In the Matter Of:

LIFESPAN/CARE NEW ENGLAND HEALTHCARE

PUBLIC MEETING

January 26, 2022

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RHODE ISLAND OFFICE OF THE ATTORNEY GENERAL AND
RHODE ISLAND DEPARTMENT OF HEALTH

PUBLIC MEETING

NOTICE OF APPLICATION

HOSPITAL CONVERSIONS ACT INITIAL APPLICATION OF RHODE ISLAND ACADEMIC HEALTH CARE SYSTEM, INC., CARE NEW ENGLAND HEALTH SYSTEM ("CNE"), KENT COUNTY MEMORIAL HOSPITAL, WOMEN & INFANTS HOSPITAL OF RHODE ISLAND, BUTLER HOSPITAL, LIFESPAN CORPORATION ("LIFESPAN"), RHODE ISLAND HOSPITAL, THE MIRIAM HOSPITAL, NEWPORT HOSPITAL, AND EMMA PENDLETON BRADLEY HOSPITAL (COLLECTIVELY, THE "TRANSACTING PARTIES")

DATE: JANUARY 26, 2022
TIME: 3:00 P.M.
PLACE: ZOOM CONFERENCE

Casey A. Bernacchio, CSR

(RECORDED MEETING COMMENCED AT 3:01 P.M.)

MS. WEIZENBAUM: Good afternoon, everyone. It's a little bit past 3:00, so I think we're ready to start. It looks like we have a full slate of people in attendance.

This is a joint public informational meeting of the Office of the Attorney General and the Rhode Island Department of Health regarding a proposed hospital conversion.

My name's Miriam Weizenbaum, and I'm chief of the civil division for the Office of the Attorney General here in Rhode Island, and I'd like to first welcome everybody who's here and thank you for taking the time to participate in this very important public meeting.

Both the Department of Attorney General and the Department of Health are responsible for reviewing the proposed transaction and either approving it, approving it with conditions, or not approving.

The transaction or conversion as proposed would place a non-profit Rhode Island parent corporation over both Care New England and Lifespan. And after that, until a system CEO is chosen, the current Care New England Lifespan CEOs

would serve as interim co-CEOs during a planning and integration process.

Lifespan and Care New England's joint application seeking approval was deemed complete on November 16th and made public on December 30th and is posted at the website of the Rhode Island attorney general.

Here from the attorney general's office is Attorney General Peter Neronha; the attorney general's insurance advocate, Maria Lenz; and members of our reviewing team.

This afternoon we will initially be hearing from the attorney general and then from the director of the Department of Health, Dr. Alexander-Scott, and associate director, Sandra Powell. This will be followed by a description of the format that we'll be following for this meeting, and then public comments.

Again, I would like to thank everybody for participating. And I'll turn it over to Attorney General Peter Neronha.

MR. NERONHA: Thank you, Miriam. Thank you for that concise setup of why we're here today.

You know, this has been a long-term process now. I'm grateful for the work of our team

here and our partners at the Department of Health really getting into what this proposed merger's all about and weighing what's in the best interest of Rhode Islanders.

Part of that process is to be informed by the public, and that's why we're here today. And I'm anxious to hear everyone's comments, and I'm grateful to all of you who are going to share them with us for doing so. Thank you.

MS. POWELL: Just checking to see if Dr. Alexander-Scott is here. She was joined.

DR. ALEXANDER-SCOTT: I'm here. I'm just looking to unmute in a different place.

But can you all hear me? Excellent.

Thank you for being with us today.

Is there an echo? It's just in my ear.

So I also want to thank Attorney General Neronha and all the members of the AG's team who are with us, and the RIDOH team today.

As he just stated, these public meetings are such an important part of our review of health system and health facility applications. Our whole public health philosophy at the Rhode Island Department of Health, as you know, is about centering the voice of the community, ensuring that

the community's voice is a part of every major conversation. In this conversation on this application, the community's voice is especially critical.

There are several criteria we are called on to consider as a part of reviewing this process, and, in essence, our charge is to ensure that any health system changes will make it so that Rhode Islanders have access to care that is safe, accessible, and affordable. We cannot take determinations on any of those counts without hearing about your experiences and your needs.

To get more specific, the review we are doing is under the State's Hospital Conversions Act. It calls on RIDOH to issue a decision on the application that is a decision to approve, to disapprove, or to approve with conditions of approval. The comments that you share today will be entered into the public record and will be reviewed closely as we work on our decision.

There is a big talented team at RIDOH who will be managing the review at RIDOH, along with department leadership. They include Sandra Powell, the associate director for the Division of Policy Information, and Communications, and who will

continue to stand in on my behalf through the course of our session today. Thank you.

Also includes Michael Dexter, the assistant director for the Center for Health Systems Policy and Regulations at RIDOH; Fernanda Lopes, the chief of our Office of Health Systems Development; Jacqui Kelley and Bruce Tedesco from our legal team; and a group of consultants we have engaged to support the team.

So thank you for joining.

And with that, I will pass it to Sandra, who will say a few words.

MS. POWELL: Certainly, Director. I'll be quite brief.

I just want to also offer my thanks to everyone who was here today. Attorney General Neronha and his time are invaluable colleagues, as the director has indicated.

Fernanda Lopes is going to give you some of the specifics relative to how people can provide comment. And with that, we will turn it over to the meeting. Thank you.

MS. LOPES: Thank you, and welcome all. My name is Fernanda Lopes, and I serve as the chief of the Office of Health Systems Development at the

Rhode Island Department of Health.

I'd like to review the framework around the administrative and procedural processes that will be undertaken during today's meeting.

First, I'd like to note that this meeting is being recorded and will be posted on the attorney general and RIDOH's websites.

We also have with us a stenographer, so we hope to establish an audio recording and a transcript of this meeting for the record.

We have a large number in attendance today. As you know, this meeting is being run virtually, and in order for it to be conducted in an organized and orderly manner, I'm requesting that everyone please remain on mute until it is your turn to provide comments. Muting will help avoid any feedback and allow us all to hear those speaking one at a time. I really appreciate your flexibility in this virtual environment.

As the link posted in the public notice for this joint public meeting is a live link, if you haven't already done so and are interested in providing comments during today's meeting, please sign up. Participants will be called on to provide their public comments according to that active

list. It's important that person speaking during the course of today's meeting identify themselves by name, affiliation, if any, and please spell it for the stenographer so that the record is clear.

Please refrain from posting reactions or engaging in chats on Zoom.

Finally, each participant in this meeting will have up to six minutes to speak. I ask that comments provided by those speaking today please be pointed, succinct, and concise so that we have an opportunity to hear from all who have public comments to share.

If you have already submitted written comments, please be advised that those are already part of the record and do not need to be repeated here today. Written comments will continue to be accepted through February 11, 2022, in place of or should you want to supplement your verbal comments today.

We're here to listen to public comments regarding the Care New England/Lifespan Hospital Conversions Act application currently under review by both agencies. All verbal and written comments will be considered by our agencies.

And with all of that said, I will call

upon Attorney Rocha to introduce Applicant representatives for some brief comments. Thank you.

MS. ROCHA: Thank you, Fernanda.

General Neronha and Dr. Alexander-Scott, again, thank you for hosting this public informational meeting.

On behalf of transacting parties, let me introduce the folks you'll hear from this afternoon.

First, Dr. James Fanale, Care New England's president and chief executive officer; Dr. Timothy Babineau, Lifespan's president and chief executive officer; and President Christina Paxson from Brown University.

So let me turn it over to Dr. Fanale.

DR. FANALE: Thanks very much, Pat.

So I want to be brief tonight. Thanks to the attorney general and to RIDOH staff and leadership for hosting these events, and I thank you very much for all the work you've done through review of the application.

In introducing at the earlier meeting on the 20th, I emphasized our commitment to quality, service, access, equity, and costs, and we continue

to pledge that. And since that's in the public record, I won't go on in detail. I won't belabor you with this again, as we were clear about that earlier in the week.

However, I hope that we all see the value that this new entity will create. It is the right time to do this, and I will pledge it will work with all parties, if it is approved, to deliver on our promises.

So with that, a very brief statement to open, I'll turn it over to Dr. Timothy Babineau.

DR. BABINEAU: Great. Thanks, Dr. Fanale.

Good evening, everybody. I would like to echo my appreciation for the work that the attorney general's office and the Department of Health has put in and will put in to examine this very important merger. I also want to thank everybody for coming out tonight. We appreciate your time. We know how busy everybody is. But hearing from the public is absolutely critical to getting this across the finish line. I, too, will be mercifully brief.

I know many of you who were on the first call are on the call tonight, and I'll just echo what I said on that call, and that's to speak to

you more as a physician than as a CEO.

And as a physician, like Dr. Fanale, who has cared for patients my entire career -- and I know I speak for Dr. Fanale -- this is absolutely in the best interest of patients. I've spent my whole life taking care of patients. Dr. Fanale has spent his whole life taking care of patients. And my ethics as a physician would not allow me to advocate for this merger if I did not think it was in the best interest of patients. It absolutely is. I said that on the first meeting. I thought it was worth repeating.

I'll just close by saying in the first meeting we heard from some doctors about the clinical programs. We're going to shift gears a little bit tonight and focus on an equally important topic, which is the new combined entity's commitment to diversity, equity, and inclusion.

As Dr. Fanale said, this is top and paramount to what the new entity is committed to doing to accelerating our efforts in the social determinants health and in the DEI space.

And a little bit later, I hope you'll hear from Carrie Bridges Feliz who leads Lifespan's Community Health Institute.

With that, I'll close, turn it over to President Paxson. And, again, thank you very much for coming out tonight. Thank you.

MS. PAXON: Thank you very much. I'm Christina Paxson. I'm president of Brown University. And I also will not repeat all the comments that I did at the last public hearing but emphasize something that I think is important.

You know, Dr. Babineau spoke to you as a physician. I'm an economist, not a physician, but Brown does have the only medical school in the state, and 60 percent of the physicians in Rhode Island are affiliated with the Warren Alpert Medical School.

I talk to my physicians. They are our faculty. They are our doctors. And for the last 10 years, since I've come to Brown, I have heard over and over and over again that while they're fantastic doctors, they feel like they could do their jobs better, they could provide better care, more integrated care, they could do better for the citizens of Rhode Island if they weren't in a bifurcated system.

Right now I think we have two subscale but complementary health systems, and they just aren't

set up to provide the best possible 21st century care.

You know, again, you can look at the members. You can assess quality. I take a lot of -- I put a lot of value in what I hear from the doctors who work in this state who are -- you know, the ones I talk to, and there are a lot of them -- are very, very much in support of this merger and think it will improve the quality of care for Rhode Islanders. Thank you.

MS. POWELL: So before we begin the formal calling of members of the public, I just wanted to take one opportunity, which I neglected earlier, to point out that, as many of us know, this is going to be Dr. Alexander-Scott's last opportunity to formally participate with us during this so critical and important review. And I know I say this on behalf of all my colleagues at RIDOH and many in the community, that we just say thank you, Dr. Alexander-Scott, for your tenacity, your commitment, your pushing all of us all the time to think more broadly than we might otherwise, and I just wanted to say thank you on behalf of all of us and all of the team. Thank you.

MS. LOPES: Thank you.

So as a reminder, please limit your comments to less than six minutes.

And I will go ahead and call upon the first person to speak, which is Javier Lozada.

MR. LOZADA: Hi. Hello. Can you hear me?

MS. LOPES: Yes, we can.

MR. LOZADA: Hi. I just had wanted to say first, in the spirit of full disclosure, I am a former Lifespan employee, having worked for Lifespan from 2011 to 2019. My name is spelled J-a-v-i-e-r. Last name is Lozada, L-o-z-a-d-a. And also I currently do work for Care New England intermittently since 2007.

I just wanted to speak to the negative impacts I believe this merger would have.

Most of the concern is with keeping care here. You know, people are going to Boston, people are going to New York anyway. A recent New York Times analysis in 2018 concluded that hospital mergers banished competition, raised prices for hospital additions, and the average price of hospital stays increased anywhere between 11 and 54 percent.

Prices rise more steeply when hospital systems buy doctors groups, as Lifespan has done

with Coastal Medical. You know, a combined Lifespan and Care New England -- let's say if there's a reimbursement dispute between Lifespan, Care New England, and Blue Cross Blue Shield or United or Tufts, could leave the patients uninsured in the interim or paying out of pocket for services rendered to them in the interim.

Lower reimbursement rates as well as from CMMS can lead to higher costs for commercial insurance statewide. And what I mean by that is if Medicaid or Medicare is reimbursing the hospitals as a set rate, a combined Lifespan/Care New England could then say to other commercial employers or folks who subscribe to the private insurance companies at a lower rate, you know, We'll have to increase your rates to make up for what a combined Lifespan/Care New England would charge us.

That would be devastating to some small businesses. Other businesses would probably not be able to offer health care to their employees. Not only small businesses, but medium-sized businesses as well.

In my estimation, this is not about patient care. This is more about branding and money. And, again, it's not about the patients.

And these higher prices that will come will not lead to better care. Competition is good, alternatives are good. A merger of these two systems is not good.

Thank you. I yield the balance of my time. Thank you.

MS. LOPES: Thank you.

Dr. Aidan Petrie?

MR. PETRIE: Thank you for that. And for clarity, I am not a doctor. I'm far from it.

So my name is Aidan Petrie, A-i-d-a-n P-e-t-r-i-e. I am the -- one of the managing Partners of the New England Medical Innovation Center and a -- the -- formally the chief innovation officer at a company called Synetica and have been working in the health care field, mostly on the product side, for a long time.

To tell you a little bit about what NEMIC does, New England Medical Innovation Center does, is we were helped, with a number of people that I can see here, set up a nonprofit with a focus of helping folk innovate in the health care field. And the Rhode Island Foundation, Commerce Rhode Island, Lifespan, Department of Labor & Training helped set us up.

We work with a -- the sort of work we do is largely education, networking, leading to funding, preparation for funding, making sure that companies know what they've got to do, and that exposes us, in turn, to a lot of different aspects of the medical field.

The folk we work with typically are -- they're out of universities. Brown, we're working right now with about five people out of professors, undergrads, PhDs. We're working with people at head of the engineering department at URI and about three, four PhDs out of there.

We also give lectures up at Harvard on medical device development, MIT, et cetera. So we're sort of a regional incubator. Call it a venture studio.

We work with a lot of folk out of Lifespan who are in various labs or in the surgical departments and so forth and do work with companies overseas and help them bring technologies and innovations to -- hopefully to this state -- we try and make this state as appealing as it can be -- with a combination of knowledge, network, and funding.

I think, importantly, we've also focused

heavily in the last year on some of the communities that are less well served in Rhode Island. So we've been setting up vaccine clinics in Central Falls and helping a pharmacy out of Wiggin Village to expand. We're working with some homeless folk who are looking to transition out of the homeless situation into -- into affordable housing and so forth.

And individuals out of high school. One of our favorite individuals right now is at the Met School, and he's come up with a legitimate innovation in a particular area, and we've had him file a patent and so forth.

I have a perspective -- over the years, leaving the sort of professional world, I also led a group at The Miriam Hospital looking at the wise and wherefores of wrong site surgery and was -- and did a -- more than a year, maybe a couple of years, at Kent Hospital, hired by the CEO there, to look at why untoward things happened in their emergency department.

And as part of that, there is a view of a highly fragmented industry filled with really good, really well-meaning, and really smart people who everybody -- I -- we never ever saw anybody in

situations who didn't want to do their best, but the situation was not set up for them to succeed.

And so when I think of this -- I'm going to call it a merger. You used a different word -- but this merger, I think that it can only benefit the health care indus- -- the health care in Rhode Island if we have a larger system that is well integrated, well informed, well managed appropriately with appropriate controls, we should be able to provide better health outcomes, we should be able to control costs, we should be able to improve the experience of health, and we should be able to lower physician and nurse burnout within that system.

And I just think that the basic construct of a larger organization properly managed will be beneficial -- significantly beneficial to the state, and -- I could -- I can talk forever, but that's my personal view right now.

MS. LOPES: Thank you. And I apologize for calling you doctor. I had that on my list. I apologize.

MR. PETRIE: I will get over it, but I was chuffed for a moment.

MS. LOPES: Gregory Allen, please.

MR. ALLEN: Can you hear me okay?

MS. LOPES: Yes.

DR. ALLEN: Thank you. Thank you very much.

My name is Gregory Allen. I'm a primary care physician in East Greenwich, Rhode Island. I speak on behalf of the Rhode Island Society of Osteopathic Physicians & Surgeons. I currently serve as their president. Our organization has concerns about the proposed merger between Care New England and Lifespan.

I'd like to bring attention to another aspect of these implications, which probably hasn't been discussed so far. It's the impact on the osteopathic medical community and their ability to provide quality care and medical education to my fellow Rhode Islanders.

What is an osteopathic physician one may ask. Some may not understand the distinction between osteopathic physicians, or DOs, and allopathic physicians, MDs, and their similarities.

Osteopathic medicine was founded in patient-centered holistic care since its inception over 150 years ago, way before these terms came into vogue in recent years.

Osteopathic physicians comprise approximately 8 percent of the total active physicians in Rhode Island and approximately 10 percent of its primary care providers.

In the late 1960s, osteopathic training and education was formally recognized by most states and the U.S. military as equal to allopathic training and education, including the NBOME, National Board of Osteopathic Medical Examiners.

By 1970, osteopathic medical students, like me, were recognized as equal and allowed to attend allopathic residencies and sit for allopathic boards. This determination was made over the objections of the entrenched traditional medical establishment at the time. And osteopathic physicians have successfully defended attempts at discriminatory practices over the years.

When I finished medical school, there was no local option for an osteopathic student with family obligations to attend an osteopathic residency here in Rhode Island. I instead accepted an offer to attend Boston University's training program at Roger Williams Medical Center in Providence. I completed my training and established my practice here. This meant I could

sit for allopathic board certification, referred to as ABIM, which I thankfully attained.

In most places, including virtually every major medical institution in the country, places like Harvard-affiliated Mass General, Yale New Haven, Johns Hopkins, Dartmouth, Tufts, the Mayo Clinic, it would not make a difference which program I attended. They all have adopted pathways for equal footing for osteopathically trained physicians to be credentialed to practice at their hospitals alongside their allopathic colleagues with commensurate training, yet two facilities right here in Rhode Island, the Rhode Island Hospital and Miriam Hospital, cling to the archaic and discriminatory policy of not recognizing this equality.

They instead keep a separate pathway for osteopathically trained doctors that obstructs their path. Even as the national accrediting agencies from both the allopathic and osteopathic training programs are literally merging, they refuse to acknowledge this truth.

Yes, even a hospital like The Miriam, founded on the very premise of inclusivity, continues to ignore national standards and exclude

physicians who are trained in osteopathic residencies and fellowships. No other hospitals in our state, or even the Greater New England area, that we could find can lay claim to such an outdated and discriminatory policy.

Why is this important to point out? Because osteopathic physicians enter primary care at a higher rate than their allopathic counterparts. We need primary care physicians in Rhode Island. Approximately one-third of our local physicians are greater than or equal to 60 years old. National stats show that 28 percent of health care leaders report that a physician has unexpectedly retired from their organization in the last year. This is not a problem for the future. It's a problem for right now.

I've read the claim that the proposed merger to include Brown University will hopefully, quote/unquote, entice medical trainees to stay in Rhode Island.

The University of New England College of Osteopathic Medicine, established in 1978, the same year as Brown's medical school, has welcomed students from Rhode Island and other New England states. I'm happy to tell you that currently

eighteen Rhode Island residents are enrolled in their first year of class at their campus in Biddeford, Maine. Mind you, these are not students who, by virtue of their attendance at an undergraduate program at the college, magically become Rhode Island residents over the course of their studies. We're talking about people, like me and colleagues, who grew up here and returned to Rhode Island to practice medicine at a very high rate. University of New England College of Osteopathic Medicine fosters local relationships, and Rhode Island is better off today because of it.

Two teaching hospitals in the state have former rotations for osteopathic students from UNECOM in their third year of medical school: Roger Williams Medical Center and Kent County Hospital.

Further, the program at Kent, which has received formal osteopathic recognition for their family medicine residency has been a wildly popular training destination for our native sons and daughters to establish themselves in their home state. Students from UNECOM sign up for the opportunity to train in Rhode Island year end and year out at three times the current capacity.

Lifespan and Brown have literally blocked osteopathic students from rotations at their hospitals despite local physicians wanting to mentor them.

Brown University, set to invest significant revenue as part of the proposed merger, will most certainly seek to take over any and all of the coveted training spots currently occupied by osteopathic students and residents within the Care New England system. This would preclude the opportunity for local training of osteopathic doctors and ultimately be a great loss.

In summary, the Rhode Island Society of Osteopathic Physicians & Surgeons ask that you carefully weigh the establishment of such a large entity in our small state. If it should be approved, we would respectfully ask that you consider measures to, A, ensure that the credentialing process for all hospitals within the new system enter the 21st century and include equal acknowledgment of ABOME, or osteopathic board certification, and ABIM, just as the Rhode Island Board of Medical Licensure and every state in the country does; and, B, to ensure that the current training slots allocated for osteopathic students

and residents in the Kent County Hospital training program, affiliated with University of New England College of Osteopathic Medicine, remain intact.

I thank you for your attention and the ability to address this important issue. I remain available to answer any questions. Thank you.

MS. LOPES: Thank you.

Brenda Clement?

MS. CLEMENT: Good afternoon. Thank you for the opportunity.

Can you hear me?

MS. LOPES: Yes.

MS. CLEMENT: Thank you, again, for the opportunity to speak. My name is Brenda Clement, C-l-e-m-e-n-t, and I'm director of HousingWorks Rhode Island, which is a research and policy organization that looks at the connectedness between housing in both economic growth but also improved health and economic outcome.

So I'm here to say -- to remind us all of an obvious fact that we know, that zip code matters. We knew that well before the pandemic. And the great work that Dr. Scott and our colleagues of Department of Health have been doing through HEZ work and other community-based

initiatives have tried to engage communities more in this work, but we know that health outcomes and educational attainment and achievement matter depending on where you live.

And so it is critically important as we contemplate a merger of any scale in this state that we keep these factors in mind and that we look carefully at social determinants of health and preventive medicine strategies and any merged entity that may come out of this.

Again, all of -- both hospital systems have been working in this space a while in different ways, but it's also going to be critical as -- if a merger moves forward that we do this in a better and bigger scale and realize that these upstream investments will not only improve health outcomes for patients, but also improve -- and hopefully reduce costs as well, too, but will all improve our neighborhoods and communities.

I also think it's important not only for the merged entity to do this to take care of patients, but also to take care of their employees and to realize that this investment is an investment in retaining -- recruiting and retaining good employees. And it's employees at all income

levels within hospital systems and delivery systems.

Unfortunately, at least in the housing space, many workers who we consider critical workers, the people who have taken care -- take care of our sickest patients in hospitals and clean the hospital rooms and serve food in the dining rooms and other things are the people who struggle most to keep a roof over their family's heads as well too.

In some written testimony that we'll submit, we'll share some examples of other hospital systems who have done some creative investments in their communities into social determinants and housing as well too.

But we think it's critical that the Department of Health and the attorney general continue to build on the good work that the individual entities have done if there's any merged entity and make strong, clear requirements for this investment moving forward. Not only requirements to do it, but a strong oversight system to make sure that it gets done as well too. And an oversight board and committee that engages community representatives is also going to be

critical as we move forward.

Zip code does matter, and our goal, certainly as HousingWorks and with many of our other housing advocates, is to make sure that all of the zip codes in Rhode Island have the same access, not only to good housing and safe housing and health care, but also educational opportunities.

We can use this -- this can either be a good time or a bad time to work towards that goal, which I hope is a shared goal. And as I said in written testimony, we'll submit some more examples about -- about this work.

But thank you again for the opportunity to raise this issue, and always happy to work with both Department of Health and attorney general with more specific guidance. Thanks again.

MS. LOPES: Thank you.

Al Charbonneau?

MR. CHARBONNEAU: Unmute.

Hi. My name's Al Charbonneau. I'm the executive director of the Rhode Island Business Group on Health. My last name is spelled C-h-a-r-b-o-n-n-e-a-u.

In another world, I spent 35 years working

as a hospital CEO. I want to begin my comments by saying, during that period, we never faced anything quite like the pandemic, so my heart and I guess my best wishes and sensibilities go out to the hospitals for the great work they're doing.

Having said that, I want to make certain that people understand that my comments will be about affordability and strengthening hospitals by changes in payment reform.

So while forming the goal -- or while the goal of forming an academic medical center is very desirable -- in fact, if I were working at one of those entities or at the medical school, I would be pushing for the same thing -- we must remain focused on the outcomes of this review, should it be approved, which is a formation of what arguably will be the most highly consolidated hospital market in the country.

The question is why is that significant and/or important, and the answer is pretty clear. People have said it before. Research on hospital consolidation clearly demonstrates that it raises costs, at best provides mixed results on quality, and academic medical centers are probably the most expensive hospitals in the country.

We should be mindful of the following: Lifespan and Care New England were formed as hospital systems in 1994 and 1996, respectively, to address the same goals, that is, raising quality and lowering costs. Forming an academic medical center creates an even more complicated hospital organization, which will attempt to address the same goals: Raising quality and lowering costs.

We should also remember that hospitals are often called or noted as the battleships that are difficult to turn, so I find it quizzical that we think of hospitals as an agent of change rather than agents that need to change.

There is significant -- there is -- it is significant that we pay attention to the data according to the National Insurance -- National Association of Insurance Commissioners and the Medical Expenditure Panel Survey. Hospital costs are the largest medical expense paid by large and small group commercial premiums here in the state. Hospital costs represent approximately 45 to 50 percent. Pharmaceuticals are approximately 18. Specialty physicians are 24 percent.

In 2020, family premiums, plus deductible, for Rhode Island indicated that we are the twelfth

most expensive state in the country. In 2020, family premiums paid by employers represented 29 percent of median family income.

In the last 10 years, large and small group commercial subscribers in the state of Rhode Island have declined by approximately 39 percent and 44 percent, respectively.

Most people think that the cost of care has something to do with the loss of subscribers. It is significant because the data reflecting expenses for all Rhode Island hospitals -- I'm not saying Rhode Island Hospital -- but a composite of all hospitals in the state of Rhode Island showed that between 1997 and 2019 hospital expenses increased approximately $2.3 billion. Hospital overhead expenses, otherwise known as "general service expenses," amounted to approximately 57 percent or -- of the 2.3 billion.

Rhode Island's overhead in non-reimbursable expenses, expressed as a percent of total expenses, is the third highest percentage in the nation. Massachusetts and Alaska are ranked first and second. Most understand what goes on in Alaska is due to the geographical situation there. And Massachusetts has been boiling with respect to

hospital costs just in the last few days.

Rhode Island's overhead per capita -- hospital overhead per capita is the fifth highest in the nation.

The reason why I cite these -- these -- the three reasons why I cite these data are as follows: The data identify hospitals as a major source of increasing commercial health insurance premiums, which means we should be extremely careful pulling the trigger on another merger, particularly in a fee-for-service environment.

The data also suggests that the payment system is not working for hospitals. When you look in 1997, for every dollar charged as recorded by the hospitals, they gained .61, 61 cents, in income. In 2019, once again, as reported by the hospitals, for every dollar charged they gained .31 cents of income.

Changing the payment system may make -- may actually be enabling for all of the ideas that we're currently examining within this process, because it would make a difference with respect to how hospitals run themselves, how they manage their costs.

The Rhode Island Office of the Health

Insurance Commissioner has convened a group looking at alternative payment models that would move the state away from fee-for-service payment, which would strengthen hospitals and make commercial health insurance affordable.

Thank you for your time.

MS. LOPES: Thank you.

Karen Malcolm?

MS. MALCOLM: Thank you. I apologize. I was having technical difficulties.

My name is Karen Malcolm. Last name spelled M-a-l-c-o-l-m. I'm the coordinator of the Protect Our Healthcare Coalition, which is a group of leading Rhode Island non-profits and consumer groups that share a goal to protect and remote quality affordable health care for all.

Since filing their application, and including at these public meetings, the existing leadership at Lifespan and Care New England has made many promises that the merger will address fundamental flaws that are existing in our current health care system, but the results of similar mergers in other states don't support their claims, as we've heard from other people speaking this evening. So I won't highlight all of the research

that's been done in that regard.

The people of Rhode Island deserve a health care system that prioritizes high-quality accessible care to all who need it, regardless of their ability to pay, that provides family sustaining jobs, improves public health outcomes, and that contributes to the economic well-being of the State. We have significant failings in our current system, and we need more than just the trust-in-us assurances that system leaders put forward.

That's why we believe that this merger should not be approved without very strict terms and conditions, such as, first, there must be a requirement for diverse representation on the newly merged system, if approved, governance board. The outcomes of the merger will actually be determined by who gets a seat at that decision-making table, and community, patient, and worker representation on the governance board is absolutely vital as decisions on population health, services, the scope of services, community investments, equitable access and mechanisms for access, as well as workforce provisions are being made.

At a minimum, we recommend that the

attorney general and the Department of Health impose a strict requirement that a community advisory committee be established with paid staff paid for by the newly merged system, and that that committee have designated seats on the governing board to which they appoint their own representatives.

That community advisory committee must absolutely include a diversity of Rhode Islanders based on geography, race, ethnicity, health topic areas, housing, food access. All of those issues must be represented on that committee.

Second, we believe conditions should be imposed that ensure affordable access to quality care. And Al Charbonneau just talked about OHIC's significant work in this regard. I would point to a paper they just published yesterday on payment models that would maximize affordability and quality. There are recommendations in that that should be a part of any terms and conditions if approval goes forward, and also the recommendations that were already outlined in the Rhode Island Foundation's report that's been submitted to you as the regulators.

Additionally, there should be requirements

on community investments that are tied specifically to population health and that target existing disparities. The fact is that people with underlying health conditions and those subject particularly to food and housing and security are at greater risk of severe illness not just from COVID, but from diabetes, heart disease, infant mortality, and other significant conditions. All of this takes a heavier toll on low income residents and people of color, and, again, expose the existing failings in our system that need to be fixed regardless of the merger.

We absolutely must, as I said, regardless of the merger, put more emphasis on population health, at least as much as on individual treatment, and we believe that there is opportunity, if the merger is to go forward, for the attorney general and the Department of Health to impose terms and conditions that really move us forward as a state.

And finally we know that this cannot be addressed by -- in this current process, but we feel it's absolutely necessary to highlight and remind people about the current lack of a robust State oversight system for our health care delivery

system.

The proposed merger would create a monopoly, a monopolized hospital market with enormous influence. Statutorily, under the terms and conditions of the Hospital Conversion Act, the attorney general and Department of Health are limited to only five years of oversight to oversee the merger in its initial phase. That isn't enough. The fact that we lack a permanent robust mechanism to oversee such a large system is a problem that we think should be considered when evaluating the application.

All of this said, thank you for the time. We appreciate the opportunity to provide comment, and have much more detail that we'll be providing in written comments. Thank you.

MS. LOPES: Thank you.

Is Matt Gunnip available?

MS. LENZ: Fern, there are several people on the phone who are identified, so I have allowed those on the phone to unmute themselves.

So if Mr. Gunnip is on the phone, please unmute to give your comment.

MS. LOPES: I can circle back.

We can go to Zakary Pereira, please.

MR. PEREIRA: Can everybody hear me?

MS. LOPES: Yes.

MR. PEREIRA: Okay. Great. Thank you.

So, hello. Good afternoon, everybody. Thank you all for being here today, and thank you to Attorney General Neronha and Dr. Alexander-Scott for hosting this hearing. I really appreciate the opportunity to speak on the Lifespan/Care New England merger.

My name is Zakary Pereira. It's Z-a-k-a-r-y P-e-r-e-i-r-a. And I am a Rhode Islander, a 27-year-old, just trying to navigate my way through our complex health care system, and I'm a candidate for office where I live in Warwick.

I am speaking here today on my own behalf, but I do know many people in my community in Warwick and around our state who agree with me, that this Lifespan/Care New England monopoly is not in the best interest of the Rhode Island public, and that Attorney General Neronha should reject the application.

Like many of the people who have already testified, I, too, have tried to navigate my way through our health care system. I'm a proud and openly gay man, and it took me a while to find a

primary care doctor -- a DO, in fact -- that I trusted to take my needs and medical concerns seriously. So thank you to Gregory Allen for highlighting the importance of DOs in our health care system.

Choice is an essential part of health care: Choice in doctors, choice in hospitals, choice in care. I for one enjoy having choice and the option to choose a primary care doctor that I think is independent and one that will look out for my best interests. Mergers like this have resulted in less and less of those independent physicians in the marketplace.

This merger, if approved, will, as we know, create a health care conglomerate that controls about 80 percent of the hospital services in this state. Monopolies like this, as we've all mentioned and the data shows, have been shown to increase costs for patients and depress wages for medical staff.

Like others, I have serious doubts and concerns about the merger, the unaccountable conglomerate it will create, and the lack of choice that it will provide for patients in Rhode Island.

This merger affects us here in Warwick.

Our local Kent Hospital is a part of it and would likely have to raise their prices, because, as we know, by removing competition from the marketplace, there's very little incentive for conglomerates like this and monopolies like this to keep costs low and provide competitive wages.

So we know the merger is under review by the FTC, but it's really the people of Rhode Island who's going to be affected by this the most, not people in D.C. So I think Rhode Islanders need to take this seriously.

So with Dr. Nicole Alexander-Scott leaving -- and thank you so much for your service, Dr. Alexander-Scott -- Attorney General Neronha, you -- it falls on you. You have before you a choice to reject, approve, or approve with conditions the Lifespan/Care New England merger.

For many stakeholders who have already outlined how this merger will affect them, as a resident of Rhode Island and somebody who has tried to make their way through our health care system in RI, I'm heavily urging you to reject this deal because it will create a monopoly, it will increase costs, and it will drive down wages for our health care staff, which -- all of which are not in the

best interest of Rhode Islanders. So, please, I urge you to please reject this merger.

Thank you so much for your time and your consideration.

MS. LOPES: Thank you.

Annette Bourbonniere?

MS. BOURBONNIERE: Good afternoon. Thank you, Attorney General Peter Neronha and Dr. Alexander-Scott, for hosting this. We're going to miss you, Dr. Alexander-Scott. I think you've done a great job. That's an aside.

I am president of the board of -- oh, I should spell my name; right? Annette Bourbonniere. A-n-n-e-t-t-e, and my last name is B-o-u-r-b-o-n-n-i-e-r-e.

So I am president of the board of Accessible Healthcare Rhode Island, which is a Rhode Island incorporated non-profit organization, and our focus is on improving accessibility of health care. And we're not talking just financial access. We have the forgotten minority here in Rhode Island. This is people with disabilities.

So according to the CDC, 26 percent of Americans have at least one disability, making us essentially the largest minority in the U.S.;

however, our health care disparities are significant. When we talk about access, we're often talking about physical access to health care.

According to a recently published study, more than 80 percent of surveyed physicians perceive the quality of lives of disabled persons to be worse than average, and that colors their willingness to provide the care that we actually need. This perception can only lead to further health care disparities for the population.

The Americans with Disabilities Act was signed into law in 1990, which is 32 years ago, and it prohibits discrimination towards individuals with disabilities.

So the concern that we have at Accessible Healthcare Rhode Island is that an organization that will control 80 percent of the health care in Rhode Island has not ever taken this into account.

Significantly, there were no representatives of the disability community involved in any of the planning or studying of this merger, and history has shown repeatedly that excluding persons with disabilities results in so-called solutions that represent perceptions of disability by those who are not yet disabled. And

as we've already discussed, the perceptions are pretty bad.

Sadly, none of the three organizations involved in this proposed merger have a history of significant compliance with the ADA. None of these organizations have considered compliance, or even this population, a priority. If you want to control 80 percent of the health care in Rhode Island, you need to be willing to address this need. We are here. We need these services.

Accessible Healthcare Rhode Island wants to make recommendations that have to address -- have to be addressed before any such merger is approved. All hospitals involved in this merger should install ceiling lifts in the diagnostic areas for the safe transfer of patients with disabilities. Dropping patients or having patients not being able to get onto equipment because of discrepancies in height is not an accessible -- is not accessible and is not acceptable.

A comprehensive plan for accessibility for all persons with disabilities for the three organizations should be submitted and approved. This plan needs to ensure adequate accessible parking, exam tables, scales -- imagine people who

go through entire pregnancies without ever being weighed once because there's not a scale available for someone in a wheelchair -- diagnostic equipment, ASL interpreters, adaptive communication who are blind, visually impaired, or otherwise cannot read. In other words, the plan should provide for compliance with all aspects of the Americans with Disabilities Act.

There should also be a plan for ongoing cultural competency training for providing health care to disabled individuals. Such training should be provided to all health care providers and ancillary staff, human resources personnel, and to all administrative personnel, including those who make purchasing and facilities decisions.

Brown University should commit to recruiting and admitting more persons with disabilities into its medical school and residency programs. It should also commit to providing education in its medical school about disability, because that really does not exist. A plan for hiring and accommodating disabled individuals at all the affected institutions should also be put into place. In other words, before such a merger can take place, compliance with federal law

regarding patient population should be established.

Those of us who have lived with disability for many years and have really been affected by the discrimination, who have had missed diagnoses, erroneous diagnoses, injuries, and other problems because of the lack of access, know that this is really important.

If you're going to control 80 percent of our health care, you need to actually provide it to us, and I think that that has to be on the table before anything can be approved. Not a promise, but an actual accomplishment.

Thank you very much.

MS. LOPES: Thank you.

Edward Fontaine?

MS. LENZ: Fern, I do not see Mr. Fontaine, but I am going to allow those on the phone to unmute themselves if Mr. Fontaine is on the phone.

Mr. Fontaine?

MS. LOPES: I will move on and circle back.

Carrie Bridges Feliz?

MS. BRIDGES FELIZ: Good afternoon. Thank you, Fernanda. I'm Carrie Bridges Feliz. Last

name spelled B-r-i-d-g-e-s F-e-l-i-z. And I serve as the vice president of Community Health and Equity at Lifespan.

I am a public health practitioner, previously working at the Department of Health here in Rhode Island, and have also worked in education, locally in the Providence School Department, as well as in other states, and the focus of my professional and volunteer work since the spanning of my career, the common thread and purpose, I spend to create the conditions that allow all people to thrive. And I know that many people in this meeting will recognize that as promoting equity.

I was able to listen to a portion of last week's public hearing and heard the concerns raised about how the merger will impact diversity, equity, inclusion, and community health. So thank you for allowing me a moment to share my perspective.

I lead Lifespan's efforts to improve the health of populations in our service areas through free health education activities, screening services, clinical interventions, lifestyle interventions, and skill building competencies, as well as programs that mitigate the social

determinants of health, like access to food, housing, and financial stability.

All of this work is only made possible through the extensive partnerships we enjoy with organizations across the region that share our goals of improving health status, health outcomes, and the experience of care.

And I see some of the partners in this work on this call, and I appreciate advancing our efforts together.

Through the proposed merger, we are absolutely committed to improving patients and prospective patients access to high-quality care. And I'll say it's not regardless of, but rather sensitive to where patients live, the languages they speak, the social factors they're navigating, and their racial and ethnic background.

As Director Alexander-Scott at the health department has said many times, and as Brenda Clement even said earlier on this call, zip code matters, and through a substantial body of evidence we know that one of the drivers of racial and ethnic disparities is racism, and we are growing, at Lifespan, unabashed at naming and -- naming racism and our opportunities to mitigate racism in

our work, as you see described in our merger application.

So, you know, we are acutely aware of existing health disparities, as well as the opportunity to leverage our resources to reduce health disparities and advance equity. And that is our goal. We want to increase the reach of long-standing programs, like Connect for Health at Lifespan, that screens patients for health-related social needs and, through trained advocates, provides navigation assistance and application assistance to access community-based and public benefit programs.

We want to grow workforces like the community health workers that have taken route in Lifespan hospitals and that have the potential to add significant value to improve access to safe and affordable care for patients.

We -- through that work, we've identified unstable housing as a significant health risk for too many patients. And as a result, again, through partnership, coordinated a medical respite pilot just last year, and joined a strategy effort launched by individuals at Integra, at Care New England's Accountable Entity, to address housing

health care. And it's because of our shared commitment to tackling these challenges that we're ambling these through significant, but not insurmountable, challenges threatening the health and well-being of our neighbors.

Again, as described in the merger application, the -- our three parties are coming together and are committed to applying our time, talent, and treasure to improve community health and well-being through collaboration instead of competition.

So allow me to be very clear. Our commitment is to do more together, not less, and we see opportunities to glean knowledge and tools that will amplify and frankly expedite our efforts.

I also want to address a necessity to diversify our workforces at all levels, especially among clinical and organizational leadership, so that we do come to reflect the communities we serve. We're not where we want to be or need to be, and we see opportunities through the merger to ramp up our programs to train and promote diverse professionals into leadership roles.

I've had the honor at Lifespan to help to create the Antiracism and Health Equity

Collaborative, and I currently serve as a co-chair of our diversity, equity, and inclusion council, which is a pillar of our 2025 strategic priorities.

As large employers are -- we know that our workforces are a slice of life in the region, and we, through that diversity, equity, and inclusion council, are working on human resources strategies relating to recruitment, retention, and promotion of employees. We're developing measures to monitor and report on key performance indicators on diversity, equity -- on the diversity, equity, and inclusion factors in our workforce. And we're engaging community partners, again, to help us understand and shape patients' and employees' experiences.

So I am supportive of the merger because of those named documented and expressed commitments to improve the health and well-being of all of the communities we serve. That is what is consistent. That's what we've committed to. That is consistent with what local data share. That's what is consistent with my experience as vice president of Community Health and Equity at Lifespan and consistent with my personal beliefs and values.

Thank you for the opportunity to comment.

MS. LOPES: Thank you.

Laurie-Marie Pisciotta.

MS. PISCIOTTA: Thank you so much.

My name is Laurie-Marie Pisciotta. My first name is spelled L-a-u-r-i-e, hyphen, Marie. Last name is P-i-s-c-i-o-t-t-a.

I'm the executive director of the Mental Health Association of Rhode Island. We are a nonprofit organization. Our mission it to improve Rhode Island's system of behavioral health care through policy development, advocacy, education, and community research.

We, too, representing consumers, have concerns about this proposed merger.

First, when combined, it's already been noted that the two health care systems would account for 80 percent of the market, and I can't think of a time in recent history when a monopoly has ever benefited consumers. We have concerns that this will raise costs for patients, and we already have a broken system where patients are on waitlists, and we're struggling to get the treatment we need when we need it.

Second, if the merger is approved, there must be a permanent and well-funded oversight

mechanism to ensure that consumers' rights are honored, that consumers have access to affordable timely high-quality care. And I'm not sure who would pay for that permanent oversight mechanism. Would it fall to the tax payers, or would the combined entity have to pay for that in perpetuity? It must be something that's permanent.

Another point is that, does Rhode Island have a good track record of overseeing large, powerful entities with deep pockets? I'm not sure that we do. I can tell you that as a behavioral health consumer, the Office of the Health Insurance Commissioner does an excellent job in their work, but that requires a lot of funding. And when they don't get all the funding needed to hire the staff that they need to do their work, I'm sure they feel that they could be doing more and wish they could be doing more if they only had the right amount of funding.

So these are some questions I ask, and I hope that you will think about these concerns. And I also hope that, again, taxpayers won't have to foot the bill for an oversight mechanism that should be paid for by the two merging entities.

Thank you for your time.

MS. LOPES: Thank you.

Michael Sabitoni?

MR. SABITONI: Hello. Good evening. Can you hear me?

MS. LOPES: Yes.

MR. SABITONI: I'm Michael Sabitoni. Last name S-a-b-i-t-o-n-i. Appreciate the time to speak with you here today about the merger and our support of the merger of Lifespan and Care New England.

For way of background, I wear a few different hats in my professional capacity. I'm president of the Rhode Island Building & Construction Trades Council, which represents over 10,000 construction workers in and around the state of Rhode Island. I'm also the business manager/secretary/treasurer of the Rhode Island Laborers District Council, which represents seven local unions, another 10,000 members, both in the public and private sector.

In my capacity as the district council manager for the laborers' union, I am chairman of the Rhode Island Laborers Health & Welfare Fund and have been since 2007. So I've seen market trends. I've monitored the health care industry for quite

some time.

Unfortunately, in Rhode Island, I've seen the, you know, continuing escalation of the cost of health and welfare. And to provide that for my members and the families that we represent -- and do not come to this decision lightly -- I actually believe that, as one of the largest purchaser of private health insurance in the state of Rhode Island, covering over 6,000 lives in a multi-employer health and welfare fund, with over 300 employers that pay into that fund, assets of over $100 million, and the amount of money that we spend -- real money in the marketplace, numbers to the tune of about $10 million annually just in the hospitals alone, 5 million through Lifespan, 2 1/2 million through Care New England, and then another 2 1/2 million through Massachusetts hospitals just over the line -- quite frankly, because of the care they provide, and Rhode Island does not have the ability to compete in that capacity -- most notably, we all have family members that usually go north for things such as cancer, unfortunately -- those are the real numbers that affect the members that we represent.

And, again, we do not come to these

decisions lightly and have had a long time to digest what we believe is in the best interest of the marketplace 'cause we are the marketplace and we do have, you know, real-time numbers on a large scale to prove what we're saying and also why we are supportive of a merger such as this.

Also, you know, when we do our collective bargaining for both our public and private employees -- the 6,000 members are on the private side of the members that I represent -- the number one cost factor in negotiations have been, since I've been chairman since 2007, is the cost of health care and our ability to, you know, get ahold of it.

So anything that we believe can allow us to have a competitive marketplace, which we believe the merger -- we're not a local Rhode Island-only health care economy. We are a regional health care economy.

So to allow the merger for Care New England and Lifespan, and then when you combine the assets of Brown University putting forward to really put us in the marketplace so that we don't lose 25 percent of our business to Massachusetts, I think truly is the game-changer that will allow us

to make real, hard investments in our health care system in a big way that are long overdue. And, again, we don't come to this decision lightly.

I had the opportunity to travel to Pittsburgh with then-Governor Chafee on an economic mission to go see, you know, what could we do to promote the meds and eds in the knowledge district -- but also, for full disclosure, my building is at 410 South Main Street, so I've been looking at this Knowledge District, or lack of it, for quite some time now. We've made great investments in the med school, the nursing school, which I'll get into in a moment.

The time is right for us now to combine our efforts and really get into the research and development and attract those type of dollars that a merger like this, when you add Brown to the mix as well, could accomplish.

And that's exactly what we saw in Pittsburgh in an old steel town. And when we had come back from that mission and looked around and had seen the impact of what a vibrant health care R&D community, with state-of-the-art facilities, and the ability for them to attract talent, to create good-paying jobs, to invest in their

infrastructure, build more buildings, build more R&S space, and have a vibrant economy, well, that was the mindset all along for the Knowledge District and the meds and eds that we wanted to put in the 195 corridor since we relocated the highway. And, you know, we have been, you know, still waiting for that to happen.

This is how it happens. This is the catalyst that we believe that will transform the city of Providence and the state of Rhode Island, quite frankly, and put us on the map to compete with, quite frankly, Cambridge and Somerset and other areas that would allow for us to then really seek the vision of what we all -- or most of us that follow this, you know, consistently. Make the investments to -- so that this state and this city and the health care system as a whole in Rhode Island can flourish.

Now, we truly believe that there are protections in place to make sure that we ensure quality of care, the cost of care to the consumer. We would never advocate for anything that would cost us more money when we sit down to negotiate our contracts, as well as that would have any impact on the quality of the care of the members

and the families that we represent. And that's why we feel so passionate about supporting this merger.

Again, doing the diligence with General Neronha and Madam Director Dr. Alexander-Scott. Do your diligence. We have full faith and courage in you. But at the end of the day, have the courage, have the vision. Make the investment into the health care system. Allow these two entities to merge for the future of the quality, the economy, and at the end of the day, the end user in the health care system for the members that we represent and for all Rhode Islanders.

I am really, really supportive of this. We've been waiting for a long time for something that would allow for this type of investment in Rhode Island. And I'll give you an example of why we know it will work.

It took some vision and courage to also have University of Rhode Island, Rhode Island College, and Brown University come together jointly -- it wasn't easy -- and occupy the building across the river right outside my window and create that joint nursing school.

MS. LENZ: Excuse me. Excuse me,

Mr. Sabitoni, your six minutes are up. So if you could just conclude succinctly, we would appreciate it.

MR. SABITONI: On behalf of the Building Trades and the Laborers District Council and the health and welfare fund, we are confident that we can get this right. Do the diligence. We support this merger wholeheartedly. And I thank you for listening.

MS. LOPES: Thank you.

Scott Molloy, please.

MR. MOLLOY: Good afternoon. Thank you for the opportunity to (indiscernible) today about the value of security offices at Women & Infants Hospital and the importance of maintaining these jobs.

My name is Scott Molloy, spelled S-c-o-t-t M-o-l-l-o-y, and I am a lifelong Rhode Island resident, originally from Cranston, now living in Warwick. I'm also a security officer at Women & Infants Hospital and a proud member of my union, 32BJ SEIU.

Prior to my nearly three years at Women & Infants Hospital, I held other security jobs for nearly four years. It means a lot to me to have a

job at WIH as more than five of my family members were born at this hospital, my sister included.

Hospital security officers are the first faces that patients and families entering the hospital see. Yeah, people often overlook us.

When first responders and health care workers are thanked for their hard work and dedication during the COVID pandemic, people tend to highlight the doctors, nurses, janitors, and even kitchen staff. They are right to thank my coworkers, but they should also be thanking security, as we are the backbone of keeping the hospital safe and secure for all.

Many look at security officers as men and women that stand at the front door and act as a deterrent, but this is not even the tip of the iceberg. The goal of a hospital security is to provide safety and support for all patients, guests, and employees in the hospital while also protecting the hospital itself. Without us, Women & Infants Hospital could not function. Period.

Our duties at Women & Infants Hospital are wide ranging and require in-depth training and skill development. We help patients get to and

from their appointments, escort them to our many off-site buildings, respond to patient and staff panic alarms and calls for assistance, deliver chemo and other medical equipment, discharge all patients that leave the hospital with newborn babies, greet and make badges for those entering the hospital, and protect others by peacefully removing unwanted visitors from hospital property without using any weapons.

Our department also has six members who are car seat certified under the Safe Kids Worldwide to assist new parents in getting their newborns into their car seats safely when they leave the hospital.

We also safely open and close over ten off-site buildings throughout Providence, often by ourselves and in unsafe neighborhoods.

On top of all of those security duties, we help with various miscellaneous tasks around the hospital, from fixing doors that aren't working properly to assisting patients and employees with dead battery jumps and so much more.

As 32BJ members, we believe that this merger could be beneficial to the Providence community but only if public health is protected

and good quality jobs for all the hospital are maintained. This will take careful oversight.

During the pandemic, many of us are working crazy hours and catching COVID. This puts not only our own health in jeopardy, but also the health of our friends and loved ones. All of us have families to take care of and need our jobs to do so.

This job gives me the opportunity to work while providing care to my sick father who has survived open-heart transplant and a kidney transplant. He requires weekly visits to his doctors. And without my job, we wouldn't get the care he needs.

Please don't merge without us. Women & Infants Hospital needs its security officers, and this community needs good jobs for working families.

Thank you for listening.

MS. LOPES: Thank you.

Dan Cahill, please.

MR. CAHILL: Hello. My name is Dan Cahill. I spell my last name C-a-h-i-l-l. I'm a resident of Providence, and I appreciate the perspective of policy folks, heads of unions, and

even employees of the hospital.

I speak as a patient, and I guess that I would reiterate and emphasize Mr. Pereira's objection. I don't think that this merger should be approved. I think it gives a monopoly status in the provision of health care, which won't be good for patients.

I had an unfortunate experience at a Lifespan hospital. I had surgery last summer, two times, on June 22nd and July 13th, and I suffered an injury during the operation because of the positioning on the operating table.

Since I have to have a similar operation in the future, I sought information about how that happened, and I spoke to two people in the administration of the operating room, Sheila Caparso and Karen Holt. Both of those people said they would get back to me with information that I really needed to avoid that kind of a problem in the next necessary surgery, and they did not.

The impression that I clearly got was that, apart from a specific organ repair relative to the surgery, if there are adverse outcomes, it really didn't matter. And it was just a severe

disappointment that speaks to the kind of care offered by a Lifespan facility.

The other objection I would have is relative to an action taken by Lifespan dating back to December of 2021 -- December 2019 -- excuse me -- December 2020, when vaccines became available, and board members and trustees of Lifespan each were able to access vaccines ahead of others that really should be given priority.

You know, you can't really argue with a priority given to people providing direct care or even those directly involved with the administration of a hospital, but to give preference to trustees and board members, I believe that betrays the trust that the public has in legitimate care that should go to those who are deserving of it rather than those who, perhaps because of their means, are a member of a board or a group of trustees.

Other hospitals did not do that, and I was very disappointed that Lifespan did. And with that kind of behavior, I think it disqualifies them for consideration for this kind of merger for that kind of activity to continue.

Thank you for the opportunity to speak.

And I, again, think that the attorney general should deny the application for merger.

MS. LOPES: Thank you.

Ian Chernasky, please.

Again, Ian Chernasky?

I'll circle back.

David Morales?

MS. LENZ: Fern, he now has the ability to unmute himself. So if he is on, he may unmute and provide comment.

MS. LOPES: David Morales?

I'll circle back.

So, Maryanne Matthews?

MS. MATTHEWS: Hello. I am driving. I hope you can all hear me okay.

MS. LOPES: Yes.

MS. MATTHEWS: I really just wanted to register my concern that there would be then another -- one more inflexible monopoly in our state and our health care system.

So here I'm looking at a decrease in the opportunity, if it's approved or -- of needed change. We have a repeated demonstration in our state with being able to address the suffrage of a Bohemic [sic] institution that has great

opportunities and resources, but not utilizing those to address the communities in which they serve in an equitable way and in a way that is actionable or accountable.

So I am just, again, saying I genuinely support the Lifespan behaviors and actions and programs, but in this case, one more monopoly in Rhode Island will provide another inflexible influential institution that would not serve and provide the resources and access to information and/or services that our underserved communities have suffered for all (indiscernible) years.

So I would ask, again, that the attorney general not support the system unless and until we were able to show actionable behaviors or practices in terms of equitable workforce, equitable providers, inclusive in many different ways as recently -- or as just shared with you like some of the other speakers.

So, again, I would like to just add that I don't know that at this point we are ready as a state to be able to provide an accountable or compliant system in terms of health care if we were to merge just one more influential Bohemic institution.

MS. LOPES: Thank you.

Do we see David Morales now? David?

MR. MORALES: Hello, everyone.

Would I be good to start, Ms. Lopes?

MS. LOPES: Yes, please.

MR. MORALES: Perfect.

Well, hello, everyone, members of the attorney general's office, and the Department of Health. My name is David Morales, and I am the State representative for House District 7 in Providence, which is home to dozens of essential hospital workers and health care patients.

Back in November, I released a statement regarding my concerns about this profit-driven hospital merger, concerns which I still share today and will elaborate on throughout my comments.

Now, across the country, dozens of hospital mergers have been approved without the proper oversight and regulations which have resulted in severe consequences, hurting working people, communities of color, and hospital workers at the expense -- at the expense of profit and the compensation of corporate executives. In specific, far too often hospital mergers have resulted in higher health care costs, a reduction of medical

services, a lower quality of care for patients.

Unfortunately, we have not received the legally binding reassurance that these harmful consequences will not happen to our state if this merger is indeed approved.

In addition, this merger would essentially create a monopoly, a monopoly within something as fragile as our hospital market, our hospital system, as Care New England and Lifespan would essentially control close to 80 percent of hospital beds, leaving Rhode Islanders with little options when pursuing care.

Therefore, at the minimum, we need legally binding agreements that guarantee further accessible and affordable care for all people with no reduction in our current health services while, at the same time, also ensuring that we're doing what we can to protect our frontline workers.

Therefore, this includes the following specific standards: The requirement that caregiver, patients, and members of organized labor be members of the board of directors; investments into our health care workforce with well-paying unionized jobs that offer competitive regional pay, benefits, and professional development

opportunities, both within the current facilities of Care New England and Lifespan and future facilities; the development of regulatory framework to prevent such a merged system from having too much power and not -- understanding as a legislature, we will definitely have to play a role in making sure that we have that oversight, and I'm prepared to do that work alongside my colleagues; along with limiting annual revenue through revenue caps, because this will prevent this merged hospital system from cutting costs or adopting concerning practices in order to maximize revenue and prioritize the bottom line.

So all of this is what we can and must do to ensure that this merger is actually in the best interest of protecting patients, the medical needs of our community, and hospital workers. Anything less must result in the immediate rejection of this merger.

And I want to note, if we are in a scenario where this merger is approved with conditions in place and they are not comprehensive conditions, myself and other legislative colleagues are already preparing a legislative agenda to address some of the needs that I just listed here,

though I would hope we would not have to go down that route.

Therefore, again, I ask that the Department of Health and the Office of the Attorney General seriously consider these proposals when making these decisions.

Thank you.

MS. LOPES: Thank you.

Dee Plumley, please.

MS. LENZ: Fern, I do not see that name on the list, but I have allowed those on the phone to unmute.

So if Dee Plumley is on the phone, please unmute to provide comment.

MS. LOPES: Okay. And I had also noticed that Alison Peservich had her hand raised.

Alison, would you like to provide comment?

MS. PESERVICH: I would, please.

My name is Alison P, as in "Peter," -e-s-e-r-v, like "Vincent," -i-c-h.

This June marks proudly my thirtieth year as an employee of Women & Infants, 29 years as a registered nurse at Women & Infants.

I would like to start by commending David Morales who last spoke. I agree with every

single thing he said. And I'd like to comment on a few of the other speakers remarks.

One thing that's puzzled me within our state, which has currently five nursing programs -- and one of the other gentleman spoke to the facility that was created in conjunction with Brown as a learning center for nursing and allied professional students -- is that we need to make a further investment along those lines.

It's puzzled me that both hospitals have historically hired traveling nurses, out-of-state nurses, who are not part of our community, to provide care in our state. If we're going to go forth with an educational investment for our nursing staff, then we need to provide jobs for our nursing staff, as David said, benefited positions, not positions that are just part-time, because our community is not just comprised of our patients. We're part of our community and patients ourselves.

So I'd just like to say let's commit to our health care workers by not only educating them, but providing them with jobs, because they know our community the best.

Thank you.

MS. LOPES: Thank you.

Dr. Michael Stewart?

I'll go ahead and circle back on Dr. Stewart.

Jeremy also had his hand raised.

Would you like to provide comment?

MR. COSTA: Yes.

My name's Jeremy Costa. I completely disagree with the merge. It is not in the best interest, not only as -- for patients, but for the employees. There has to be some type of incentification to maintain the current workforce that you do have right now. They are diminishing by thousands across the country in itself. And to have one company or -- control 80 percent of the market is -- you know, is going to affect not only people in their pockets for their co-pays, but it's also going to have collateral consequences, because we're going to be looking at the people that are passing -- you know, unless there's a trust that is going to give every Rhode Islander life insurance, which -- unless they were to give everyone life insurance, which they have the ability to do for five years, it would be -- it's an absolute no, you know. And I think that if it is considered, that a Lifespan policy should be put -- it should be given

to every essential worker that works in that hospital.

There should also be some incentification to where they are not just crediting the nurses -- for instance, Good Neighbor programs are only given to police officers, first responders, and nurses -- they need to be for all essential workers.

LPNs, if you're using them in the same capacity as a registered nurse, they need to be incentivized by housing incentives federally since they are a federal institution. They're not paying taxes on 70 percent of their properties right now to municipalities, and municipalities are losing out because of all the tax revenue that they're not paying.

You know, that's going to create more damage and put more stress on the taxpayers, because they're going to be spending more money prepaying for their services, and there's not going to be any competition to bring that price down.

So I completely disagree unless there's a life insurance policy that's given to all the medical workers and there's some type of -- for all working class, that there's some life insurance policy that is given -- and they have the money

now. This would be the perfect time to set up that trust fund -- to be able to, you know, separate out that money to make sure that there's some type of security there, because it doesn't look like they're going to be -- it doesn't look like they're going to be honest with us in the end, and they're going to be able to hide a lot of information because of the HIPAA laws and -- it's just very uncomfortable for 80 percent of one state to go to -- it's just very uncomfortable, and it's not a smart business move, and it's not good for the working-class people. Absolutely not.

That's all I'm going to say. Thank you.

MS. LOPES: Thank you.

I'm going to go ahead and call on those that signed up to speak but didn't speak when I called on them the first time.

Matt Gunnip?

MS. LENZ: Fern, I still do not see that name, but those on the phone may unmute themselves now.

So if Mr. Gunnip is on the phone, please provide comment.

MS. LOPES: Edward Fontaine?

Ian Chernasky?

Dee Plumley?

Dr. Michael Stewart?

Is there anyone else in attendance who would like to provide comments or additional comments but have not had an opportunity to speak tonight or -- please raise your virtual hands or if you can go ahead and speak.

MS. LOPES: Niyoka Powell, please.

MS. POWELL: Hi. My name is Niyoka Powell, spelled N, as in "Nancy," -i-y-o-k-a. My last name is Powell, P, as in "Peter," -o-w-e-l-l.

I was a nurse for Butler Hospital until the pandemic. I was on the front lines on Block Island all last summer doing all of the COVID testing, and I helped out at a couple of nursing homes during the pandemic.

I do not believe that a merger is actually going to benefit Rhode Island at all merely for the fact that everybody else have been putting out there that, you know, 80 percent is quite the monopoly, and the care itself, even before the pandemic, at any of these hospitals needed to be revised before converging into one mega hospital organization.

That being said, the treatment of staff,

regardless of where they worked, whether they were medical staff or not, security or not, or just the groundskeep, these people are people who devote their lives to these organizations that leave them out in the cold.

Merging these hospitals only deteriorates the lifestyle that all these people are living on barely any kind of wage already, only to see upper management or only to see people in corporate get bonuses after bonuses after bonuses.

Regardless of where this money is coming from, I think the system itself is already flawed. And in order for us to move forward as a state, in order for us to have some kind of allegiance to the clients that we take care of, we need to make sure that the bone structure of these hospitals are already fixed before you merge to something else and go under some other kind of politics.

If that cannot be done, if people who sit at a high level think that they are not accountable for the care that is currently happening in Rhode Island or prior to this merger, if the merger happens, because, you know, nobody listens to the people who actually work on the front lines, then I think that they should

probably all be fired, because that's what you're doing to people. You're taking away their livelihood. You're taking away the care that they can provide to people.

And not only that, when it comes to the flow of the hospital environment or even the assisted living environment, so many patients are already lacking in so many things that the money you're going to invest into something even bigger makes no sense. The patients are the ones that are going to suffer. The employees are the ones that are suffering. Not corporate, not the merger companies. These are the people that are suffering.

And in order for this to even make any sense to me, Rhode Island needs to be bigger. You have to divide the country into a much bigger space for Care New England and Lifespan to make sense in such a small state to think that a merger is a good idea.

There's no heart in these people. They need to grow up and realize they're destroying lives of people. And if they can't do that, then, no, this merger is not gonna happen.

And that's all I have to say. Like,

literally, there's no care in health care anymore. That is all.

MS. LOPES: Thank you.

Is there anyone else in attendance who would like to provide comments but hasn't had a chance to? Please raise your virtual hands at this point.

MS. LOPES: Ann Marie, please.

MS. GAUVIN: Hi. My name is Ann Marie Gauvin. I am a cytotechnologist at Women & Infants Hospital.

My concern is -- we've just seen it over the border in Massachusetts, that Brigham and Women's and Mass General's huge merger has become significantly a monopoly and it has increased costs across the board, and now they want to impinge and put a surgicenter in Massachusetts to further decimate the community facilities.

Are we not looking at that merger as an example of how this one could possibly fail? Because it's not certainly working out great for a lot of patients in Massachusetts with the costs being driven up.

And that's all I have to say.

THE REPORTER: Ann Marie, could you spell

your last name for me?

MS. GAUVIN: Sure.

G-a-u-v-i-n.

And I live in Massachusetts. This has been written up in the Boston Globe as well.

MS. LOPES: Thank you.

Is there anyone else in attendance that would like to provide comment? Please raise your virtual hand.

This public meeting is scheduled to run until 5:00.

I see Niyoka. You have additional comments?

MS. POWELL: I just had a quick question in regards to employment, because I know that if you're working for Care New England, you can only work for one Care New England hospital.

How will a merger affect the employment status of all of these employees who have jobs through Lifespan as well?

That's just my quick concern about that. That's all.

MS. LOPES: Thank you.

Is there anyone else interested in providing public comment?

This public meeting is scheduled to run until 5:00 p.m., so we will hold it open until then.

MS. LOPES: Dan Cahill, please.

MR. CAHILL: Thank you, again. I spoke earlier, but I had a question, and since you had a few minutes, could the representative of the attorney general's office or the Department of Health or both explain where you are in the process? I joined the meeting late, and I'm sorry if this is a bit repetitive, but, you know, in the final minutes of the meeting, maybe you can explain what comes next, and what the attorney general in particular will be considering.

Thank you.

MS. WEIZENBAUM: Sure. I'm happy to respond to that, Mr. Cahill, and for others.

Again, I'm with the Office of the Attorney General, and where we are in the process is still in the review phase.

So the -- you know, the process began with the parties filing -- filling out an application that was tailored to this proposed transaction, and it took, you know, several months for us to collect information to complete the application.

Once we deemed the application complete, then we follow up with additional investigation, which includes getting statements under oath from people and that.

We are now at the point where the statutory deadline, the date by which we have to issue a decision, is March 16th. And when I say "we," I mean the Office of the Attorney General and the Department of Health.

So what -- what we're looking at when we review is driven by the language in the statute. So the statute has a provision for transfer of interests for non-profit hospitals. And the Department of Health will -- has their set of criteria that they have to consider that mostly pertain to quality of care and care in the community in very broad brush strokes. We both have criteria that pertain to financial questions.

And then the attorney general has criteria that pertain to a number of factors, including sort of due consideration by the boards that made this decision. So we look at their decision and see if it's considered appropriate factors.

And then in addition, the Office of the Attorney General considers whether this is proper

from an antitrust perspective.

MR. CAHILL: Thank you.

I'd just make the further comment that I think your website needs to have a little bit more clarity on the process. This talked about the event. You referenced the legal documentation, including the application, but I think it would be good for all of us to know what your timetable is and maybe a little bit about your consideration, including where the comments from these public hearings go and how they're considered. Just a request.

MS. WEIZENBAUM: Yeah. Thank you for that comment.

MS. LOPES: Jeremy?

MR. COSTA: Yes. Real quick.

She mentioned that financial -- the financial aspects are also a major consideration and also a line item.

Are you looking at the lost revenue in regards to the taxable income that could be coming into the municipalities, as they own 80 percent of the assets of the health care industry? Are you looking -- is that being reviewed at the lost revenue?

For instance, they own a parcel of land, which is about 9 acres, down in the center of Downtown Providence, right off of 195 and Eddy Street, and I was just wondering -- because it hasn't been taxed in nine years. So I was just wondering if you have calculated the lost tax revenue from the municipalities because of these federal subsidized corporations that are merging. Has anybody calculated that number? Is there anyone that could answer that question?

MS. WEIZENBAUM: Yes. Sorry. It took me a moment.

We can't -- we can't speak to the investigation that -- while it's ongoing, so I'm afraid to say that you'll need to wait for the decision to come out.

We are -- I will say that the statute requires us to look at the financial condition of the hospitals, but beyond that, I can't really say while it's currently under investigation.

MS. LOPES: So I would reiterate that this is a public meeting to hear comments from the public. I can refer you to, or even put on the chat, our -- a link to the Department of Health's website as it relates to the Hospital

Conversions/Mergers Program. And the summary and time line and any information pertaining to hospital conversions questions, you can certainly take a look at our website there.

Jason Drapeau?

MR. DRAPEAU: Yes. Hi. Thank you. I spoke on the 20th, and so I'm not going to take up a lot of time.

I would just like to say that the people of Rhode Island are smart. They know who to believe. And for two days now we've heard many, many, many frontline bedside employees from security to nursing, sanitary, housekeeping, all kinds of people, raising grave, grave concerns. And we've heard executives with, you know, great big paychecks saying, Don't worry. We promise to do no harm. I think everybody knows who you can believe here.

Thank you.

MS. LOPES: Karen Malcolm?

MS. MALCOLM: Thank you.

Just since there's a few minutes here, do -- is there -- has a date and time been settled on for the third public comment session that you had mentioned last week? And you may have said it

and I missed it. I was not on at the opening of the meeting.

MS. LENZ: Yes, Karen. That public meeting will be held on February 10th from 6:00 p.m. to 8:00 p.m., and we will issue a public notice for that meeting.

MS. MALCOLM: Thank you.

MS. LOPES: Rosie, would you like to provide public comment?

MS. ROSSNER: Hi. Yes. My name is Rosanna, R-o-s-a-n-n-a, Rossner, R-o-s-s-n-e-r, and I've been an employee here at Women & Infants for 34 years.

And I just basically wanted to share one thought, and that is would any of us want anything that controls 80 percent in our lives? When you go fill up your car with gas, would you want 80 percent of the gas stations owned by the same entity and, therefore, controlling the price? When you go to the grocery store, would you want 80 percent of our grocery stores controlled by the same person, the same entity, the same company, and thereby controlling all the prices?

Just a small thought to kind of share it with the rest of our daily lives. That's all.

MS. LOPES: Thank you.

We have a couple of minutes left. Again, if anyone would like to provide additional public comment.

I see a hand raised. Jeremy again?

MR. COSTA: Just one question.

Was Kent Hospital run -- during the pandemic, was it run by Lifespan or -- was it run by them? Is Kent Hospital run by -- or run by Lifespan? Is it managed by Lifespan, Kent Hospital currently, right now? Can anybody answer that question?

MS. WEIZENBAUM: Kent Hospital is owned by Care New England.

MS. LOPES: Michelle Parent?

MS. PARENT: Hello. My name is Michelle Parent. I have been an employee at Women & Infants as a registered nurse for 32 years. And I hesitated to ask this question earlier because I'm not sure if this is not the proper forum. If it is not the proper forum, I do apologize.

Both Lifespan and Care New England have separate unions. In fact, within Care New England, there are separate unions; one for Women & Infants and another for Kent.

How is it being proposed that they are going to handle the merger with these different unions, and how are they proposing that there's going to be enough money left to fund pensions and whatnot and to do it equally? Is everybody going to be put to the lowest common denominator, or are the others going to be brought up to, you know, the higher level?

I don't know if this is the proper place. If it's not, I do apologize, but I have been concerned about this question. Thank you.

MS. LOPES: Thank you.

We can take your question as a comment, but this is not a forum to ask and engage in questions and answers. So I appreciate your questions into the record.

And, Maria, would you like to give some comments?

MS. LENZ: I would, but I do see one hand, and given the time, this will be the last comment.

MS. LOPES: And the person's name? Was it Brun- --

MS. LENZ: It was Bruni. I will unmute.

MS. LOPES: Thank you.

MS. BRUNI: I've got a question.

I'm sorry, but I agree with the lady that asked before. Where we can ask those type of questions? Like, how's it going to work? Because unless they -- if they merge -- like, some jobs make more money in one hospital, some make less money on a different hospital. We are concerned, because in some of these hospitals, people have been there for years. Like, what is going to happen? Are they going to -- are -- do we to have to reapply for the job? We get really concerned on -- we need somebody to hear us too.

MS. WEIZENBAUM: Again, this isn't the -- this is a forum for public comment, and thank you for expressing your concern. That will be included in the record as a public comment, and -- even though it's not a question-and-answer forum. So thank you for that.

MS. LENZ: And, Fern, just for the record, I wanted to point out that we have had well over 200 participants today at this afternoon meeting, peaking with 283 participants at 4:10 p.m. -- excuse me -- at 4:10 p.m. And right now, at 5:02 p.m., we still have 189 participants.

Thank you all for your comments today.

MS. LOPES: Attorney General Neronha?

MR. NERONHA: Yes. Thank you.

I just wanted to thank everybody for participating in this public comment session, and also to reassure those of you who have asked questions.

Those are questions that we will consider asking ourselves. So I don't want you to think that because we're not answering your questions that we don't take them seriously. We very much do. This, for me, has been an exercise, among other things, in identifying issues that we can then follow up on.

So I thank you for raising all of these points, even in the context of a question that we can't answer in this space, but it is a question that we will take to heart and perhaps ask ourselves. So thank you for bringing those questions to our attention.

And thanks so much to everybody who commented today or just listened in to the conversation. Thank you very much.

MS. LOPES: Thank you.

Thank you, all, for participating today. This concludes our public meeting regarding the

CNE/Lifespan HCA application. Again, thank you for your participation. Have a good night.

(MEETING CONCLUDED AT 5:03 P.M.)

C E R T I F I C A T E

I, CASEY A. BERNACCHIO, Shorthand Reporter and Commissioner, hereby certify that the foregoing is a true, accurate, and complete transcription of my stenographic notes taken at the time of the aforementioned matter.

This proceeding was done remotely via web conference and may result in some inaccuracies and/or dropped words created by audio conflicts that may arise during any web-based event.

IN WITNESS WHEREOF, I have hereunto set my hand this 2nd day of February, 2022.

CASEY A. BERNACCHIO
SHORTHAND REPORTER

MY COMMISSION EXPIRES:
DECEMBER 31, 2023

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