, and the question
2 is will PMH change their quality program or maintain it,
3 and the answer is, very simplistically, we took a look at
4 it, and the answer was that they have a great program,
5 and we don't anticipate making any changes to the
6 program.
7 The issue of why the two-year mark, the
8 answer always gets back to the question of how do things
9 change within the health care industry within two years
10 and what new things will occur, and we want to make sure
11 that, as we improve Prospect's quality program, that we
12 don't have an entity that is going to be isolated, so it
13 was strictly that.
14 It is meant to be a placeholder, and then,
15 as the organizations have worked together for two years
16 and we moved forward, it was just a placeholder, is
17 really what it was.
18 MR. LAZARUS: Okay. You also submitted a
19 quality assurance commitment with ECHN at the beginning
20 of the hearing. Could you talk a little bit about that
21 and discuss it from the details incorporated in there?
22 MR. CROCKETT: Yeah, so, the commitment is
23 several fold, and it really, then, or I think relates
24 back to one of the original questions that we had just

1 before the break, which is how does the local leadership,
2 as well, comply with kind of a corporate oversight, and I
3 think the three of them kind of tie together.
4 The commitment starts off with this is it.
5 There's multiple things that ECHN is currently doing on
6 their quality program. A, their quality program, two,
7 the level of staffing that they have associated with it
8 and the people that are doing it, three, they're
9 participating and have been long participants in the high
10 reliability organization, and they've got some other
11 internal programs related to patient satisfaction, risk
12 and some other of those measures.
13 So the commitment we have is not only just
14 to maintain the program, but to, A, maintain staffing
15 and/or improve the staffing and maintain all the current
16 things that they're currently doing.
17 The other thing is that, from their visit
18 that they had when they went to Rhode Island, there were
19 some things that our CharterCARE facility was actually
20 doing that they would actually like to bring down to
21 ECHN, so our commitment to them is that anything that
22 we're doing in any of our other organizations then we
23 will make sure that the right resources are brought into
24 ECHN, as well, too.

1 So, very specifically, how we look at the
2 quality is that we're going to, A, maintain it, and, two,
3 anything we do to change it is going to be an add-on, and
4 it's going to be done in consultation with ECHN.
5 MR. ZINN ROWTHORN: Steve, can I ask one
6 question?
7 MR. LAZARUS: Yes.
8 MR. ZINN ROWTHORN: I meant to ask you
9 before. You referenced that designation of high
10 reliability organization a couple of times. Can you tell
11 me what that is? Who bestows that? What it signifies?
12 MR. CROCKETT: Yeah. A high reliability
13 organization it's actually a formal program that an
14 organization commits to, and it's a long-term commitment,
15 and the goals of a high reliability organization are to
16 make sure that the processes that are put into place
17 protect the patients and provide a safe environment for
18 the patients to receive care.
19 It's a significant commitment, not just in
20 financial, but in organizational time and energy
21 associated with it, and it looks at not only the
22 processes that are occurring in the organization, but,
23 more importantly, making sure the organization is
24 committed to understanding when it doesn't work and

1 fixing the processes, so that the organization becomes
2 consistent in how the care is actually being delivered
3 and reducing the variability and improving the outcomes.
4 And, so, organizations that participate in
5 it, they do go through outside training specifically to
6 it, and they go through outside audits to make sure that
7 they are continuing with what they're doing and the
8 reporting associated with it.
9 We actually have seen, you know, I think
10 the Connecticut facilities this is an initiative that's
11 been done for a while now in Connecticut. We were
12 introduced to it through our work with CharterCARE in
13 Rhode Island, and, over this past year and a half, we've
14 been so impressed with the work that they've done up in
15 Rhode Island that we're looking now to actually roll it
16 out into our other facilities in California and Texas.
17 MR. ZINN ROWTHORN: It's a privately
18 granted accreditation?
19 MR. CROCKETT: I don't know the answer to
20 that.
21 MR. ZINN ROWTHORN: It's not a government
22 designation?
23 MR. KARL: No. No. You volunteer to
24 become designated as an HRO. Just if I can put it in a

1 nutshell, if you don't mind, the State hospitals would
2 commit to a CHA, Connecticut Hospital Association,
3 committed to becoming a high reliability organization,
4 and it almost, again, in a nutshell, it almost follows
5 the pilot's checklist, okay? Anyone can stop the line.
6 It goes all the way down to the issues that we deal with
7 with the right side surgery, correct side surgery and so
8 on and so forth.
9 It empowers everyone in the organization.
10 If they see something that doesn't seem to be happening
11 that's appropriate, they can put their hand up and stop
12 it, without any type of repercussions, whether they're
13 telling a physician you need to stop here, I think we
14 have a problem, and that's in a nutshell what HRO is.
15 MR. ZINN ROWTHORN: Thank you. That's
16 all.
17 MR. LAZARUS: I have a couple of questions
18 for Ms. Dorin. You had testified that you visited PMH
19 hospitals in California. Which ones did you visit?
20 MS. DORIN: We visited Southern California
21 at Culver City.
22 MR. LAZARUS: And you reviewed
23 documentation you had mentioned earlier at those
24 hospitals?

1 MS. DORIN: Not there. We reviewed
2 documentation on our visit to the Rhode Island hospitals.
3 MR. LAZARUS: Okay, so, what did you
4 review at the California hospitals in your visit?
5 MS. DORIN: Well it was actually I would
6 say it was more of a visit than a review. I mean there
7 were several of us from ECHN and several Prospect members
8 that went to the hospital.
9 We spoke with a number of different
10 departments, and we did some site tours. We were on a
11 couple of different floors of the hospital.
12 MR. LAZARUS: So what was your goal for
13 visiting the hospitals in California?
14 MS. DORIN: Well, as part of the process
15 for selecting an acquisition partner, we felt that we
16 really needed to sort of see what was going on firsthand
17 and in person, so that was the primary intent, to go out
18 and put, you know, faces to names and to see how
19 employees are operating in the hospitals.
20 I don't mean operating in the traditional
21 sense, but, you know, as a sort of walk around the
22 floors, and we had an opportunity to speak to people
23 extemporaneously to get their thoughts on how it was
24 working for a Prospect hospital. We spoke with doctors.

1 MR. LAZARUS: When did you visit?
2 MS. DORIN: We visited last May, May of
3 2015, and we visited the CharterCARE hospitals in June of
4 2015. June of 2015.
5 MR. LAZARUS: When did PMH first bring to
6 ECHN's attention the problems it had at the Southern
7 California hospitals?
8 MS. DORIN: That's on the timeline, and
9 that is in -- they called February 1st?
10 MR. KARL: Yeah. If I can answer?
11 February 1st, I was informed by Mr. Reardon that they
12 have some issues regarding inspections at a couple of
13 hospitals out in LA.
14 MR. LAZARUS: Okay and that's the timeline
15 that we're going to be getting as a late file?
16 MR. KARL: Yes.
17 MS. DORIN: Yes.
18 MR. LAZARUS: Thank you.
19 MS. MARTONE: Ms. Dorin, Kim Martone,
20 OHCA. Would it be possible to provide any records or
21 reports, findings from the quality evaluation team? Is
22 there anything generated from that? That would be
23 appreciated.
24 MS. DORIN: Sure. Sure.

1 HEARING OFFICER HANSTED: Okay. That will
2 be Late File No. 5.
3 MR. LAZARUS: Ms. Dorin, you had mentioned
4 a collaboration by the eastern region hospitals on the
5 quality issues in your testimony. Can you elaborate on
6 the structure of the structure, and who will comprise --
7 who will this collaboration team -- what would it be
8 comprised of, what individuals?
9 MS. DORIN: I would say that that is
10 probably to be determined at this point, but, as we have
11 been talking with Prospect and as our quality team had
12 visited with the CharterCARE hospitals in Rhode Island,
13 we saw great opportunities to further collaborate and
14 share best practices, and Prospect is committed to doing
15 that, as I believe Von referenced and Tom, also.
16 MR. LAZARUS: All right.
17 HEARING OFFICER HANSTED: Maybe, just for
18 the benefit of the public here, could you just go through
19 and summarize the timeline that you're going to submit to
20 the panel?
21 MS. DORIN: Well it's six pages.
22 HEARING OFFICER HANSTED: Okay.
23 MS. DORIN: I'd be glad to.
24 HEARING OFFICER HANSTED: I'm sorry?

1 DR. O'NEILL: It's sort of a blow-by-blow
2 timeline of what we did once we knew about the IJ issues
3 at Prospect and everything that we did internally with
4 our management team and the Board.
5 HEARING OFFICER HANSTED: Okay.
6 MR. KARL: I'll just walk you through a
7 couple of points, if that would be helpful.
8 HEARING OFFICER HANSTED: That would be
9 helpful, and, for the public that's here, this document
10 will be on OHCA's website if you want to review it in
11 detail.
12 MR. KARL: So I'm going to condense when
13 we first heard about it, because what we needed to do,
14 again, internally is take a deep dive into the inspection
15 documents.
16 There's a data room that was downloaded to
17 us that has thousands of pages, and the quality team
18 jumped all over that.
19 I, then, on February 19th, I met with the
20 Board Chair, Dr. O'Neill, and Vice Chair, Joy Dorin, to
21 discuss the or disclose the regulatory issues in
22 California.
23 Dr. O'Neill stated that he felt it would
24 need to be brought forward to the Board of Trustees.

1 There was a meeting with the Board of Trustees on the
2 25th of February.
3 The Board of Trustees, at that point,
4 brought forward and appointed a subcommittee of the
5 Transaction Committee, led by Joy Dorin, the Vice Chair,
6 because she was also the Chair of the Transaction
7 Committee.
8 We brought in our QI experts and, also,
9 our attorneys. They went through a significant due
10 diligence process. On March 2nd, we had detailed phone
11 conversations with those individuals from PMH, Von and so
12 on and so forth.
13 We then also did a deep dive into, you
14 know, is there any concern, as it relates to any of the
15 equity partners, you know, something like this would
16 occur, and we also looked at that.
17 Then, on March 4th, our quality team went
18 up to Rhode Island, Our Lady of Fatima and Roger
19 Williams, did a detailed deep dive into their quality
20 program, and, when they came back, they were extremely
21 impressed with the additional resources that were brought
22 forward at CharterCARE that we felt could help bolster
23 some of our quality programs in Connecticut.
24 They, of course, were very interested in

1 HRO, because the Connecticut Hospital Association is
2 contracting with the Rhode Island Hospital Association to
3 roll out the HRO initiative.
4 We, then, again went through detailed
5 meetings twice week, Board members, the Transaction
6 Committee with Prospect. We reviewed all of the
7 inspections. Also, the immediate jeopardy, did some
8 comparisons about how regulators do inspections out in
9 California versus what happens in Rhode Island and
10 Connecticut.
11 We, then, had a special Board meeting on
12 the 23rd to discuss all of our findings, this is March
13 23rd, and we felt that our concerns were satisfactorily
14 answered. We created that side letter that obviously is
15 an exhibit, and we will continue to follow-up with,
16 obviously, the responses to the findings.
17 This is going to be prolonged. This isn't
18 something that CMS is going to come down and say, okay,
19 it's all over with. It's going to be prolonged for a
20 while, so we had agreed to stay very close to that.
21 The side letter, you know, I guess I would
22 say this. We feel very strongly about our quality
23 program. Obviously, we received awards. Connecticut has
24 a different handle on quality than some of the other

1 states.

2 The issue that I think we're dealing with
3 here, as we created this side letter, we wanted some type
4 of written commitment from Prospect that they're not
5 going to jump in and mess with our quality program, and
6 the two-year period was, you know, Joy said she wanted
7 five years, and, you know, a lot of other people said,
8 you know, two years, three years, and, again, it's not
9 really the timing period.

10 It's a matter of we thought two years
11 would be enough time for the Chief Quality Officer at
12 corporate to get her feet wet, to take care of the issues
13 that happen out in California, to better understand
14 regulatory issues, as it relates to the Texas hospitals,
15 the Rhode Island hospitals, the Connecticut hospitals,
16 and, also, then, form, as they do now for a lot of other
17 scorecards for performance measures, to then have,
18 whether it's weekly or biweekly, calls between all of the
19 quality leaders to do some comparisons and, also, to
20 match outcomes to see who is doing best practices and so
21 on and so forth, so that's kind of it in a nutshell.

22 HEARING OFFICER HANSTED: Okay, thank you.

23 MR. SALTON: Can I ask a follow-up
24 question on the remit? Maybe just take a minute on that?

1 The first provision provides they're going
2 to maintain your programs for two years, the second
3 provision talks about maintaining the QA program.
4 Consistent with best practices in the programs in Rhode
5 Island, which one will govern if there's any consistency?
6 MR. KARL: That's a great question. If
7 we're following -- much of this is, obviously, the
8 federal HCAHPS CMS, HCAHPS.
9 Those that pertain to Connecticut
10 obviously will be following ours. Those that pertain
11 separately to Rhode Island will follow by the Rhode
12 Island hospitals.
13 I would say this, because this is, again,
14 this is brand new, so speaking just from my lips, we have
15 to form an eastern region quality program, and not
16 necessarily even an eastern region. It really has to be
17 a Connecticut and a Rhode Island, so we better understand
18 quality services, so we can do some local comparisons
19 versus nation comparisons.
20 DR. LEW: Henry, if I could just add, you
21 know, from corporate, if what is happening in
22 Connecticut, as you say, if there's not a meeting of the
23 minds, if it's working, we don't want to come and mess
24 with it.

1 We're certainly here to support everything
2 that they're doing, and, as we fix our issues in
3 California and our Chief Quality Officer gets on board
4 and really understands extremely well what's happening
5 across segments, you know, I'm sure she'll be able to
6 offer some input and support, but whether we're talking
7 about quality, or business development, or recruitment,
8 or staffing, we defer to the local leadership, and if
9 it's working, there's no reason for us to fix it.
10 MR. SALTON: Okay. The agreement also
11 provides there's an acknowledgement by Prospect that,
12 following the closing, the local Board, I assume that's
13 the Advisory Board, will have oversight over the quality
14 assurance program.
15 By oversight, does that mean that they
16 have actual delegated authority, or they're just going to
17 be reviewing it and reporting in an advisory way? I'm
18 not sure what oversight means.
19 From a regulatory perspective, oversight
20 means one thing. From an advisory concept, it means
21 something else.
22 MR. CROCKETT: Delegated.
23 MR. SALTON: Would you elaborate on it for
24 the record?

1 MR. CROCKETT: Yeah, so, the way that we
2 have reached the agreement is that, obviously, the
3 corporate Board has ultimate responsibility for the
4 financial and quality of any organization, and, with
5 that, there are going to be a delegation of physician
6 credentialing, as well as the quality program to the
7 local Advisory Board.
8 The local Advisory Board will be made up
9 of physicians within ECHN, as well as some community
10 members associated with that.
11 MR. SALTON: Have you done a delegation
12 like this in the other hospitals?
13 MR. CROCKETT: We do, at CharterCARE.
14 MR. SALTON: Could you give us a copy of
15 that delegation, so we can see that if that's the model?
16 MR. CROCKETT: I believe, yeah. I think
17 we can.
18 MR. SALTON: Okay.
19 HEARING OFFICER HANSTED: That will be
20 Late File No. 6.
21 MR. SALTON: That's all I have right now.
22 Thank you.
23 MR. LAZARUS: I'll address the next couple
24 of questions towards ECHN. It's mentioned in the

1 responses to the pre-hearing questions that ECHN
2 reviewers visited PMH's Rhode Island hospitals as part of
3 its quality review investigation and found that the
4 quality programs had been enhanced in notable ways since
5 Prospect's acquisition.
6 Can you elaborate a little bit on that and
7 provide some examples?
8 MR. KARL: I can. Again, I'm going to ask
9 Linda Quirici to come up, please. She was the one, who
10 headed up the inspection.
11 MS. QUIRICI: So this is for the Rhode
12 Island hospitals, correct?
13 MR. LAZARUS: Yes.
14 MS. QUIRICI: Okay, so, myself and two
15 experts came with me on March 4th. We visited both
16 hospitals, which is Roger Williams and Our Lady of
17 Fatima, and we met with the Quality, Safety and Risk
18 Departments and Infection Control, so those are the areas
19 that we concentrated on in both hospitals.
20 So some of the enhancements that we saw
21 that we were quite excited about, to be honest with you,
22 is PMH brought safe transitions of care, which has
23 significantly reduced their readmission rates.
24 Pharmacists and an LPN were brought on board for follow-

1 up calls, and they saw a significant decrease in their
2 readmission rates, and that's something that all
3 hospitals are looking at for the betterment of the
4 patient, as well as that's something that CMS looks at,
5 so we really were interested in that.
6 They are integrating the two hospitals,
7 eliminating duplication of services, which is much more
8 efficient, so that was great.
9 We saw a huge investment in the renovation
10 of the two hospitals with the patient in mind. They were
11 improving all their handicap access. In places where
12 they had stairs, they were now putting handicap access
13 and elevators to help with handicap, so that it was with
14 the patient in mind.
15 They improved lighting. They had single
16 rooms, which is much preferred by patients, open concept
17 nursing units, which is definitely best practice for
18 patient care, and they had plans for future renovation
19 there, as well, looking for new emergency departments,
20 etcetera, so we saw physically a lot of construction
21 going on, a lot of improvements in both hospitals, so
22 that's great, and that would be a great help to us, as
23 well.
24 So they've integrated some of their

1 departments. They have a very robust quality department.
2 They've supported new positions to ensure that the
3 quality standards and metrics are met.
4 PMH recognized Roger Williams focused on
5 quality and safety and supported that process that was
6 already in place, which is what they're planning on doing
7 for us, as well, and they increased their staffing and
8 patient satisfaction area, which is great to hear, as
9 well, because that is, you know, patient experience,
10 patient satisfaction is very important. It's something
11 that Eastern Connecticut Health Network is working on,
12 so, again, we're looking for similar kinds of
13 improvements here.
14 Let's see. We did see their quality
15 improvement diagram, which was very good, how they report
16 up to the Board, which that was great, and, in speaking
17 with the Chief Nursing Officers at both hospitals, PMH
18 allowed autonomy in managing the departments that are
19 meeting their performance measure, so if they're doing it
20 right, you know, they're encouraging that, and those
21 departments that are not meeting expectations are
22 assisted by this corporate oversight that they've talked
23 about, so that's kind of the best of both worlds.
24 PMH assisted the hospitals in pursuit of

1 certifications, things, such as stroke, diabetes and
2 total joint replacement. They have a good outreach for
3 primary care doctors and started an IPA there, which has
4 been very helpful.
5 They were in the process of developing the
6 various VP positions for oversight of the PMH systems, so
7 that was in place, and this is the local leadership
8 talking to us about that. It wasn't PMH. It was the
9 local leadership talking to us about that.
10 Okay. They provided tools to assist with
11 staffing and productivity, so to make sure that they were
12 efficient, and that was great. They look at processes,
13 PMH looks at processes through evidence-based standards.
14 They analyze cost and outcomes to choose the best
15 pathway, which is best practice, and that's something
16 that we would want to do.
17 They support a multi-disciplinary review
18 of any events, which is great. They had strong legal
19 support, which the hospitals felt was very helpful. They
20 improved processes in recycling and reprocessing with the
21 support from PMH.
22 Infection control, there was no cutting
23 corners in infection control, and that was really great
24 for me to hear, because as PMH is putting it number one,

1 really that's something number one in our organization,
2 as well, and that's in our safety plan, I mean our
3 quality plan for 2016.
4 So they had a very robust Infection
5 Control Department. Again, fully staffed at both, and I
6 looked at all the job descriptions, and they talked about
7 their processes. Very solid. Very solid. Something
8 that, again, we'll want to talk with them more about as
9 we go forward.
10 Okay. The other thing is they provided
11 their metrics display and organized dashboard. There was
12 really great dashboard from these two hospitals that
13 looked at all their quality measures and put their
14 targets, you know, what their benchmarks are and what
15 their scores were, so you could very clearly see it was
16 very organized on an Excel spreadsheet, and we're, again,
17 hoping to emulate that, so we had a great visit.
18 MR. LAZARUS: Thank you. As part of the
19 quality assurance commitment, are these some of the
20 recommendations you're looking to implement say in the
21 next two years at ECHN?
22 MS. QUIRICI: Well, as part of that, and I
23 think it talked about it, that these things will be
24 available to us, we'll communicate with them, you know,

1 as we have done, and their best practices we'll adopt
2 those, and they'll adopt our best practices, so, again,
3 the best of both worlds to share between the hospitals.
4 MR. LAZARUS: All right, thank you.
5 MS. QUIRICI: Okay.
6 MR. LAZARUS: As a result of ECHN's
7 investigation into the compliance and quality issues
8 connected with PMH's California hospitals, did ECHN
9 consider asking PMH whether its local Advisory Board
10 could have authority than presently where it would only
11 recommend authority to ensure ongoing quality care to
12 ECHN hospitals? Would you like me to repeat the
13 question?
14 MR. KARL: Would you please repeat that?
15 MR. LAZARUS: Yeah. As a result of ECHN's
16 investigation into the compliance and quality issues
17 connected with PMH's California hospitals, did it
18 consider asking PMH whether its local Advisory Board
19 could have more authority than presently to ensure
20 ongoing quality of care at ECHN hospitals?
21 DR. O'NEILL: We didn't consider that,
22 specifically, as you've phrased it, but what I think --
23 see, we tried to consider how this is going to work out
24 practically speaking, and, right now, our Board, the

1 Board of ECHN, has a lot of input into the quality
2 standards that the organization has.
3 In the future, the Advisory Board is going
4 to have a similar practical role. In other words, the
5 Advisory Board consists of physicians and community
6 members. One of their main roles is to oversee quality
7 and patient safety, so if Prospect is reassuring us that
8 our quality program will be supported, then it will be
9 implemented through the interaction between the Advisory
10 Board and the management team.
11 So when the Board looked at it, you know,
12 over the past four months, or four weeks, ever since this
13 started, we felt that we had the assurances that we
14 needed to make sure that we were going to maintain
15 quality for the next five years, let's say. Did you want
16 to add something?
17 MS. DORIN: And beyond, because the
18 commitment letter, you know, does -- oh, okay. Right.
19 So the local Board, the responsibilities the local Board
20 are actually enumerated in the asset purchase agreement,
21 and it says, and I'm reading from page 63, "The local
22 Board shall, among other things, serve as a resource for
23 buyer with respect to buyer's investment of the capital
24 commitment, maintenance and implementation of the

1 strategic business plan, and be responsible for medical
2 staff credentialing at the hospitals, maintain and
3 oversee the quality assurance programs at the hospitals,
4 and oversee and manage the accreditation process for the
5 hospitals."
6 MR. ZINN ROWTHORN: But I think what we've
7 just heard is that there's a delegation of actual
8 authority to the local Board with respect to quality
9 issues, is that correct, beyond an advisory capacity?
10 MR. CROCKETT: I think I understand your
11 question, but I'm not exactly for sure.
12 A MALE VOICE: Do you want to restate it?
13 MR. ZINN ROWTHORN: Yeah.
14 A MALE VOICE: Maybe say it another way?
15 MR. ZINN ROWTHORN: I think we've heard a
16 little bit about just now about what the asset purchase
17 agreement talks about with respect to the Advisory
18 Board's authority. Subsequent to that, we have the side
19 letter agreement, and your answer, Mr. Crockett, to
20 Attorney Salton's question, which was that there is a
21 delegation of authority on quality issues or will be to
22 the local hospitals, similar to what's done in Rhode
23 Island, is that correct? And that's a delegation, not
24 just advisory authority, as contemplated in the asset

1 agreement, but actually authority.
2 MS. VOLPE: I think Mr. Crockett testified
3 that, for physician credentialing, there's certainly a
4 delegation of authority.
5 MR. ZINN ROWTHORN: I think it was beyond
6 that.
7 MR. CROCKETT: Well, for the two-year
8 period, I mean what we have committed to is that we're
9 not going to be modifying the program, as setup
10 currently, and only looking to actually enhance it.
11 MR. ZINN ROWTHORN: Okay. We had a
12 colloquy a few minutes ago about what paragraph two in
13 the side letter means when it refers to local Boards
14 having oversight over the quality assurance program and
15 what oversight means in that context, which was as the
16 answer when a delegation of authority.
17 MR. SALTON: As opposed to merely
18 oversight, and I think, when we spoke, I said there's
19 advisory and there's authority with oversight, and you
20 said, and I want to clarify this, because this is
21 important, you're delegating actual authority for them to
22 have oversight, meaning something comes up, and the local
23 Board says, wait a minute, we don't want to be here, we
24 want to be over there, or are you saying this is just an

1 advice, and the management of the hospital, which you
2 guys will now have control over, will decide whether to
3 follow that advice or is it actual authority over the
4 quality assurance program, not accreditation?
5 MS. MATTHEWS: I'm sorry. I mean if you
6 do look at the language in here, it is serving as a local
7 resource with respect to the investment in capital, of
8 the capital commitment, but then it does end the
9 maintenance and implementation, but then it's actually
10 the local Board is to be responsible for medical staff
11 credentialing and maintain and oversee quality assurance
12 programs, so we read that as a real delegation of
13 authority on those matters, as opposed to serving as a
14 resource and advisory in connection with the spend on the
15 capital commitment.
16 MR. CROCKETT: Actually, let me read
17 through the actual words.
18 MR. ZINN ROWTHORN: I just want to put on
19 the record, Attorney Matthews, you were reading from what
20 document?
21 MS. MATTHEWS: I'm sorry. I was reading
22 from the asset purchase agreement, Section 5.27 of the
23 asset purchase agreement.
24 MR. ZINN ROWTHORN: Thank you.

1 MR. CROCKETT: And, so, that's now been
2 updated with a side letter, and I want to just read the
3 one sentence that actually speaks to I think what would
4 be termed a definition of delegation specific to this,
5 and it says that "Buyers shall not implement any
6 modification to the seller of quality programs without
7 first obtaining the approval of the local Board for such
8 modifications, which approval shall not be unreasonably
9 withheld." That's what we tried to do to actually define
10 the delegation.
11 MR. SALTON: So that's distinct from the
12 end of the prior section, where it says, the end of
13 paragraph two -- do you have letter in front of you?
14 MR. CROCKETT: I do.
15 MR. SALTON: "The local Board shall have
16 oversight over the quality assurance program," so is that
17 -- we're trying to figure out how these things interplay,
18 if they do at all.
19 MR. CROCKETT: Well we're hoping that they
20 overlay each other, not in conflict, which is that the
21 local Board shall have oversight of the program, and the
22 point of paragraph three was to clarify what the role of
23 the oversight was, which is that Prospect cannot make any
24 modification to the program.

1 MR. SALTON: Okay, so, that’s clear. I
2 understand there’s obviously a difference there, because,
3 in one instance, you could say status quo, we can’t
4 change status quo of the program, as developed by the
5 hospitals, but then the local Board might want to go
6 beyond status quo and not really change it, but maybe
7 augment it or do other kinds of things, decide that more
8 resources are necessary, without changing the program,
9 but that might be considered within the scope of
10 oversight, but what you’ve clarified, at least from your
11 understanding, and I hope that’s what the hospital’s
12 understanding is, also, is that, in fact, the oversight
13 merely means what paragraph two provides, which is change
14 in the status quo, without approval of the local Board.
15 MR. CROCKETT: That’s our understanding.
16 DR. O'NEILL: That’s our understanding.
17 MR. SALTON: Okay.
18 MR. LAZARUS: The next questions actually
19 have to do with the topic of community needs health
20 assessment.
21 PMH states in the application that it will
22 support and implement ECHN’s community needs health
23 assessment plans through 2016. What does that actually
24 mean by that? I believe that’s on page 2178.

1 MR. KARL: Dennis McConville will respond
2 to that.
3 MR. LAZARUS: Sure.
4 MR. DENNIS McCONVILLE: Steven, may I ask
5 you to please repeat the question?
6 MR. LAZARUS: Sure. PMH states in the
7 application that it will support and implement ECHN's
8 community needs assessment plans through 2016.
9 MR. McCONVILLE: Yeah, so, filed with the
10 application were the highlights of our community health
11 needs assessment plan that was conducted by ECHN, and we
12 continue to implement that plan and the programs
13 associated with that plan, and Prospect has agreed to
14 support us in that ongoing effort, but, at the same time,
15 it's about time for us to conduct a new community health
16 needs assessment, and that is our plan, and we anticipate
17 that that be supported by PMH.
18 MR. LAZARUS: And PMH is in support of
19 that?
20 MR. McCONVILLE: Yes.
21 MR. LAZARUS: Okay.
22 MR. ZINN ROWTHORN: Did we have that
23 answered from PMH? Was that your question?
24 MR. LAZARUS: Yes. We can have PMH say

1 it, get on the record. That would be even better.
2 MR. REARDON: This is Tom Reardon again.
3 Let me comment on this. Community needs assessment, I
4 think as you phrase it, relates really to an IRS
5 requirement for 501(c)3 corporations. In order to get
6 tax-exempt status, you need to go through a community
7 needs assessment, among other things, and, so, as a for-
8 profit, it doesn't apply to us, per se.
9 Having said that, we've agreed to go ahead
10 with the implementation of the community needs assessment
11 through 2016 and to conduct another community needs
12 assessment within the next two years.
13 Now, having said that, we are all about
14 looking at the community. Everything we do is focused on
15 looking at the community. We do that type of assessment
16 internally constantly. We just don't necessarily use an
17 outside consultant to help us in that regard.
18 I mean think about it. Many of our
19 hospitals are safety net hospitals. We are constantly
20 looking at the needs of the community.
21 One of the speakers spoke about what we're
22 trying to do, in terms of knitting together mental health
23 and physical health. That's a huge, huge effort.
24 I mean, right now, if you take care of a

1 person, who has a behavioral health problem and you fix
2 their physical health problem and you discharge them and
3 they go under a bridge and do whatever they do, they're
4 going to be back in the hospital in 10 days or 10 weeks.
5 And, so, what we're trying to do is knit
6 together the two programs, so that we have plenty of
7 resources that actually focus on those patients if
8 they're assigned to us as members under population
9 management, and we also are out there trying to stitch
10 together with our CRC model resources, whether it's
11 mental health resources in the community or even beds in
12 the community, as opposed to in a hospital.
13 So we're constantly focused on community
14 needs. It's just I wanted to make the distinction
15 between community needs assessment in the sense of a
16 501(c)3 and the community needs we all always are
17 assessing all the time.
18 DR. LEW: So if I could just add on to
19 that, it's certainly necessary, as it relates to what's
20 required as a not-for-profit, but it's not sufficient for
21 us and that we need to do more.
22 We need to look at how we're actually
23 improving the access for the population and be able to
24 have patients flow into our system with all the programs

1 that I talked about earlier.
2 So, yes, it’s part of our overall
3 strategy, but it’s not the only thing that we would need
4 to look at. It’s part of it, but not the whole picture.
5 MS. MARTONE: Thank you for stating that.
6 That’s actually, as well, OHCA’s mission, is to ensure
7 that residents of the state have improved access,
8 enhanced access to health care service, so, with that, we
9 do ask all hospitals to report and to participate in
10 these assessments, report their findings, report their
11 implementation plan, provide us some times with updates
12 periodically, and, by law, we can’t ask for the data that
13 really goes into the collection of that and having all
14 the hospitals in the state report and have, hopefully, at
15 one point, standardized.
16 We also use that in our Certificate of
17 Need program in evaluating Certificate of Need
18 applications, looking for unmet need, underserved areas,
19 and making sure services are provided to the community
20 there, so that is typically what we ask of the hospitals
21 in this state.
22 MR. LAZARUS: PMH, I think it was stated
23 in the application that it’s PMH’s intention to involve
24 the local Board in the assessment process, as well as

1 facilitate public input, and that PMH will publicly
2 disseminate their community needs assessment and its
3 implementation strategy-wise website, as you mentioned.
4 Would you involve the local Boards for
5 both Manchester Memorial Hospital and Rockville General
6 Hospital?
7 MR. REARDON: Absolutely. Absolutely. We
8 rely on community. Look, we desperately want to partner
9 with ECHN. We want to be here in Connecticut, but as
10 much as we want to be here, we'll never know the
11 community as well as the community members, and, so, we
12 absolutely rely on and talk to the Boards in both
13 communities, as well as other community members.
14 MR. LAZARUS: All right, thank you.
15 MR. ZINN ROWTHORN: Is it anticipated that
16 a community needs assessment or something in the nature
17 of a community needs assessment will be undertaken, in
18 order to inform the decisions about how to spend down the
19 capital commitment?
20 MR. McCONVILLE: So the way we'll go about
21 getting to the strategic capital plan is through a
22 strategic planning process that will have several inputs.
23 It will have the results of the community
24 health needs assessment, which would include both

1 secondary data, that data that's available through
2 various sources, and primary data, which is often most
3 difficult to collect, which is directly from patients,
4 learning about their health behaviors and lifestyles.
5 It would also include input from an
6 environmental assessment we would do relative to what's
7 happening around our service area with regards to other
8 providers in the programs that they have available to
9 residents of our communities.
10 And, importantly, it will also involve
11 input from the IPA Board. We now have this physician-led
12 organization, physician-governed organization that will
13 be assessing the health care that's delivered to our
14 patients.
15 They will understand what the gaps in the
16 care are, what programs are needed, what resources will
17 need to be deployed to make sure that our continuum is
18 complete, comprehensive, and does the best possible job
19 of caring for the patients.
20 MR. ZINN ROWTHORN: Thank you.
21 MR. LAZARUS: Who would be on the local
22 Boards with the qualifications to determine public health
23 needs or disparities impacting minorities and underserved
24 population, and how is this done in other PMH hospital

1 communities? I guess it's a two-part question.
2 MR. KARL: So speaking for ECHN going
3 forward, the model that Prospect Medical uses throughout,
4 as I understand, throughout the country that they will
5 implement here, which we're very much in favor of, is the
6 Board will be comprised of 10 members, five community
7 members that are from the primary and secondary towns
8 that we currently serve with diverse backgrounds,
9 obviously to fit the current service area, and five
10 physicians, independent practicing physicians in the
11 surrounding areas.
12 Those physicians will have -- will be made
13 up of different specialties, and they will, then, act and
14 take the lead as the governing Board of the organization.
15 I will also be on that Board as the leader.
16 MR. CROCKETT: And that setup is
17 consistent of how we work in our other markets that we
18 modeled ECHN to be consistent.
19 MR. LAZARUS: The next set of questions
20 actually have to do with the community benefit. The
21 application makes clear that PMH is committed to
22 continuing to treat patients, regardless of ability to
23 pay, and providing financial assistance to patients that
24 qualify, based on the need, in the same manner ECHN by

1 adopting their charity care policy.
2 Is the commitment conditioned or limited
3 in any way?
4 MR. SPEES: It is not. Only subject to
5 any changes in laws or regulations that would require a
6 change.
7 MR. LAZARUS: Thank you. PMH has said
8 it's spending on community volunteer services and
9 community benefits will be developed, based on
10 confirmation or identification of communities' priority
11 needs.
12 In the application, ECHN describes that
13 the Maternity Care Center on the Rockville General
14 Hospital campus that was just featured in the CHA
15 Community Benefits Report for the hospital as providing
16 free maternity services to uninsured and underinsured
17 women in Vernon and surrounding towns. Is this a program
18 that would continue?
19 MR. KARL: Yes. That program will
20 continue. There's a significant community need on the
21 Rockville side for access purposes. Those individuals
22 are seen by rotating OBGYN physicians and Advanced
23 Practice Nurses.
24 Those patients many times do not have

1 primary care physicians or OBGYN physicians. Once those
2 patients are worked up, they are, then, when it's time to
3 be delivered, they are, then, moved over to Manchester
4 Memorial Hospital for delivery and follow-up.
5 MR. LAZARUS: Okay, now, some of the other
6 programs, such as the Manchester Memorial Family
7 Development Center programs, are funded either through
8 the state or federal grants, and, you know, they're
9 featured in the community benefits report.
10 Has ECHN explored the ability to keep
11 these programs funded if the hospitals are converted to
12 for-profit?
13 MR. KARL: Yes. We've taken a deep dive
14 in that area, and there are -- most of them can move
15 across, even though it is a for-profit, because these are
16 fully grant funded.
17 There are some that cannot. Those grants
18 may not be kept whole. That subsidy will be, then,
19 covered by PMH as they come into the community.
20 I was just corrected, that we were now
21 informed that all are transferrable. That wasn't the
22 case two weeks ago.
23 MR. LAZARUS: How long will the process of
24 evaluating the community benefits program will continue

1 to support, continue the support? What will be the
2 finished products, I suppose? Do you want me to repeat
3 the question?
4 How long will the process of evaluating
5 the community benefits program -- I'm sorry. It's not
6 written well here in my notes.
7 MR. KARL: That's okay.
8 MR. LAZARUS: I think I edited it too
9 much. Will you be evaluating the community benefits
10 program and looking at all the different programs that
11 you're supporting within it, and, if so, what's the
12 timeline for that to do that?
13 MR. KARL: Okay, so, let me answer that in
14 a couple parts. We will be rolling out or beginning a
15 2016 community needs assessment.
16 MR. LAZARUS: When?
17 MR. KARL: Immediately after closing, so
18 we're hoping this gets approved, and, again, as Mr.
19 McConville mentioned, it's quite in depth to construct
20 this community needs assessment.
21 It's not only the data that you receive,
22 but it's actually phone calls and looking at the current
23 disease states in the areas, what we've seen clearly.
24 Just for an example is the prevalence of

1 diabetes, vascular issues associated with that, and now,
2 as of late, that we're all struggling with, and I'm sure
3 that it's going to come across, is the opiate issue that
4 we're dealing with.
5 We just most recently had a discussion --
6 MR. LAZARUS: I'm sorry, Mr. Karl. I was
7 specifically asking about the community benefit program,
8 not the community needs assessment.
9 MR. KARL: Oh, okay. Sorry.
10 MR. LAZARUS: I'm sorry. I didn't want to
11 cut you off.
12 MR. KARL: My error. It was getting
13 blinded in my mind, so I apologize for that. Prospect
14 has agreed to continue our community benefit programs
15 going forward.
16 MR. LAZARUS: And speaking of which, PMH
17 has said they're projecting to an increase in the
18 community building activities through 2019, based solely
19 on inflation, and it assumes no change in Medicaid
20 population served in the community, regarding the
21 community benefit program offered at the hospitals. How
22 do we interpret the statement?
23 MS. VOLPE: Do you have a bates stamp, as
24 to where that is in the application?

1 MR. LAZARUS: Yes. Page 3232.
2 MR. KARL: Can we have a moment just to
3 look that up?
4 MR. LAZARUS: Absolutely.
5 MR. KARL: Do you want to continue while
6 we're doing our homework, or would you like us to take a
7 break?
8 HEARING OFFICER HANSTED: Why don't you go
9 to the next question, then we can come back?
10 MR. LAZARUS: Well it sort of relates to
11 the same question, so we'll take a moment.
12 MR. SPEES: Sorry. Could you repeat the
13 question?
14 MR. LAZARUS: Sure. Absolutely. PMH has
15 said that it is projecting an increase in community
16 building activities through 2019, based solely on
17 inflation, and it assumes no change in Medicaid
18 population served or compliment of the community benefit
19 program offered at the hospitals, so we're trying to
20 understand what that statement really says.
21 MR. SPEES: Basically, it was just a
22 commitment, in terms of continuing to fund the community
23 need, community benefit programs at the historical levels
24 with an inflation rate over time.

1 MR. LAZARUS: And that was my next
2 question that I was trying to get to. Thank you. The
3 next couple of questions actually have to do with the
4 underserved areas in primary care, so, on page 2188, ECHN
5 describes some of the safety net services provided in the
6 Rockville section of Vernon and the northwestern part of
7 Mansfield as establishing a family medicine practice in
8 Rockville and in Vernon. How large are these practices?
9 MR. McCONVILLE: I'm sorry. I might have
10 to ask you to repeat the question. How large is the
11 practice in Vernon, in the Rockville section of Vernon?
12 MR. LAZARUS: Yeah.
13 MR. McCONVILLE: Okay. I would have to
14 provide you with the actual numbers of patients that are
15 managed through that practice. I would have to get you
16 that information at a later date, but it is a mature
17 practice.
18 MR. LAZARUS: We're trying to get the
19 number of physicians in the practice.
20 MR. McCONVILLE: Okay. There is a
21 physician and an APRN.
22 MR. LAZARUS: Okay, so, a single physician
23 and single APRN at the Vernon location?
24 MR. McCONVILLE: At the Rockville

1 location.
2 MR. LAZARUS: At the Rockville location.
3 HEARING OFFICER HANSTED: What about
4 Vernon?
5 MR. LAZARUS: What about the Mansfield?
6 Yeah, the Mansfield location.
7 MR. McCONVILLE: We don't have a location
8 in Mansfield.
9 MR. LAZARUS: Oh.
10 MR. McCONVILLE: We have independent
11 primary care physicians that practice at locations in
12 Vernon and Tolland and Coventry, all of which draws some
13 patients from Mansfield.
14 MR. LAZARUS: All right, thank you. It's
15 also stated in the application that ECHN has imaging labs
16 in Tolland and presently no location changes are
17 proposed, although it is expected that ECHN ambulatory
18 network will be expanded and services configured to
19 promote most efficient delivery of care.
20 If these are professional service areas
21 and PMH says it's going to be aggressively recruiting
22 physicians for these areas, would there be an increase in
23 staffing levels at these locations?
24 MR. McCONVILLE: That would all depend on

1 what the data shows. I mean, currently, we offer those
2 services through a combination of services offered
3 through the Tolland Imaging Center, which is a joint
4 venture, through our laboratory services, which are
5 affiliated, obviously, with the hospitals, and then
6 through some independent practices, physician practices,
7 whereas they have found more demand for their services.
8 We have done what we can to help them with
9 the recruitment of additional providers. We will do a
10 medical staffing plan. We're always looking at what the
11 need is for physicians in service areas, and then we go
12 about recruiting physicians to that plan.
13 MR. LAZARUS: Is that one of ECHN's goals,
14 to recruit additional physicians?
15 MR. McCONVILLE: We would like to have as
16 many physicians associated with our Independent Practice
17 Association as possible to get the very best coverage and
18 comprehensive coverage for the population served by ECHN.
19 That is all to the benefit of the programs
20 that will be available for population health.
21 MR. LAZARUS: How successful has ECHN been
22 in retaining residents and interns in its GME program for
23 family medicine?
24 MR. McCONVILLE: So of the first

1 graduating class, which were four physicians, one of
2 those physicians is a member or an employee of our
3 Medical Foundation, and, for the current graduating
4 class, which has six third year residents, we have
5 recruited and signed up one of those graduates, as well,
6 so we're in the second year of having graduated classes
7 from the program.
8 MR. LAZARUS: Okay, thank you. I guess
9 this question is more directed towards PMH. How did
10 Rhode Island primary care network grow to 105 from 18
11 when the Charter hospitals were acquired by PMH in 2014?
12 DR. LEW: Steven, the 18 were employed
13 physicians, and we've increased that to nearly 80
14 employed physicians. The over 100 that you're referring
15 to are the primary care physicians that are part of the
16 IPA, and the IPA is made up of and well over 300
17 physicians, but some of those are employed and some of
18 those are independent, but, basically, what we started
19 doing while we were going through the process of
20 conversion and getting the regulatory approvals is we
21 began to lay the ground work for our model, and what that
22 would entail is going to the state and establishing a
23 risk-taking entity to allow to take financial risk from a
24 health plan, and we've already done that in Connecticut.

1 We also get other necessary regulatory
2 licenses to act as third party administrators and do
3 utilization review.
4 We engage the health plans, because our
5 goal, again, is to move from a volume fee-for-service
6 world to a value-based type of payment with the health
7 plans.
8 And then the third component of building
9 our model is to create the physician network, so we start
10 engaging the physicians well in advance of closing on a
11 hospital, because, you know, it really serves -- it tells
12 the community what we're about, it starts to align the
13 physicians with the hospital, and it gives us a head
14 start on building the model.
15 And, from that, if I could just share what
16 we've done in Rhode Island, is we took that model and
17 infrastructure that we built and taking a value-based
18 contract from the large payer in Rhode Island, and we
19 went to the Governor of the state of Rhode Island, and we
20 proposed a Medicaid pilot to deliver a coordinated care
21 to the Medicaid population in Rhode Island at a lower
22 cost.
23 Rhode Island is similar to Connecticut, in
24 that there's a Medicaid spending problem, and our

1 proposal, which was approved, allowed the state or will
2 allow the state a savings of $6 million a year, but, to
3 do all of these things and to work with the payers and to
4 work with the government on these types of pilots, you've
5 got to set the groundwork, and that's identifying the
6 needs that you've asked Dennis about in figuring out
7 where the gaps are in care, and then for us to go out in
8 the network and build relationships with the community
9 clinics and the FQHCs, the Federally-Qualified Health
10 Centers, to make sure we have a very robust network to
11 take care of a population, if we were to embark on a
12 Medicaid pilot.
13 MR. ZINN ROWTHORN: Steve, can I ask a
14 follow-up?
15 MR. LAZARUS: Go ahead.
16 MR. ZINN ROWTHORN: Dr. Lew, how is the
17 Rhode Island Medicaid operation structured? Is that
18 paid, based on a risk or value model by the state, so PMH
19 hospitals receive a certain amount of money to, at their
20 risk, to treat a Medicaid population?
21 DR. LEW: We will eventually get there,
22 yes, but we're not quite there yet.
23 MR. ZINN ROWTHORN: Got it. And just one
24 other question, if I might, Steve.

1 MR. LAZARUS: Um-hum.
2 MR. ZINN ROWTHORN: My apologies. The
3 doctors in the IPA, who are employed, and those, who are
4 not employed by the hospitals, but participating, do they
5 have equal access to the electronic medical record system
6 to communicate with the electronic medical record system?
7 DR. LEW: Yes. If you're part of the IPA
8 network, we interface with the physician EMR the same.
9 Certainly, if doctors are employed and sharing an office
10 on the same system, it makes it a lot easier, but we've
11 figured out a way, through a lot of years of experience
12 in interfacing with hundreds of different EMRs that are
13 being used by physicians out there, so it really doesn't
14 matter to us if it's independent, or employed, or EMR,
15 differences in EMR systems. We treat them the same.
16 MR. ZINN ROWTHORN: Thank you.
17 MR. LAZARUS: Dr. Lew, did you mention
18 that you have a risk-taking entity established in
19 Connecticut already?
20 DR. LEW: Yes, we do.
21 MR. LAZARUS: Okay.
22 MR. REARDON: If I can just add to that,
23 Mitchell? In addition to a risk-taking entity, which is
24 a preferred provider network, we've also gotten a TPA

1 license and a utilization review license.
2 HEARING OFFICER HANSTED: What is a TPA
3 license?
4 MR. REARDON: Third Party Administrator.
5 MR. ZINN ROWTHORN: How many lives are
6 covered in your risk-based operation in California?
7 DR. LEW: Nearly 300,000.
8 MR. ZINN ROWTHORN: And from your
9 experience, is there a kind of quantum of lives necessary
10 to successfully operate a risk-based system in a
11 particular service area?
12 DR. LEW: No, Perry, there's not a magic
13 number, but if they're in a tightly-managed geographic
14 area, such as a Manchester and Rockville, Vernon, that
15 would be a lot easier.
16 You know, certainly would love to start
17 off with a couple of few thousand seniors, maybe 5,000,
18 10,000 Medicaid recipients, and, you know, if we get
19 5,000, 10,000 commercial lives, that would be a great
20 start, but we certainly could build the capacity to
21 manage, as we do in certain pockets in Southern
22 California, Orange County, for example, 120,000 members
23 under management.
24 MR. ZINN ROWTHORN: Thank you. Thank you,

1 Steve.
2 MR. LAZARUS: So the lessons you've talked
3 about and learned from Rhode Island, that's a model
4 you're looking to establish in Connecticut and,
5 specifically, at ECHN?
6 DR. LEW: Yes. Yes. So we would love to
7 support the employed physician model, because, if doctors
8 need the stability and they want to be employed, we want
9 to be available, and let's line up those doctors now,
10 fill the pipeline, so when the deal closes, we can bring
11 them into the family, but, at the same time, we recognize
12 that there are a lot of physicians that still want to
13 remain independent, and that's fine with us, too.
14 So we have already worked on our contract
15 templates for the physicians within the IPA. We've
16 established the Physician Leadership Board already, and,
17 as everything else we do, we will rely on the local
18 physicians to go out and grow the network and to talk
19 about the virtues of coordinated care.
20 And, as I've already stated, we've engaged
21 the health plans, and what's really nice in the state of
22 Connecticut is that the payers recognize this migration
23 to value-based payments, and, so, we're getting a lot of
24 traction there, and I think, once we get the network

1 established and the health plans, a couple of health
2 plans on board and show the proof of the model here in
3 Connecticut, would love to entertain a Medicaid pilot
4 with the State, offer savings with better outcomes.
5 MR. LAZARUS: All right, thank you. The
6 Prospect provider group, the Connecticut ECHN, LLC that
7 you had mentioned in the application and PMH's other
8 affiliated IPAs, are there any agreements preventing
9 providers from directing patients to providers outside
10 the IPA, out of the network providers?
11 DR. LEW: If a doctor is part of the IPA,
12 a primary care physician is part of the IPA, and they
13 want to refer the patient to a specialist, they would
14 need to refer the patient to an in-network specialist.
15 That's just part of the contractual agreement that we
16 have, and that's what the health plan wants, also.
17 MR. LAZARUS: Okay.
18 MR. REARDON: But, of course, if I could
19 just add to that, even though there are specialists
20 within ECHN, there are also tertiary and quaternary
21 services that we'll need, and we simply contract with
22 that for the network.
23 MR. LAZARUS: Okay.
24 DR. LEW: So if there were services that

1 could not be provided at one of the ECHN hospitals, we
2 would contract for those services at other facilities.
3 MR. LAZARUS: Thank you.
4 A FEMALE: VOICE: Excuse me. I'm just
5 wondering when the community members are going to have
6 the time to ask questions. We've all been here three and
7 a half hours, and all I hear is discussion. I would be
8 interested in hearing what the community had to say.
9 Thank you.
10 MR. ZINN ROWTHORN: Thank you, ma'am. We
11 are also very interested in hearing what the community
12 members have to say, and we'll stay here as late as we
13 need to stay here to hear whoever wants to be heard.
14 We appreciate your patience. We
15 understand that this is a lot to listen to, but this is
16 an important part of our process.
17 We do invite you, if you do have a time
18 constraint this evening, to submit a comment online.
19 Every comment that we receive will be available online,
20 so I understand, I suppose, the frustration there, and we
21 do appreciate your patience.
22 MR. LAZARUS: How successful has PMH been
23 in securing contracts with major payers in launching the
24 IPAs, managing at-risk contracts and complying with

1 national committee for quality assurance network advocacy
2 standards when you're still growing these physician
3 networks?
4 DR. LEW: So as far as securing health
5 plan contracts? I think that was the first part of your
6 question.
7 MR. LAZARUS: Yes.
8 DR. LEW: We have contracts with all the
9 major payers in California. In Texas, we haven't been
10 around as long. We have probably three contracts and
11 working on getting additional contracts.
12 Certainly, our relationships and
13 experience in California has helped us with the larger,
14 more national payers.
15 In Rhode Island, we are contracted with
16 the largest payer in the state, which has about 70
17 percent of the market, and we are establishing additional
18 contracts for the Medicaid pilot or two MCOs, Managed
19 Care Organizations, in the state. Here in Connecticut,
20 we're currently in conversations.
21 And the second part of your question,
22 Steven?
23 MR. LAZARUS: The IPA managing at-risk
24 contracts and complying with the national committee for

1 quality assurance.
2 DR. LEW: Right, so, in terms of
3 compliance, I'll refer back to one of the slides that I
4 showed earlier. The largest Trade Association for
5 delegated medical groups, CAPG, California Association
6 Physician Groups, has a standard, based on a lot of NCQA
7 requirements, and it's a very rigid scoring system, and
8 we've reached the highest level, elite status, for four
9 years in a row, so I think, from quality and compliance,
10 we've done a very good job over the last several years
11 and certainly always a focus of ours.
12 Excuse me. There was another part of your
13 question? Oh, risk, managing risk.
14 MR. LAZARUS: Um-hum.
15 DR. LEW: Managing risk is always a
16 challenge, but, again, we see the health plan and the
17 payers migrating to putting more risk onto the providers.
18 We've got a lot of experience doing it,
19 and I think we're very good at negotiating good
20 contracts, fair contracts, but what it makes us do is
21 assure that care is administered and delivered in the
22 right place at the right time.
23 When I spoke earlier about a lot of the
24 programs that we have for patients, taking care of them

1 across the continuum, what that does is it prevents
2 readmissions and unnecessary admissions, and, so, we can
3 reduce the cost, because we're really doing a great job
4 of managing under financial risk.
5 MR. LAZARUS: All right, thank you.
6 HEARING OFFICER HANSTED: Before we
7 continue with our questions, we're just going to take a
8 10-minute break.
9 (Off the record)
10 HEARING OFFICER HANSTED: We'll get
11 started again. We're back on the record. Thank you,
12 all, for coming back.
13 As Perry mentioned before the break, we're
14 going to cut to the public comment portion of tonight's
15 hearing, and then we'll go back to the questioning of the
16 Applicants.
17 (Whereupon, the public spoke.)
18 HEARING OFFICER HANSTED: We will continue
19 with OHCA's questioning. Mr. Lazarus?
20 MR. LAZARUS: Dr. Lew, you had testified
21 that the implementation of CRC involves rewarding
22 physicians for positive quality outcomes, not outputs, by
23 a shared savings, pay for performance standards and
24 benchmarks, and that these incentives would provide

1 effective and improving quality outcomes in PMH's other
2 markets.
3 Can you describe the benchmarks and
4 incentives you've referred to?
5 DR. LEW: Sure. So what are the
6 incentives that we lay out for physicians to ensure
7 quality? We create a report card for our physicians, and
8 there are certain quality measures specifically on this
9 report card, ranging from whether a patient had their
10 screening blood test, cholesterol, hemoglobin A1c,
11 preventive measures, mammograms, bone densitometry,
12 proper medication, refilling their medications.
13 I mean there's a whole list of probably 35
14 different measures that we would look at, and we know
15 and, as proven through studies, is that, if a patient has
16 these measures done, they're probably going to have
17 better health than those that don't have these things
18 followed.
19 And, so, what we do is we incentivize the
20 physician to perform these tests on their patients, and
21 it's a financial incentive to make sure that they perform
22 these measures, and we go even further. We support them.
23 I'll refer back to one of my slides, when
24 I talked about our Quality Care Coordinators. We have

1 teams of people that will call the patients to remind
2 them to go see their doctor, to make sure they have these
3 preventive measures, and will coordinate the appointments
4 with the patient and the physician offices.
5 If physicians' offices are inundated and
6 they can't accommodate, we actually setup within the
7 community what we call wellness clinics, so these are
8 more convenient sites for patients to come to, and, if we
9 need to, we provide transportation, and if they don't
10 have transportation, we will go to the home. I talked
11 about our homebound program.
12 So we take a lot of different steps to
13 ensure that the patients have the proper quality measures
14 to take care of their health, and, yes, we incentivize
15 the physician to do it, but, a lot of times, they don't
16 have the resources within their office to provide it, so
17 we provide it for them, and we give the doctors the bonus
18 anyways. It's just good relationship.
19 MR. LAZARUS: Thank you.
20 MS. CARMEN COTTO: Hi. Carmen Cotto, OHCA
21 staff. My questions are of a financial nature, so I will
22 probably be directing my questions to Mr. Aleman and Mr.
23 Spees.
24 My first question is please discuss PMH's

1 future financial stability and ability to provide future
2 financial support to the Connecticut hospitals it is
3 acquiring as it continues to merge and acquire hospitals
4 in other markets that are in poor financial health, such
5 as the one most recently in New Jersey that was in
6 bankruptcy.
7 MR. ALEMAN: Well let me speak,
8 specifically, to the Connecticut transaction and the
9 health prospect from a financial standpoint.
10 We had approximately a compound annual
11 growth rate of about 25 percent year-over-year. It’s
12 been driven through organic growth in our platform
13 facilities, as well as growth in our acquired facilities.
14 We work very closely with all acquisitions
15 in the transactions, up to the point of the close of the
16 transaction and post to ensure that the facilities are
17 operating efficiently, are cost effective, work very
18 closely with the teams from a program analysis and bring
19 all of our skill sets that Von and some of the operators
20 can speak to in great detail on how we work with the
21 facility, so they’re efficient and cost effective, and,
22 also, in the analysis of programs that ultimately the
23 community supports and, as Tom has stated, can grow
24 programs once again.

1 So every acquisition that we're taking a
2 look at, inclusive of the New Jersey transaction, will be
3 making a profit from day one, earnings before profitable
4 earnings, where, when we started working them, they were
5 not in opposition, so we have a demonstrated track record
6 of working with acquisitions up to the point of close to
7 improved performance and continue that performance post.
8 So, to get to your question, I think I've
9 demonstrated or discussed the historical growth of
10 Prospect. So we've taken a look at all the acquisitions,
11 including Connecticut. We are confident in the growth
12 potential of these facilities, and I have the utmost
13 confidence that every commitment that we have made to
14 these transactions on specifically ECHN that we have the
15 financial wherewithal to carry through on those
16 commitments.
17 MS. COTTO: Thank you. When we asked the
18 Applicants in reference to the funded sources for this
19 proposal, you indicated that, as of September 30, 2015,
20 PMH had in excess of $110 million in funds available, and
21 that you also indicated that PMH generates over $7
22 million in free cash flow per month. Is that still the
23 case, as of today, they $110 million funds available?
24 MR. ALEMAN: Yeah. Funds available on

1 hand currently are in excess of $65 million. By the time
2 this transaction closes, I anticipate we will be, once
3 again, close to the $100 million number. What has
4 transpired during that period is the acquisition of East
5 Orange General Hospital, which is really the differential
6 there, and, then, from a free cash flow standpoint, we're
7 actually in excess of $7 million, so that's what will
8 help grow our available cash up and through the point of
9 the close of this transaction.
10 MS. COTTO: Okay.
11 MR. ALEMAN: So no change in the cash
12 flow.
13 MS. COTTO: Now you also provided the same
14 answer for the proposal related to Waterbury, so could
15 you elaborate how you intend to support both proposals
16 with the same amount of funds available?
17 MR. ALEMAN: Same answer applies. So,
18 once again, the growth of our capital on a month-in and
19 month-out basis generating anywhere from about $10 to $15
20 million of free cash flow on a monthly basis, with our
21 capital commitments in place, if you were to take a look
22 at our September 2015 just purely cash generated from
23 operations, it was in excess of $75 million.
24 Our capital commitments through East

1 Orange and the Connecticut facilities are under $40
2 million on an annual basis, and this is without any
3 further growth in some of our recent acquisitions.
4 During this period, in the last let's call
5 it 12 to 16 months, we've opened up a couple of closed
6 facilities of which are now starting to generate cash
7 into our system, as well as continued growth within our
8 Texas and Rhode Island facilities.
9 MS. COTTO: And you also indicated that
10 there was an additional $40 million available to a credit
11 line through Morgan Stanley. What is the status of that
12 loan right now, and how much do you have available there?
13 Is it still $40 million?
14 MR. ALEMAN: It is $10 million. We took
15 out -- we tapped the revolver to help close the East
16 Orange transaction in New Jersey, but, once again, I
17 anticipate, by the time that we get to the close of this
18 transaction, there will be roughly about $30 million
19 available in that revolver.
20 MS. COTTO: Okay. Do you have any other
21 funds available exclusive of Morgan Stanley? Any other
22 credit line that you will be able to use as a funding
23 source for this proposal?
24 MR. ALEMAN: None are needed, but the

1 answer is yes. We're fairly, when you take a look at
2 other for-profit systems, relatively lowly levered on an
3 adjusted EBITDA kind of net of cash, where it's just a
4 little over two. On an EBITDA, debt-to-EBITDA ratio,
5 we're just a little over three.
6 Some of the larger systems there leverage
7 ratios are over six. I just mention this, that you
8 generally have a lot of capability. We're fairly
9 conservative in the debt that we take on.
10 Part of that is that, for whatever reason,
11 if we need to tap the credit markets, we can. We have
12 very active relationships with all of the investment
13 banks, and that's part of my role and responsibility, to
14 maintain those relationships.
15 MS. COTTO: I have one more question in
16 reference to the free cash flow. Has it in the past or
17 will in the future PMH use this free cash flow that's
18 available to pay any dividends?
19 MR. ALEMAN: No. There are none
20 currently. We haven't paid a dividend to our private
21 equity group since 2012. None are currently planned
22 currently, and I do not anticipate any in the future.
23 MS. COTTO: I thought that it was a
24 payment of $100 million.

1 MR. ALEMAN: That was in November 2012.
2 MS. COTTO: That was ’12?
3 MR. ALEMAN: Yes.
4 MS. COTTO: Thank you. As part of our
5 review, we requested that you provide to us supporting
6 documentation related to the credit ratings, and the
7 information that you provided to us indicated that the
8 credit agencies have given PMH an upgrade on the credit
9 ratings, but that rating was based on all the things, on
10 expected increases in revenue, EBITDA and cash flow as a
11 result of soon-to-be-acquired hospitals, including those
12 in Connecticut.
13 Can you please elaborate on financial
14 gains for PMH’s -- this proposal?
15 MR. ALEMAN: I’m not sure if understand
16 your question, but let me try and answer, and you can
17 tell me if I address it or not.
18 MS. COTTO: Okay.
19 MR. ALEMAN: With the credit agencies,
20 specifically, Moody’s and S & P, I have meetings with
21 them on a quarterly basis.
22 Part of their -- two of their concerns
23 with Prospect historically have been, A, concentration in
24 California, so they have looked for us to develop and

1 expand our model outside of California, and then, with
2 the acquisitions of Nix in San Antonio, Texas and
3 CharterCARE in Rhode Island, how did we perform on those
4 transactions? It's easy to go off and you can acquire
5 and bring in the revenue to your system, but do you
6 actually perform? Do you actually work to turn those
7 facilities around and integrate your model into those
8 facilities?
9 So, through this last credit upgrade by
10 Moody's and S & P, what they focused on was the
11 integration of CharterCARE and the improvement and
12 financial performance at CharterCARE, so I think what
13 you're referencing is, as we look to expand our model
14 into other states, one of their areas of focus is will we
15 continue to be successful in our integration of those
16 facilities and the integration of our model to
17 demonstrate the improvement in financial and operational
18 performance, like we did in CharterCARE, at the other,
19 you know, in other acquisitions.
20 That's going to be a continued focus of
21 theirs in Connecticut, New Jersey, and Pennsylvania, as
22 well.
23 MS. COTTO: Okay, thank you. My next
24 question is also related to the credit ratings report.

1 They also -- the credit rating agencies also expressed
2 some concerns on PMH's ability to achieve sustained
3 revenue growth, due to the exposure to the California
4 Quality Assurance program's timing, cash flow timing.
5 Please discuss whether the fees,
6 reimbursement timeline will hinder PMH's ability to
7 provide cash to ECHN to support any future cash
8 shortfalls related to the capital community.
9 MR. ALEMAN: The current program in
10 California is in place through December 2016. There is
11 already -- the process is already in motion to extend
12 that program through 2019.
13 Where their comment comes from is there
14 are certain facilities that get very large dollars from
15 that program, and their cash flow is solely dependent on
16 that.
17 There have been delays in the program in
18 the past when they go into place. Prospect is
19 significantly less affected than other systems in
20 California, due to our diverse model, and, specifically,
21 the medical group segment, which is based in California,
22 continues to see strong cash flow from that segment, and
23 it's not just on the hospital side, as well as continued
24 strong cash flow from our Texas facilities, Rhode Island

1 facilities, and, once again, this gets to concentration.
2 If you can diversify yourself from purely
3 those hospitals and systems that depend on that cash
4 flow, obviously, then, you're less affected by any delays
5 in payments. We're about as diversified, I think, as any
6 health system there is, not only since a key component of
7 our company is the medical group side, but as well as the
8 hospital services side.
9 Medical group side makes up roughly about
10 28 percent of our revenue and, obviously, cash flow that
11 comes from it.
12 MS. COTTO: In reference to the capital
13 projects plan, can you provide us with the timeline for
14 that?
15 MR. SPEES: Well, as I mentioned earlier,
16 so the commitment that we have within the purchase
17 agreement is to fund or commit to fund within five years
18 of the closing. We're obviously not going to wait until,
19 you know, year four and a half to deploy that capital, so
20 what we're really -- what we're doing once we close the
21 transaction is immediately start the strategic planning
22 and capital planning process, and, so, we'll begin to
23 layout and identify the projects that we want to invest
24 the capital in, and, so, that will happen relative

1 quickly after closing.

2 There will be some projects that have been
3 noted as critical and will be invested fairly quickly
4 after the closing, and then the remainder will be the
5 result of this planning process.

6 MS. COTTO: Do you have a list of those
7 projects that you deem critical, that you know already
8 that are deemed critical?

9 MR. SPEES: We included several of the
10 items that were at least being considered as part of the
11 CON application.

12 MS. COTTO: Those are the ones that we
13 already have. We already have those, yes.

14 What is the status of PMH's plans to
15 attract a capital investment partner?

16 MR. ALEMAN: There is no active process
17 currently going on right now.

18 MS. COTTO: Okay. I have one more
19 question, and it's for Mr. Karl, and my question is
20 related to the audited financial statements.

21 We would just like you to explain what is
22 meant by the following statement, and I'm going to read
23 it to you. It's note one of the audited financial
24 statements.

1 It states, "As of September 30, 2015,
2 management has not finalized the purchase agreement, and
3 the trustees believe that the network will continue with
4 its normal operation and as a going concern for the
5 foreseeable future." What did you mean with that
6 statement?
7 MR. KARL: Michael Veillette will respond.
8 He's the Systems CEO, CFO.
9 MS. COTTO: Okay.
10 MR. MICHAEL VEILLETTE: So, Carmen, could
11 you just do me a favor and just repeat the question? I
12 did hear it, but I just want to --
13 MS. COTTO: Sure. We just want you to
14 explain what this means, what you meant under note one in
15 the audited financial statements. The statement reads as
16 follows.
17 "As of September 30, 2015, management has
18 not finalized a purchase agreement, and the trustees
19 believe that the network will continue with its normal
20 operation as a going concern."
21 MR. VEILLETTE: Okay, so, we had actually
22 the same comment in the prior year financial statements,
23 so, in essence, from the auditor perspective, nothing has
24 really changed, in terms of how close we are to having a

1 deal finalized at the time the audit was concluded.
2 The APA has not yet been signed, and
3 because in just a general climate in the State of
4 Connecticut what happened the year before, they view the
5 condition and the circumstances as meeting the definition
6 of a going concern.
7 MS. COTTO: Okay.
8 MR. VEILLETTE: I mean, if you look at the
9 financial performance of ECHN over the last five years,
10 as Mr. Karl presented earlier in the afternoon, you can
11 see the continued deterioration of the balance sheet and
12 the continued struggle to perform to generate a profit
13 from operations, from core operations, so that, in
14 essence, defines our situation as being considered a
15 going concern.
16 MS. COTTO: What are you doing right now,
17 aside from this proposal, to address this, or are you
18 relying on this proposal?
19 MR. VEILLETTE: Absolutely relying on this
20 deal to be completed. There’s no doubt about that. Are
21 we sitting on our hands as stewards of the organization?
22 No.
23 We’re working on a number of initiatives
24 that you would expect to be going through, in terms of

1 just, as Mr. Karl, again, referred to earlier,
2 productivity efficiency, looking at our labor
3 opportunity.
4 We've worked very aggressively I would say
5 in a nimble fashion since the fiscal year began, and we
6 have been -- and we're not the only hospital in the
7 state, but looking at what we had facing, coming into
8 2016, having some significant news roll out about 12 days
9 prior to the beginning of the fiscal year with the
10 potential recision of all supplemental payments, after we
11 had already put our operating budget before our finance
12 and our Board in September, we then had to go back, you
13 know, to the drawing board, so to speak, and come up with
14 at least one or two other budgets for 2016, with an eye
15 on hopefully, you know, if we had to get through the
16 year, that perhaps we could still get through the year
17 and maybe not trip a bond covenant, okay?
18 But as you're probably familiar, there's
19 been a lot of fluidity in the current year with regard to
20 supplemental payments and whether we'd be receiving them
21 or not, so our challenges continue to be very, very
22 extraordinary. Nothing has really changed from that, but
23 I assure you we're doing everything possible that we can
24 to continue to operate, as you would expect, but the

1 condition is quite dire.
2 If you look at the last five years, our
3 cumulative profit from operations over that five-year
4 window is $7 million, and that is with considering some
5 one-time items in there that I wouldn't consider part of
6 core operations, so you look at that five-year window,
7 and that five-year window isn't going to improve.
8 If anything, it's become a little bit even
9 darker out there for us, considering the cutbacks. I
10 understand there's been some news today of maybe partial
11 restoration of the restorations, but that's not going to
12 make our outcome any --
13 Look at our capital, what we're putting in
14 and what we're spending on capital in these last five
15 years. It's not enough. We're not able to -- our free
16 cash flow is very, very meager, and we're getting to the
17 point right now where we are concerned about actually
18 being -- not generating free cash flow. Does that?
19 MS. COTTO: Yes, it does. Okay.
20 MS. MARTONE: I just have one question.
21 The four individuals, who are hired and being hired
22 basically to be the management team, in terms of quality
23 assurance, are they available to come to any of these
24 hearings at all, so we could kind of ask them, as a

1 panel, in terms of, you know, what their plans are, in
2 terms of addressing these deficiencies or confirming that
3 there will be no quality of care concerns at our
4 Connecticut hospitals, maybe to share some of their
5 experiences if they've dealt with any of these types of
6 issues?
7 Obviously, you can see that our concern at
8 OHCA, and I'll speak for OHCA, is that there are serious
9 deficiencies, and we just want to make sure that our
10 Connecticut hospitals maintain the high quality that they
11 have been providing, so I'm just wondering if that's even
12 a thought or possibility.
13 MR. CROCKETT: I think it may be --
14 obviously, I wouldn't be able to get him here for
15 tomorrow's hearing. We could figure out what needs to be
16 done.
17 MS. MARTONE: Okay. I'd appreciate if you
18 can get back to me on that, because, you know, I think
19 they're the ones that could answer if they truly have the
20 capacity to be able to do this, especially when they're
21 overseeing, what, 14 hospitals?
22 MR. CROCKETT: The corporate team actually
23 will be supplemented by -- it won't be just four people.
24 The four people that I've identified are going to have

1 what I consider to be leadership responsibility.
2 MS. MARTONE: Right.
3 MR. CROCKETT: There will be people,
4 additional people within the corporate structure to
5 assist them. I anticipate we will have a regional
6 Director of Quality for the east coast, a regional
7 Director for Quality on the west coast, and then support
8 team underneath them, which will include what I call a
9 survey readiness team for the organizations, and there
10 will be several people on that, as well.
11 The four people I identified are just the
12 four, is the leadership of the quality, not just the
13 entire team.
14 MS. MARTONE: Okay. They're the ones that
15 are accountable, though, for it? That's what we're
16 trying to get.
17 MR. CROCKETT: Right.
18 MS. MARTONE: Is it the corporate level?
19 Is this team? Who can provide us some assurances?
20 MR. CROCKETT: Well it will be the new
21 individual, as I said, starts on Monday that will have
22 the overall responsibility.
23 MS. MARTONE: Thank you.
24 HEARING OFFICER HANSTED: Thank you, all.

1 At this point, OHCA has concluded with its questions, so
2 I'll turn it over to the Office of the Attorney General
3 for its questions.
4 MR. ZINN ROWTHORN: Thank you, Kevin. We
5 do have some questions, each of us, and OHCA's questions
6 have been comprehensive and touched on subjects,
7 obviously, that are of interest to us, as well, so we
8 will attempt to be brief in our questions.
9 I do want to give you the opportunity, and
10 we would be interested to hear your response to some of
11 the public commentary we received tonight, and not to
12 each one, but there were some common themes in those
13 statements having to do with beyond the Advisory Board
14 anticipated in the transaction whether and how the
15 hospital system will continue to engage the community,
16 the broader community or communities served, and serve
17 and engage individual patients within the hospital.
18 I'd be grateful to hear any thoughts that
19 you have on those themes that we heard. I'll take it
20 from anyone. Mr. Karl, perhaps?
21 MR. KARL: Sure. So everyone's opinion is
22 heard quite clearly. I have to always take a step back
23 and think about the 300 corporators that we have that
24 represent the communities that we currently serve.

1 The corporators elect the Board of
2 Trustees. The corporators fill the current existing
3 committees that are in place. The corporators, then,
4 that are on committees then graduate to the Board of
5 Trustees, and this is cyclical, so we're turning our
6 Board of Trustees over on a regular basis.
7 Personally, I find it interesting, when
8 community members feel as though they're not being
9 properly heard, because the 300 corporators truly are
10 breathing, living in this community, and, as we go
11 forward, the mechanisms that I see that would be kept in
12 place is a rotating group of local Board members, local
13 community members that those five individuals that are on
14 the Board representing the community will continue, and
15 they will have two and three-year terms, so they will be
16 rotating off while new members, then, rotate back on, so
17 we will have new members coming on to the Board of
18 Trustees.
19 In fact, two of the existing Board members
20 will have two-year terms, and three of the Board members
21 that we'd like to bring on, again, from our corporators
22 will be brand new to the organization, so we are, at
23 least from where I sit, I'm going to have to pass it over
24 to the new owners, we are very open to hearing other

1 options that may be out there.
2 I did hear some concerns. We're very open
3 to having other people that are interested in
4 participating on the local Board of Trustees to come in
5 and meet with the current Board, meet with corporators,
6 meet with myself, and bring that forward.
7 That's what we do as a community
8 organization.
9 DR. LEW: Perry, I would just add that,
10 you know, with our model, because there are so many
11 touches that we make to patients, I talked about the
12 homebound program and our Quality Care Coordinators that
13 reach out and they call patients, there's plenty of
14 opportunity for the community and patients to give
15 feedback as they're receiving care, and we take those
16 very seriously, because patient satisfaction is the
17 reason why we're able to grow, because patients tell
18 their friends to sign up with this network, because
19 you're going to get great care.
20 So while we don't have a formal committee,
21 if you will, that patients serve on, or members of the
22 community serve on, because of the multiple touches
23 within our model that patients receive, there's plenty of
24 opportunity for feedback.

1 MR. ZINN ROWTHORN: Great. Well I
2 appreciate that. I think one of the blessings of running
3 community hospitals for as long as you have is that there
4 is a sense of engagement and expectation of engagement
5 that arises over time, a proprietary sense, in effect,
6 over the direction of the hospitals and the communities.
7 I'm glad to hear that that's been
8 recognized as an important value to recognize going
9 forward. I'd encourage you to think about that as you go
10 forward with this transaction and share with us as we go
11 any thoughts you have about what's worked to this point
12 and how to preserve that, what's worked in your
13 experiences in your other hospitals, as far as engaging
14 the communities that they serve and the direction of the
15 hospital as you go forward, so I appreciate that, those
16 answers, and I'll turn it over to Henry.
17 MR. SALTON: Again, as Perry noted, I
18 think a number of the things that we were thinking about
19 asking have been covered by some of the questions in OHCA
20 and some of the answers we've gotten so far.
21 One area I wanted to explore a little bit
22 more is the capital commitment issues. So the hospitals
23 indicated that one of the reasons why they pursued a sale
24 was because their view was that their capital improvement

1 needs that could not be met needed to be addressed, and
2 I'm wondering if, again, not asking for accounting level
3 of guarantee, but what would you quantify those kind of
4 capital improvement needs that need to be addressed on
5 the two campuses in the next five years?
6 MR. KARL: Okay, so, our physical plant
7 internally -- well, you have to look at it a few
8 different ways, so please bear with me as I go through
9 this.
10 Our physical plant internally
11 aesthetically is ugly. The wallpaper is ripped. There's
12 scratches on the walls in the patient rooms. The beds
13 the patients are in I replaced them when I first started
14 12 years ago. The floors are worn. Aesthetically, the
15 organization looks as though that it has not been
16 maintained.
17 I can tell you that, over the past five
18 years, the capital that we have expended has gone into
19 backup generators, boilers, elevators, those behind the
20 scenes costs that keep the organization functioning.
21 What we need to do now is actually prepare
22 the organization for the future. There's a lot of
23 hospital-acquired conditions. It's something that we
24 live with all the time that scares the bejesus out of all

1 of us.
2 The last thing you want to do is get a
3 patient come into the organization with an issue and end
4 up with a hospital acquired issue. What we'd like to be
5 able to do is get our organization into single occupancy
6 beds. We'd like to upgrade our ORs. They are way
7 undersized. They're only 45 years old.
8 We currently have, you know, as others, as
9 Dr. Karl had mentioned, we've invested in some pieces of
10 equipment that we found were extremely necessary; robots.
11 We need to upgrade those robots. We need
12 to replace our CAT scanners. We need to replace our
13 MRIs. We need to replace some of the basic necessities
14 to take care of patients.
15 We have several different patient
16 monitoring systems that we've pieced together over the
17 years. They work extremely well. They need to be
18 replaced.
19 We need to invest in some subspecialists,
20 whether they're hand surgeons, whether they're
21 neurologists, whether they're bariatric surgeons.
22 There's obviously a significant obesity epidemic and so
23 on and so forth.
24 We currently have these plans on the

1 docket. We've had these plans for quite some time. We
2 have a 20-year-old EMR. They used to call them HIS,
3 Hospital Information System. We have an HIS that needs
4 to be upgraded. That's about $25 million.
5 There aren't returns on investments for a
6 lot of these things, but these are the things that we're
7 going to need to put in place in the future, so we can
8 appropriately and properly care for the patients that we
9 currently care for. That's just off the top of my head.
10 MR. SALTON: So would you kind of ballpark
11 what you think those needs would require for capital
12 investments?
13 MR. KARL: What I just threw at you right
14 now?
15 MR. SALTON: Yeah.
16 MR. KARL: About 40 million.
17 MR. SALTON: Okay and I understand that
18 Prospect's commitment of 75 million is to provide
19 improvement, capital improvements to the benefit of the
20 hospital business and for the benefit of the service
21 areas of the two hospitals, and I understand you don't
22 have specifics, as far as allocation, like do we want to
23 put so much in MRI, do we want to put so much in building
24 a new doctor's office building, or a parking garage for

1 our patients, but is there a sense of commitment that
2 this $40 million out of the 75 million will be going to
3 the campus or somewhere in that, some relative proportion
4 that's close to that?
5 MR. KARL: Yes.
6 MR. SALTON: Now I want to make sure your
7 partners agree.
8 MR. KARL: Okay.
9 MR. SALTON: Because I see a little glint
10 in the eye.
11 MR. SPEES: Well my only hesitation is
12 that we haven't reviewed all of those capital plans with
13 the local leadership and the local Board and the
14 management. It certainly sounds like the kinds of things
15 that you would expect to find in circumstances like this,
16 and it all sounds like the kinds of capital investment
17 that we would want to make to actually build on the very
18 significant initial capital investment that we're going
19 to make, so I can't make an unequivocal commitment like
20 that, without having had the opportunity to review the
21 detailed disciplined approach to capital that we'll use.
22 MR. SALTON: So in doing your due
23 diligence on the acquisition of these hospitals, you guys
24 didn't look at the capital improvement demands that the

1 hospitals have before signing to acquire them?
2 MR. SPEES: Well we looked at, generally,
3 the physical condition and the assets, but we haven't
4 prepared a detailed capital expenditure plan. We
5 certainly reviewed the capital needs list and deferred
6 maintenance list, which Peter has described, but have not
7 made a formal commitment, yes, we're going to do that,
8 we're going to do that, we're going to do that.
9 In fact, we wouldn't. That's really part
10 of our model here, is we work with local management and
11 local leadership to identify those projects, so we would
12 definitely give a lot of credence and weight to Peter's
13 view of and local management's view of what the capital
14 needs are and where they're best allocated.
15 MR. SALTON: You've made a three-year
16 commitment to keep operating both facilities as acute
17 care hospitals. Why only a three-year commitment?
18 MR. KARL: That's all we asked for, quite
19 honestly.
20 MR. SPEES: We stepped into the prior
21 transaction, and that was one of the terms in the prior
22 transaction.
23 MR. SALTON: Would you be open to a longer
24 commitment?

1 MS. VOLPE: No. It's not negotiated in a
2 vacuum. You know that, Henry. I mean there's so many
3 provisions in the asset purchase agreement that went into
4 this. I mean, really, when you talked about have they
5 looked at the capital needs, they spent a lot of time
6 figuring out how much it was going to cost to pay all the
7 pension liabilities.
8 I mean there was a lot of due diligence in
9 recognizing how much money really needed to be spent here
10 to preserve and maintain these hospitals.
11 MR. ZINN ROWTHORN: I'll ask a different
12 question. Do you foresee circumstances three years out
13 under which Prospect might make a determination that it
14 no longer wishes to run an acute care hospital?
15 DR. LEW: As you sit here today, the
16 answer is obviously no. The problem that we always run
17 into is you never know what happens from a federal
18 government regulation perspective or even from a state
19 regulation perspective, in terms of how health care is
20 provided.
21 So, in a vacuum, if all regulations were
22 to stay the same and there were no substantial changes,
23 then I think the answer is I don't see that, but the
24 reality of the situation is that we don't control the

1 federal or the state regulations.
2 As a responsible business health care
3 provider, we have to be able to be adaptive to both of
4 those changes, so your point is that, usually, you don't
5 see changes occurring in a short time, but five years
6 down years the road, six years, seven years down the
7 road, I don't know if anybody could sit in our seat and
8 say that there are no changes that would have an impact.
9 MR. SALTON: So, at this point, you
10 haven't done any assessment or evaluation of a
11 consolidation of services between the two hospitals to
12 try to locate one or close one?
13 I mean some people weren't around, but we
14 used to have a hospital in the north end of Hartford that
15 was acquired by another hospital, and it got scaled down
16 and then disappeared, so that's one of the concerns I'm
17 trying to anticipate.
18 MR. CROCKETT: Our commitment is to
19 maintain the services for the three-year period. Getting
20 back to our original sort of our presentation, as we look
21 to go into value-based health care providing, we actually
22 look to expand the service we're providing underneath the
23 management of the population, and, so, is there services
24 that are needed that are currently being provided outside

1 of the community?
2 Our goal would be to actually bring those
3 services into the community at both of the facilities and
4 I guess underneath the auspice of being the provider
5 underneath health population management, so, actually,
6 for the next few years, that's actually what our
7 objective is.
8 MR. ZINN ROWTHORN: So the testimony, if I
9 could summarize it, is that, absent substantial
10 regulatory at the federal and/or state level, you would
11 not anticipate ceasing to operate in these communities
12 these two acute care hospitals?
13 MR. CROCKETT: I don't see -- I don't
14 think there's anything that we see on the horizon that
15 would change that, so that's accurate.
16 MR. REARDON: And take a look at our track
17 record. We've never closed a hospital. We are a growth
18 company, not a contraction company, but we can't predict
19 five, 10 years down the line.
20 MR. SALTON: Okay. One of the conditions
21 to the capital commitment I understand is that PMH is
22 reserving the right to defer the commitment beyond the
23 five-year period of the state or federal authorities,
24 enact requirements after closing that discriminate

1 against for-profit hospitals and cause the hospital
2 businesses to suffer a decline of EBITDA more than 10
3 percent in a year.
4 I just want to clarify. It's both those
5 conditions. It's not one or the other, so the fact that
6 the federal government passes something that seems to be,
7 I don't know how we determine that, discriminates against
8 the for-profit hospital, but doesn't actually impact to
9 the extent indicated your -- hit the 10 percent number,
10 that's not -- that would not, then, be a basis for
11 deferral?
12 MR. SPEES: That's correct.
13 MR. SALTON: Okay.
14 MR. ZINN ROWTHORN: Let me take the
15 opportunity to editorialize a little bit about that
16 condition to the capital commitment.
17 On this side of the table at least, our
18 function is to evaluate the fairness of the transaction,
19 and that evaluation includes that $75 million commitment.
20 It doesn't include a $75 million
21 commitment that may evaporate, depending on the
22 regulatory atmosphere and how that changes federally or
23 on a state level.
24 And, so, this is an issue that we've

1 confronted in past proposed transactions, and it's one
2 that kind of regulatory legislative change carve out to a
3 commitment that forms a substantial part of the value of
4 the transaction is one that we've had a dim view of, so
5 I'll say that comment for your benefit and give you the
6 opportunity to respond to it.
7 MR. SPEES: I wish I had the language in
8 front of me, but I'll speak from memory. So it's
9 actually a very, very narrow commitment that is intended
10 if there's some adverse regulatory development that is
11 specific to for-profit hospitals only, so it's really
12 meant to be something very narrow and extremely unlikely.
13 MR. ZINN ROWTHORN: Okay. One should not
14 be surprised to see a condition that relates to that
15 purported carve out if this transaction were to be
16 approved.
17 MR. SALTON: Okay. I'm leaving capital
18 commitment, and I only have one other question, which is,
19 if you're a local physician, primary care physician or
20 otherwise, they're participating the CRC and they're
21 saying, okay, what are the obligations or requirements
22 for this local physician to participate in the CRC?
23 Do they have to be a member of the IPA?
24 Do they have to be employed by the Medical -- part of the

1 Medical Foundation?
2 DR. LEW: They can be employed or they can
3 remain independent. That's one of the values of the
4 model, is it can engage physicians, depending on where
5 they are in their career and what their desires are for
6 employment or not.
7 Contractually, they need to be part of the
8 network and referred to physicians within the network.
9 We're going to hold them to quality standards that are
10 written out in the contract and tell them what quality
11 metrics they're going to get bonused on and what's going
12 to be asked of them, and there are a lot of other
13 requirements related to submission of encounter data or
14 usage of EMR and using best practices, as it relates to
15 taking actually management of a patient.
16 So, you know, basically, they've got to
17 stay within the network, refer patients that are part of
18 our network, keep them in the network, and we hold them
19 to the quality standards, but they don't have to be
20 employed.
21 So you could have a doctor, who is part of
22 the IPA, that might go to another hospital. They may
23 actually be employed by someone, a system down the
24 street. That's what's nice about our model and our

1 system. It’s open, and, so, we are not a closed system
2 in all of our markets. We have relationships with our
3 competitors, okay?
4 We can use our model as a way to reach out
5 and really start to manage population together.
6 MR. SALTON: Okay, so, just, again, from a
7 layperson’s perspective, so someone brings their spouse
8 to the emergency room one day at Manchester Memorial
9 Hospital, their family physician is an old-timer, who is
10 not participating in the IPA, and they’re admitted,
11 because they have a condition, which requires some long-
12 term chronic maybe follow-up, that the CRC would be a
13 perfect kind of thing for population management, so if
14 this patient wants or the hospital says we want you to
15 participate in this population management process we
16 have, do they have to then leave their physician?
17 Do they have to get their physician to
18 sign up, or do they have to go to someone else? When you
19 talk about managing a population, where you have some
20 providers in the community, who may or may not be in your
21 IPA, I’m wondering how that works.
22 DR. LEW: Yeah, so, Henry, what we would
23 do is offer to have that patient brought into our
24 programs and to be part of the care management program.

1 We call it Care Plus, and, so, even though they're not
2 part of the IPA, they can still access the services,
3 because it's better for the patient, and you don't want
4 that patient to have to be readmitted.
5 What happens, so, we're doing this in
6 other markets through an ACO and feeding patients into
7 our model, is they like it, and they want access and to
8 be part of a program, and, so, when it comes time to open
9 enrollment to convert and be part of the network by
10 signing up for a plan, that's what ends up happening.
11 So, to answer your question, no, they
12 don't have to be part of a network to access the
13 services, because, again, we still need to take good care
14 of the patient and make sure they don't get readmitted.
15 MR. SALTON: Okay. Gary, do you want to
16 ask some questions?
17 MR. GARY HAWES: Good evening. My name is
18 Gary Hawes. I work at the Attorney General's Office,
19 and, as noted at the beginning of this hearing, one of
20 our primary responsibilities is the protection of the
21 charitable funds, as those are seen the hospital, itself,
22 being a charitable organization, the investment that the
23 community has in the hospital, and, specifically, the
24 actual charitable funds that the hospitals hold. Lots of

1 people give funds to the hospitals.
2 I really only have one question and a
3 couple of requests for some late-filed exhibits, but,
4 before I get there, I want to point out that the reason
5 that I have so little is because the production that I
6 got was wonderful.
7 I have found ECHN, and I haven't had to
8 ask much at PMH, because I'm more with the ECHN
9 charitable assets, but it's been a great production, so
10 thank you very much.
11 And there was actually a production
12 yesterday morning, and that's where some of my requests
13 and questions come from, and these relate to the funds.
14 There are about I'd say approximately about 100 funds
15 that ECHN holds, either Manchester, Rockville, or the
16 foundation, itself.
17 One question I have concerns the fund. My
18 understanding is it's still in the midst of probate, and
19 some distributions have been made. This is the Raymond
20 F. Damato Fund or Estate, excuse me, and the fund number
21 is, as it was submitted in Certificate of Need
22 Application, 11.1-30, and the recently submitted filing
23 talks about the ideas and the plan that ECHN has for the
24 distributions that may come. Although the interest is

1 vested and some of the distributions have been made, not
2 all of them have been made, and, so, the ECHN has a plan
3 and has discussed with the executor what might happen
4 with that.
5 My question is to what extent has ECHN
6 committed to this proposal? In discussion at Board
7 meetings, has there been a Board vote about what ECHN
8 would like to happen with the Damato distributions?
9 DR. O'NEILL: We're going to ask our legal
10 counsel to answer that, and then I'll give you a little
11 side comment.
12 MR. HAWES: Thank you.
13 MS. JOYCE TICHY: So far -- can you hear
14 me? My name is Joyce Tichy. So, so far, what we have
15 done with our Board is that we -- the Board has been very
16 interested in and hopeful to ensure that the funds made
17 available through this request fully honor the memory of
18 Mr. Damato.
19 He was a very well-known, deeply-loved
20 person in the community, and just to give a little bit of
21 background, he owned a number of properties in the
22 Manchester area.
23 If you drive around Manchester and you
24 happen to see apartment buildings with a covered wagon in

1 front of them, that was his signature. They are really
2 all over, and, when you drive by, you know that that was
3 his trademark.
4 He was not only a good and very loyal
5 person in the community. He was also a very successful
6 businessman, and, so, when he left funds to ECHN and
7 others, he really just spread the benefit of all he had
8 done throughout his life.
9 So, in that regard, knowing the history of
10 Mr. Damato, the interest of the Board was to make sure
11 that the intentions that he expressed through this
12 bequest were honored, and we understood that his primary
13 interest was not only to enhance the health of the
14 community, but, through his other bequests, we knew he
15 was very interested in education.
16 Actually, another part of his bequest went
17 to Manchester Community College. Another went to another
18 institution, not-for-profit institution of education in
19 Connecticut, I mean in Manchester, East Catholic High
20 School.
21 So, in thinking about this and knowing, as
22 the Board does, some of the things that were expressed to
23 you earlier, that it’s very important to maintain
24 physicians in the community, to enhance our GME program,

1 so that physicians want to stay in Manchester and serve
2 Manchester, the thought of the Board was to arrange for
3 the transfer of the funds to the entity, the University
4 of New England College of Medicine, that currently
5 managers are graduate medical education program, with the
6 restriction that the monies generated would and could
7 only be spent in Manchester to further graduate medical
8 education, with the further condition that, insofar as
9 the monies would be needed to pay off ECHN's debts as
10 part of the transaction, which, of course, is foremost
11 for us, it would first be used toward that purpose.
12 So our Board is very interested in this
13 concept. It meets a lot of where we think it's best for
14 the money to go, and it also is, by its nature, it would
15 be significant enough to matter to show that there was
16 importance to the grant that he gave.
17 One of the options would be actually to
18 finance a portion of the building where graduate medical
19 education could be done and, insofar as possible, provide
20 a naming opportunity to the building, so that his name
21 would remain there for everyone to see.
22 So that's where it is. Where our Board
23 has gone at this point is we have -- they have authorized
24 us to pursue this with Unicom, and we have followed that

1 instruction by continuing conversations with Unicom.
2 We also, because we know that matters of
3 this nature are of interest to the community and that the
4 function of you all is to ensure that those interests are
5 honored, we are actually waiting to see if you have any
6 comment on it.
7 Were you to be agreeable to that, and I
8 know that Mr. Hawes may have some thoughts about the
9 structuring of it, we, then, would proceed with this
10 process and continue to converse with Unicom and put
11 together a resolution to the effect that we have
12 described, but, at this point, there is no final Board
13 resolution that sends the money over.
14 Another thing, just to add to this, is the
15 executor of the estate we've met with him a couple of
16 times, and he is very interested, also, in making sure
17 that this money is used in the way that would be
18 appropriate to Mr. Damato's money, and he has expressed a
19 strong positive view toward this for all the reasons that
20 I've just described.
21 So that's where we're at, and, certainly,
22 if we could, if you have any thoughts about how to
23 construct this appropriately, we are happy to hear those.
24 We just want to do this right.

1 DR. O'NEILL: So just to add one more
2 thought, what the Board did was we passed a resolution to
3 pursue this idea with the executor and with the Attorney
4 General. We didn’t commit to any program.
5 MS. TICHY: We actually are hopeful that
6 we could meet with one or more members of your office to
7 describe the various kinds of facilities or possibilities
8 that this money could be used for, one of which could be
9 part of the building.
10 Another would be possibly this would be
11 second, sort of have a list of things, but sort of lower
12 on the list, but possibly appropriate, as well, would be
13 to finance the actual medical education of the students
14 that come through Manchester.
15 Getting a medical education is
16 phenomenally expensive. It’s an extreme weight on the
17 shoulders of physicians, who then basically spend the
18 first portion of their career just paying back the money,
19 so if we could finance education in that way, with a hope
20 that the person receiving the money would stay in
21 Manchester, that is also a possibility.
22 Ultimately, the goal would be to make sure
23 that the restriction is for medical education and in a
24 health-related capacity, because that’s what clearly his

1 bequest was intending. Did I forget anything?
2 MR. HAWES: Thank you. In yesterday's
3 production, too, there were two outstanding issues with
4 respect to funds, and, so, my request is going to be just
5 for I guess a late-filed exhibit that addresses these two
6 issues, and, if there's a problem with that, also, I
7 would like to hear about that.
8 The E. Stevens Henry fund, it's Fund 11.1-
9 55, this is one that my understanding is there's some
10 difficulty trying to understand exactly how it should be
11 classified, so for those of you, who are wondering about
12 the classification systems we have, some are restricted
13 funds, as to spending and to use, and we try to
14 understand exactly how all that plays out, and then how
15 those funds are going to ultimately be transferred to the
16 new foundation, which is part of, also, of our
17 jurisdiction.
18 So this one is, I guess, a difficult,
19 well, I know it's a difficult nut to crack, so it
20 indicated that the hospital was currently evaluating
21 this, and, so, a resolution of that, should you be able
22 to get there, would be great as a late-filed exhibit, so
23 I think that would be --
24 HEARING OFFICER HANSTED: That would be

1 Late File No. 7.
2 MR. HAWES: Late File 7. And I think we
3 can just do it in the same exhibit, if that exhibit can
4 be a submission to our office.
5 You had indicated here that you're
6 updating the values of the funds. I'm trying to remember
7 what they were current as of. It was September 30, 2015,
8 so I don't know the date that you could do that, if it
9 can be March 31, 2016. I'm not sure if you can get us
10 numbers for that, but that would be our most current fund
11 valuation that we would definitely like to use.
12 As I indicated, too, one of the other
13 areas that we have jurisdiction over and our job starts
14 kind of after the transaction and creating a new
15 foundation, and ECHN has presented to us a good draft
16 Certificate of Incorporation and Bylaws for this new
17 foundation, but one of the things, in addition to all
18 these specific funds that will most likely be transferred
19 there, is whatever charitable assets the fair market
20 value that's remaining the assets of ECHN that's
21 transferred over.
22 My review shows that the most recent
23 analysis of that is a little outdated, so I just want to
24 ask for an update on this. It's a table, actually. It's

1 a simple table, something that I can actually follow, and
2 it was submitted to us in the response to the first and
3 second letters of deficiency that were sent out by our
4 offices. It was Table No. 8, and it was on page 2210,
5 and it's the Net Proceeds Analysis.
6 My understanding is we don't need to go to
7 the $115 million option, that we can just go with the
8 $105 million option, but if that can be updated to, you
9 know, whatever current numbers that exist and be filed,
10 again, it can be filed along with the same document, just
11 to provide us the most current information on that, that
12 would be great, and I understand it's as current as you
13 can be, with lots of things shifting.
14 That's all I have. Thank you.
15 MR. ZINN ROWTHORN: So I think that wraps
16 up our collective questions. We took public comment out
17 of order from our agenda, so, at this point, we'll ask if
18 there's anyone, who has come in since the public comment
19 section, or was here, but thought of something they'd
20 like to say, and open that up to the floor. Anybody?
21 MS. VOLPE: If at all possible, we'd like
22 an opportunity to make sure we address your concerns
23 thoroughly on the capital commitment.
24 We understand that's an issue and a

1 concern, and, you know, we've had an opportunity to look
2 at the provision. Again, this is a leftover provision
3 from another transaction, and, you know, we made
4 commitments and to step into it, but if you could indulge
5 us just for a few minutes to talk among ourselves and get
6 back to you?
7 MR. ZINN ROWTHORN: We'd be happy to do
8 that. We're going to be together again tomorrow, so we
9 could push that over until tomorrow.
10 MS. VOLPE: Sure.
11 MR. ZINN ROWTHORN: But I appreciate that,
12 Michele. On behalf of the Attorney General's Office and
13 the Attorney General, I want to thank all of you for your
14 input.
15 This has been a long, but I think very
16 productive, from our perspective, helpful and informative
17 afternoon. We appreciate your patience with our process.
18 To the members of the public, who are
19 still here or who were here, we thank you for your input.
20 We were very happy to see such a big crowd, so thank you,
21 all.
22 For those, who have an appetite for it,
23 we're going to do it again tomorrow in Vernon. All are
24 welcome. Some are required. (Laughter) But thank you,

1 and have a good evening.
2 HEARING OFFICER HANSTED: Just one point
3 of housekeeping before we leave. The late files, those
4 will be due April 8th. Does that give enough time for
5 everything?
6 MS. VOLPE: What is the plan, in terms of
7 keeping this open? I mean do you plan on keeping this
8 open beyond April 8th?
9 MR. ZINN ROWTHORN: Well I can tell you,
10 with respect to at least the issue of the immediate
11 jeopardies, we would like to keep that open up through
12 our decision date to receive documents that go back and
13 forth between the parties and CMS, so, at least to that
14 respect, I think we'd like to be as up-to-date as
15 possible, and then I don't know if others have thoughts
16 about keeping the record open.
17 HEARING OFFICER HANSTED: I'm not opposed
18 to it. I just want to set a finite date.
19 MS. VOLPE: Sure. Could we, depending on
20 what late files we hear for tomorrow, could we agree on a
21 date tomorrow?
22 HEARING OFFICER HANSTED: That's fine.
23 MS. VOLPE: So we know the totality of
24 what we're producing, and we'll be in a better position?

1 HEARING OFFICER HANSTED: Yes. Yes. So
2 we'll set a date at tomorrow's hearing.
3 MS. VOLPE: Thank you.
4 HEARING OFFICER HANSTED: Okay, thank you,
5 everyone.
6 (Whereupon, the hearing adjourned at 7:38
7 p.m.)

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