



December 23, 2012

John Calabria, Director  
Certificate of Need and Acute Care  
Licensure Program  
NJ Department of Health and Senior Services  
Office of Legal and Regulatory Compliance  
Market and Warren Streets,  
P.O. Box 360  
Trenton, New Jersey 08625-0360

Re: CN #FR ,                      Application for Transfer of License of  
St. Michael's Medical Center to Prime Health Care Services, Inc.

Dear Mr. Calabria:

Please accept this written submission on behalf of New Jersey Appleseed Public Interest Law Center. As stated herein, we request that the Department deny this Certificate of Need ("CN") application, because the business model implemented by Prime Health Care Services Inc., does not serve the public interest, and is antithetical to the recommendations of the "Final Report for: Greater Newark Healthcare Services Evaluation," dated March 2, 2015, publically known as the "Newark Navigant Report."

Notwithstanding our strong opposition to this sale, especially since the taxpayers of New Jersey will be compelled to finance this transaction to the tune of over \$180 million, we acknowledge that this proposed sale has emerged out of a bankruptcy proceeding, and the Department may be more reluctant to reject this application than it was several months ago. Though as a public policy matter we lament what we perceive to be a misuse of the bankruptcy court, such criticism is best directed at the Attorney General's office, and will not be explained herein. Accordingly, short of rejecting this application (on the basis that the Department prefers the other bidder or desires NJ HCFFA to credit bid if the matter were to return to the bankruptcy court), we urge the Department to take an active role in ensuring that the proposed sale of the assets of Saint Michael's Medical Center ("SMMC") to Prime Healthcare Services, Inc. ("Prime"), does not "result in the deterioration of the quality, availability or accessibility of health services" in the communities currently served by SMMC. N.J.S.A. 26:2H-7.11(b). We

New Jersey Appleseed  
Public Interest Law Center of New Jersey  
744 Broad Street, Suite 1525  
Newark, New Jersey 07102

Phone: 973.735.0523 Fax: 973.710-4653  
Email: steinhagen\_pilc@yahoo.com  
Website: www.njappleseed.org

believe that such action must include the development of strong, meaningful and targeted conditions that your Department intends to enforce. Such conditions must ensure maintenance of service to Medicaid, uninsured and other indigent patients at current levels (not just a percentage of volume), fair pricing and contracting, fair and legal debt collection processes, alignment of beds with the needs of the Greater Newark area, increased provision of out-patient clinics, participation in the Greater Newark Healthcare Coalition and any other regional health planning initiatives, proper use of the emergency room, financial transparency, and community accountability. For if the new operators of SMMC cannot be restrained from engaging in several practices that prevail at their California and other non-New Jersey hospitals, especially around Prime's emergency room practices, the transfer of license to them is likely to have an adverse impact on University Hospital, Beth Israel Hospital, Clara Mass Hospital, and East Orange General Hospital and the residents of the City of Newark. We also respectfully request the opportunity to submit additional comments and/or appear before the State Health Planning Board once the staff's recommendations on this application have been submitted to the Board.

#### Incorporation of CN Comments re Transfer of St. Mary's Hospital to Prime

Given the fact the proposed new owner of SMMC is the same company that purchased St. Mary's Hospital in Passaic,<sup>1</sup> we believe that NJ Appleseed's CN comments, dated January 14, 2014, are relevant to the proposed transfer. Rather than repeat those comments, we hereby incorporate those comments herein and highlight our comments regarding Prime's track record. As we stated on pp 2-3,

NJ regulators can mine the file developed by their counterparts in Rhode Island to find the deeply disturbing aspects of Prime's business model that it is trying to export to several states from California. These include, but are not limited to a pending Medicaid fraud investigation, allegations contained in now three pending lawsuits of up-coding, misuse of the emergency room (the recent whistleblower suit alleging excessive admissions through the emergency department rather than observation), "kidnapping" of patients, rendering unnecessary medical services, use of an out-of-network insurance model, and other abusive, if not illegal practices. Each of these complaints must be carefully scrutinized, and the Department must seriously consider whether this entity is the right owner for a New Jersey hospital. We know that the California AG has determined not to permit Prime to acquire more hospitals in that state,<sup>2</sup> and while other states desperate for capital to keep financially strapped essential hospitals open have permitted Prime to come in, if we do so in New Jersey we can only do so with very strict conditions to ensure that they do not further disrupt our hospital system that is the most expensive in the country, and some would say quite dysfunctional in some parts of the State.

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<sup>1</sup> New Jersey Appleseed did not participate in the CN process regarding the sale of St. Clare's Hospital System to Prime.

<sup>2</sup> Since these words were written, the California AG entertained a hospital application by Prime; but, it is our understanding that Prime has rejected the conditions the AG imposed and has walked away from the transaction.

These comments still pertain, since it is our understanding that none of the mentioned investigations or allegations (set forth in court pleadings) has been resolved in Prime's favor.

Department's Obligation Pursuant to N.J.S.A. 26:2H-8 and N.J.A.C. 8:33-4.9

With respect to the Department's obligation pursuant to the CN process (governed by N.J.S.A. 26:2H-8 and N.J.A.C. 8:33-4.9), New Jersey Appleseed has often reminded the Department that the Commissioner has an obligation to "satisfy the legislative preference for a regulatory review that will serve as a check on undue harm to [New Jersey's] valuable, and vulnerable, urban hospitals," such as University, Beth Israel, Clara Maas and East Orange General hospitals. In re Application of Virtua-West Jersey Hospital Voorhees for a Certificate of Need, 194 N.J. 413, 436 (2008). In order to satisfy this obligation "to guard against severe or pervasive negative impacts on urban hospitals," *id.*, the Commissioner must provide an analysis of the impact that a particular CN will have on the delivery of health care services in a region, and conversely, cannot just accept the proffers of an applicant. *Id.* at 435.

The importance of the Commissioner's obligation to provide an analysis of the impact that a particular CN will have on the delivery of health care services in a region is especially important in this case because the community has limited resources to secure and analyze relevant data which the Department routinely collects, and in some instances, may not release due to proprietary concerns. Specifically, the Department has access to data regarding emergency room admissions, service charges, readmission rates, quality indicators, insurance claims data, charity care levels by number of patients as well as cost, and other information that may provide an insight as to what is actually occurring on the ground in Newark. At this time, less than one year after Prime took over St. Mary's (and only months since it acquired St. Clare's Hospital System) members of the community are limited to anecdotal evidence as to the changes occurring at those facilities, and whether Prime's ownership of St. Mary's has had a negative impact on St. Joe's Hospital, located in Paterson. Furthermore, there is reason to believe that Prime has remained in-network at St. Mary's as a temporary measure until it secures licenses for all the hospitals it would like to purchase in New Jersey.

Accordingly, we believe that it is the obligation of DHSS to do a thorough analysis of the Prime's current practices in other states prior to handing it yet another nonprofit hospital (i.e., a community, socially owned asset). Examining the track record of a potential licensee is the heart of the Department's CN process, and the Department cannot shut its eyes simply because of the strength of the political connections that the new owner may have with the Governor or because this matter now emerges from the bankruptcy court. More specifically, the Department simply cannot accept empty promises or empty rhetoric about improving quality while lowering costs for patients and taxpayers through continued "competition" without careful scrutiny as to what is really going on at Prime's out-of-state hospitals.

Toward that end, we are submitting a November 2014 report prepared by the research department of SEIU-UHW regarding "Emergency Department Practices at Prime Hospitals" in California. It was submitted during public processes governing the proposed sale of a hospital to Prime in California, and was considered by the Attorney General's Office in that State. The Report states,

[A]n analysis of Medicare data show that ED practices at Prime hospitals should warrant greater scrutiny. Outpatient observation services, used to avoid unnecessary admissions, are extremely rare at Prime hospitals, while Prime's rate of admissions from the ED is well above most other large hospitals systems. If a hospital with a high ED admission rate has a lower rate of outpatient observation discharges, this might suggest overutilization of inpatient services. Id. at p. 1.

Promoting overutilization of inpatient services through the emergency department is a serious concern in the context of SMMC and its brand-new publically funded emergency room. We respectfully request that you consider this data in your evaluation of whether to transfer SMMC's license to Prime.

### The Navigant Report and Commitments to Implement Its Recommendations

As you know, the New Jersey Health Care Facilities Financing Authority Department released the Newark Navigant Report on March 2, 2015, approximately two years after SMMC's submitted its initial CN application. The Report does an analysis of current and projected need for utilization of hospital services in the Greater Newark Area (in the context of volume and market share by zip code, population and growth by age, zip code and health insurance coverage, net migration by service line, hospital utilization rates, emergency department demand, physician age, and community need for ambulatory care and out-patient services) and makes recommendations to reduce beds, eliminate duplication of services and provide a continuum of care to residents that requires the transformation of the hospitals involved and better coordination among them. The Report directly states,

Based on our analysis of the Planning Area, it is unclear how the transfer of the assets of any of the study hospitals through a sale to another party would resolve the underlying overcapacity and unnecessary service duplication in the Planning Area. Rather, such transaction would seem more likely to perpetuate the status quo than to facilitate the redeployment/transformation of resources to align capacity with need in the Planning Area. Transferring the assets of one or both of these hospitals would perpetuate – and probably intensify – the competition for the decreasing number of patients in the Planning Area. Nor would transferring the assets through a sale help and address the current degree of fragmentation of the healthcare delivery system in the market. And a sale of one or both of these facilities would be unlikely to facilitate the organization of physicians. In effect, sale of one or both hospitals would appear to continue the status quo, which would not address the excess capacity and unnecessary duplication of services. Newark Navigant Report at 86-87.

Accordingly, we request that the Acting Commissioner, like she recently did with respect to the Transfer of Ownership of East Orange General Hospital, CN #FR 140503-07-01, employ the Newark Navigant Report as a “useful planning tool” and impose conditions on the purchaser of SMMC to make the very changes to the hospital that are required, but which the Board of SMMC to date has resisted making. Letter to Martin Bieber from Cathleen D. Bennett, dated September 16, 2015, at p. 3. Reduction of licensed beds, increase in out-patient services,

elimination of duplicate services with other hospitals, and emphasis on primary and ambulatory care rather than increased admissions through the emergency department are what Newark needs, and what Prime should be required to provide if it wants to purchase SMMC.

### Essential Conditions

From the above comments, it is apparent that New Jersey Appleseed is primarily concerned with the details of the transformation of health care contemplated in the Newark Navigant Report, and the introduction of the out-of-network/reliance on emergency room admission model that Prime is offering (based on its practices in its California hospitals) into the Greater Newark area. Accordingly, we request that in addition to the substantive requirements that the Commission should impose (as it did in the recent case of the transfer of East Orange General Hospital) to ensure reduction of in-patient beds, excess capacity, fragmentation of care, and other ills existing in the Newark hospital system, the Commissioner take action to ensure that the process of coordinating care and transforming services among and between the five-area hospitals analyzed in the Newark Navigant Report be a public process involving all stakeholders. The transformation of healthcare in the Greater Newark area cannot be left to Prime, to be decided behind closed doors with or without the participation of University, Beth Israel, Clara Maas and East Orange hospitals. Physicians, community service providers, elected officials, insurance plans, consumer advocates and planners, and hospital administrators must all be engaged in a process, and the outcome must be accepted by all hospitals involved. University Hospital is a significant public asset; Beth Israel and Clara Maas are community assets; SMMC and EOGH will be private. Nonetheless, they are all licensed by the State and thus are subject to regulation and restraint to ensure the public interest. We therefore request that you condition the transfer of license to Prime on its participation in such a public process, and on its consent to implement the recommendations emerging from that process in addition to those now required by DHSS.

Second, the State must take action to prevent the introduction of the out-of-network model implemented by Prime in its California hospitals, and primarily CarePoint in Hudson County. NJ Appleseed understands that DHSS may prefer New Jersey legislators to take the first step, but administration and oversight of New Jersey's health care system is within its purview, and it must take all steps necessary to protect the health, safety and well-being of New Jersey residents as it relates to the State's healthcare infrastructure. Now, at the time, when Prime is requesting the State for the privilege of operating a hospital is the time to act. The State must require Prime to operate as an in-network facility and to require it to condition physician privileges on that requirement as well. In the alternative, we request that any approval of the CN application before you include the following conditions:

1. Prime must be required to assume and continue each of the current commercial insurance contracts of SMMC that were in effect on December 31, 2015, for at least 18 months after licensure;
2. As the California AG imposed, Prime must fully participate in Medicaid/New Jersey Family Care and must maintain contracts with all Medicaid Managed Care providers;

3. Upon transfer of SMMC to Prime and for one year thereafter, Prime shall not modify the charge master for Christ to increase any rate more than 10% of the charge in effect on December 31, 2015; and
4. If Prime provides notice to terminate any insurance contract at any time, or imposes excessive charges at least 10% above the statewide average, it may be ordered to pay rebates or subject to other appropriate remedies to be determined by DOBI and DHSS.

Consumers have been, and continue to advocate for strong insurance rate review with prohibitions against excessive and unreasonable health insurance premiums. Now is the time for consumers to focus on the role of physicians and hospital providers in causing excessive and unreasonable health care costs. We are doing so in our persistent efforts to prohibit balanced billing in the context of surprise medical bills. DHSS must take an aggressive stance on this issue as well and, in this matter, must condition the transfer of SMMC's license to Prime on requirements that will end, if not radically restrict Prime's historical reliance on admissions through the emergency room and remaining out-of-network.

#### Other Considerations

New Jersey Appleaseed also urges DHSS to impose certain conditions we have previously supported with respect to other hospital conversions. Some are also specific to Prime based on the California AG's requirements which were tailored to restrain the known practices of that entity. Such conditions include:

1. With respect to Prime's post-transaction commitment for capital improvements and working capital, it must provide DHSS with information supporting such investments in the facility, in addition to any other debt incurred on the hospital's behalf;
2. Prime must hire at least 90% of Prime's current employees on a full-time basis, which must include 100% of those covered by the collective bargaining agreement, and must continue to maintain nurse/patient ratios sufficient to ensure safety and quality, and must continue to provide such employees with health insurance coverage;
3. Prime must make adequate commitments to continue to serve its fair share of indigent and underinsured persons in the community by accepting a specifically defined commitment to maintain not just the same level of charity care that is now provided at SMMC, but a minimum volume of charity care. Levels of charity care cannot be met by using bad debt and inflation;
4. Prime must create a Local Governing Board with full authority and fiduciary responsibility for SMMC. Such Board should consist of medical staff, physicians, the Chief Medical officer, a designated member from the Newark City Council, and community representatives of social service providers in the community, among other board members;

5. All Executive Officers of SMMC must be legally responsible to obey any conditions imposed by DHSS;
6. All Prime hospitals in the State must use and follow debt collection procedures that follow and comply with state and federal law;
7. In the event that Prime finances this transaction with a sale-leaseback, Prime must disclose and provide to DHSS the terms of its lease and any conditions that may impact the delivery of care at SMMC;
8. Given the significant amount of State HCFFA bonds assigned to SMMC, if Prime sells SMMC facility for more than the purchase price, within five years of its acquisition, NJ HCFFA should be able to capture revenues net post-transaction investment to be used to pay back bondholders;
9. A review of the CN Application also reveals that there are no commitments to ensure financial transparency. Historically, the Department has conditioned its approval of for-profit conversions by requiring the for-profit hospital to report to the Department all monies going into the entity, and all monies going out of the entity for a minimum of three years post-acquisition. We urge that the Commissioner to impose such condition herein.
10. Prime has also failed to provide information indicating that it will avoid conflicts of interest in patient referrals. Because this transfer of assets will result in a hospital that will now be accountable only to private investors, it is critical that DHSS compel HHO to adopt strict procedures to avoid conflicts of interest in-patient referrals. These procedures must be applied if healthcare providers, physicians, insurers, board members of the staff of the new SMMC are offered the opportunity to invest or own an interest in Prime or any of its affiliates. It is clear that a failure to adopt a conflicts of interest policy in patient referrals may have an adverse impact on the quality of services provided, and the capacity of the hospital to respond to the actual needs of the community; and .
11. Because of SMMC's past practices with respect to Community Advisory Groups (CAG), New Jersey Appleseed is especially concerned about SMMC's future accountability to the community. New Jersey Appleseed does want to point out, more generally, that the creation of hospital CAGs, whose members are appointed by hospital boards and typically include several locally elected officials, have not provided sufficient accountability anywhere in New Jersey, at least in communities where there has been an elimination of services or diminished access to services. If hospital CAGs were able to effectively monitor and ensure access to quality services as currently constituted, SMMC would not have been able to renege on its commitments to the Newark community upon the closing of Columbus and St. James Hospitals; Meadowlands, would not have been able to transform itself

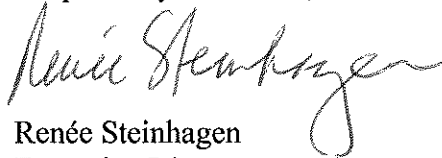
into an enlarged ambulatory care center (as predicted by NJ Appleseed in its CHAPA remarks submitted at that time); and Bayonne Medical Center would not have been able to eliminate its obstetrics and gynecology department, contrary to the conditions set forth in its CN. New Jersey Appleseed does not have an immediate solution to this problem, but invites DHSS to redesign its CAG requirement so as to ensure community accountability.

As you know, CHAPA permits DHSS to hire an independent health care monitor (paid for by Prime for a period of three years to monitor and report quarterly on community health care access by the owners, including levels of uncompensated care for indigent persons. N.J.S.A. 26:2H-7.11(i)). New Jersey Appleseed will address this issue in our CHAPA comments that will be submitted to the Attorney General on or after January 5, 2016.

#### Conclusion

As we have previously stated to DHSS, New Jersey Appleseed can no longer merely ask for imposition of conditions since many of those conditions do not seem to adequately restrain business practices that have an adverse impact on the delivery of health care in the State, and in many cases have negatively impacted the ability of a hospital system in an area to transform itself to meet the needs of its residents. We thus strongly urge the State Health Planning Board and DHSS to disallow Prime to operate SMMC, which we believe should be placed in the hands of an operator that will reorganize that facility in accord with the Newark Navigant Report. A denial of the CN application in this case does not mean the closure of SMMC. Rather, the Board of SMMC can return to the bankruptcy court and select Prospect Medical Holding's bid that it chose to overlook. NJ Appleseed believes that such alternative would place the license in a organization that has already stated its intent to align East Orange General Hospital with the recommendations of that Report. On the other hand, the NJ HCFFA may still decide to credit bid, and then lease the hospital to a nonprofit entity that will not only implement the recommendations of the Newark Navigant Report, but also may be able to generate revenue to satisfy the bondholders. In this case, Newark needs a nonprofit operator that will adequately serve all the residents in the Greater Newark area and will contribute to solving New Jersey's systemic problems in its health care system rather than exacerbating them.

Respectfully submitted,



Renée Steinhagen  
Executive Director



## EMERGENCY DEPARTMENT PRACTICES AT PRIME HOSPITALS

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Prime Healthcare Services (Prime) had over 400,000 emergency department (ED) visits at its 14 California hospitals in 2013.<sup>1</sup> Its facilities and physicians are expected to provide these patients with the appropriate level of care to ensure optimal health outcomes. However, an analysis of Medicare data show that ED practices at Prime hospitals should warrant greater scrutiny. Outpatient observation services, used to avoid unnecessary admissions, are extremely rare at Prime hospitals, while Prime's rate of admissions from the ED is well above most other large hospital systems. If a hospital with a high ED admission rate has a low rate of outpatient observation discharges, this might suggest overutilization of inpatient services.

Reimbursements for observation services are often lower than those for an inpatient level of care. An inpatient level of care generally costs more to provide and accordingly receives greater levels of reimbursement – on average, about \$5,000 more in Medicare reimbursement for an inpatient admission as opposed to a corresponding outpatient visit with observation, according to one study<sup>2</sup> – therefore a hospital may have a perverse incentive to admit ED visitors unnecessarily in order to receive the higher associated payments.

In fact, the U.S. Department of Justice recently settled with Community Health Systems, Inc. (CHS) for \$89.15 million to resolve allegations that it violated the False Claims Act by billing Medicare, Medicaid, and Tricare for medically unnecessary admissions presenting in the emergency department from 2005-2010. The federal government alleges CHS's practices were part of a "corporate-driven scheme" to increase inpatient admissions of federal program beneficiaries over the age of 65 who could have been treated in an observation or outpatient setting.<sup>3</sup>

### OUTPATIENT OBSERVATION SERVICES

When patients visit a hospital's emergency department to receive care, they are either treated in an outpatient setting or if their condition is acute enough in physicians' judgment, they are admitted to the hospital as inpatients. Some ED patients' conditions may appear to be acute enough that an admission could be warranted, but still the decision of whether to admit them or not is unclear until after a period of continued monitoring. For such patients, observation services – an outpatient level of care – may be more appropriate than an automatic admission.

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<sup>1</sup> OSHPD Utilization Data 2013

<sup>2</sup> Report on Medicare Compliance, Vol. 15, Num. 37. "In Hospital Observation Struggle, Uncertain Outcomes May Justify Inpatient Admissions." October 23, 2006.

<sup>3</sup> United States Department of Justice, Office of Public Affairs, Press Release 8/4/14 (Accessed on 8/8/14).

## OUTPATIENT OBSERVATION SERVICES AT PRIME HOSPITALS

An analysis of Medicare claims data shows that observation claims at Prime hospitals are exceedingly rare. Figure 1 shows the system's average observation rate among ED encounters between FFY 2007 and 2012.<sup>4</sup> Prime's average is *below 0.5% in every single year*. The national average, on the other hand, was at roughly 4% in 2007 and has increased steadily since, reaching more than 6% in 2012. Observation claims for Medicare beneficiaries are so rare at Prime hospitals that we would not be able to report individual hospital rates for most years due to cell size suppression requirements intended to protect patient privacy.

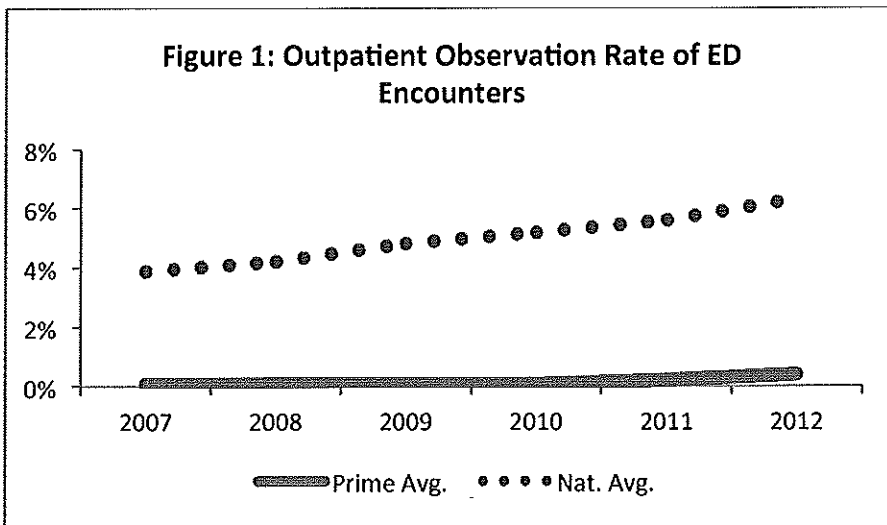
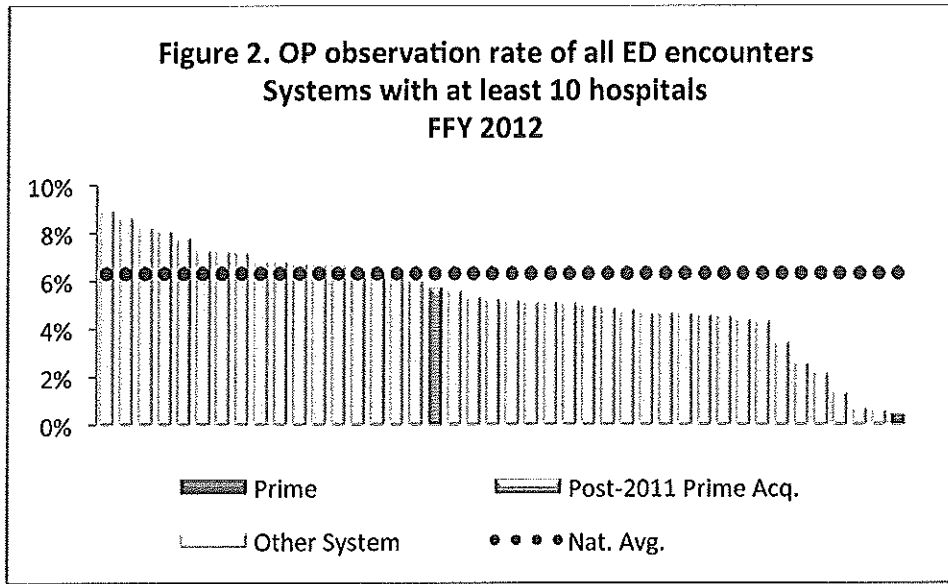


Figure 2 compares Prime's system average observation rate to those of other large systems in FFY 2012. While many other systems fall short of the national average rate, Prime's nearly 0% rate has few peers – and this is at Prime's high point during the period of FFY 2007 to 2012. Prime's acquisitions from years following FFY 2011 have been included as a group in the chart as well. Grouped together, they produced a rate of nearly 6%; it will be important to see if their behavior changed in 2013, once data becomes available.

<sup>4</sup> We calculate a hospital's observation rate as its rate of ED outpatient discharges with observation charges out of all ED encounters. Observation charges are identified via Medicare claim revenue center codes. Additional methodology is available upon request.



**ADMISSIONS AT PRIME HOSPITALS**

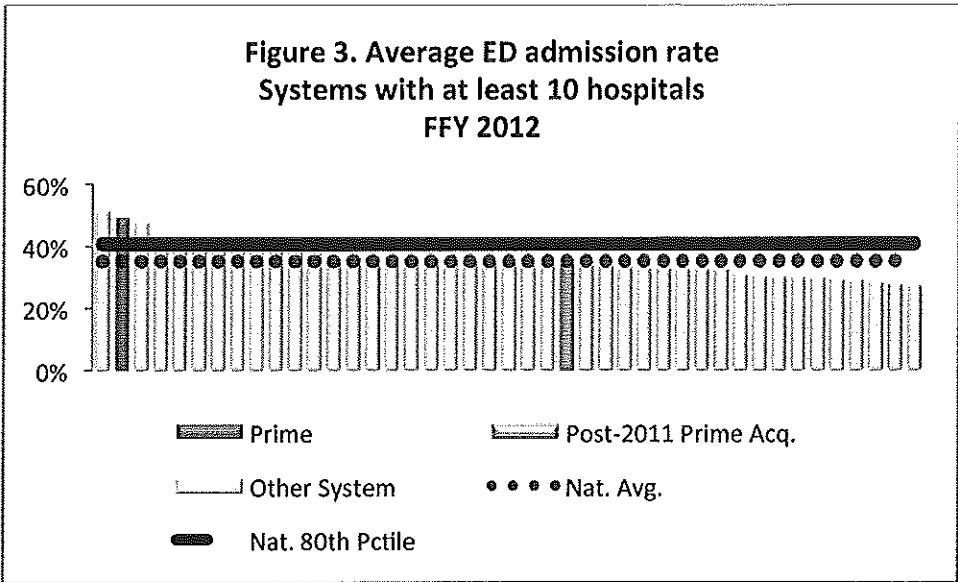
Compared to other hospitals, admission rates among Medicare ED encounters are higher at Prime-owned facilities. Furthermore, these practices appear to begin at many Prime hospitals after their acquisition by the system.

Figure 3 shows the average ED admission rate at Prime hospitals in FFY 2012, and it compares it to other large hospital systems as well as to national benchmarks.<sup>5</sup> As is immediately clear, Prime’s system average<sup>6</sup> – represented by the red bar – is one of the highest among large systems in the country. Furthermore, not only does the Prime system’s average of 49% exceed the weighted average national ED admission rate of 35%, it is also above the ED admission rate below which 80<sup>th</sup> percentile of qualifying US hospitals fall. Indeed, 12 of Prime’s 14 hospitals in FFY 2012 are above the 80<sup>th</sup> national percentile for ED admission rates. As a point of reference for future analysis, Prime’s acquisitions from years following FFY 2011 have been included as a group in the chart, as they were either not under Prime’s control during this year or they had just entered it within the year.<sup>7</sup> Collectively these hospitals – represented by the green bar – have an ED admission rate below the national average in FFY 2012.

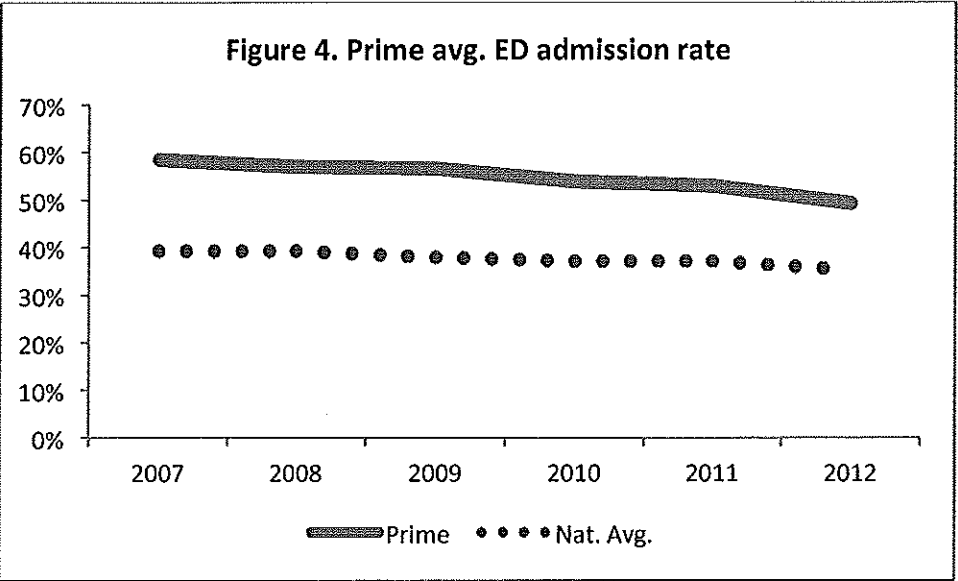
<sup>5</sup> Analysis performed using claims data from the Medicare Inpatient and Outpatient Standard Analytical Files (SAF). Only short-term acute care facilities were included in this analysis. ED claims were identified via their revenue center codes and/or HCPCS codes, following ResDAC’s suggestions. See “How to Identify Emergency Room Services in the Medicare Claims Data.” Technical Brief, ResDAC Publication Number TN-003. Only hospitals with at least 12 qualifying ED admissions and at least 12 qualifying ED outpatient discharges within a given year were included in this analysis. Additional methodology is available upon request.

<sup>6</sup> In this analysis, hospitals are included as part of the Prime system average calculations beginning in the first Federal Fiscal Year after their acquisition by Prime.

<sup>7</sup> These hospitals did not have a common system affiliation prior to acquisition by Prime, and most are located in states other than California. They are grouped together here only for comparison to the hospitals that are under Prime control as of FFY 2011.



Prime's high ED admission rates are not limited to 2012. Figure 4 shows Prime's system average ED admission rate – and the corresponding national average – from FFY 2007 through 2012. While the number of Prime hospitals changes over this time due to acquisitions that occurred during the period, the system average remains consistently well above the national average. Over this span, the national average was somewhere between 35% and 40%, but Prime's system average hovered between about 50% and 60%.



**ED ADMISSION RATES AT INDIVIDUAL PRIME ACQUISITIONS**

Exploration of Prime's acquisitions reveal that these high hospital ED admission rates appear to follow their acquisition by Prime. The following charts present the ED admission rate across years for hospitals acquired

by Prime in FFY 2006 or later. A common result appears: a large jump in the hospital's admission rate within a year of acquisition, which then remains high in the years following.

