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December 29, 2014

The Honorable Kamala Harris
Attorney General
Department of Justice
300 Spring Street
Los Angeles, California 90013

Re: Proposed Sale of Daughters of Charity Health System to Prime Healthcare Services: OPPOSE

Dear Attorney General Harris,

Health Access California, the statewide health care consumer coalition, committed to quality, affordable health care for all Californians for over 25 years, opposes the transaction which would result in the sale of five hospitals operated by the non-profit Daughters of Charity Health System to the for-profit Prime Healthcare Services.

Health Access sponsored much of the underlying legislation which grants the Attorney General authority to review, approve, deny or impose conditions on hospital transactions. We and our coalition partners here in California and elsewhere have offered substantial comment on other non-profit transactions in health care, and oppose based on that experience.

Charitable Trust: Accurate Valuation in the Context of the Affordable Care Act?

The Daughters of Charity operate five hospitals, some of which have been in operation for more than a century. The people of California gave these hospitals non-profit charitable trust status so that the Daughters of Charity might provide health services to those in need in the community. This trust status relieved the Daughters of Charity of the obligation of paying taxes to the state and the community which they served. The value of the assets created because of the charitable trust is substantial. It has been our experience that assets may be undervalued in these transactions. We ask that the Attorney General use the full extent of her powers—including securing an independent, third-party valuation-- to assure the full, fairmarket value of these assets.

In particular, we note that any valuation of these assets must take into account the transformation of the larger health care system being wrought by the extraordinary implementation of the Affordable Care Act here in California. California has cut in half the number of uninsured, from over six million to about three million. Recent projections indicate that this trend is likely to continue and

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the number of uninsured is expected to decrease further. Most of these hospitals are located in precisely the geographic areas most likely to benefit from that dramatic increase in the number of Californians with health insurance. While there will be remaining uninsured that need to be cared for, any valuation, and the required health impact analysis, must take into account the increase in covered lives in the communities served by these hospitals. More paying customers should make these hospitals more valuable, not less.

The valuation of assets and the assessment of this transaction must also take into account further changes in the role of hospitals in the healthcare system. From readmission penalties to penalties for health acquired infections to the system goals of the Brown Administration's "Let's Get Healthy California" initiative, hospitals that serve their communities are being asked to be part of a more integrated care delivery system. In the current discussions on the Medicaid 1115 waiver, the state and federal governments are encouraging hospitals to provide integrated care that reaches deep into the community.

As best we can determine from the documents provided associated with this transaction, Prime Healthcare Services has not offered a vision of these hospitals as part of an integrated care delivery system. Instead, there has been a troubling history, discussed below, in which Prime Healthcare Services often failed to contract with health plans, both public and commercial and in which Prime Healthcare Services appears to operate on a different understanding of what an emergency is or what a billable condition is.

Conditional Commitment to Hospital Services

In its newspaper advertisements, Prime Healthcare Services states that it will:

- **Keep emergency room and trauma centers open.** Prime Healthcare has never sold or closed a hospital and its emergency rooms are always open to all and have cared for over 600,000 patients annually.

Yet the documents filed with the Attorney General make at best a very conditional commitment to keep emergency services open.

In its statement of the reasons the board of Daughters of Charity believes that the transaction is reasonable or desirable, under Section 999.5 (d) (1) (C), the DCHS Board states:

1. **Post-Closing Hospital Services:** Prime committed to preserve the Health System's hospitals as general acute care hospitals with open emergency rooms for not less than five years after the closing, *subject to physician availability, the needs of the community, and financial viability.* [Definitive Agreement, Section 7.8(b)] (Emphasis added)

In the Definitive Agreement between the Daughters of Charity Health System board and Prime Healthcare Services, Section 7.8 (b) reads:

> (b) To ensure adequate access to Medicare and Medi-Cal patients, for a period of not less five (5) years following the Effective Time, Prime Healthcare will continue to operate the Hospitals as general acute care hospitals under the California Health and Safety Code Section 1250 and shall continue to offer an open emergency room, *subject to the availability of physicians* on the respective Hospital's medical staff qualified to support such services and *subject further to such changes as may be necessary or appropriate based on community needs, market demand and financial viability of such services*. (Emphasis added)

Please contrast this with the following section, on Prime's commitment to maintain the chapels:

> (c) For a period of not less than five (5) years following the Effective Time, Prime Healthcare will maintain the existing chapels at the Hospitals to be used for the celebration of the Catholic mass and other religious services, and provide an appropriately staffed and funded pastoral care service at the Hospitals.

No caveats, no "subject to", no conditions: the chapels will be maintained.

Health Access does not object to maintaining the chapels: we do object to the very conditional and limited commitment to maintain health services. We examine in turn each of the very conditional and limited commitments made by Prime in its Definitive Agreement with the Daughters of Charity.

1. *"Subject to physician availability"* on the respective Hospital's medical staff qualified to support such services

   Whether a hospital has available physicians on its staff is purely within the control of the hospital. A functioning hospital must have physicians on staff that can provide care (as well as employing registered nurses and a panoply of other health professionals and employees). Whether there are physicians available or not is within Prime's control: other hospitals do what is necessary to attract and retain qualified physicians. Either this condition is unnecessary because Prime intends to attract and retain qualified physicians or it makes meaningless the commitment to maintain services.

2. *Subject further to such changes as may be necessary or appropriate based on community needs,*

The determination of whether "such changes" are "necessary" or "appropriate" "based on community needs" is purely within Prime's control. Prime determines what is necessary or appropriate. Prime determines what the community needs are.

This is precisely why the Attorney General was given authority to condition transactions on the impact on the health of the community: to assure that California communities could count on their hospital being there when they needed it. It is the Attorney General, not Prime, who must determine what changes are necessary or appropriate and what the community needs are.

Because of the transformation of the health care system underway as a result of the Affordable Care Act and other efforts here in California, oversight of the needs of the community should continue for at least a decade to assure that the communities served by these hospitals continue to have their needs met in this time of transformation.

3. *Subject to...market demand and financial viability of such services*
   Again, the determination of market demand and financial viability of services is purely within the control of Prime Healthcare. And this condition alone makes meaningless the commitment to maintain hospital services since Prime alone determines what constitutes market demand and financial viability.

Commitment Limited to Emergency Care and Basic Services

Not only is the commitment to hospital services extremely conditional, and reliant on conditions purely within the control of Prime Healthcare, but the commitment in the definitive agreement is limited to a commitment to operate general acute hospitals and a commitment to offer emergency room services.

A general acute care hospital is required to have eight basic services, including medical, surgical, nursing, anesthesia, radiology, laboratory, pharmacy and dietary. The commitment of Prime Healthcare is to operate a general acute care hospital consistent with California law. This commits Prime Healthcare to offering medical, surgical, nursing, anesthesia, radiology, laboratory, pharmacy and dietary services. It does not commit Prime Healthcare to offer any of the other hospital, skilled nursing, sub-acute or outpatient services now offered by the Daughters of Charity hospitals.

A general acute care hospital is not required to offer the broad array of services offered by these Daughters of Charity hospitals, from labor and delivery to skilled nursing, to cancer treatment, to kidney transplants to cardiac care, orthopedic surgery or acute rehabilitation. Each of these is a "special service" not required

for licensure as a general acute care hospital under Health and Safety Code Section 1250.

Yet the only two commitments required in the Definitive Agreement are that Prime Healthcare operates these facilities as general acute care facilities and offer emergency services. Under the Definitive Agreement, Prime could eliminate many, most or all services which are not one of the eight basic services or the emergency room and still meet its commitment under the Definitive Agreement.

It is precisely because communities rely on hospitals to provide a broader array of services that the Attorney General was given the responsibility to conduct a health impact analysis for each transaction. These five hospitals have been an important part of these communities, and California, for many decades. We have reviewed the health impact analyses which make recommendations as to which services the communities need maintained or even expanded. A commitment that is limited solely to operating a general acute care hospital and offering emergency services is not sufficient to meet the needs of these communities.

Limited Commitment: Medicare and Medi-Cal Only (And Not Even Managed Care); Not Covered California or the Remaining Uninsured

The commitment made in the definitive agreement is further limited only to Medicare and Medi-Cal patients. While the state and federal governments have a clear interest in assuring that Medicare and Medi-Cal patients receive the full range of care that they need, there are other Californians who rely on these hospitals, including those with commercial coverage, those covered through Covered California, and those who remain uninsured. Yet the Definitive Agreement is limited by its initial clause: "To ensure adequate access to Medicare and Medi-Cal patients," and thus fails to recognize the need of other Californians for hospital services. Over one million Covered California patients are in lower-income working families that also need access to care. In particular, projections by University of California-Berkeley suggest that there may be as many as three million remaining uninsured Californians, even after full implementation of the Affordable Care Act. To not have any commitment to serve this population is deeply troubling, especially in the impacted areas. This is particularly problematic in light of the troubled history of Prime Healthcare.

Further, as noted by the Local Health Plans of California, there is no commitment to contract with Medi-Cal managed care plans—even though more than 70% of Medi-Cal patients are in Medi-Cal managed care. And there is no commitment to contract or continue to contract with Medicare managed care plans, despite the dominance of managed care in California's Medicare market. Similarly there is no commitment to contract or attempt to contract with commercial carriers or with Qualified Health Plans with contracts with Covered California, California's health benefit exchange. Given the troubled history of Prime Healthcare and its previous

failure to contract with many health plans, the commitment to serve "Medicare and Medi-Cal" without a commitment to serve those Medicare and Medi-Cal beneficiaries enrolled in managed care raises questions—as does the failure to include commercial coverage, Covered California and the remaining insured.

Commitment to Only Legal Minimums

Much of what Prime offers as "commitments" are already legally required elsewhere. We are troubled by Prime making a point to say that they will merely follow existing law. These commitments to the legal minimums include:

- A commitment that emergency rooms are open to all comers—as required by both state and federal law.
- "No patient shall be turned away because of age, race, religion, gender, sexual orientation, payment source or ability to pay"—again, as required by state and federal law.
- "Provide for an appropriate medical screening examination to any patient presented to the emergency room who has a medical emergency, or who, in the judgment of the staff physician, has an immediate emergency need." Again this is the legal minimum.
- "Its emergency rooms are always open to all" (*Sacramento Bee* paid advertisement, December 7, 2014.) Again this is the legal minimum for an emergency room.

A Troubling History

The conditional and limited commitments made by Prime Healthcare are more troubling given its history.

- Emergency care: post-stabilization care

Health Access participated in a Senate Health informational hearing in Los Angeles about Prime Healthcare. Numerous witnesses testified, including physicians and patients. Prime Healthcare, contrary to California law, held patients after they were stabilized and did not check with the originating health plan about whether the health plan wished to provide care at a contracting facility once the patient was stabilized and ready for transfer. Prime Healthcare relied on a definition of stabilization that, as best we could tell, was used by no other hospital or health plan—but does yield additional payments to Prime. This was compounded by a lack of negotiated contracts with health plans so that a disproportionate share of Prime's patients was emergency room admissions and paid as out-of-network admissions. Consumers who end up out-of-network are not protected from higher charges and the cost of their care may not accrue to the out-of-pocket maximum required under the Affordable Care Act, thus exposing consumers to thousands of dollars of cost not covered by their health insurance. It was a troubling pattern—impacting patients and their finances--that

was confirmed as aberrant in numerous conversations with others in the health care industry. We recognize that Prime has a different view of this but it seemed unusual behavior for a health system.

- Unusual patterns of unusual conditions.

Similarly, deeply-researched articles by California Watch found unusual patterns of unusual conditions diagnosed at Prime Healthcare, all of which were more lucrative than the more usual patterns of conditions or complications. This includes septicemia, and most infamously kwashiorkor, a rare form of malnutrition usually found only in some children in African famines. We have reviewed the data which we believe has appropriately prompted pending investigations by state and federal governments. While Prime will cite that no formal action has been taken by either the state or federal government with respect to fraud, we note that we have watched other fraud investigations of health care systems take years to unfold, so these media investigations are troubling.

- Collective bargaining agreements are legally binding agreements.

Collective bargaining agreements are legally binding agreements. Most of California's 450 hospitals have collective bargaining agreements. While labor disputes occur from time to time, most of the hospitals with collective bargaining agreements respect those agreements and act within labor law. Again, Prime has a troubling history of accusations of labor law violations.

- Failure to keep commitments made at the time of a transaction

Both here in California and in other states when Prime has committed to maintain services prior to a transaction, those commitments have not always been kept. While it is difficult for us to know the specifics of each situation, again the pattern is troubling.

- Potential impact on health system of a whole community

All together, these above practices as described are problematic in their own right, especially if they are allowed to extend to new hospitals in California, potentially impacting patients in those areas. But these practices by any one hospital would also have a community-wide impact, impacting patients, nearby providers, taxpayers and public programs. A provider that is new entrant to a community and that appears as Prime appears to behave can change the entire regional health system, as other plans and providers seek to react or compete.

Health Impact Analyses highlight additional needs

Health Access California has reviewed the Health Impact Analyses posted on December 24, 2014. We have had some prior experience in reviewing such analyses. We offer comments on these analyses.

First, in each instance, these hospitals are critical providers in their communities, albeit for somewhat different reasons. St. Francis and St. Vincent's in Los Angeles County are located in medically underserved areas with a high proportion of Medi-Cal (over a third) and of uninsured: these are precisely the kind of hospitals whose market role is being transformed by the expansion of coverage as a result of the Affordable Care Act. O'Connor is proximate to the hospital operated by Santa Clara County—and Santa Clara County both O'Connor and St. Louise enough to offer to buy them, the highest testament to the view of the County as to the need for these hospitals. St. Louise, Seton Daly City and Seton Coastside are not geographically proximate to other hospitals.

Second, we would urge that a network adequacy analysis, looking at geographic proximity standards under California law be completed, particularly for St. Francis, St. Louise, Seton Daly City and Seton Coastside. California law requires a hospital within 15 miles or *30 minutes* for commercial managed care and within 10 miles for Medi-Cal managed care. We think such an analysis will demonstrate that even the hospitals which are not in severely underserved areas are necessary in order for health plans to meet current law in terms of network adequacy. While the commercial plans seem unconcerned, we note that they were wrong, often very wrong, about the need for adequate networks for those newly covered through Covered California. The results of such a geographic adequacy analysis may lead to additional conditions.

Third, the Health Impact Analyses recommend that most services, charity care, community benefit, physician contracts, Medi-Cal managed care contracts and Medicare participation be in place for either five or ten years depending on the service and the facility. In all transactions, Health Access supports concrete, specific obligations to maintain services, charity care, community benefit, physician availability, Medi-Cal managed care contracts and Medicare participation. Our general preference is for the longer period though we recognize that the Health Impact Analyses differentiate based on the service and the community. We raise the additional concerns:

- In addition to maintaining Medi-Cal managed care contracts, another condition should be added to ensure adequate provider networks, particularly for Covered California.
- Distinct part nursing facility beds: these hospitals operate a significant number of skilled nursing beds which operate as a distinct part of the hospital. The Analyses treat these beds as interchangeable with skilled nursing facility beds on freestanding facilities: in our understanding of California's long term care services, this is not correct. Our understanding is that:

- DP/NFs have different (and higher) Medi-Cal reimbursement structure than freestanding nursing homes
    - Historically DP/NFs served somewhat higher acuity patients than freestanding skilled nursing facilities
    - Medi-Cal would not pay a higher rate unless the higher level of care was medically necessary.

  For these reasons, we ask that the Attorney General direct MDS to re-analyze its assumptions on nursing facility care to determine whether the DP/NF beds currently operated by the Daughters serve somewhat higher acuity long term care patients than free-standing facilities. If our understanding is correct that this is the case, we would then ask that the Health Impact Analyses be amended to reflect that these beds are not interchangeable with freestanding SNF beds and to determine whether these DP/NF beds should be subject to conditions similar to those for psychiatric or obstetrical units.

Fourth, Health Access affirms that there will be a continuing need for both charity care and community benefits. While the Affordable Care Act has transformed health coverage, particularly here in California, recent analyses indicate that 3-4 million Californians will remain uninsured, including over one million undocumented Californians. A robust and relatively recent literature on social determinants of health, recently reviewed by the National Quality Forum, indicates that health outcomes are correlated with income, occupation, race/ethnicity, non-English language and other variables that characterize the service areas of these hospitals. Being poor is bad for your health, so is being a person of color: maintaining community benefit programs at the current level (or even higher) is amply justified by an ample academic literature. The community benefit programs identified in the Analyses are among the sorts of community benefits aimed at addressing the social determinants of health.

Fifth, the Analyses require compliance with California law on seismic standards so that these hospitals are not closed as a result of failure to comply. While the Health Impact Analyses recommend that the buyer spend sufficiently to comply by the year 2019 with the seismic requirements through the year 2030, nowhere is there a discussion of compliance post-2030. Health Access is concerned about this transaction with respect to the provisions related to seismic compliance:

- Prime Healthcare has offered $150 million in capital improvements but Seton Medical Center alone has seismic needs that exceed that amount. This does not take into account other capital needs, such as for health IT.
- It does not seem financially prudent to impose conditions through the year 2025 only to have some of these hospitals closed in the year 2030 for failure to comply with the seismic standards that take effect in the year 2030. The year 2030 is now fifteen years away, within the planning horizon for major capital improvements. From what we can determine from the Analyses, some of these facilities face major capital costs to comply

with the post-2030 standards, far beyond the few hundred million contemplated by Prime Healthcare.

For these reasons, we ask that the Attorney General consider an additional condition to require Prime Healthcare to develop within the next five years a capital plan, with knowable benchmarks similar to those required by OSHPD, for compliance with the post-2030 standards.

Enforceable Commitment to Necessary Hospital Services

The conditional and limited commitment by Prime Healthcare to the communities and the State of California which granted the charitable trusts of these five hospitals is not sufficient to protect the interests of the communities these hospitals serve. Whether it is labor and delivery at St. Louise, organ transplants at St. Vincent's, trauma care and neonatal intensive care at St. Francis, stroke care at O'Connor or cardiovascular at Seton, Prime has not committed to maintain any of these services. Prime Healthcare has committed only to operate five general acute care hospitals offering the most basic of basic hospital services and to offer emergency services—and only "*subject to physician availability, the needs of the community, and financial viability*", all of which are purely within the control of Prime Healthcare pursuant to the Definitive Agreement.

Health Access is opposed to the approval of this transaction as detailed because Prime Healthcare has not committed to preserve the healthcare services that these hospitals currently provide to the communities they serve. Health Access is opposed to this transaction in the absence of clear and enforceable commitment to protect and preserve patient health, patient finances, taxpayers, public program integrity, and the health system of each community. Health Access is opposed to approval of this transaction because it is not clear that the valuation has taken into account the transformation of the healthcare system underway as a result of the Affordable Care Act.

For these reasons, Health Access respectfully requests that the Attorney General reject this proposed transaction.

Thank you for your consideration. Please contact us with any questions.

Sincerely,

Anthony Wright
Executive Director