Health Care Market Oversight

Transaction 006
Adventist-MCMC
30-Day Review Report

April 13, 2023

Oregon Health Authority

About this Report

This report summarizes analyses and findings from Oregon Health Authority's preliminary (30-day) review of the proposed material change transaction of Adventist Health System/West and Mid-Columbia Medical Center. It accompanies the Findings of Fact, Conclusions of Law, and Final Order ("Order") issued by Oregon Health Authority on April 13, 2023. For legal requirements related to the proposed transaction, please reference the Order.

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If you have any questions about this report or would like to request more information, please contact hcmo.info@oha.oregon.gov.

Executive Summary

The Health Care Market Oversight (HCMO) program reviews proposed heath care business deals to make sure they support statewide goals related to cost, equity, access, and quality. After completing a review, the Oregon Health Authority (OHA) issues a decision about whether a business deal, or transaction, involving a health care company should proceed. On January 24, 2023, OHA confirmed receipt of a completed Notice of Material Change Transaction ("Notice") from Adventist Health System/West ("Adventist Health" or "Adventist"), a nonprofit religious health system.

Proposed Transaction

Through this transaction, Adventist Health will acquire Mid-Columbia Medical Center ("MCMC"), a nonprofit corporation that operates a community hospital, a cancer center, and 22 health care clinics in and around The Dalles, Oregon. MCMC will become a member hospital of the Adventist Health network in Oregon, which includes Adventist Portland and Adventist Tillamook hospitals, and part of the Adventist Health system. Adventist Health will provide $100 million in funding ("capital commitment") to MCMC over ten years and expects to continue to offer MCMC's existing health care services locally in MCMC's service area.

OHA's Review

OHA completed a 30-day preliminary review of the proposed transaction to assess the likely impact of the transaction across four domains: cost, access, quality, and equity. OHA reviewed documents and other materials submitted by Adventist Health in connection with the Notice, issued a series of follow-up questions and information requests, and analyzed data from various publicly available sources. OHA held a 14-day public comment period and received 50 written public comments.

Key Findings

OHA's preliminary review analyses and findings are presented in the Review Report.

Cost

MCMC is facing significant financial challenges; it posted a $10 million operating loss in 2022, and its days cash on hand is below acceptable thresholds for hospitals in Oregon. It recently suspended medical oncology services at Celilo Cancer Center due to staffing shortages. Should these trends continue, OHA believes there is considerable risk that MCMC will be forced to further cut services in the next 12 months. The proposed transaction will substantially improve MCMC's financial condition. OHA has placed conditions to monitor Adventist's spending of the capital commitment.

Access

MCMC is a critically important provider of inpatient hospital care, primary care, and specialty care to Oregon communities in the Columbia Gorge. Adventist and MCMC assert that the transaction will not reduce access to services and is needed to maintain current access levels. They expect that the transaction will enable MCMC to expand services for residents of its service area, although Adventist Health's future decisions regarding service offerings will be subject to financial and staffing constraints. OHA has imposed conditions aimed at ensuring that access to essential services is maintained in the ten years following the closing of the transaction.

Quality

MCMC's performance on quality measures has been uneven in recent years. The COVID-19 pandemic, staffing challenges, and financial issues at MCMC are likely to have contributed to worse quality outcomes. Adventist has made commitments that may improve quality, including capital investments, efforts to recruit and retain staff, and quality improvement initiatives and technology. OHA will monitor MCMC quality measures in follow-up analyses.

Equity

MCMC is the only secular hospital serving a large geographic area; the closest hospital is part of a Catholic health system. Public comments raised concerns that Adventist, a faith-based organization, may restrict access to care for some services, including gender-affirming care, reproductive health services, and Death with Dignity Act services. MCMC facilities have low volumes for some of these services and refer patients to other providers. OHA has applied conditions to its approval of the transaction to ensure that Adventist and MCMC keep their commitments and continue to make existing MCMC services available for at least ten years following the closing of the transaction.

Conclusions and Decision

Based on preliminary review findings, **OHA approved the transaction with conditions on April 13, 2023**. (See Findings of Fact, Conclusions of Law, and Final Order.) OHA made its decision based on this criterion:

- **The transaction is in the interest of consumers and is urgently necessary to maintain the solvency of MCMC.** The transaction will not lead to horizontal consolidation and thereby restrict competition. Adventist has committed to maintaining substantially all MCMC's facilities, services, and programs, including existing reproductive and end-of-life services. Adventist and MCMC maintain that the affiliation will enhance MCMC's ability to attract and maintain physicians and expand services for local communities. MCMC is facing significant financial challenges, and there are solvency concerns for the hospital if the transaction is not completed. Adventist will assume MCMC's current financial obligations and has committed to investing $100 million of capital in MCMC over the next ten years.

The transaction is approved subject to the conditions summarized below.

Access conditions

1. For ten years following the closing date of the transaction, Adventist and MCMC shall use commercially reasonable efforts to continue to operate and maintain MCMC as a licensed general hospital.
2. For ten years following the closing date of the transaction, Adventist and MCMC shall use commercially reasonable efforts to continue to operate and maintain existing MCMC facilities, services, and programs at or above current service levels.
3. For ten years following the closing date of the transaction, Adventist and MCMC shall use commercially reasonable efforts to maintain existing MCMC services at current levels and maintain referral policies for reproductive health care services, gender affirming care, and Death with Dignity Act services.

4. For ten years following the closing date of the transaction, Adventist and MCMC shall maintain participation in public health care coverage programs, including Medicaid.
5. Within one year following the closing date of the transaction, Adventist and MCMC shall have used commercially reasonable efforts to restore medical oncology services at Celilo Cancer Center.
6. MCMC and Adventist shall not significantly reduce, restrict, or terminate facilities, services, or programs described in 1-5 unless they have requested and obtained OHA's approval for such changes.
7. If unplanned provider departure(s) at MCMC result in significant temporary reductions, restrictions, or terminations of the facilities, services, or programs described in 1-5, MCMC and Adventist shall notify OHA in writing within five business days, including documentation to support the need for such temporary changes.

Capital investment conditions

8. Adventist shall invest $100 million (the "Capital Commitment") in MCMC under the terms of the Affiliation Agreement.
9. Within five business days of the completion of a Capital Investment Plan, detailing how the Capital Commitment will be spent, Adventist and MCMC shall share the plan with OHA.
10. Within five business days of the completion of the Urgent Capital Needs Plan, Adventist and MCMC shall submit a copy of this plan to OHA.

Annual reporting condition

11. For ten years following the closing date of the transaction, Adventist and MCMC shall submit an annual report to OHA describing compliance with approval conditions and spending of the $100 million Capital Commitment. Adventist and MCMC shall share a public version of the annual report on MCMC's website.

OHA will assess the impact of the transaction on quality of care, access to care, affordability, and health equity by conducting follow up analyses at minimum one year, two years, and five years after the transaction is completed. These analyses will include follow-up on concerns or observations noted in the Review Report.

About HCMO

In 2021, the Oregon Legislature passed House Bill 2362, giving the Oregon Health Authority (OHA) the responsibility to review and decide whether some transactions involving health care entities should proceed. In March 2022, OHA launched the Health Care Market Oversight program (HCMO). This program reviews proposed health care transactions such as mergers, acquisitions, and affiliations to ensure they support statewide goals related to cost, equity, access, and quality.

The HCMO program is governed by Oregon Revised Statute 415.500 et seq. and Oregon Administrative Rules 409-070-0000 through -0085.

In the authorizing statute, the Oregon Legislature specified what types of proposed transactions are subject to review and the criteria OHA must use when analyzing a given proposed transaction. The Oregon Legislature also authorized OHA to decide the outcome of a proposed transaction. After analyzing a given proposed transaction, OHA may approve, approve with conditions, or reject it.

The Health Care Market Oversight program fits within OHA's broader mission of ensuring all people and communities can achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality, affordable health care.

Proposed Transaction

On December 23, 2022 OHA confirmed receipt of a Notice of Material Change Transaction ("Notice") from Adventist Health System/West ("Adventist Health" or "Adventist"). The Notice describes plans for Adventist Health to acquire Mid-Columbia Medical Center ("MCMC"). Adventist Health and MCMC are sometimes collectively referred to as the "Entities".

OHA reviewed the Notice and determined, based on the information provided in the Notice, that the proposed transaction (the "transaction") is subject to review. Entities meet the revenue thresholds specified in Oregon Administrative Rule (OAR) 409-070-0015, and the proposed transaction is otherwise covered by HCMO in accordance with OAR 409-070-0010.

On December 27, 2022, OHA notified the Entities that their submission was incomplete and requested additional information.

On January 24, 2023, OHA confirmed receipt of a complete application and began a preliminary review of the transaction. Preliminary reviews must be completed within 30 days of OHA's confirmation of receipt of a complete Notice, unless extended in accordance with applicable statutes and administrative rules.

This report describes the transaction, OHA's approach to the review, its findings, and OHA's conclusions of law based on these findings.

Since MCMC is a nonprofit hospital, it is subject to regulation by the Oregon Department of Justice (DOJ) Charitable Activities Section. Adventist and MCMC separately notified DOJ of the proposed transaction. OHA and DOJ staff coordinated on the review of this transaction but will issue separate decisions.

Entities Involved

The main entities involved in this transaction are Mid-Columbia Medical Center, Adventist Health, and Stone Point Health.

Mid-Columbia Medical Center (MCMC)

MCMC is a nonprofit corporation based in The Dalles, Oregon. Founded in 1901, MCMC is the largest employer in Wasco County, with more than 850 employees.[1]

MCMC serves residents of north-central Oregon and Washington along the Columbia River, including Wasco, Sherman and Gilliam counties in Oregon and Klickitat County in Washington. In 2021, MCMC provided approximately:[2]

- 1,500 outpatient surgeries
- 2,000 inpatient hospital stays
- 13,000 emergency department visits
- 212,000 outpatient visits

In 2021, MCMC's total revenue from patient services was more than $130 million, with profits totaling $1.7 million ($0.5 million from operating activities).[3] Net cash from operating activities was negative $5.7 million in 2021, and the corporation ended 2021 with $22.5 million in cash assets.

> *"MCMC is an anchor institution in The Dalles and Columbia River Gorge […]. The breadth of specialty services currently available at MCMC is a truly valuable benefit for a community of our size."*
>
> - MCMC Chief Medical Officer, January 13, 2022

MCMC has a history of adhering to the Planetree philosophy of person-centered care, though it is not currently certified.[i] [4]

Facilities and Services

MCMC currently owns and operates a community hospital licensed for 49 beds, four federally certified rural health clinics (RHCs), 18 outpatient clinics, and the Celilo Cancer Center (see table below for full list of locations).

MCMC's hospital offers a range of services including emergency services, general surgery, labor and delivery, newborn care, cardiology, orthopedics, neurology, cancer care, urology, and more. It is federally designated as a Sole Community Hospital (SCH) and Rural Referral Center (RRC). Because of these designations, MCMC is eligible for the 340B Drug Pricing Program, which allows the hospital to purchase prescription drugs at discounted rates.

MCMC also meets Oregon's criteria for designation as a "Type B" hospital (50 or fewer beds located within 30 miles of another hospital).

In addition to the main hospital, MCMC operates outpatient clinics that provide primary, specialty, urgent, and surgical care. See the table below for information about MCMC's locations.

MCMC recently announced it is temporarily discontinuing medical oncology services (including chemotherapy and immunotherapy) at Celilo Cancer Center, effective February 28, 2023.[5] This change is further discussed in the Access section below.

Federal Designations

The Centers for Medicare and Medicaid Services (CMS) designates various hospital and clinic types for regulatory and payment purposes.

A **Sole Community Hospital (SCH)** is a hospital located in a rural area or at least 35 miles from another hospital. Additionally, no more than 25% of residents or Medicare beneficiaries staying at the hospital are admitted to other like hospitals.

A **Rural Referral Center (RRC)** is typically a hospital located in a rural area where at least 50% of Medicare patients are referrals, and 60% of Medicare patients live at least 25 miles away.

A **Rural Health Clinic (RHC)** is a primary care clinic located in a rural area designated as having a shortage of health care providers. RHCs qualify for enhanced reimbursement rates from Medicare and Medicaid to cover higher costs for providing care in underserved areas.

A **Critical Access Hospital (CAH)** is a hospital with 25 or fewer beds that provides 24/7 emergency care and is located more than 35 miles from another hospital. A CAH designation allows hospitals to receive benefits designed to improve the sustainability of the facility.

[i] Planetree is a model of patient-centered care that seeks to create healthy, encouraging environments for patients and their caregivers and address the needs of the surrounding community.

Facility Name	Description (services)	Location
The Dalles		
Mid-Columbia Medical Center	Main hospital building	1700 E. 19th Street The Dalles, OR 97058
Celilo Cancer Center	Cancer treatment center	1800 E. 19th Street The Dalles, OR 97058
Columbia River Women's Center	RHC & specialty clinic (obstetrics & gynecology)	1810 E 19th Street The Dalles, OR 97058
MCMC Surgical Clinic	Surgery clinic	1810 E 19th Street The Dalles, OR 97058
Columbia Gorge Urology	Urology clinic	1805 E. 19th Street The Dalles, OR 97058
Occupational Medicine	Occupational health, laboratory	1825 E19th Street The Dalles, OR 97058
Columbia Gorge ENT & Allergy	Ear-nose-throat & allergy clinic	1815 E 19th Street The Dalles, OR 97058
Columbia Gorge Medical Clinic	RHC & specialty clinic (family medicine, neurology, dermatology, pediatrics)	1935 E 19th Street The Dalles, OR 97058
MCMC Family Medicine	RHC (family medicine, behavioral health, family medicine laboratory)	1620 E. 12th Street The Dalles, OR 97058
Water's Edge Medical Center	RHC & specialty clinics (outpatient therapy, urgent care, internal medicine, nephrology, cardiology, orthopedics, and sleep medicine)	551 Lone Pine Blvd., The Dalles, OR 97058
Visiting Health Services	Home-based care (nursing, physical therapy, occupational therapy, speech pathology, social work, home health aides)	1730 E 12th Street The Dalles, OR 97058
Other Locations		
MCMC Specialty Clinics at Nichols Landing	Multi-specialty center (urology, orthopedics, cardiology)	33 Nichols Pkwy, Suite 350, Hood River, OR 97031

Governance

MCMC is governed by a Board of Trustees consisting of ten members. Board members have backgrounds in health care, social work, nonprofit leadership, construction, public administration, natural resources, social services, and business. One board member has a medical degree.[6]

Partnerships

MCMC relies on various clinical affiliations and partnerships to provide certain specialty services. MCMC currently has a clinical partnership with the Northwest Regional Heart and Vascular team at

Adventist Health Portland to provide cardiology services to MCMC patients.[7] Other provider organizations affiliated with MCMC include: [8]

- Diagnostic Radiologists, P.C. (radiologist interpretation services),
- Columbia Gorge Pathology Associates LLP (pathologist interpretation services)
- Oxford Anesthesia Management, LLC (anesthesiology services)

Until late 2021, MCMC had a clinical collaboration agreement with Oregon Health & Science University (OHSU) for these services. The OHSU agreement, effective 2014 through 2021, also included general surgery, orthopedics, endocrinology, and primary care.

Dry Hollow

Dry Hollow Professional Center, Inc. ("Dry Hollow") is an Oregon for-profit corporation affiliated with MCMC. Dry Hollow owns and operates a medical professional building.[9]

Mid-Columbia Health Foundation

Mid-Columbia Health Foundation ("MCH") is an Oregon nonprofit corporation affiliated with MCMC. The Foundation was established in 1983 to raise funds for MCMC with the goal of ensuring access to high quality health care in the Columbia Gorge region.[10]

Adventist Health

Adventist Health is a nonprofit religious health system serving more than 80 communities in California, Hawaii, Oregon, and Washington.

The company is headquartered in Roseville, California and is one of several large health systems in the U.S. that are associated with the Seventh-day Adventist Church. Its mission is "Living God's love by inspiring health, wholeness and hope."[11] The Seventh-day Adventist Church has been operating hospitals and health care facilities since the 19th century; Adventist Health was formed in 1980 when two regional health systems merged.[12] While church leaders serve on Adventist Health's board of directors, the company states that the Seventh-day Adventist Church does not control or have ownership in the Adventist Health.[13]

Adventist Health's workforce consists of 37,000 individuals including employed physicians, allied health professionals, and support services. In 2021, the company saw $5.2 billion in total revenue, $149 million in operating losses, and overall profits of $8 million.[14] Net cash from operating activities was $145 million, and the system ended 2021 with $304 million in cash assets. In 2022, Adventist Health reported more

Adventist Health by the numbers

Workforce

- 37,000 employees

Financials (2021)

- $5.2 billion total revenue
- $149 million operating loss
- $8 million total income

Facilities

- 23 hospitals
- 379 clinics
- 15 home health agencies
- 8 hospice agencies

Visits and admissions

- 4.2 million outpatient visits
- 725,000 emergency room visits
- 240,000 hospice and home health visits
- 128,000 hospital admissions

Payer mix

- 44% Medicare
- 30% Medicaid
- 24% Commercial and other
- 2% self-pay

than 128,000 hospital admissions and 4.2 million outpatient visits.[15] In 2021, about 44% of patients had Medicare coverage.

The Pacific Northwest region, to which Oregon hospitals belong, accounts for about 13% of Adventist Health's total patient revenue.[16]

Facilities and Services

Adventist Health owns or operates 23 hospitals, 379 clinics, 15 home care agencies, eight hospice agencies, one continuing care retirement community, and three joint venture retirement centers. In Oregon, Adventist Health owns and operates Adventist Health Portland and has a long-term lease to operate Adventist Health Tillamook in partnership with Tillamook County.

The table below lists hospitals affiliated with Adventist Health in Oregon, Hawaii, and California.[17]

State	Hospitals	
California	Adventist Health and Rideout	Adventist Health Selma
	Adventist Health Bakersfield	Adventist Health Simi Valley
	Adventist Health Clear Lake	Adventist Health Sonora
	Adventist Health Delano	Adventist Health St. Helena
	Adventist Health Feather River*	Adventist Health Tehachapi Valley
	Adventist Health Glendale	Adventist Health Tulare
	Adventist Health Hanford	Adventist Health Ukiah Valley
	Adventist Health Howard Memorial	Adventist Health Vallejo
	Adventist Health Lodi Memorial	Adventist Health White Memorial
	Adventist Health Mendocino Coast	Dameron Hospital
	Adventist Health Reedley	
Hawaii	Adventist Health Castle	
Oregon	Adventist Health Tillamook	Adventist Health Portland

*Closed due to fire damage.

Governance

Adventist Health is governed by a 12-member corporate Board of Directors, which includes leaders from the Seventh-day Adventist Church.[18] The corporate Board of Directors serves as the legal board for individual Adventist Health hospitals.[19] Adventist Health hospitals, however, may maintain their own community boards or have foundations with separate boards, such as the Adventist Health Portland Foundation.[20]

Some Adventist Health hospitals operate under a subsidiary holding company called Stone Point Health (see below for more information about this subsidiary). The proposed transaction plans for MCMC to be under Stone Point Health after the close of the transaction.

In 2022, Adventist Health announced administrative and leadership re-structuring and brought in a new Chief Executive Officer, Chief Financial Officer, and Chief Operating Officer.[21] In 2023, Adventist Health announced further reorganization, including administration reductions. The re-organization is part of Adventist Health's strategic plan to centralize operations and operate more efficiently.[22]

Mergers, Acquisitions, and Partnerships

In recent years, Adventist Health has grown through leveraging acquisitions, affiliations, and partnerships to build its network of hospitals and clinics, particularly focused on rural areas and independent hospitals facing financial challenges.[23]

Since 2017, Adventist Health has pursued multiple transactions to grow their network of affiliated hospitals and health care providers.

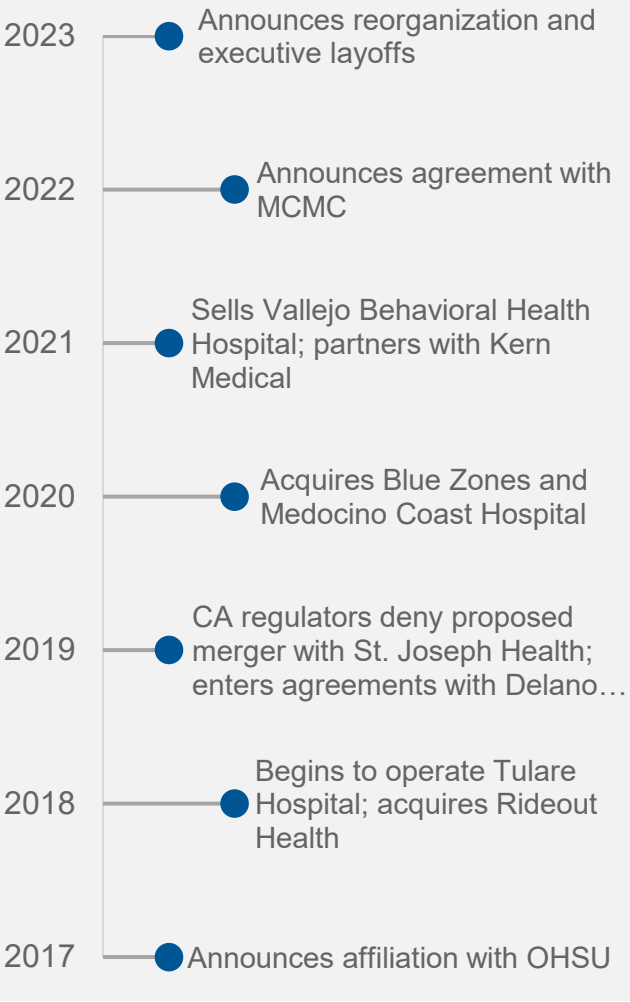
In 2020, Adventist Health signed an agreement with Mendocino Coast District Hospital, a 25-bed critical access hospital in California. Per the agreement, Adventist Health will manage and operate the hospital and must maintain at least 25 beds, emergency care, and acute care services.[24] [25]

In 2020, Adventist Health acquired Blue Zones, a company focused on identifying communities where people live longer lives and working with communities to build environments that support health and well-being.[ii] By acquiring Blue Zones, Adventist Health states that they will:

> *"…gain ground in shifting the balance from healthcare–treating people once they are ill–to transformative well-being–changing the way communities live, work and play. Blue Zones widens our impact from only reaching our hospitals' communities in four states, to a global mission practice."* [26]

In 2019, Adventist Health entered into an affiliation agreement with Delano Regional Medical Center and an agreement to manage Dameron Hospital.[27] [28]

Timeline of select Adventist Health growth activities



In 2019, Adventist Health sought to merge with St. Joseph Health, a large Catholic health system based in California. The California Department of Justice denied the transaction, citing the potential for increased costs and concerns about access and availability of health care services.[29]

In 2018, Adventist Health reached a lease agreement to re-open Tulare Hospital, which had closed due to bankruptcy in 2017, including its birthing center.[30]

Adventist Health Tillamook

Adventist Health operates Adventist Health Tillamook, a 25-bed rural hospital with affiliated clinics and services. Adventist Health Tillamook hospital includes emergency, surgery, laboratory, and

[ii] One of the original Blue Zones is a Seventh-day Adventist community in Loma Linda, California.

birthing services, and operates nine rural health clinics and four urgent care locations. In 2022, Adventist Health Tillamook had 45,949 outpatient visits and 214 inpatient stays.

Since 1973, Tillamook County has had a long term-management lease agreement with Adventist Health to operate the hospital with affiliated clinics and services.[31] The current agreement is effective through 2045.

Adventist Health Portland

Adventist Health Portland includes a 302-bed acute care hospital, 27 medical clinics, and home care and hospice services in the Portland metro area. Adventist Health Portland had 116,783 outpatient visits and 1,802 inpatient stays in 2022.

Since the beginning of 2018, Adventist Portland has had an affiliation agreement with OHSU to integrate clinical services.[32] Through this agreement, Adventist Health continues to own separate hospital licenses, capital assets, and employees. OHSU and Adventist Health Portland are part of the same network and share a bottom line. This agreement does not include OHSU's education or research lines, nor does it include any other Adventist Health hospitals. Adventist Health Portland's board of directors aligns with the corporate Board of Directors for Adventist Health System.[33]

Stone Point Health

Stone Point Health is a California nonprofit organization. It is an intermediate holding company within the Adventist Health system and is not involved in any other activities or businesses. The governing board of Stone Point Health is the same as the corporate Board of Directors of Adventist Health. Adventist Health has a management services agreement with Stone Point Health to provide corporate services. Under the transaction terms, Stone Point Health would become the sole corporate member of MCMC.

Rationale for the Transaction

MCMC first announced in January 2022 that it was exploring whether to remain independent or partner with another health care organization. According to MCMC's Chief Executive Officer (CEO), the process would help identify the best strategy for "the future of healthcare in the Columbia Gorge River region."[34]

"Today's healthcare industry is continually being challenged, with rural community hospitals like ours facing the strongest headwinds."

- MCMC CEO, September 2022

"We recognize that partnering with another health system could potentially help us move forward with our plans in a way, and at a pace, that we could not achieve on our own."

- MCMC Board member, August 2022

Partnership Exploration

As part of this exploration, MCMC's Board of Trustees, leadership team, and physician leadership planned to evaluate potential partners based on the following priorities:[35]

- Keeping more care local by investing in and building a more robust physician and provider team, with a focus on primary care and specialty services.
- Maintaining and enhancing employee and provider satisfaction.
- Investing in its employees.
- Improving rural and community care.
- Exploring innovative rural health care models for person-centered care close to home.
- Offering a wide breadth and depth of specialty services.

- Supporting its Planetree person-centered mission.
- Creating a superior healthcare campus, with all private rooms and expanded high-quality care in a collaborative, technologically advanced environment.
- Ensuring local input and a commitment to collaborate with community partners.

MCMC's Board of Trustees worked with Juniper Advisory, an investment banking firm specialized in health care to review potential health system affiliates. In August 2022, MCMC announced the selection of as Adventist Health as its chosen system, citing Adventist Health's shared mission and vision, rural health expertise, investment in communities and staff, and dedication to the long-term viability of its affiliated health systems.[36]

Driving Factors

Based on the Entities' filings and OHA's review of contemporaneous news sources and press releases, MCMC's interest in a partnership or affiliation with a larger health system was driven by three interrelated factors: capital needs, recruitment challenges, and other financial considerations.

Generally, these factors were not unique to MCMC. Rural hospitals are generally less profitable than hospitals in urban areas, due to lower patient volume, older and sicker patient populations, a higher share of Medicaid or uninsured patients, difficulties finding clinical staff to work in rural areas, and other challenges.[37] Lower profitability translates, over time, to smaller financial reserves to use for capital or strategic spending such as facility improvements, recruitment incentives, and new technology systems. It also becomes difficult to generate investment income that may help bridge operating losses. Although rural hospitals receive additional federal and state support, this may not be sufficient for some rural hospitals to remain financially viable. Financial difficulties have driven numerous rural hospitals in other states to close in recent years.[38]

The below sections describe how these factors affected MCMC specifically in 2021-2022. See the **Findings & Potential Impacts** section below for further discussion of how the proposed transaction may address these issues.

Capital Needs

MCMC's main hospital facility was built in 1959 and, by 2022, needed substantial upgrades and repairs. At a presentation to Wasco County Commissioners in late 2021, MCMC described the current hospital as "outdated and costly to maintain," noting it lacked space for expansion to house providers together (rather than in multiple locations) and meet community needs for behavioral health services. [39]

To address these challenges, MCMC planned to build a new hospital including all private patient rooms, state-of-the-art diagnostic equipment, and an expanded Emergency Department (ED).[40] MCMC initially planned to finance the construction through operating revenues, investment returns, and charitable contributions.[41] In a January 2022 interview with local press, MCMC's CEO stated funding for the new facility could come from a federal agency loan (e.g., the U.S. Department of Housing and Urban Development or U.S. Department of Agriculture).[42] He noted that a partnership would help with funding.[43]

> *"Confronting these access-to-capital and other financial challenges, MCMC concurrently evaluated whether to remain independent or to seek affiliation with a large, stable, well-regarded, and like-minded corporate partner."*
>
> - Adventist Health & MCMC Supplemental Information Packet, January 18, 2023

As MCMC's financial performance deteriorated in 2021, so did its chances of obtaining a loan to finance the new campus construction. Affiliation with a larger, more financially stable health system was thus an attractive option for accessing the needed funding.[44]

Recruitment Challenges

MCMC considered partnering with a health system to build its provider team and facilitate recruitment and retention of physicians and other clinical staff.[45] Recruiting physicians and other advanced practice providers is generally more difficult for rural hospitals.[46] The COVID-19 pandemic exacerbated these challenges, making workforce a key concern across the U.S. health care system. In addition to these broader trends, MCMC suffered multiple physician departures, particularly among primary care providers, after several staffing agreements with OHSU ended in late 2021.[47]

Under MCMC's collaboration with OHSU, OHSU-employed physicians were the exclusive providers of primary care services at MCMC. OHSU was responsible for the recruitment, hiring, and employment of primary care providers to serve MCMC patients. The collaboration also included professional services agreements in general surgery, cardiology, orthopedics, and endocrinology whereby OHSU physicians provided services at MCMC locations.[48]

Other Financial Considerations

In announcing the Adventist Health affiliation plans, MCMC cited the goal to "maintain and enhance the immediate and long-term financial viability of MCMC" at the top of its list of objectives for the transaction.[49] MCMC's operating performance and financial condition have worsened in recent years. The corporation reported an operating loss of $9.8 million in 2022, and cash assets declined from $31.5 million in 2020 to $5.7 million by the end of 2022. Annual cash flows from operating activities dropped from (positive) $28.2 million in 2020 to negative $20.2 million in 2022.[50] MCMC's CEO cited significantly higher costs, staffing shortages, and the end of pandemic-related government aid as key contributing factors.[51]

Transaction Terms

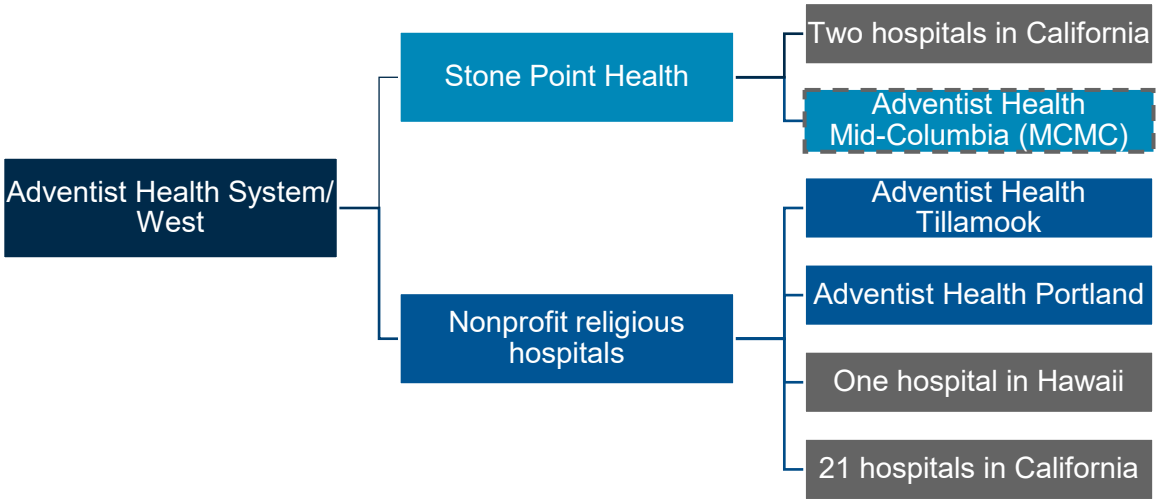
On August 1, 2022, Adventist Health and MCMC signed a non-binding Letter of Intent ("LOI") outlining the terms of the proposed acquisition. On March 1, 2023, the Entities executed an Affiliation Agreement ("affiliation agreement") building on and formalizing these terms. The following is a summary of the transaction terms:

- Adventist Health will acquire MCMC, making MCMC a member hospital of the Adventist Health network in Oregon and part of the overall Adventist Health system. Adventist Health will assume all the assets and liabilities of MCMC and its affiliated entity, Dry Hollow Professional Center, Inc.
- The transaction will be implemented through Adventist Health's wholly owned subsidiary, Stone Point Health. Stone Point Health will become the sole corporate member of MCMC, thereby making Adventist Health the indirect parent of MCMC. (See organizational chart below.)
- Adventist Health will provide $100 million in funding ("**capital commitment**") to MCMC over the ten years immediately following the close of the transaction. Allowable uses for these funds include (1) capital expenditures, such as long-term improvements to the facilities at MCMC's main healthcare campus in The Dalles, (2) funding MCMC's net operating losses, (3) establishing, reestablishing, expanding, or retaining medical service lines, and (4) hiring, replacing, or retaining MCMC providers and staff.

- Adventist Health will make various commitments regarding provision of services and resources to MCMC, maintenance of clinical services, provision of charity care and community-based health programs, employment of MCMC's medical staff, and retention of MCMC employees.
- MCMC will remain an Oregon nonprofit corporation and maintain its status as employer of record for its personnel.
- MCMC will have a legal board of directors, the "**Corporate Board**," consisting of Adventist Health's board of directors, which will be responsible for MCMC's actions under state law. The Corporate Board will also serve as the directors of Stone Point Health.
- MCMC will also have a local board of directors, the "**Community Board**," which will include current MCMC board members, to provide oversight of MCMC operations and input to the Corporate Board.
- MCMC will be re-branded as "**Adventist Health Mid-Columbia**."
- The legal status of Mid-Columbia Health Foundation will not be affected by the transaction, although Adventist Health will assume MCMC's right to nominate directors or officers of the foundation.
- The affiliation agreement would be in effect for ten years following the date of transaction closing.

The below sections provide a summary, based on the affiliation agreement, of Adventist Health Mid-Columbia's governance and Adventist Health's commitments during the ten-year term of the agreement.

Post-Transaction Organizational Chart*



** Based on Exhibit D to Supplemental Information Packet filed by Adventist Health System/West, January 18, 2023.*

Governance of Adventist Health Mid-Columbia

Corporate Board

Under the affiliation agreement, the Corporate Board will bear ultimate responsibility for MCMC's actions under state law.[iii] The Corporate Board will oversee and delegate responsibilities in specific

[iii] Corporate Board members would also serve as directors of Stone Point Health.

areas to a Community Board. The Corporate Board will also delegate certain powers and functions to the president and other corporate officers of Adventist Health Mid-Columbia.

President

According to the affiliation agreement, the president of Adventist Health Mid-Columbia will be appointed by the chair of the Corporate Board. The president will manage day-to-day operations of Adventist Health Mid-Columbia and act as a liaison between the Corporate Board, the Community Board, and the medical staff of Adventist Health Mid-Columbia. Under the affiliation agreement, the responsibilities of the president will include:

- Carrying out all policies and procedures established by the Corporate Board.
- Executing contracts authorized by the Corporate Board.
- Maintaining physical properties in good operating condition
- Supervising collection and spending of funds consistent with annual budgets.
- Establishing goals and a long-range strategic plan for Adventist Mid-Columbia.
- Developing a plan for organizing Adventist Mid-Columbia's personnel.
- Selecting, employing, and overseeing employees of Adventist Mid-Columbia, including development of personnel policies and practices.
- Preparing annual operating capital expenditure and cash flow budgets for submission to the Corporate Board.
- Preparing other periodic reports on professional service and financial activities and presenting to the Board as required.

MCMC's current President & CEO and other current members of MCMC's executive leadership team will undergo a review and evaluation process conducted by Adventist Health.[iv] They will have opportunities to be considered for appropriate leadership roles within the broader Adventist Health system and will be assured an "ongoing role" in developing MCMC's strategic plan, operating budget, and capital budget.

Community Board

According to the affiliation agreement, the Corporate Board will appoint members of a committee called the Community Board. The Corporate Board will delegate powers and duties to the Community Board for the local operations of Adventist Health Mid-Columbia, and the Community Board will provide input to the Corporate Board. The Community Board will be governed by bylaws established as part of the affiliation agreement.[52]

Membership

The Community Board will consist of between nine and 23 members serving for two-year terms. According to the affiliation agreement, these members will include:

- The president of Adventist Health Mid-Columbia
- The CEO of Stone Point Health (who will act as board chair)
- The chief of staff of the medical staff
- Up to five other medical staff physicians
- Members of the public.

[iv] The affiliation agreement defines MCMC's Executive Leadership Team to include its President & Chief Executive Officer, Chief Financial Officer, Chief Information Officer, Chief Medical Officer, Chief Operating Officer, Chief Nursing Officer, Chief Clinical Officer, Medical Staff President, Medical Staff Vice President, and Medical Staff Secretary, as well as current members of the MCMC Board. These individuals are identified in Exhibit 3.15 of the affiliation agreement.

To be eligible for membership, members of the public will need to be aged 21 or over, have "an interest in health care matters," and support the goals of Adventist Health Mid-Columbia.[53] Additionally, membership selection will consider whether the person is:[54]

- Well-known and respected in the community.
- Involved in humanitarian activities, civic and service organizations, and community affairs.
- Successful in personal business matters.
- Able to make meaningful, relevant, and concise contributions to discussions and help make decisions.
- Able to give expert counsel using practical, technical, or professional knowledge and skills.

The Community Board will initially include all current members of MCMC's board of trustees, representatives from Adventist Health, medical staff physicians, and qualified community members. Former MCMC board members will serve on the Community Board for the remainder of their current term.

Responsibilities and Functions

According to the affiliation agreement, responsibilities and functions of the Community Board will include:

Planning and monitoring

- Evaluating Adventist Health's compliance with its commitments under the affiliation agreement. The Board could request documents and other information needed from Adventist Health to assess compliance.[55]
- Participating in the development of Adventist Health Mid-Columbia's strategic plan and approving the plan.
- Providing institutional planning to meet the health care needs of the community Adventist Health Mid-Columbia serves.
- Monitoring Adventist Health Mid-Columbia's clinical and financial performance.
- Providing input and advice to Adventist Health on any elimination or material reduction in Adventist Health Mid-Columbia's facilities, services, or programs.

Advisory

- Reviewing and advising Adventist Health Mid-Columbia's president regarding the annual operating budget, long-term capital expenditures plan and other short- and long-range plans.
- Providing input on the performance of Adventist Health Mid-Columbia's president and leadership team and advising Adventist Health on the hiring of the president. This would include conducting formal reviews of the president's performance.
- Consulting with the Corporate Board on the selection and retention of Adventist Health Mid-Columbia's president.
- Liaising with the Corporate Board through the President, including providing the Corporate Board with copies of all meeting notices, agendas, and minutes of the Community Board.

Medical staff management

- Overseeing, organizing, and supervising Adventist Health Mid-Columbia's medical staff. This includes approving medical staff bylaws, rules and regulations and ensuring the medical staff establish mechanisms to deliver high quality care.
- Deciding on medical staff appointments, reappointments, clinical privileges, and corrective action.
- Communicating with Adventist Health Mid-Columbia's administrative and medical staff, and ensuring medical staff are represented through attendance at Community Board meetings.

Quality and safety

- Ensuring a safe environment within Adventist Health Mid-Columbia's hospital and clinics for employees, medical staff, patients, and visitors.
- Establishing standards for service quality at Adventist Health Mid-Columbia and policies implementing these standards.
- Overseeing medical staff activities to preserve and improve quality and efficiency of patient care.
- Ensuring that Adventist Health Mid-Columbia's staff comply with all relevant laws and regulations, including the Health Care Quality Improvement Act.
- Cooperating with the president to make sure Adventist Health Mid-Columbia maintains applicable accreditations and eligibility for participation in selected payment programs (such as Medicare and Medicaid).

The Community Board will also be tasked with establishing and approving policies and procedures for carrying out these functions and responsibilities.

Integration Committee

Under the affiliation agreement, MCMC and Adventist Health will jointly appoint an Integration Committee responsible for coordinating the integration of MCMC and Adventist Health. This committee will consist of an equal number of MCMC and Adventist Health representatives and will be tasked with developing a plan to achieve "administrative and other savings" from the affiliation. The Integration Committee will also be responsible for overseeing MCMC's access to and implementation of Adventist Health corporate services, such as back-office support, quality improvement protocols and policies, technology infrastructure, joint purchasing programs, and other resources. (See **Appendix A: Commitments in the Affiliation Agreement** for details.)

Capital Commitment

The affiliation agreement provides four main uses for the capital commitment:

1. Capital expenditures.[v]
2. Funding MCMC's net operating losses.
3. Establishing, reestablishing, expanding, or retaining medical service lines.
4. Hiring, replacing, or retaining MCMC providers and staff.

Adventist Health commits to spending up to $6 million of the $100 million in the first two years post-closing on "capital needs deemed most urgent by the President of MCMC and the Oregon Network President of Adventist." This would include "urgently-needed major medical equipment" for MCMC's main hospital campus.[56]

The affiliation agreement provides that a portion of the capital commitment shall be used for planning, procuring, and implementing at MCMC an instance of the Epic Electronic Medical Record (EMR) system, to be interoperable with, or the same instance of, Adventist Health Portland's Epic EMR system.

The Entities have further stated that the capital commitment may be used for other expenses associated with the integration of MCMC into the Adventist Health system. Such expenses may

[v] Capital expenditures are defined in the affiliation agreement as "any expenditure which, in accordance with GAAP, would be required to be capitalized and shown on the consolidated balance sheet of MCMC, or which, with respect to information technology and other shared expenditures, would be required to appear on Adventist Health's balance sheet but would be beneficially used by MCMC."

include costs for converting MCMC's software systems and platforms for email, productivity, accounting, and human resource functions.[57]

The affiliation agreement also provides that the majority of the capital commitment shall be used for the following purposes:

- To revitalize and make long-term improvements to the facilities at MCMC's main healthcare campus in The Dalles.
- To finance strategic expansions for the benefit of MCMC.
- To purchase equipment and information technology software or systems, or finance capital projects costing $500,000 or more.
- To develop new health care facilities for MCMC.

Adventist Health and MCMC have agreed to convene a **Capital Committee** following the close of the proposed transaction. The committee would include representatives of the MCMC executive team, one member of its medical staff, and one member of the Community Board.

The Capital Committee will be charged with developing a **Capital Investment Plan** identifying the specific projects on which the $100 million should be spent and developing a budget and timeline for implementation of these projects over the 10-year investment window. The Capital Committee will be required to present its plan to Adventist Health's corporate Board of Directors for approval within eight months following the transaction's close. A decision on the Capital Investment Plan will consider MCMC's current needs and economic performance.

Will a new hospital be built?

Adventist Health and MCMC have continued to explore the building of a new facility as part of discussions surrounding the transaction. In the fall of 2022, the parties commissioned Moss Adams to assess the commercial viability of building a new hospital campus versus making improvements to existing facilities. The Entities provided the following summary of the analysis and conclusions:

"Moss Adams analyzed MCMC's financial, patient and medical services data; data on health care demand and providers in and around The Dalles; and estimated construction and capital improvement costs. Moss Adams concluded that projected demand for services and MCMC's projected future cash flows would not be sufficient to sustain the costs of construction of a new hospital campus at this time."

The affiliation agreement provides that Adventist Health shall have the sole discretion to review, modify, reject, or approve the Capital Investment Plan, following consultation with the Community Board. Any material modifications shall require the Capital Committee to develop an alternative plan for approval by the Community Board and ultimate approval by Adventist Health.

Other Commitments by Adventist Health

The affiliation agreement specifies numerous other commitments by Adventist Health regarding its actions following the close of the transaction. These involve the provision of corporate services, maintenance and growth of clinical services, provision of charity and community care, relationships with MCMC's medical staff, recruitment of physicians and advance practice providers, employee retention, and management of Adventist Health Mid-Columbia.[58] See **Appendix A: Commitments in the Affiliation Agreement** for detailed information about these commitments.

Findings & Potential Impacts

OHA compiled available data and information to examine the potential impacts of the transaction across four domains: access, cost, quality, and equity. OHA's analyses considered the following sources:

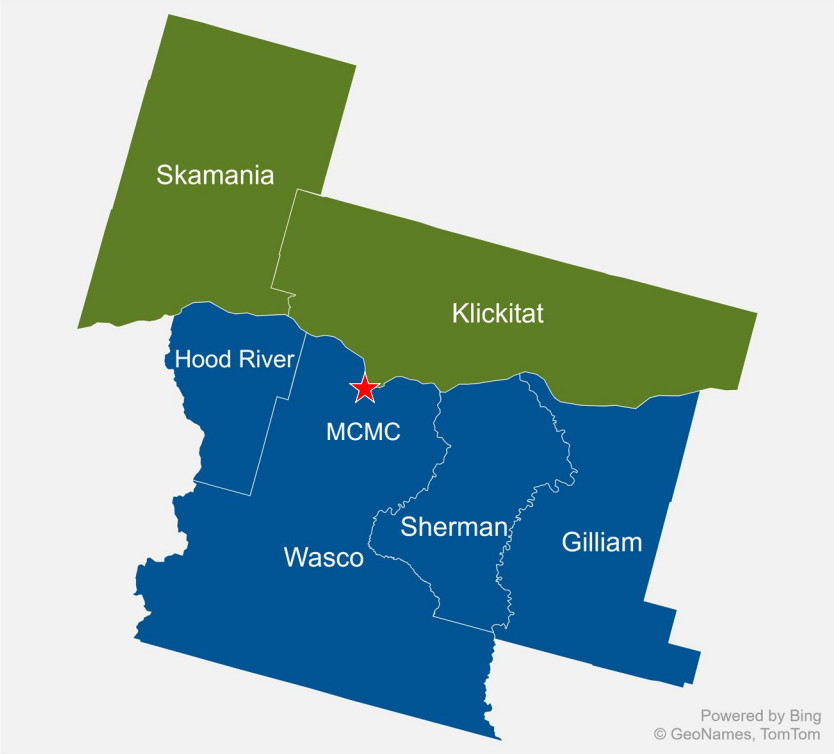
- The terms of the transaction (see **Transaction Terms**).
- Materials provided by the Entities in connection with OHA's review.
- Public comments on the transaction.
- Discharge data, financial data, and community benefit data on Oregon's hospitals.
- Oregon's All Payer All Claims database.
- Other publicly available data, research, and reports.

Data sources and years studied are detailed below and in **Appendix C: Reporting Methodology**.

Overview

The Columbia Gorge Region

The Columbia Gorge region includes counties that border the Columbia River in Oregon and Washington. These counties are mostly rural, covering 10,284 square miles.[59] MCMC is located in The Dalles, OR in Wasco County.



Agriculture is a key industry, along with tourism, healthcare, forestry, and technology firms.[60] With nearly 1,000 employees, MCMC is the largest employer in Wasco County. The next largest employers - Northern Wasco County School District, Oregon Cherry Growers, and Fred Meyer – have 500 or fewer employees.

Roughly 84,000 people live in the Columbia Gorge region. [61] The agricultural industry often relies on migrant and seasonal farm workers, which can result in seasonal variations in the population.

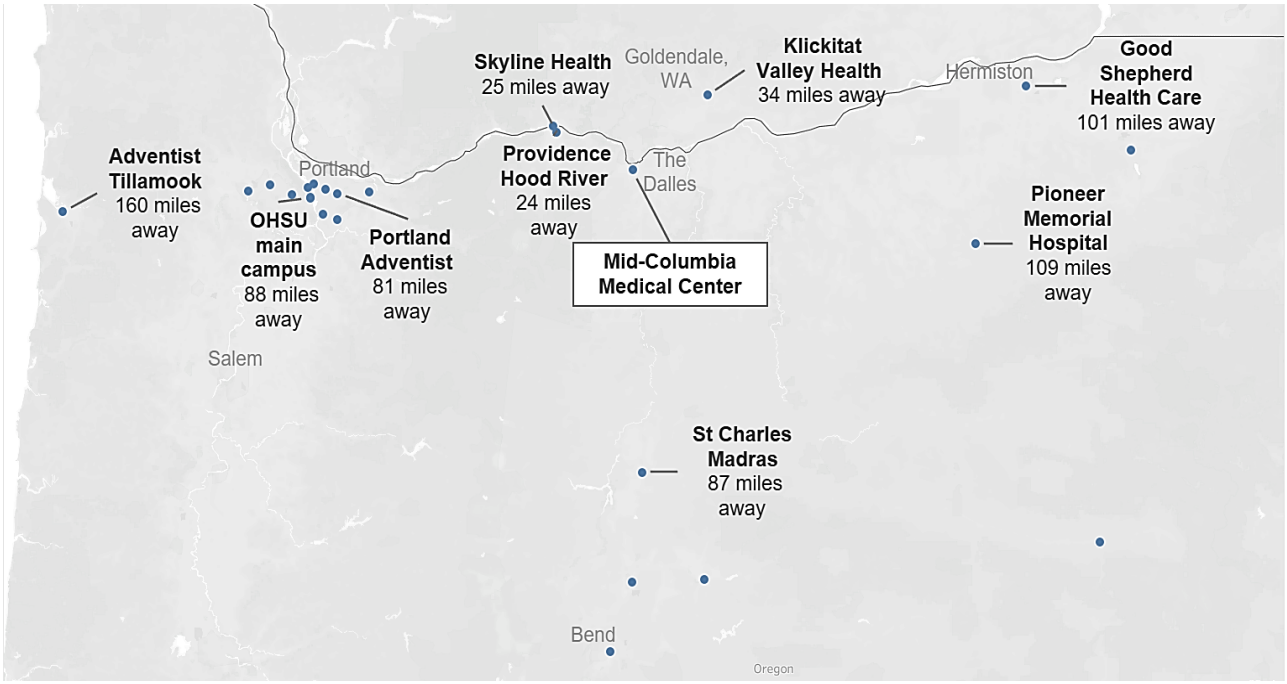
Hospitals and Health Care Facilities

MCMC is one of several health systems operating in the Columbia Gorge region. The table below shows hospitals in the region, as well as hospitals that are in neighboring regions.

Hospital	Designations	Location	Beds	Miles from MCMC
Mid-Columbia Medical Center	Type B, SCH, RRC	The Dalles, OR	49	--
Providence Hood River	Type B, CAH	Hood River, OR	25	24

Hospital	Designations	Location	Beds	Miles from MCMC
Skyline Health	CAH	White Salmon, WA	14	25
Klickitat Valley Health	CAH	Goldendale, WA	25	34
Adventist Health Portland	DRG	Portland, OR	302	81
St. Charles Madras	Type B, CAH	Madras, OR	25	87
OHSU	DRG	Portland, OR	576	88
Good Shepherd	Type A, CAH	Hermiston, OR	25	101
Pioneer Memorial Hospital	Type A, CAH	Heppner, OR	21	109
Adventist Health Tillamook	Type A, CAH	Tillamook, OR	25	160

MCMC is about 25 miles from the nearest hospitals to the west and the north. To the south, the nearest hospital is 87 miles and the nearest hospital in Oregon to the east is 101 miles.



Health Care Workforce

Health care facilities depend on the availability of qualified physicians, nurses, and other clinicians to adequately meet community health care needs. A sufficient workforce can help ensure that people get the right care at the right time, while a lack of adequate staff can result in reduced services, delayed or deferred care, and lower quality of care.[62] One way to assess whether a region has sufficient primary care, dental health, or mental health providers is Health Professional Shortage Area (HPSA) designations. HPSA designations show whether there is a shortage of providers for a geographic area or for specific populations, such as low-income individuals or migrant seasonal farm workers (MSFW).[63]

The table below shows HPSA designations for Oregon counties in the Columbia Gorge.

County	Primary Care	Mental Health	Dental Health
Gilliam	Geographic	Geographic	Low Income
Hood River	MSFW	Low Income	MSFW
Sherman	Geographic	Low Income	Low Income
Wasco	Low Income MSFW	Low Income	Low Income

OHA also looked at how many nurses, physicians, and nurse practitioners are available to serve the population. See the table below for 2021 population-to-provider ratios.

While Wasco County's population-to-provider ratios were similar to the statewide ratio in 2021, nearby Sherman and Gilliam counties had very few or no registered nurses, physicians, and nurse practitioners.[64] In Wasco County, where MCMC is located, there was one registered nurse for every 140 people; however, in Gilliam County, there was one nurse for every 1,597 people. Sherman County had no registered nurses.

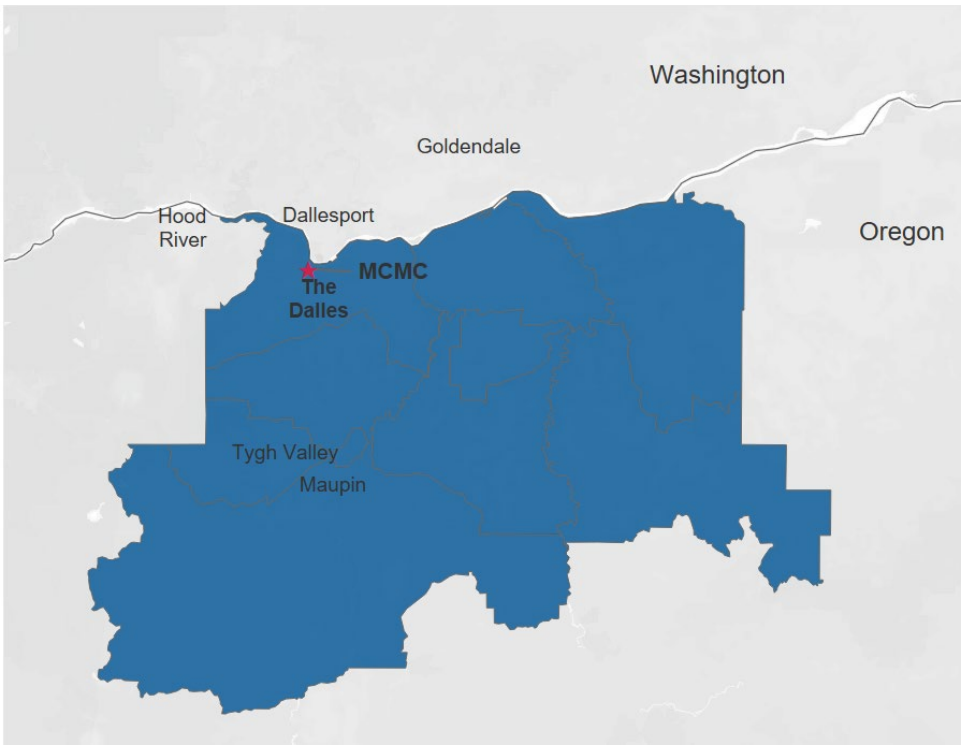
Region	Registered Nurse ratio	Physician ratio	Nurse Practitioner ratio
Gilliam County	1,597:1	No providers	2,452:1
Hood River County	195:1	315:1	2,438:1
Sherman County	No providers	299,858:1	No providers
Wasco County	140:1	321:1	1,176:1
Oregon	**163:1**	**331:1**	**1,429:1**

MCMC Service Area

To understand the geographic regions and populations served by MCMC, OHA defined the primary service area (PSA) for MCMC inpatient services. OHA used this PSA to calculate market shares, identify comparison providers, and define regional populations.

The MCMC service area defined here is different from the MCMC service area identified by the Entities in the Notice and affiliation agreement, which includes Wasco, Hood River, Sherman, and Gilliam counties in Oregon and Klickitat and Skamania counties in Washington.

To calculate MCMC's PSA, OHA identified the contiguous zip codes where 75% of patients with an inpatient discharge at MCMC reside. While MCMC serves patients in other states, particularly Washington, HCMO's charge applies to Oregon residents; therefore, analyses in this report only include data for people living in Oregon zip codes. The map below shows the PSA for MCMC based on this methodology (see **Appendix C: Reporting Methodology** for details).



According to American Community Survey 5-year estimates, nearly 30,000 people live in MCMC's PSA. All of the zip codes in the service area are designated as rural. OHA designates Sherman and Gilliam counties as "frontier" counties (defined as counties with six or fewer people per square mile).

Age and Sex

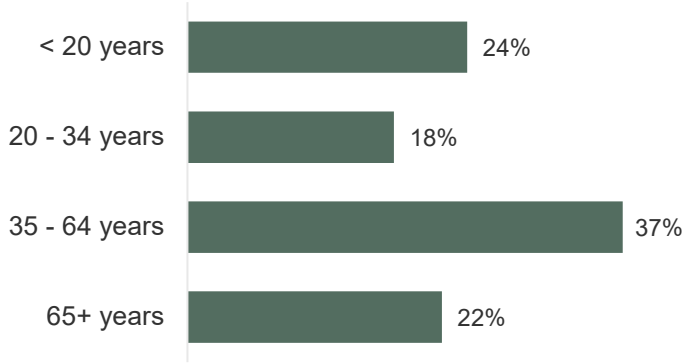
The service area population is split nearly evenly between female and male residents.

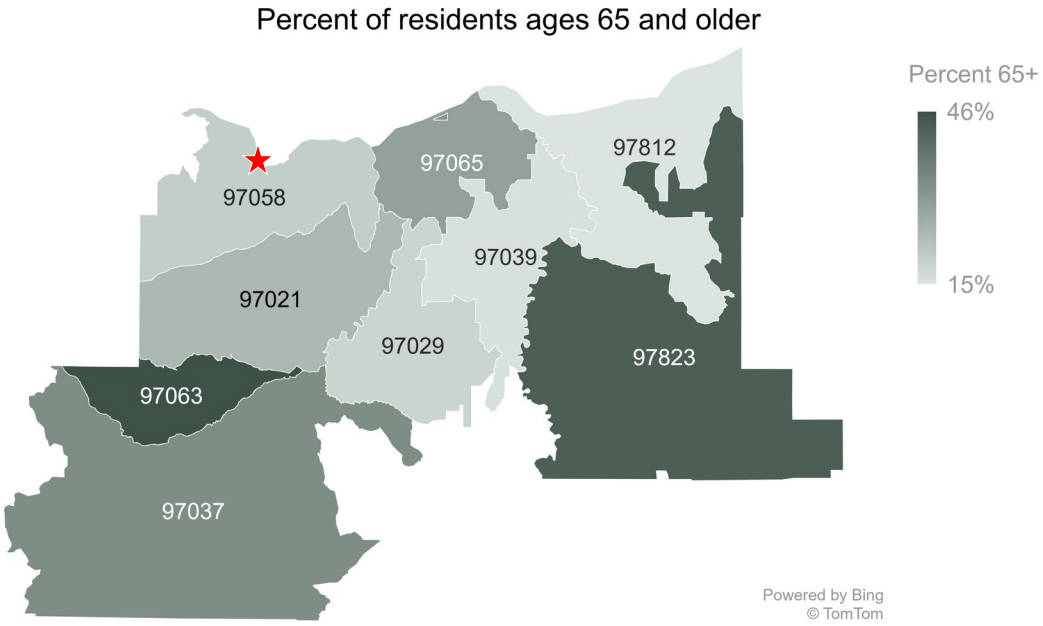
The largest age group in MCMC's service area is 35-64 years old. The area has a sizeable population of older adults, with 22% of residents aged 65 and older.

The population of individuals ages 65 and older varies for PSA zip codes, from 15% to 46%. (See map below.) People ages 65 and older represent the highest share of the population in zip codes 97063 (around Tygh Valley) and 97823 (around Condon). See the map below.

Service area population by sex

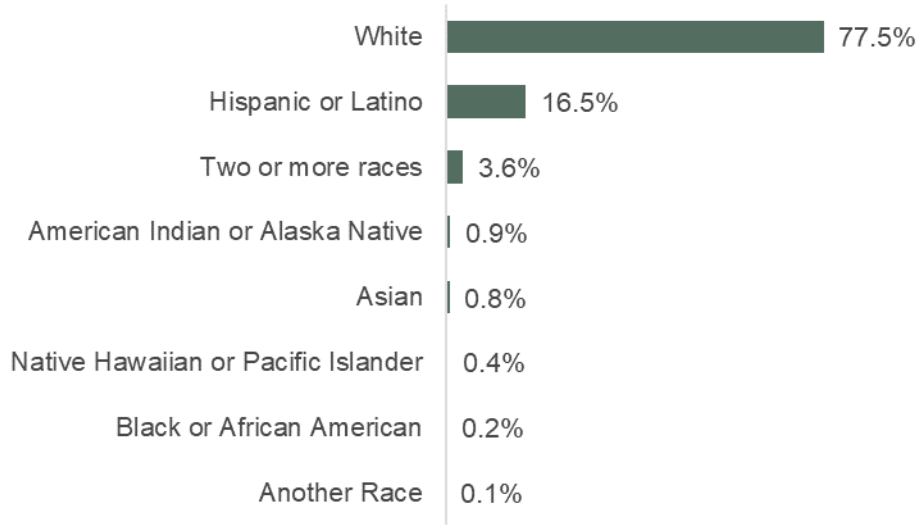
Service area population by age group





Race, Ethnicity, and Language

White and Hispanic or Latino are the largest racial/ethnic groups in the service area. The largest share of Hispanic/Latinx residents is zip code 97058, where 20% of residents identify as Hispanic or Latino.



Race and ethnicity categories are consistent with federal OMB (Office of Management and Budget) standards and do not comply with Oregon's REALD (race, ethnicity, language, and disability) and SOGI (sexual orientation and gender identity) standards.

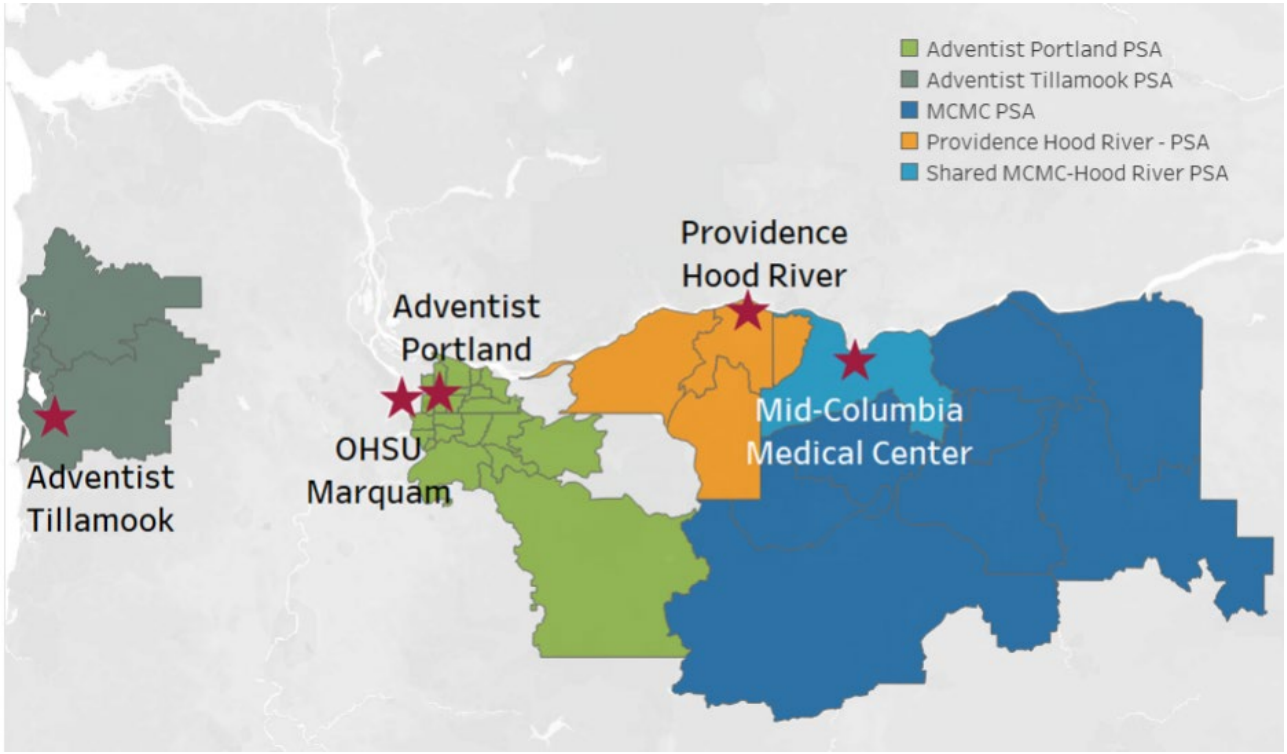
Nearly 13% of residents in the PSA speak a language other than English and 90% of people who speak a language other than English speak Spanish. About 5% of residents in the PSA indicate they speak English less than very well; of those 93% speak Spanish. The population with limited English proficiency is concentrated in zip code 97058 where MCMC is located (6.2% of residents).

Education and Income

Roughly 59% of residents of the service area have at least some college education, which is below the statewide rate of 68%. One-third of households have annual incomes of $75,000. About 11% of the service area population has incomes at or below the federal poverty level, compared with 12% statewide.

Adventist Health and Nearby Hospital Service Areas

MCMC has some overlap with Providence Hood River's primary service area. MCMC does not overlap with the primary service areas of any other Oregon hospitals, including Adventist Health hospitals in Oregon.



Market Share & Consolidation

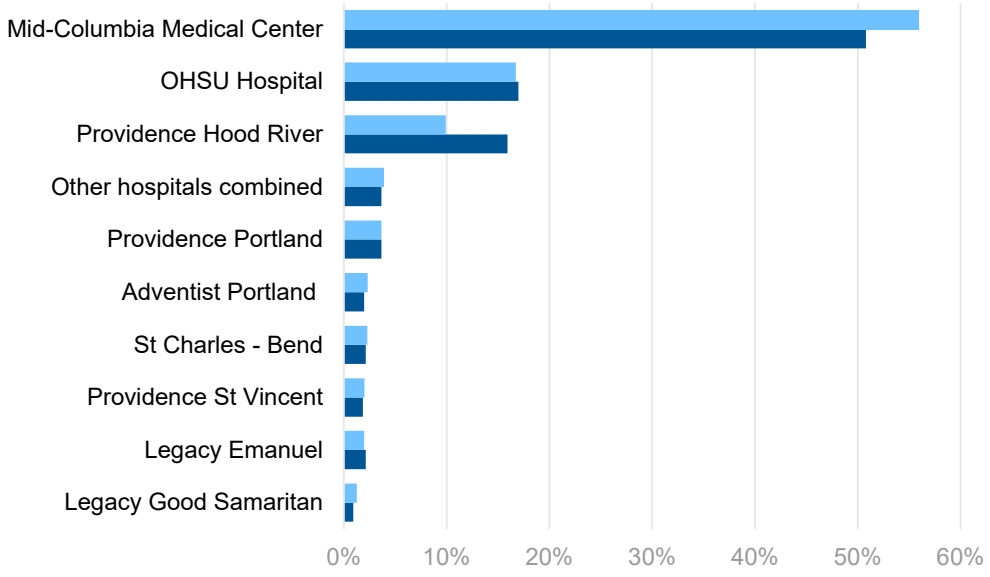
OHA's market share analysis generally looks at what share of total patient volume or revenues across comparable health care entities in the geographic service area is attributable to each of the Entities involved in the transaction.

For this review, OHA took the relevant "market" to be acute inpatient hospital services for residents of MCMC's PSA.[vi] To calculate market shares, OHA assessed MCMC's and other hospitals' share of inpatient hospital stays using data from the Hospital and Emergency Department Discharge database (HDD) for the years 2019-2021.

Market Shares

OHA's analysis found that for the three years from 2019 to 2021, MCMC accounted for 56% of inpatient hospital stays (discharges) among residents of its PSA. Other than MCMC, many residents received inpatient care at OHSU and Providence Hood River hospitals, which accounted for approximately 17% and 10% of hospital stays, respectively, in 2019-2021. At the system level, Providence Health & Services (including Providence Hood River, Providence Portland Medical Center, and Providence St. Vincent Medical Center) held the second largest share (22%) of inpatient hospital stays.

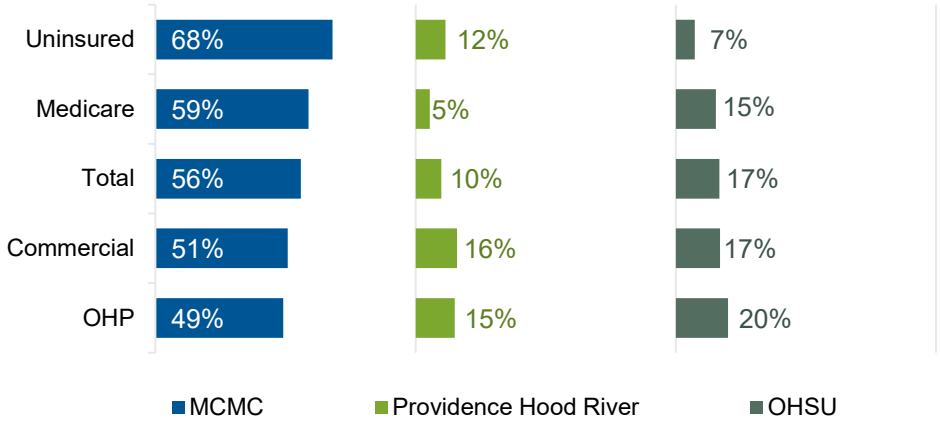
Across **all insurance types**, 56% of inpatient hospital stays for patients living in the PSA were at MCMC in 2019-2021. Among **commercially insured** patients, 51% of stays were at MCMC.



MCMC's share of inpatient hospital stays was highest among PSA residents without health insurance (68% of hospital stays) and Medicare enrollees (59%). Among commercially insured patients, MCMC accounted for 51% of PSA residents' hospital stays in 2019-2021, whereas OHSU and Providence Hood River accounted for 17% and 16%, respectively.

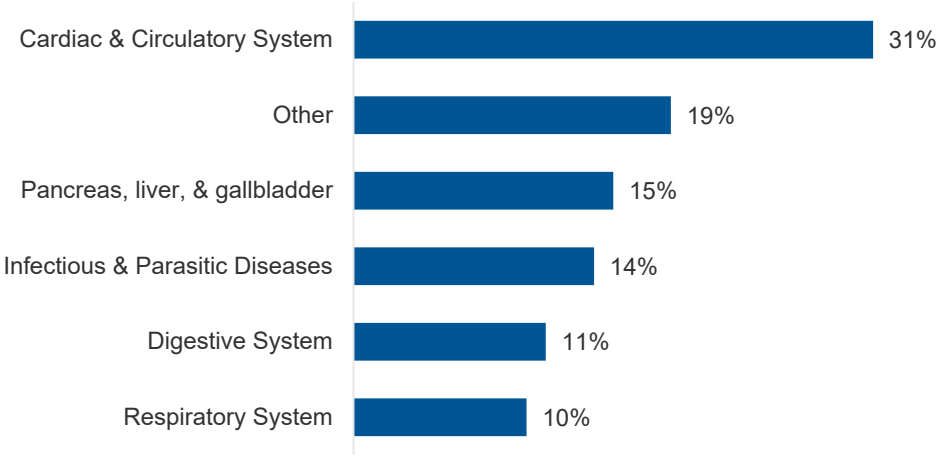
[vi] Precise market definition typically requires more complex economic analyses, which OHA generally reserves for comprehensive reviews.

MCMC's share of hospital stays for patients living in the PSA was highest among uninsured individuals and people enrolled in Medicare.



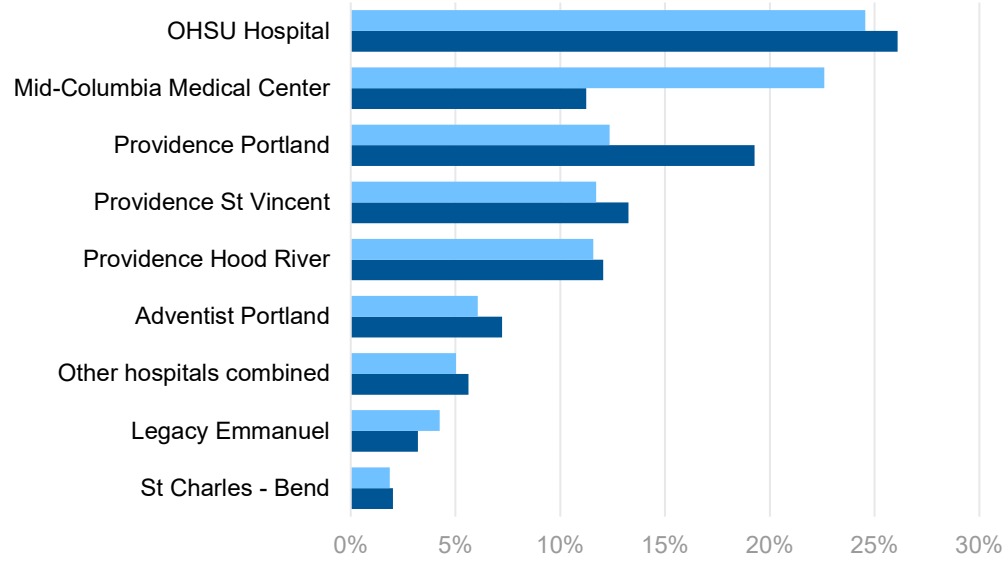
Adventist Portland represented 2.3% of inpatient stays among residents of MCMC's PSA across all insurance types. Among commercially insured patients, Adventist Portland's share was similarly small at 2%. OHA analyzed Major Diagnostic Categories (MDCs) associated with these stays and found that approximately one-third of MCMC PSA residents who accessed inpatient care at Adventist Portland sought care for cardiac-related diagnoses. As noted earlier, MCMC partners with the Northwest Regional Heart and Vascular team at Adventist Health Portland to provide cardiology services to MCMC patients. Other MDCs for which patients go to Adventist Portland include infectious diseases, disorders of the pancreas/liver/gallbladder, and respiratory conditions.

When people who live in MCMC's service area had a hospital stay at Adventist Portland, the most common reason was cardiac and circulatory system diagnoses.



Compared to all diagnoses, MCMC's share of hospital stays was smaller for cardiac and circulatory system diagnoses. Across all insurance types, MCMC's share was 23% (versus 56%), and for commercial stays MCMC held 11% (versus 51%). Other providers serving PSA residents admitted with these types of diagnoses included Providence Health & Services hospitals (36% across all insurance types) and OHSU Hospital (25%). Adventist Portland represented 6.1% of inpatient stays among residents of MCMC's PSA across all insurance types.

Across **all insurance types**, 23% of inpatient hospital stays for cardiac and circulatory system diagnoses were at MCMC in 2019-2021. Among **commercially insured** patients, 11% of stays were at MCMC.



Consolidation

OHA's market share analysis indicates, not surprisingly, that MCMC holds a dominant position in the "market" defined for purposes of this preliminary review as inpatient hospital services in the PSA. MCMC, Providence Health & Services hospitals, and OHSU collectively accounted for almost 90% of inpatient hospital stays among commercially insured PSA residents in 2019-2021. These data imply a Herfindahl-Hirschman Index (HHI) of over 3,000, which is above the threshold (2,500) set by federal antitrust agencies for a "highly concentrated" market.[65] After the close of the proposed transaction, HHI would increase by approximately 200 points, which would imply (based on federal guidelines) at least a moderate level of concern about an increase in market power (See **Market Share and Consolidation Methodology** for details on HHI calculations).

These HHI figures should be cautiously interpreted, however. HHI calculations hinge on the definition of the "market" in which the Entities compete. Precise market definition typically requires more complex economic analyses, which HCMO generally reserves for comprehensive reviews.[66] While approximately 2% of hospital stays for PSA residents are at Adventist Portland, many of these stays may be for specialized services (tertiary care) not available at MCMC. More importantly, Adventist Portland is located well outside of MCMC's service area, 81 miles away from MCMC, which would make it an unattractive option for many people living in the PSA.

Considering the lack of service area overlap and distance between MCMC and Adventist Portland, OHA does not consider the proposed transaction to pose significant concern regarding horizontal consolidation. The transaction may result in some consolidation in specialty services such as cardiac care, although MCMC and Adventist already have an affiliation to provide cardiology services.

The transaction does represent cross-market consolidation by joining hospitals operating in different geographic regions of the state (e.g., Columbia Gorge and Portland Metro). OHA estimated based on 2019-2021 discharge data that the transaction will increase Adventist Health's share of Oregon's market for inpatient hospital services by approximately half a percentage point, from 2.9% to 3.4%.

Cost

HCMO reviews consider how transactions may affect prices for health care services in Oregon and potential effects on total spending on health care services by insurers, employers, and government payers. HCMO may also assess the impacts of the transaction on the financial condition of the health care companies involved. For this preliminary review, HCMO's cost analyses addressed how affiliation with Adventist Health may affect MCMC's financial condition and prices relative to other hospitals in Oregon.

MCMC's Financial Condition

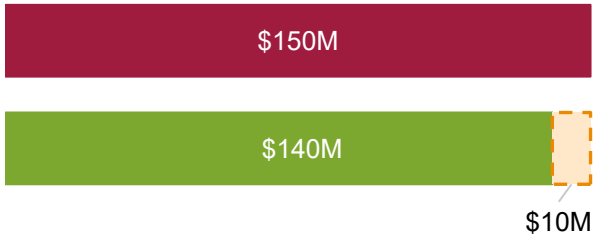
To assess MCMC's financial condition, OHA analyzed metrics on profitability and solvency for the fiscal years 2012 through 2022. For 2012-2021, OHA used audited financial data reported to OHA, and for 2022, OHA relied on preliminary fiscal year 2022 data obtained from the Entities.[67] OHA also reviewed confidential submissions from the Entities including additional details on MCMC's current financial condition and expectations for the next 12 months.

Profitability

To assess profitability, OHA analyzed MCMC's operating performance, as measured by operating revenue, operating expenses, and operating profit/loss (margin).

Based on preliminary figures, MCMC generated $140 million in operating revenues in 2022 and $150 million in operating expenses, leading to an operating loss of close to $10 million (operating margin of negative 7%).

MCMC reported $150M in **operating expenses** and $140M in **operating revenues** in 2022, generating a $10M **operating loss**.



MCMC reported net patient revenues of approximately $124 million in 2022, representing close to 90% of total operating revenues. Outpatient services accounted for 66% of MCMC's gross patient revenues in 2022, followed by inpatient services (21%) and emergency department services (13%).

Profitability Metrics

Operating revenue: Revenue (dollars) generated from operating health care facilities. The majority of this is generally patient revenue.

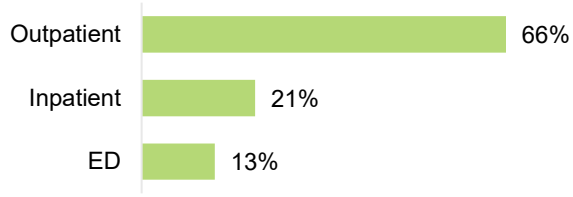
Operating expenses: Amount of money spent on running the hospital or health system.

Operating profit/loss: The difference between operating revenue and operating expenses.

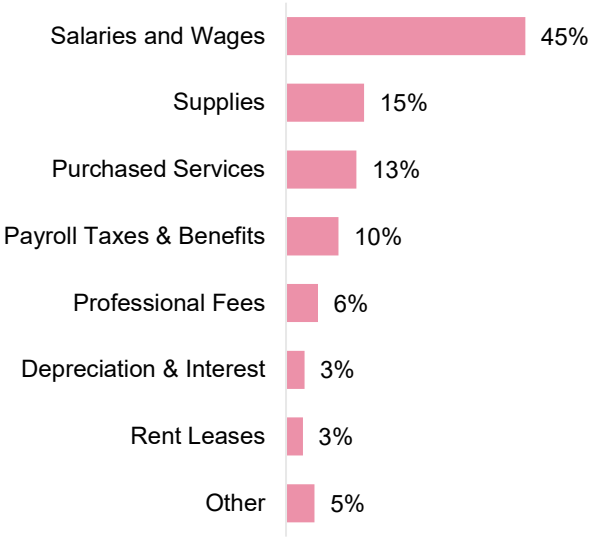
Operating margin: Operating profit/loss expressed as a percentage of operating revenue.

Patient revenue: Revenue from providing services to patients. For MCMC, this includes revenues from inpatient, outpatient, and emergency department services. Patient revenue can be expressed in gross or net terms. Gross patient revenue reflects amounts payers or patients are charged for services, whereas net patient revenue is the amount collected based on contractual arrangements and accounting for any financial assistance discounts.

Outpatient services accounted for 66% of MCMC's gross patient revenues in 2022, followed by inpatient (21%) and ED services (13%).



Salaries and wages accounted for 45% of MCMC's operating expenses in 2022, followed by supplies (15%) and purchased services (13%).



The largest component of MCMC's operating expenses was salaries and wages for its employees, accounting for 45% of operating expenses ($67 million) in 2022. Other major expense categories included supplies (15% or $22 million), purchased services (13% or $20 million), and payroll taxes and benefits (10% or $15 million). Purchased services included spending on temporary ("locum") providers and traveling nurses.

MCMC's operating performance in 2022 was significantly weaker compared to 2021, when it reported an operating profit of $1.4 million. Operating expenses increased by $5 million (3.5%) from 2021 to 2022, whereas operating revenues fell by approximately $6 million (4.2%) year-over-year. [vii]

The decline in operating revenues was driven by an 8% ($17 million) drop in gross outpatient revenues. On the expense side, spending on purchased services increased by $2.4 million (14%) and miscellaneous expenses increased by approximately $1 million (47%). **See Appendix D: Supplemental Data** for additional details.

MCMC's **operating expenses** increased by $5 million from 2021 to 2022...

...and **operating revenue** decreased by $6 million.

MCMC's CEO described the financial challenges facing rural hospitals such as MCMC in a December 2022 letter to the community:[68]

> *The stressors of the pandemic have since given way to skyrocketing costs, major gaps in staffing, the end of government aid and sicker patients than we have ever seen before.*

[vii] 2022 and 2021 operating results based on Exhibit A of Supplemental Information Packet for Notice of Material Change Transaction Filed by Adventist Health System/West, Public Version, February 13, 2023.

In their submissions to OHA, the Entities stated:[69]

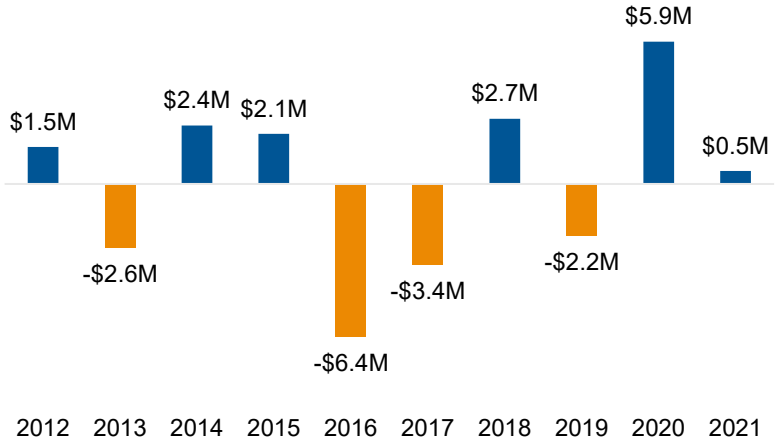
> *[The] financial losses that many health systems, including MCMC, incurred to compensate locums [sic] providers, traveling nurses, and other temporary replacement staff members will take years to make up.*

As these statements acknowledged, hospitals around the country were facing similar challenges, particularly workforce shortages exacerbated by the pandemic. OHA's Hospital Reporting Program's analysis of financial data found negative operating margins overall across Oregon's acute care hospitals in the first three quarters of 2022. Higher labor costs drove a 9.6% year-over year increase in operating expenses from Q3 2021 to Q3 2022.[70]

MCMC's CEO noted that hospitals nationally were paying on average $5,000 per week for travel nurses and up to $5,000 per day for temporary providers.[71] Despite these high costs, MCMC was relying on temporary providers to keep several service lines in operation. To reduce expenses, MCMC announced it had "consolidated several divisions" within the hospital, sharing support staff across providers and clinics, and focusing on maintaining "core services."

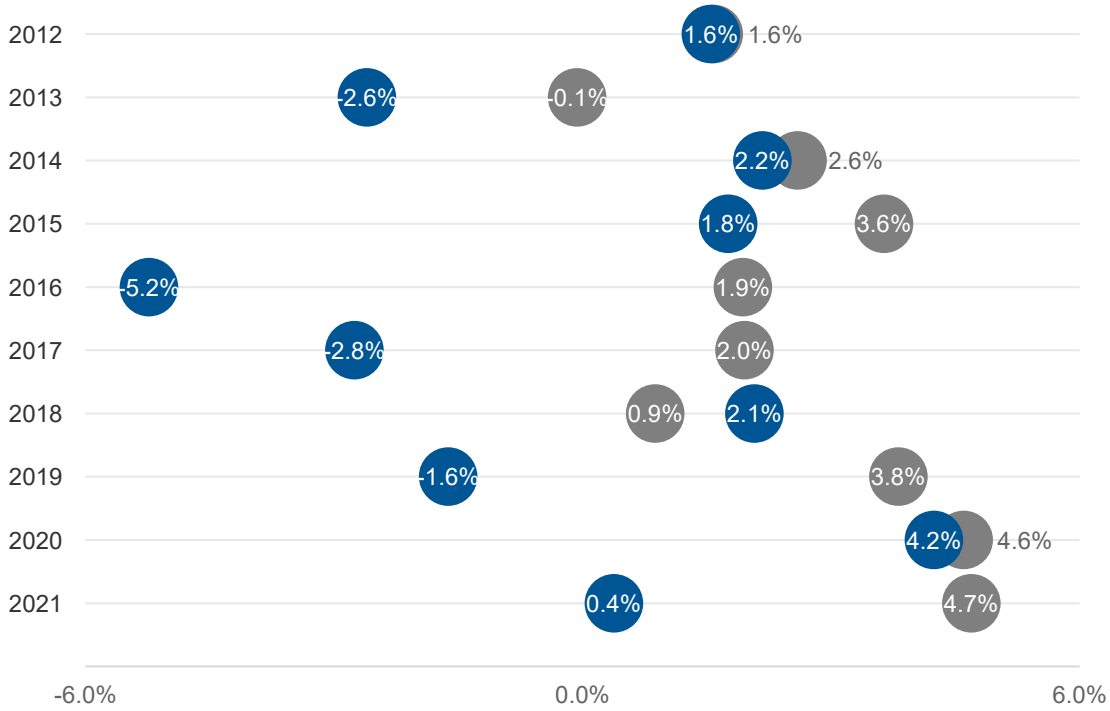
Looking back over the ten previous years (2012-2021), MCMC's operating performance, based on audited financial results, ranged from a loss of $6.4 million in 2016 (representing an operating margin of negative 5%) to a profit of $5.9 million in 2020 (4% operating margin). Operating profits for 2020 included $10.7 million in COVID-19 relief grant funding from the federal government.

Over the ten years from 2012 to 2021, MCMC recorded **operating losses** in four years and **operating profits** in six years. On average for 2012-2021, MCMC's annual operating profit was $74,000.



Compared to the average across Oregon's Type B hospitals, MCMC's operating margin was lower in all but two years. In 2021, the average operating margin for Type B hospitals in Oregon was 4.7% compared MCMC's operating margin of 0.4%.

Between 2012 and 2021, **MCMC's** operating margin was lower than the average across Oregon's **Type B hospitals** in all but two years.



Type B hospitals are small hospitals (50 or fewer beds) located within 30 miles of another hospital. See **Appendix C: Reporting Methodology** for a list of hospitals and other details on OHA's methodology. While the comparison to Type B hospitals as a group is informative, it is important to keep in mind that there are significant differences within this group with respect to system affiliation, patients' insurance coverage, population demographics, and other local, regional, and hospital-level characteristics that may influence profitability. Fourteen of Oregon's 21 Type B hospitals are affiliated with a health system.

Solvency

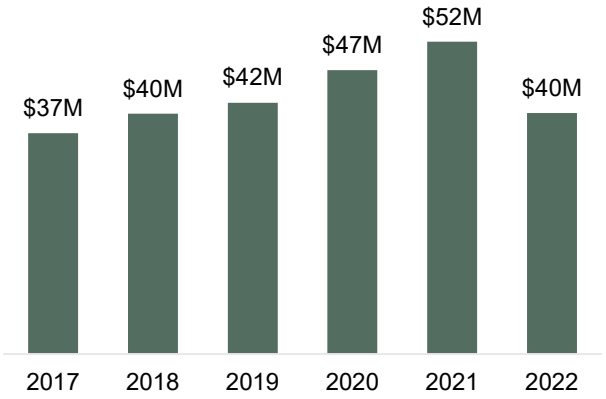
OHA analyzed metrics commonly used for gauging the solvency of hospitals and other companies. Solvency refers to the ability of an entity to make future payments on its debts. OHA used data from MCMC's audited financial statements for 2012-2021 and preliminary 2022 information submitted by the Entities in response to HCMO's request.[72]

MCMC's cash balance decreased from $23 million to $6 million from December 2021 to December 2022. Based on this balance and other assets available to meet MCMC's general expenditures, OHA estimated days cash on hand (DCOH) at 85 days as of December 2022, down from 119 days in December 2021.[viii] By comparison, OHA's Hospital Reporting Program generally considers 90 days as a threshold for DCOH.

[viii] OHA calculated DCOH for 2021 as $Total\ liquidity/(Operating\ expenses - Depreciation) * 1/365$. Total liquidity captures total financial assets available to meet cash needs for general expenditures within one year. OHA's December 2022 DCOH estimate used total current assets as a measure of total liquidity.

MCMC reported $104 million in total assets and $64 million in total liabilities as of December 2022, leaving net assets (equity) of $40 million, down from $52 million in December 2021. MCMC's net assets grew between 2017 and 2021. MCMC's solvency improved in 2020 as the hospital received $10.7 million in federal COVID-19 relief funding. In addition, MCMC reported advance payments from CMS for Medicare services totaling $14.8 million. MCMC was required to begin repaying this amount in 2021.

MCMC's **net assets** increased from 2017 through 2021 but declined in 2022.



Solvency Metrics

Days cash on hand (DCOH): Number of days an entity can operate without any additional revenue, based on its balances of cash and other assets that can be quickly sold or otherwise converted to cash ("total liquidity").

Assets: Resources owned by an individual or organization that have economic value. These may include cash, buildings, land, equipment, and financial assets (e.g., stocks, bonds, and bank deposits).

Liabilities: The value of items owed by an individual or organization, e.g., loans, unpaid rent, or money owed to suppliers, customers, or employees.

Net assets: The value of assets after total debt has been subtracted (total assets – total liabilities), also referred to as equity.

Potential Impacts

Impact on MCMC's Financial Condition

OHA's analyses and the Entities' submissions clearly demonstrate the current financial difficulties facing MCMC.

MCMC's profit margins have been chronically low over the past ten years, resulting in low cash reserves from which to fund facility improvements, equipment upgrades, and other strategic investments. MCMC quickly spent additional COVID-19 dollars it received from the federal government in 2020 as labor costs increased and staffing shortages required the hospital to pay for expensive temporary providers to keep offering services. It reported a $10M operating loss in 2022, its worst performance in ten years, and current cash on hand is below benchmarks. Should these trends continue, OHA believes there is considerable risk that MCMC will be forced to cut services in the next 12 months.

The transaction is likely to substantially improve MCMC's financial condition. As part of the transaction, Adventist Health has committed to various actions that can be expected to improve MCMC's solvency, reduce certain operating costs, and promote longer-term profitability, including:

- Providing funds to cover MCMC's operating losses.
- Assuming responsibility for MCMC's current financial obligations to banks and suppliers.
- Committing financial resources to establishing, expanding, and retaining medical service lines. If successful, these efforts should help to increase operating revenues, generate new revenue streams for MCMC and lower unit costs (by spreading fixed costs over larger service volumes).
- Contributing financial resources, expertise, and health system relationships to recruitment and retention of providers and staff needed to maintain and expand services. Such efforts would also reduce MCMC's reliance on temporary providers and traveling nurses, helping to lower staffing costs.
- Funding long-term improvements to MCMC's facilities, new equipment, and technology investments.
- Providing access to Adventist Health's bulk purchasing arrangements (reducing supply expenses) and more favorable lending terms (reducing borrowing costs).

Entity Statements about MCMC's Financial Condition

In the Notice and supplemental materials, the Entities stated:

[In] the recent past, MCMC's ability to maintain its full array of medical services has been pressured by a lack of staffing coupled with a more difficult financial picture. Consummation of the proposed transaction will immediately help address the latter of these two issues […].

The proposed transaction will favorably affect MCMC's ability to address its capital needs because it will provide the health system with greater access to funding. MCMC believes that the Adventist capital investments will lead to dramatically faster, more extensive, and more beneficial improvements to MCMC's facilities and major movable equipment than MCMC could reasonably achieve as a free-standing community hospital over the ten-year horizon of Adventist's commitment.

While Adventist Health has also felt the impacts of workforce shortages, rising labor costs, and other nationwide cost pressures, its financial position is significantly stronger than MCMC's.

As a health system with hospitals, clinics, and affiliation arrangements in multiple states and geographies, Adventist Health's revenues are considerably more diversified (i.e., less reliant on the success of any one hospital or facility). Health systems generally also benefit from economies of scale and greater purchasing power enabling them to obtain supplies, equipment, and other inputs at lower unit prices. They are also generally able to borrow money more cheaply (at lower interest rates) than independent hospitals. Health systems can often leverage this purchasing power to gain access to a broader range of investments, including ownership stakes in other clinics or forming joint-ventures with other types of medical service providers, increasing their non-operating revenue streams.

Adventist Health experienced operating losses of $74 and $149 million respectively in 2020 and 2021, but these were offset by income from its investment portfolio, resulting in overall net income (profit) of $8 million in 2021, down sharply from $111 million in 2020. Despite declining profitability, the value of the system's net assets remained stable at $3.1 billion, including $2.3 billion in investments and $2.2 billion worth of property and investments as of December 2021.[73]

The credit rating agency Fitch announced in November 2022 that it was maintaining an "A" rating for Adventist Health's debt, while revising its outlook for future rating changes from "stable" to

"negative" due to recent operating losses. Fitch analysts attributed operating losses to "adverse economic conditions" driven by wildfires in certain regions, COVID-19, and industry-wide "acute labor pressures." However, they expressed confidence in Adventist Health's management's ability to restore profitability in 2023. Fitch also noted that the system's liquidity position was "adequate" and its cash and short-term investments "comfortably" exceeded the agency's requirements.[74]

OHA will assess changes in MCMC's financial condition following the close of the transaction in HCMO's follow-up analyses.

Cross-Market Effects

As noted earlier, the transaction would represent "cross-market" consolidation among hospitals serving different geographic markets in Oregon. Adventist Health currently operates hospitals in Portland and Tillamook whose service areas do not overlap with MCMC's service area. The transaction would expand Adventist Health's presence in Oregon's market for inpatient hospital services to MCMC's PSA in the Columbia Gorge region.

Following the transaction's close, commercial health insurance plans interested in contracting for MCMC services will ultimately be negotiating with Adventist Health, as is standard practice for health system-owned hospitals. The Entities noted in submissions to OHA:

> *Adventist provides centralized managed care and commercial payer negotiation services for its existing member hospitals. Adventist therefore contemplates providing such services for MCMC […].*[75]
>
> *Following the Closing Date, Adventist Health and its Affiliates will provide MCMC with access to […] payor contracts, managed care support systems and strategies (including administrative and technical support with respect to capitation and integration of MCMC into Adventist Health's managed care networks and payor contracts, as applicable), accountable care organizations and other health reform initiatives and physician networks in the same manner and on the same footing as other hospitals Affiliated with Adventist Health.*[76]

Research studies on the effects of cross-market mergers involving hospitals have found that these transactions may lead to price increases.[77] While more research is needed to understand the mechanisms behind these price increases, one frequently cited explanation is the "common customer" theory. Hypothetically, a larger employer could be a "common customer" of Hospital A (located in Portland) and Hospital B (located in the Columbia Gorge region) if some of its employees live in Portland and others live in the Gorge. This employer would prefer to purchase a health plan whose network includes both hospitals. A health system that owns hospitals in both regions may have more bargaining leverage when negotiating contracts with insurers that serve such employers. By negotiating a "bundled" contract that includes all hospitals in the system (versus allowing for separate contracts for each hospital), a health system may be able to obtain higher reimbursement rates from insurers.

Research also shows that system-affiliated hospitals generally have higher prices than independent hospitals. One recent study found that prices paid to health system hospitals were 31% higher than prices paid to non-system hospitals.[78] Another analysis showed that when an independent hospital was acquired by a hospital system operating outside its service area, the independent hospital's prices increased by 17%.[79] Of Oregon's 60 hospitals, 42 are affiliated with a health system.

Given this evidence, OHA has general concerns about potential increases in hospital prices associated with cross-market effects and system affiliation. However, OHA's preliminary review has not found specific evidence that such increases are likely to occur because of the transaction. The Entities have stated in HCMO submissions that they will work to keep future price increases below Oregon's health care cost growth target.[80] HCMO's follow-up analyses will carefully assess future price changes at MCMC and other Adventist Health hospitals.

Access

As a rural health system serving a large geographic area, MCMC provides a crucial access point for people in surrounding communities to receive health care.

Current Performance

To understand MCMC's role in providing access to care for people living in its PSA, OHA looked at the following:

- Services and patient volume (inpatient hospital stays, primary care, and specialty care)
- Patient demographics
- Payer mix (insurance type)
- Providers and staffing

OHA used 2019-2021 data from the hospital discharge database (HDD) to quantify inpatient hospital stays for Oregon residents and assess inpatient demographics and payer mix. For primary care and specialty care, OHA used All Payer All Claims (APAC) data for Oregon residents from 2018-2020. Service area data are from the American Community Survey 2021 five-year estimates. See **Appendix C: Reporting Methodology** for more information on data sources.

A key component of access is the availability of providers. OHA also examined MCMC's recent experiences and outcomes for provider recruitment and retention.

Services and Patient Volume

OHA examined the number of patients served and services provided at MCMC for inpatient hospital stays, primary care, and specialty care. Inpatient stays occur at MCMC's acute care hospital. MCMC operates four Rural Health Clinics that provide primary care and obstetrics and gynecological services: Water's Edge, Columbia Crest, MCMC Women's Center, and MCMC Family and Internal Medicine. MCMC operates seven outpatient specialty care clinics, providing the following services:

- Allergy
- Cardiology
- Dermatology
- Ear, nose, and throat
- Neurology
- Occupational health
- Oncology
- Orthopedics
- Outpatient surgery
- Sleep studies
- Urology

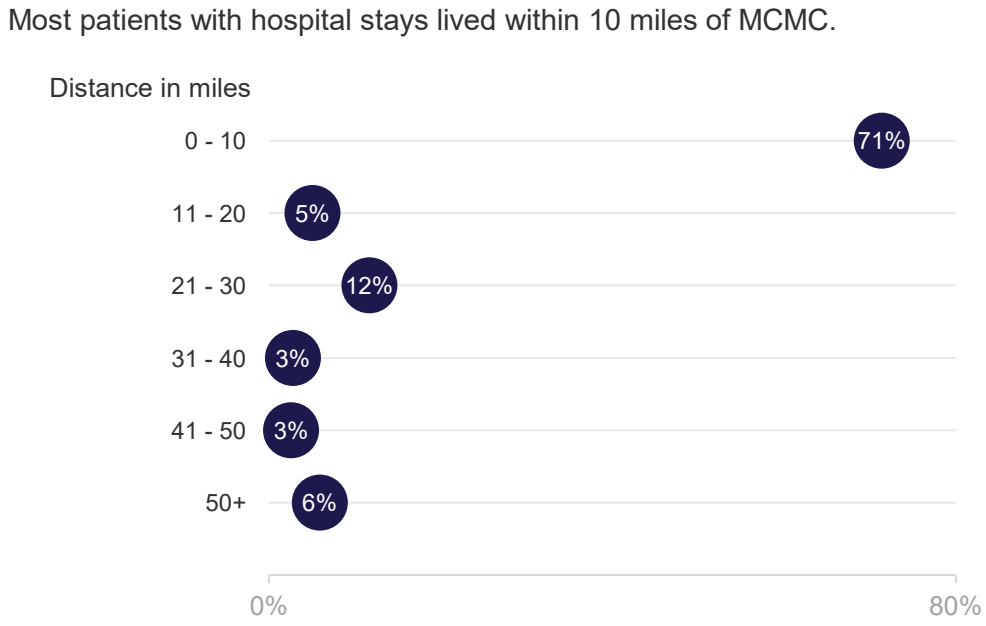
The table below shows approximate number of MCMC services for patients who lived in the PSA between 2019-2021.

Inpatient	4,600 discharges	3,350 patients
Primary Care	140,000 visits	17,000 patients
Specialty Care	77,000 visits	13,000 patients

Inpatient hospital stays
The top reasons that patients had a hospital stay at MCMC in the 2019-2021 time period were:

- Infectious diseases and parasitic infections (13% of all hospital discharges)
- Pregnancy and childbirth (12%)
- Newborn and neonates (11%)
- Respirartory system (11%)
- Digestive system (9%)
- Circulatory system (9%)
- Musculoskeletal system and connective tissue (9%)

These figures are based on Major Diagnostic Categories (MDCs) recorded in inpatient discharge data.The majority of patients with MCMC hospital stays lived within within ten miles of MCMC, although about a quarter of patients (24%) lived 20 or more miles away.



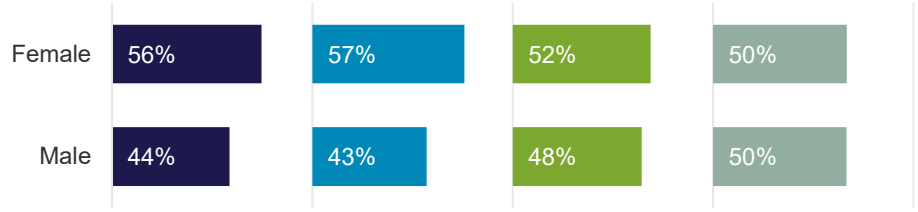
Patient Demographics

To better understand who receives services at MCMC, OHA looked at demographic information for MCMC patients, including age group, sex, and race/ethnicity. OHA also looked at how representative the MCMC patient population is of the overall service area population. Service area population data were obtained from American Community Survey 2021 5-year estimates.

Sex

A greater share of MCMC patients were female, compared to the population overall. Females accounted for a greater share of primary care patients, while males were most represented in specialty care.

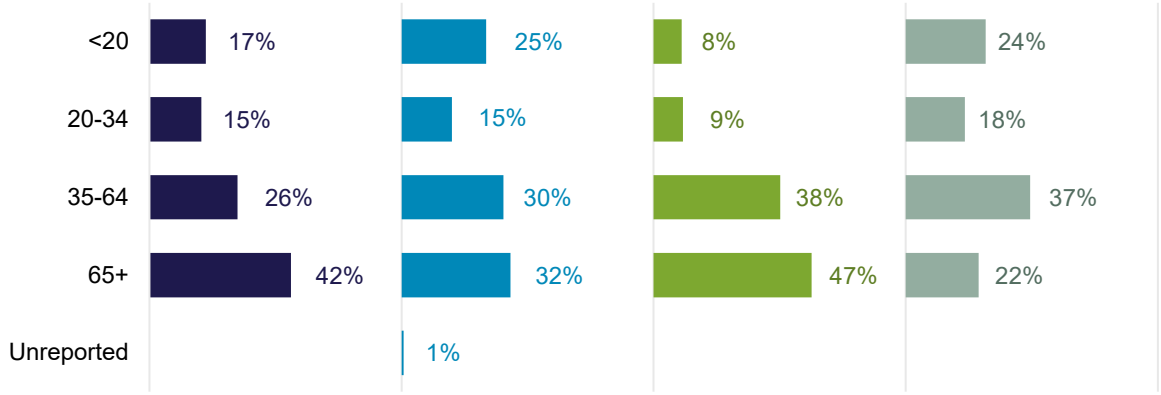
Sex of **inpatient**, **primary care**, and **specialty care** patients at MCMC compared with the **service area** population.



Age

Patients who had an inpatient hospital stay or specialty care visit at MCMC tended to be older than the service area population. Primary care patients were more representative of the service area population that is 20 years or younger.

Age groups of **inpatient**, **primary care**, and **specialty care** patients at MCMC compared with the **service area** population.



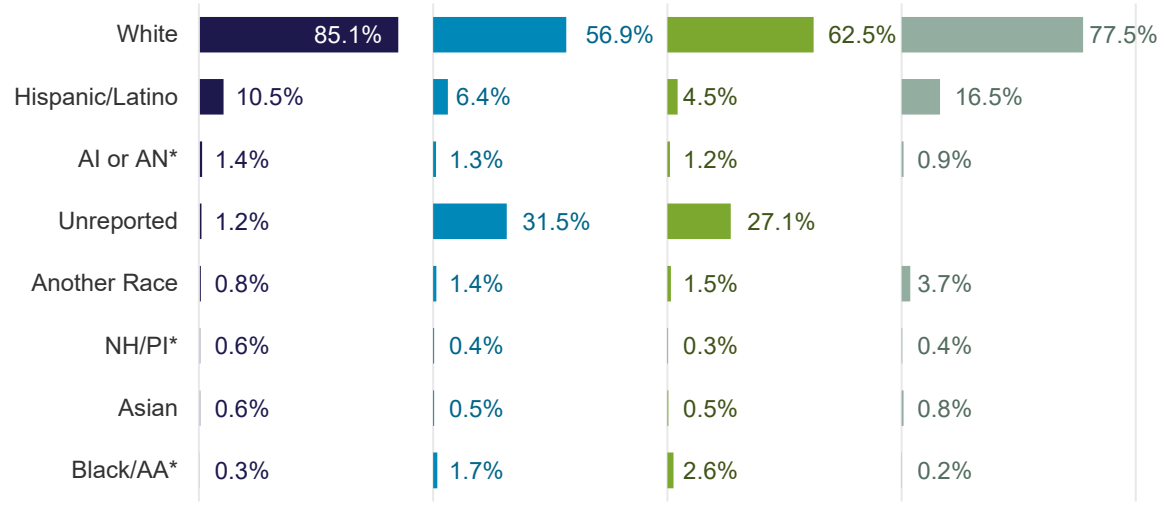
Race/Ethnicity

Compared to the service area population, Hispanic/Latino patients were underrepresented among MCMC's patients. Most MCMC patients who received primary care and specialty care services are White. MCMC provided more primary care services to Hispanic/Latino patients, while a higher percentage of Black patients received specialty care services.

Race and ethnicity information is not consistently reported to Oregon's APAC database. Where race and ethnicity data are not available, OHA includes the percentage of individuals for whom

data were not reported. Race and ethnicity information w not available for more than 25% of MCMC's primary and specialty care patients.

Race/ ethnicity of **inpatient**, **primary care**, and **specialty care** patients, compared with the **service area** population



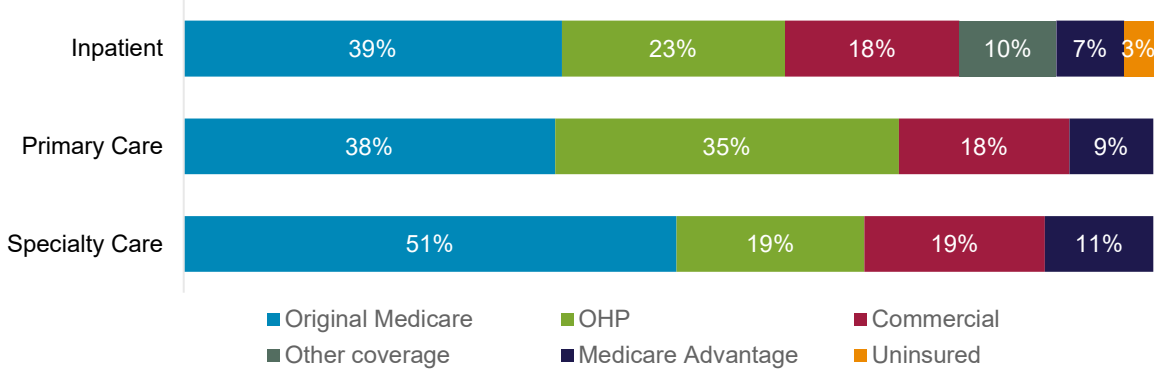
** AI or AN: American Indian or Alaska Native; NH/PI: Native Hawaiian/ Pacific Islander; Black/AA: Black/African American. Race and ethnicity categories are consistent with federal OMB (Office of Management and Budget) standards and do not comply with Oregon's REALD (race, ethnicity, language, and disability) standards.*

Payer Mix

Payer mix refers to what type of coverage pays for the services that MCMC provides to patients.

Original Medicare accounted for the greatest share of payments. Specialty care had the highest rate of Original Medicare payments, while primary care had the highest rates of payments from the Oregon Health Plan (OHP or Medicaid). While inpatient data from HDD includes information about patients with any kind of coverage and uninsured patients, APAC data (used for primary and specialty care) does not include information for uninsured patients or those with certain types of coverage, such as TriCare or worker's compensation.

Original Medicare was the most common payer type across inpatient, primary care, and specialty care.



Provider Staffing

As noted earlier (see **The Columbia Gorge Region**), all Oregon counties in MCMC's PSA were designated HPSAs, and Gilliam and Sherman counties had provider-to-population ratios well below the Oregon average. These workforce shortages make clinician recruitment and staffing particularly challenging for rural hospitals such as MCMC.

Like many hospitals and health systems, MCMC's clinical staffing challenges have worsened in recent years.

MCMC leadership have cited COVID-19 burnout, increased costs, sicker patients, and providers leaving the profession as key obstacles, as well as attracting providers to work in rural settings.[81] [82] Additionally, the termination of MCMC's collaboration with OHSU in late 2021 led to a reduction in primary care providers serving MCMC patients, with 14 providers leaving.[83] The Entities noted in supplemental responses that MCMC remains short of its target number of primary care providers (PCPs).[84] OHA received many public comments related to this transaction that also highlighted the lack of providers and the challenges it creates for patients.

> *"The dwindling availability of physicians in this area has been a troubling development for over a year. I am still waiting to be notified of who my new primary care provider will be to replace the one that left a year ago. One can't help but think the resources of Adventist will be a positive for overall health services here."*
>
> - Public Comment

In December 2022, MCMC's CEO announced that 14 OHSU providers in primary care, general surgery, and orthopedic surgery would be joining MCMC.[85] Of these, 13 had previously been serving MCMC patients under the collaboration with OHSU.[86] MCMC had also added four new primary care clinicians, three behavioral health providers, and new physicians specializing in ear, nose & throat, urology, and general surgery. The statement emphasized that despite these successes, MCMC was facing a "critical staffing shortage" and outlined some steps MCMC was taking to address workforce issues: [87]

- Engaging a dedicated provider recruiter
- Continuing programs to train support staff
- Temporarily pausing medical oncology services at Celilo Cancer Center

Service closures

As of February 28, 2023, MCMC no longer offers medical oncology services at Celilo Cancer Center, including chemotherapy and immunotherapy. In an announcement, MCMC stated that services were discontinued due to not having a sufficient staff to deliver care to patients.[88] Other services – such as radiation oncology and surgical cancer care – will not be impacted. In media reports, MCMC leadership has indicated that they intend to restart medical oncology services, stating:[89]

> *"We will most definitely be starting up again…That's why we want to retain all of the Celilo staff, so they are in place when we get the program up and running again. Everybody here is putting tremendous effort into pulling every lever they can to bring cancer care back to the Gorge."*

The Entities informed OHA that they currently expect to restore medical oncology services at Celilo in April 2023, with provider coverage at least three days per week.[90]

In November 2022, MCMC announced that it would be closing its Water's Edge fitness center to the public, citing pandemic challenges to running the fitness center and a need to cut costs while maintaining key medical services.[91] MCMC does not intend to re-open the fitness center, as it does not consider this to be part of its core service offering.[92]

Potential Impacts

MCMC is a critically important provider of inpatient hospital care, primary care, and in specialty care to Oregon communities within its geographically dispersed service area. Any service reductions or closures following the transaction could adversely impact access to a wide range of health care services, with serious implications for health outcomes, particularly for older adults and other people with limited access to transportation. The suspension of medical oncology services at Celilo Cancer Center is a case in point.

Adventist Health and MCMC claim that transaction will not reduce access to services and is needed to maintain current access levels. They expect that the transaction will enable MCMC to expand services for residents of the Columbia Gorge by providing the needed capital and recruitment support. Expanded local access would include specialist and sub-specialist medical services, telemedicine and other "innovative" services, and seamless access services from other Adventist Health providers.[93]

The Entities argue that, as part of Adventist Health (and under the affiliation agreement terms), MCMC will have more resources for recruitment of physicians and advanced practitioners. If the deal does not go through, MCMC anticipates that they will face more challenges in recruiting and retaining staff, as well as maintaining services at the current level and reversing the recent service pause at Celilo Cancer Center.[94]

Entity statements about access

In the affiliation agreement, Notice and supplemental materials, the Entities stated:

Adventist Health shall continue to operate MCMC as a hospital after Closing and shall continue to operate substantially all existing MCMC facilities, services, and programs in a manner consistent with MCMC's mission and operations immediately preceding Closing […].

No reduction or elimination of existing health care services is anticipated in connection with the proposed transaction. Instead, the parties intend to expand existing services and will investigate adding new services over time.

The proposed transaction will ensure that patients in The Dalles and surrounding communities will have long-term access to high-quality health care, delivered locally by talented medical professionals in modernized facilities.

Absent affiliation with Adventist, MCMC expects that its ability to recruit new physicians and other providers would become more difficult.

In addition to financial resources, Adventist Health would share its models for physician employment and professional services arrangements to help MCMC build stronger relationships with providers. Opportunities for collaboration between MCMC and Adventist Health physicians would further help to address staffing issues.[95] They also argue that an affiliation with Adventist Health would make MCMC a more attractive employer, by providing a nicer physical work environment, better equipment and tools, and enhanced training and wellness resources.[96]

Following the close of the transaction, Adventist Health's corporate Board of Directors would have the ultimate authority to decide on any changes to MCMC's facilities, services, and programs. While the Entities are not currently expecting to reduce or eliminate any existing MCMC health care services as part of the transaction, research and experience from other states highlight that such

reductions are not uncommon following health system acquisitions. Maternity and pediatric services have been found to be most vulnerable to closure following consolidation, particularly those provided by rural/community hospitals. One study found that health system affiliation may improve rural hospitals' financial performance but may also reduce access to services for patients. The study found after affiliations, rural hospitals saw significant reductions in on-site diagnostic imaging technologies, the availability of obstetric and primary care services, and outpatient nonemergency visits.[97] Another study found that merged rural hospitals were more likely than independent rural hospitals to eliminate maternal/neonatal and surgical care.[98]

OHA recognizes that Adventist Health's decisions on any changes to MCMC services following the close of the transaction will, to some degree, be driven by the financial performance of MCMC's service lines. They will also be affected by Adventist Health and MCMC's ability to successfully implement plans to recruit and retain staff. Because these future outcomes are inherently uncertain, OHA has imposed several conditions aimed at ensuring that access to services is maintained in the ten years following the closing of the transaction. (See **Conclusions** for more details about these conditions.) In follow-up analyses, OHA will monitor for compliance with conditions and analyze the impact of the transaction on access to care for populations in MCMC's service area.

Quality

OHA assessed MCMC's performance on hospital quality measures that focus on patient outcomes, safety, and patient experience.

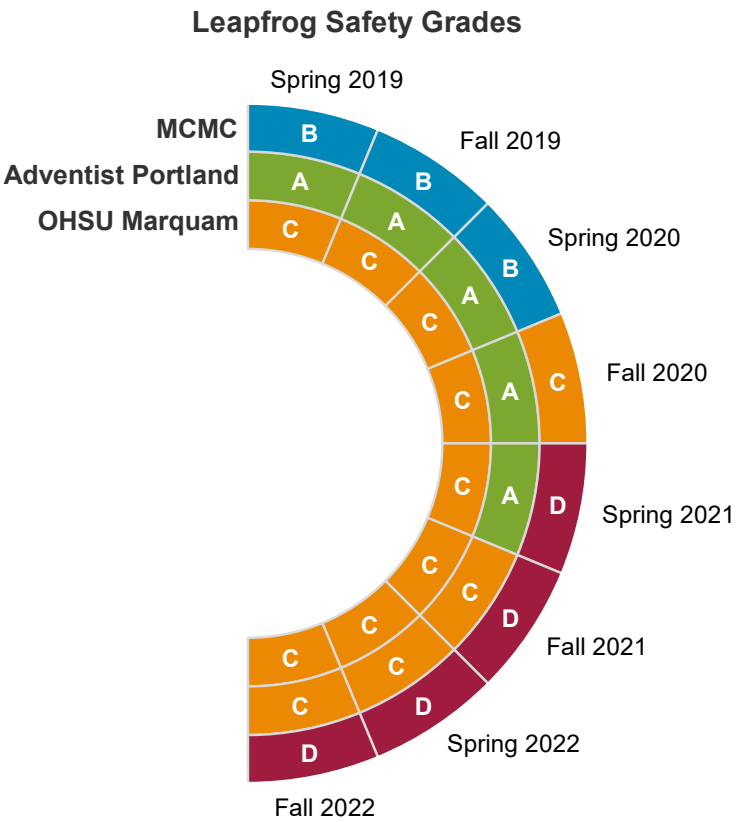
Current Performance

OHA used publicly available data from CMS quality measures and Leapfrog Safety Grade scores to assess MCMC's hospital performance compared to Adventist Health hospitals in Oregon and other hospitals.

Patient Outcomes

Leapfrog grades acute care hospitals on patient safety and makes those grades publicly available. Hospital safety grades are based on standard quality measures, survey data, and other supplemental data sources. Leapfrog compiles performance on a hospital's ability to protect patients from preventable errors, accidents, injuries, and infections. Leapfrog then assigns one of five letter grades – A (best), B, C, D, or F (worst) – based on an individual hospital's performance. Grades are reported for spring and fall of each year.[99]

OHA looked at available Leapfrog data for MCMC, Adventist Portland, and OHSU hospitals. Leapfrog data are generally not available for Critical Access Hospitals; therefore, we do not have data for Providence Hood River (the nearest hospital to MCMC) and Adventist Tillamook.



According to Leapfrog patient safety scores, MCMC's safety grades have gotten worse in the last three years. MCMC's "D" grade for Fall 2022 ranks it last among the 34 hospitals in Oregon that are reported in Leapfrog.[100]

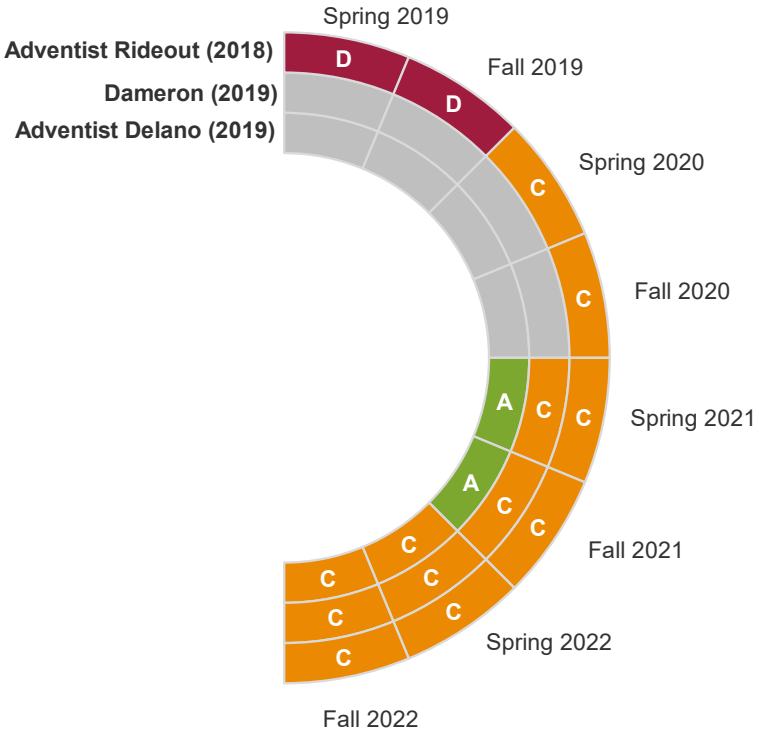
The drop in MCMC's scores follows a national trend of declining patient safety since the onset of the COVID-19 pandemic.[101] In Oregon, 47% of hospitals had an "A" grade for Spring 2022, dropping to 38% "A" hospitals in Fall 2022.[102]

When OHA asked about declining Leapfrog scores, the Entities questioned the reliability of Leapfrog data for smaller hospitals such as MCMC and pointed to CMS's HealthCare Compare as a more appropriate source for data on quality.[103]

OHA also looked at Leaprfrog scores for hospitals in California that Adventist Health recently acquired or affiliated with to understand post-transaction changes in quality. Adventist Health acquired Rideout Health in 2018 and entered agreements with Delano and Dameron hospitals in 2019. Other recent affiliations, including Mendocino Coast and Tulare hospitals, do not have available Leapfrog grades.

Leapfrog did not report grades for Dameron and Adventist Delano prior to Spring 2021. Dameron scores remained flat, while Adventist Delano scores dropped from "A" to "C." Scores for Adventist Rideout improved slightly following the acquisition of the hospital. The COVID-19 pandemic complicates quality performance trends, as many measures that inform hospital grades significantly worsened since 2020.[104]

Leapfrog Safety Grades for recent Adventist affiliates



CMS Star Ratings

CMS Star Ratings provide consumer-facing information about a hospital's performance on quality measures and patient experience. The overall star rating is based on how a hospital performs across different areas of quality, such as treating heart attacks and pneumonia, readmission rates, and safety of care. Patient survey ratings look at patients' experiences of care on topics like how doctors and nurses communicated, how responsive staff were, and cleanliness of the hospital environment. CMS considers performance on dozens of measures to assign a rating of one to five stars, with five stars signifying the best rating. Data for the Star Ratings presented below were last updated in January 2023.

Hospital	Overall star rating	Patient survey rating
MCMC	★★★☆☆	★★★★☆
Providence Hood River	★★★☆☆	★★★★★
Adventist Portland	★★★☆☆	★★★☆☆
Adventist Tillamook	★★★☆☆	★★★★☆
OHSU Marquam	★★★★☆	★★★★☆

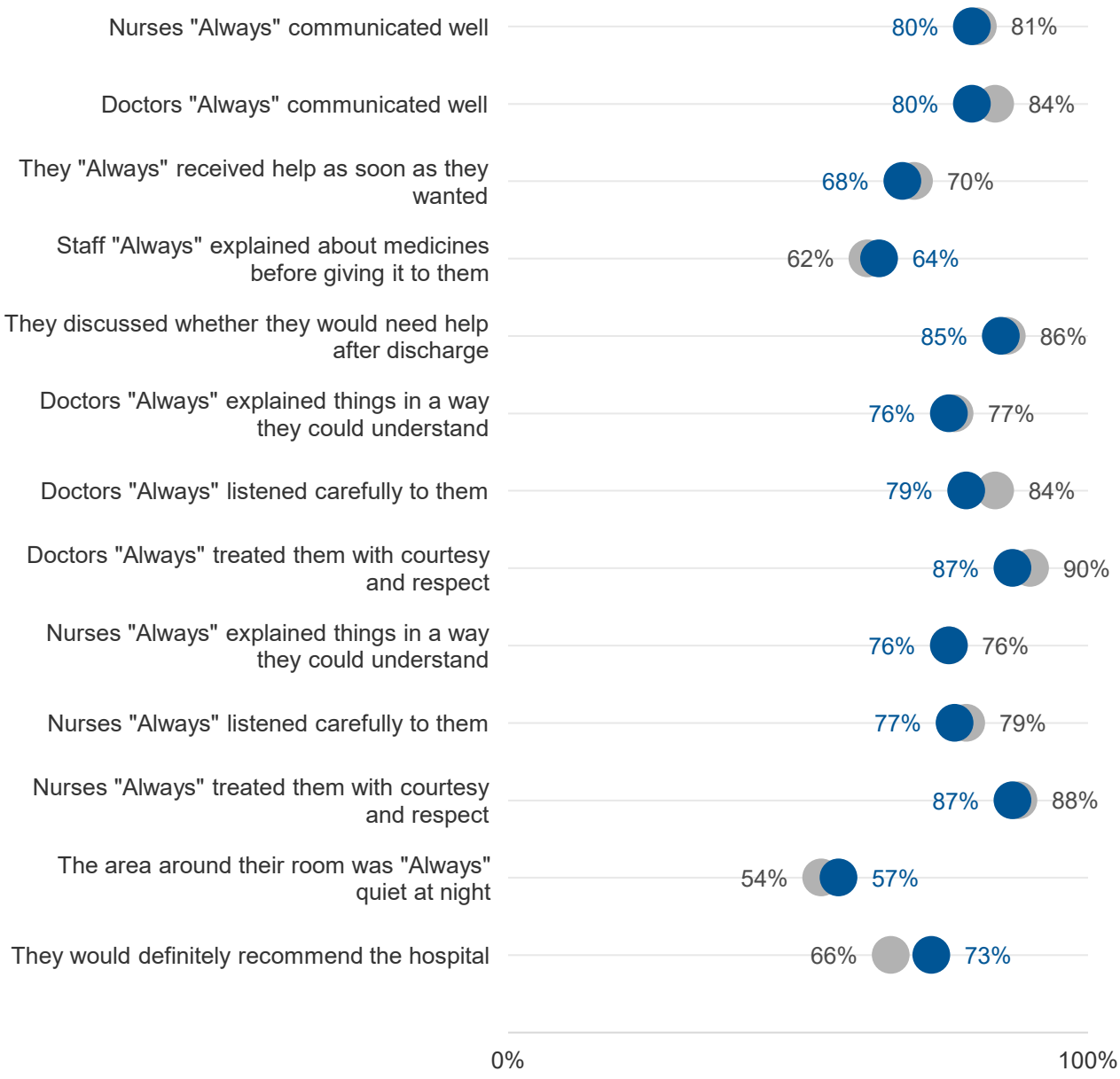
MCMC's overall rating is 3 stars. Nationally, about 29% of hospitals have a 3-star rating. MCMC has a 4-star patient survey rating. See below for a more detailed discussion of patient experience measures.

Patient Experience

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a standardized survey that measures patients' experiences with hospital care. HCAHPS includes 19 questions related to provider communication, responsiveness of staff, care transitions, and patient ratings of hospitals.[105]

The chart below shows MCMC's 2021 HCAHPS scores compared to statewide. Higher percentages are better for all of the listed measures.

MCMC 2021 HCAHPS scores compared to **Oregon State** 2021 HCAHPS scores



MCMC HCAHPS scores were similar to statewide scores for most measures. Compared to statewide, more MCMC patients said they would "definitely recommend the hospital". Fewer

MCMC patients reported that doctors “always” listened to them carefully and doctors “always” communicated well.

Healthcare Associated Infections

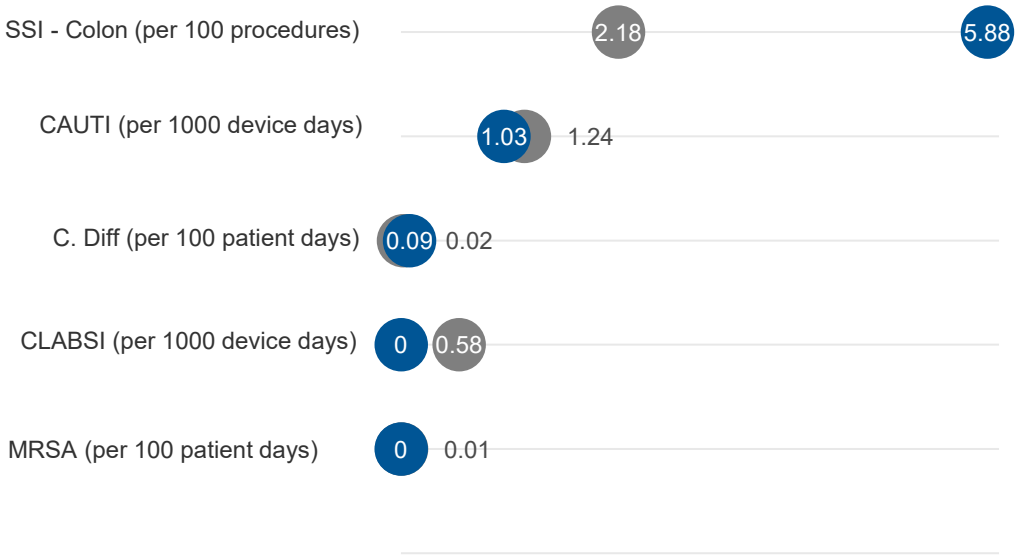
Healthcare associated infections (HAI) are infections people get while they are receiving health care for another condition. HAIs can happen in any health care facility, including hospitals. HAIs can cause significant illness and death in patients. Hospitals can prevent and reduce the occurrence of HAIs by adhering to effective safety practices.

CMS reports on hospital HAI performance and OHA examined MCMC’s performance on the following measures:[106]

- Central line associated bloodstream infection (CLABSI)
- Catheter associated urinary tract infection (CAUTI)
- Surgical site infection (SSI, for both colon and abdominal hysterectomy)
- Methicillin resistant Staphylococcus aureas bacteremia (MRSA)
- Clostridium difficile (C. diff), an infection of the large intestine and colon

The chart below shows MCMC’s 2021 performance compared to statewide performance. Higher rates indicate worse quality. MCMC had worse rates of colon surgical site infections compared to statewide. CAUTI, MRSA, and C.diff rates were comparable to statewide, and MCMC performance was better than statewide for the CLABSI measure.[ix]

MCMC performance was worse than **statewide** for the colon - surgical site infections measure.



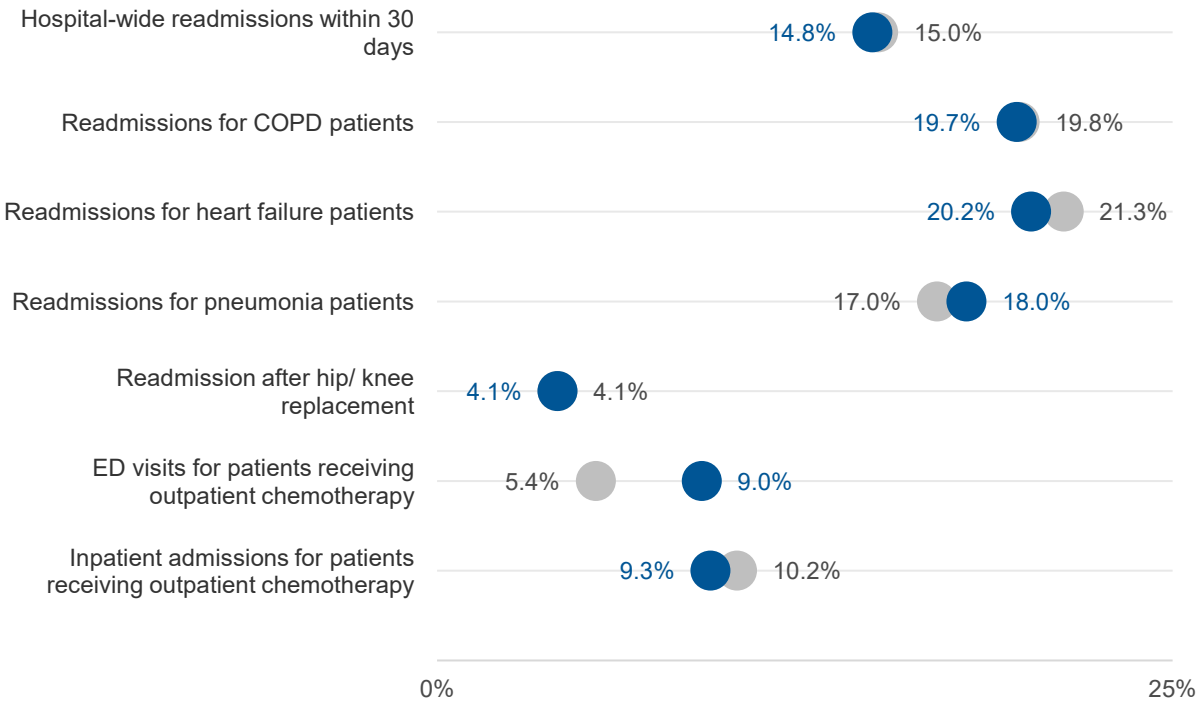
Unplanned Visits and Readmissions

High quality care can keep patients from needing to return to the hospital to receive additional care. OHA looked at unplanned hospital visits and readmissions for MCMC using publicly available data from CMS.[107] The chart below shows MCMC’s performance compared to national rates. See

[ix] The data for MCMC did not include any abdominal hysterectomies; therefore that measure is not reported.

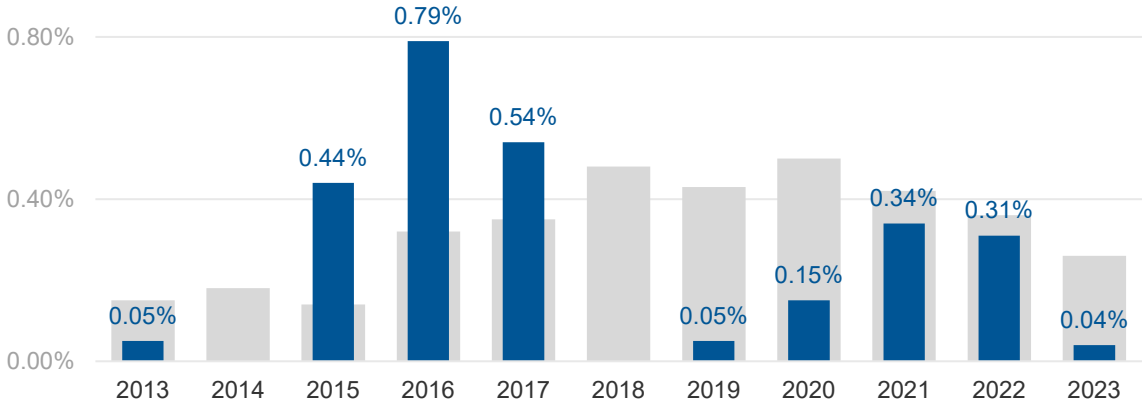
Appendix B: OHA's Review for more information about measurement time periods for these measures.

MCMC performance was worse than **national rates** for ED visits for patients receiving outpatient chemotherapy.



CMS's Hospital Readmissions Reduction Program evaluates hospital readmissions, and CMS penalizes hospitals that have high readmissions. Penalized hospitals can lose up to 3% of each Medicare payment in a year.[108] In 2023, 21 (of 34 eligible) Oregon hospitals received penalties. MCMC was among the hospitals on this list, receiving a 0.04% reduction in Medicare payments. Since 2013, MCMC has been penalized every year except for 2014 and 2018. The chart below shows MCMC payment penalty amounts for each year of the program, compared to the statewide average penalties.[109]

MCMC readmission penalties were highest in 2016 and have been lower than the **statewide average** since 2019.



Potential Impacts

MCMC performance on quality measures has been uneven in recent years. COVID-19 uncertainties, staffing challenges, and financial issues at MCMC can all contribute to worse quality outcomes. MCMC's Leapfrog grades have declined since 2019, and it has received payment penalties from CMS for high readmission rates. Patient experience scores for MCMC are similar to state averages and MCMC performs similar to or better than statewide on most health care acquired infections.

The Entities anticipate that the transaction will positively affect health care quality at MCMC. Adventist Health plans to integrate MCMC into system-wide quality and safety improvement programs and management structures. The Entities also expect MCMC's quality performance to benefit from Adventist Health's investments in medical equipment and facilities upgrades, clinician recruitment and training efforts, and access to various other Adventist Health system resources.

Adventist Health has made some commitments that may improve quality, including capital investments, efforts to recruit and retain staff, and investments in quality and safety improvement initiatives and technology. If successful, plans to replace temporary providers with employed clinicians and recruit additional primary care providers could contribute to quality improvements. Patient safety appears to be a particular quality concern that would require Adventist Health's attention.

Entity statements about quality

In the Notice and supplemental materials, the Entities stated:

Adventist has recently undertaken system-wide quality and safety improvement initiatives addressing reduction in hospital-onset infections, elimination of medication errors and fall prevention, among other focus areas. MCMC will be integrated into all future initiatives and will share in access to system-wide learnings, data analysis and best practices. Adventist also regularly conducts personnel training, performance reviews and audits related to quality and safety improvement and provides oversight and resources to the quality and safety functions and committees at each clinical site.

Adventist Health is leveraging technology to increase quality and efficiency throughout the system. This results in greater patient satisfaction and improved outcomes, in addition to reduced readmissions and shorter lengths of stay (which, in turn, decrease the cost of care). MCMC will gain access to the same technology and care methodologies as a result of the proposed transaction.

Given MCMC's financial challenges, special attention should be paid to ensure that quality of care does not decline further as Adventist Health focuses on improving MCMC's financial outlook. Changes that enhance profitability may not be compatible with improvements in quality of care. OHA will monitor MCMC quality measures in follow-up analyses.

Equity

OHA looked at current practices at MCMC and Adventist Health to advance equity and the potential impacts of the transaction on health equity.

Current Performance

OHA assessed community benefit spending, access to care for priority populations (such as migrant and seasonal farm workers), and access to services that may be subject to restrictions by faith-based institutions.

Community Benefit Spending

Community benefit refers to services, activities, or programs that hospitals provide to improve the health and wellbeing of their local community. Nonprofit hospitals are required to provide and report their community benefit activities in lieu of paying certain taxes. OHA reports two main buckets of community benefit spending: unreimbursed care and direct spending. (See sidebar for definitions.)

In Oregon, acute care hospitals are also required to meet minimum spending floors for community benefit. Each year, OHA assigns a minimum spending floor for each eligible hospital. For 2022, MCMC's community benefit spending floor was $7,167,123 and for 2023 it is $7,243,459.[110]

MCMC uses the region's community health needs assessment to prioritize direct spending investments. 2020-2022 MCMC priorities included:[111]

- Increasing the availability of culturally and linguistically appropriate materials
- Increasing same day appointment capacity
- Increasing primary care provider assignment
- Distributing food boxes to vulnerable populations
- Providing pain management education programs
- Providing free wellness and lifestyle coach programs
- Providing Mommy & Baby wellness programs

Community Benefit Categories

OHA groups hospitals' reported community benefit spending into two types: direct spending and unreimbursed care.

Direct spending is money hospitals spend to improve community health, reduce health disparities, or address social determinants of health. It may include paying for health professional education, community health improvement activities (such as vaccination clinics), and cash and in-kind investments in community initiatives or groups.

Unreimbursed care is medical care that hospitals provide at reduced or no cost. Examples may include charity care, subsidized health services, and unreimbursed Medicaid charges.

Charity care (a type of unreimbursed care) refers to financial assistance that hospitals provide to patients who cannot afford to pay a medical bill. Charity care may cover all or part of the total costs.

The Lown Institute ranks hospitals based on community benefit spending. In 2019, MCMC ranked 48 out of 54 ranked hospitals in Oregon, receiving a "C" grade in this area.[x] Adventist Portland ranked 22nd and Adventist Tillamook ranked 5th in the state during this time period. These rankings were based on charity care spending, community investment, and Medicaid revenue. Rankings did not include unreimbursed care, health professionals training, and research.[112]

[x] MCMC received an overall "A" social responsibility grade from the Lown Institute, ranking 10th in the state on factors such as equity (which includes community benefit spending), value, and outcomes. Community benefit was MCMC's poorest performing area.

MCMC's community benefit spending trends

OHA analyzed MCMC's community benefit spending using Hospital Community Benefit Data for the years 2017 through 2021.

MCMC reported $15.7 million in total community benefit spending for 2021.[113] As a percentage of operating expenses (11%), this was slightly lower than the average across all Oregon hospitals (13%). MCMC's community benefit spending ranged from 5% of operating expenses in 2019 to 11% in 2017 and 2021.

The decline in spending from 2017 to 2019 came primarily from a 57% ($4.9 million) drop in reported costs for unreimbursed Medicaid charges. Spending rebounded in 2020, growing by 85% ($4.9 million) in 2019 to $11.6 million. The increase was driven by a $4.8 million increase in spending for subsidized health services, a component of unreimbursed care costs.[xi]

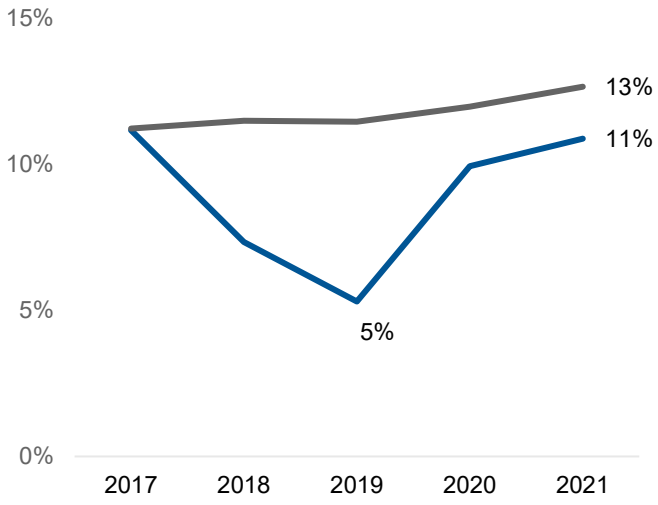
2021 saw the implementation of House Bill 3076 (passed into law by Oregon's legislature in 2019), which is likely to have impacted hospitals' reporting practices.[114]

Consistent with statewide trends, unreimbursed care accounted for the majority of MCMC's community benefit spending. The share of spending on unreimbursed care increased from 68% of total community benefit dollars in 2019 (compared to 75% statewide) to 95% in 2021 (compared to 78% statewide).

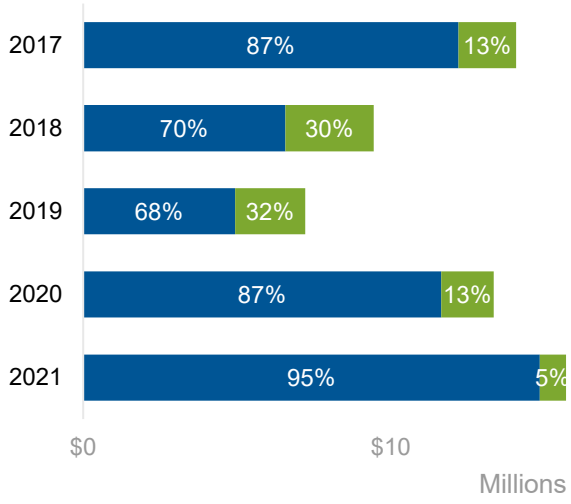
MCMC's direct spending dropped both in absolute terms and as a percentage of total community benefit spending, from $2.3 million (32%) in 2019 to $0.9 million (5%) in 2021. The statewide direct spending share hovered around 22-25% in 2017-2021.

Looking at categories within unreimbursed care, Medicaid charges have comprised the largest share of spending for all years in the 2017-2021

MCMC's total community benefit spending as a percentage of operating expenses dipped to 5% in 2019 but was back to 11% by 2021, slightly below the **statewide average**.



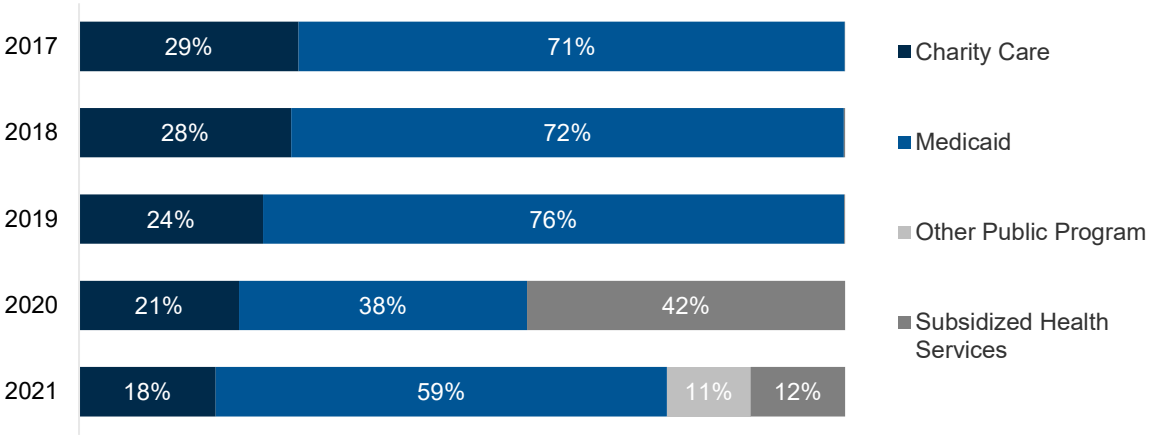
Unreimbursed care accounted for most of MCMC's community benefit spending, reaching $14.8 million in 2021. The share of **direct spending** decreased from 32% in 2019 to 5% in 2021.



[xi] Subsidized health service costs are expenses for hospital clinical services that are provided at a financial loss, because they meet an identified community need. This may include costs for 24-hour emergency departments at rural hospitals, inpatient and outpatient behavioral and mental health services, hospice, and home health services.

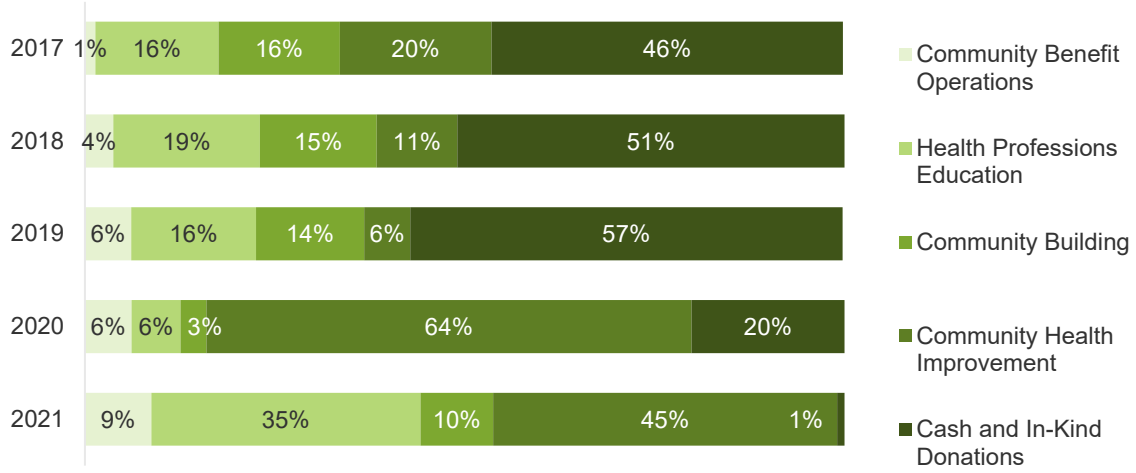
period. In 2020, Medicaid charges decreased to 38%, increasing back down to 59% in 2021. Other public programs and subsidized health services had minimal spending until 2020.

Medicaid charges account for the the largest share of MCMC's unreimbursed care. **Subsidized health services** and **other public programs** only became sizable shares of spending in 2020 and 2021, respectively.



Cash and in-kind donations accounted for the largest share of direct spending in 2017, 2018, and 2019, making up 46%-57% of total direct spending. In 2020, cash and in-kind donations dropped to 20% and fell further to 1% of total direct spending in 2021. Meanwhile, community health improvement increased from 6% of total direct spending in 2019 to 64% in 2020. These large shifts suggest changes in MCMC's approach to reporting of direct spending, likely in response to new requirements and guidance related to House Bill 3076.

Prior to 2020, the largest direct spending category was **cash and in-kind donations**. In 2020 and 2021, **community health improvement** made up the largest share.



Services Potentially Subject to Faith-Based Restrictions

Federal laws protect health care entities, including hospitals and health systems, and individual providers that refuse on religious or moral grounds to perform or assist in performing certain health care duties.[115] MCMC is currently a secular hospital, and many public comments raised concerns that Adventist Health, a faith-based organization, may restrict access to care for some services, including gender-affirming care, reproductive health services, and "death with dignity" services.

MCMC facilities have low volumes for some of these services and may refer patients to other providers for care. As such, it's also important to consider counselling and referral practices as a key component of access to care.

> *"Will elective termination of pregnancy, tubal ligations, voluntary sterilizations, morning after pills, other contraception, all be permitted in the hospital and the practices it acquires? What about us [sic] 'death with dignity' – medically assisted dying? I would want to make sure that there are no limitations imposed on these services because of the faith-based nature of the acquiring entity."*
>
> - Public Comment

Reproductive health services

Reproductive health services, including birth control, sterilization, emergency contraception, fertility treatments, and abortion care, are included in HCMO's definition of essential services. Most people access reproductive health services at some point in their life. For example, 90% of females ages 18-64 have used some form of contraception in their lifetime, and 24% of women will have an abortion by the end of their child-bearing years.[116] [117] Roughly one in ten men receive a vasectomy.[118] Emergency contraception can be crucial care for victims of sexual assault.[119]

Most induced abortions are provided in clinic settings, rather than hospital settings, and MCMC facilities perform very few induced abortions; according to APAC data, fewer than 10 were performed by MCMC providers in the 2018-2020 time period. In 2021, 32 abortions were reported for residents of Wasco County, 22 for Hood River County, fewer than 10 for Sherman County, and none for Gilliam County. Most of these abortions occurred in Multnomah County.[120]

Gender-affirming care

Gender-affirming care refers to a range of social, psychological, behavioral, and medical interventions that are designed to affirm a person's gender identity when it conflicts with the gender they were assigned at birth. Services may include counseling, hormonal treatment, or surgery.

According to hospital discharge data for 2019-2021, MCMC did not deliver any inpatient services where gender dysphoria was the primary diagnosis. (Gender dysphoria refers to distress or unease related to a mismatch between person's gender identity and sex assigned at birth.) Looking at claims data for 2018-2020, around 50 patients received specialty care related to gender dysphoria from MCMC providers and about 30 received primary care services related to gender dysphoria.

MCMC has an existing policy related gender-affirming care. The policy provides guidance and expectations for providing care to transgender patients, including use of names and pronouns, confidentiality of personal information, room assignments, access to rest rooms, and consent for services.[121] Adventist Health also has an existing policy related to gender identity and patient care, which includes a provision related to staff training.[122]

End-of-life services
The Oregon Death with Dignity Act allows terminally ill people in Oregon who meet specific qualifications to end their lives by self-administering a lethal dose of medication that has been prescribed for that purpose. To qualify, patients must be:

- At least 18 years old.
- Capable of making and communicating health care decisions to health care providers.
- Diagnosed with a terminal illness that will lead to death within six months.

Since 1998, 45 patients living in Central Oregon and the Columbia Gorge region have died after taking death with dignity medications, including 8 in 2022. Nine physicians in this region reported writing death with dignity prescriptions for patients in 2022.[123] MCMC does not have a policy that specifically addresses the Death with Dignity Law, although it is referenced in MCMC's policy on end-of-life decision making.[124]

Services for migrant workers
Per the Entities submissions, MCMC's Medical Management Department coordinates a range of services and supports for migrant workers. Services are delivered in a "culturally-appropriate way" and include medical, behavioral health, translation/language, housing, nutrition, transportation, and financial assistance services. MCMC also conducts outreach to the migrant worker community, including visits to worker camps, free health screenings at community events, and participation in the Serving Oregon and Its Migrants by Offering Solutions (SOMOS) program. The Entities have stated in response to OHA's questions that Adventist Health is "fully committed" to supporting MCMC's services and programs for migrant workers.

Potential Impacts

To assess impacts of the transaction on health equity, OHA examined potential changes from the transaction in the following areas:

- Community investments/community benefit spending
- Charity care/financial assistance
- Faith-based policies

Community Investments

Under the transaction, community benefit spending decisions would be subject to the approval of Adventist Health's corporate Board of Directors, although MCMC's Community Board would have the opportunity to inform decisions primarily affecting the local community.[125]

In supplemental responses to OHA's questions, Adventist Health stated it was committed to supporting MCMC's community health initiatives targeting vulnerable populations and MCMC's collaboration with community partners through the Community Health Needs Assessment process.[126]

The Notice describes Adventist Health's plans to "enhance" MCMC's current patient navigation program

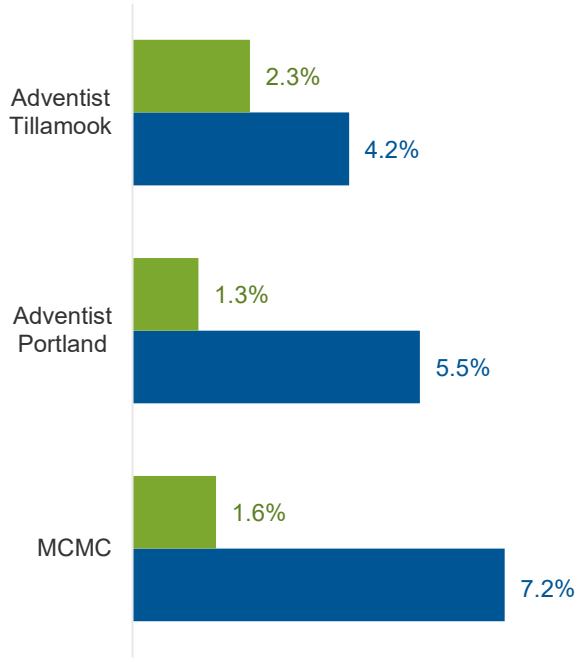
> *"Following Closing, Adventist shall ensure that MCMC continues to provide support to and participate in community-based health programs at levels reasonably consistent with previous years, subject to Adventist Health's satisfactory assessment of their effectiveness and financial viability, including cooperation with local organizations that sponsor healthcare initiatives to address identified community needs and improve the health status of the elderly, poor, and other at-risk populations in the MCMC Service Area."*
>
> - Affiliation agreement, Section 3.11(b)

initiated in August 2021 which addresses chronic disease management and social determinants of health. The affiliation agreement also includes commitments relating to levels of spending on community-based health programs (see box on previous page). Over the 2014-2021 period, MCMC's direct spending on community benefit initiatives represented 1.6% of its operating expenses, marginally higher than Adventist Portland (1.3%) but lower than Adventist Tillamook (2.3%).

It is difficult to anticipate how the transaction would impact the composition of community benefit spending, particularly the direct spending component.

Overall, given Adventist Health's current community benefit spending levels and commitments to maintain MCMC programs, OHA does not expect any substantial changes in MCMC's community investment levels or strategies. MCMC and Adventist Health will continue to be subject to requirements for minimum spending on community benefit initiatives set by OHA's Hospital Community Benefit Program.

In the 2014-2021 time period, MCMC had the higest rate of **unreimbursed care** as a percent of total operating expenses, while Adventist Tillamook had the highest rate of **direct spending**.



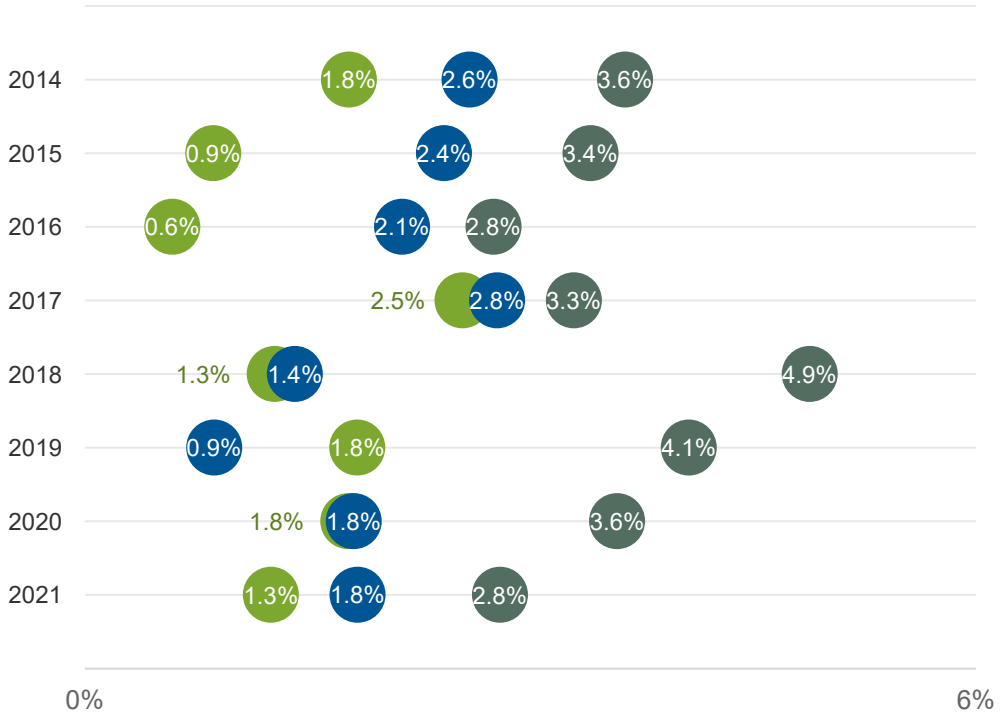
Charity Care and Financial Assistance

Under the affiliation agreement (Section 3.11(a)), MCMC will adopt Adventist Health's policies and procedures for financial assistance. Adventist Health states in the Notice it is "committed to honoring MCMC's legacy of serving all patients, regardless of their ability to pay." [127] It further describes its charity care resources as "robust" and claims the transaction would complement and enhance MCMC's own charity care program.

OHA's reviewed the current financial assistance policies of MCMC and Adventist Health and found no evidence to suggest that Adventist Health's policies would represent a reduction in financial assistance for MCMC patients overall. In addition, financial assistance by hospitals in Oregon is governed by ORS 442.614 which sets the minimum percentage adjustments to patients' costs based on household income. These rules preclude any changes in financial assistance thresholds facing MCMC patients following the transaction.

Based on community benefit data for the years 2014 through 2021, Adventist Tillamook had higher spending on charity care (as a percentage of operating expenses) than MCMC, whereas Adventist Portland's spending was generally lower. Differences between Adventist Portland and Tillamook likely reflect differences in income levels among the patient population.

MCMC's charity care spending as a percentage of operating expenses was greater than **Adventist Portland** but lower than **Adventist Tillamook** for most years between 2014 and 2021.



Impact of Faith-Based Policies

During the public comment period, OHA received many comments raising concerns that faith-based restrictions on services could have a large impact on patients living in MCMC's service area, with some populations, such as women, LGBTQIA+, terminally ill, and pregnant patients, being particularly impacted. MCMC is the only health system serving a large geographic area, and the closest hospital, Providence Hood River, is part of a Catholic health system. If the current service level is not maintained, patients who are transgender, experiencing terminal illnesses, and/or seeking reproductive health services may have to travel further to receive care, or may go without needed care.

As Catholic and other faith-based health systems have expanded, there have been documented instances of secular hospitals ceasing some services after combining with a faith-based health system. For example, in 2021, Virginia Mason in Seattle merged with a Catholic Health System, CHI Franciscan. Upon merging, the Entities announced that abortion care and "death with dignity" services would be discontinued.[128] Some policies to restrict services can result in negative health outcomes for patients. One study looking at state-mandated abortion bans found that outcomes for pregnant patients with serious complications worsened when bans were implemented.[129]

Reproductive health services

In the Notice, the Entities state:

> *[MCMC] will also continue to make the full range of reproductive services available to patients, since Adventist Health imposes no religious-based restrictions on medical procedures and services.*

In supplemental materials, the Entities stated:[130]

> *Both MCMC and Adventist are committed to providing a full range of high-quality health care services, including reproductive and end-of-life services. Neither organization has policies, procedures, or practices that curtail or otherwise attempt to influence the rights or obligations of their respective providers to do what they believe is in the best interests of their patients. Importantly, despite being a religious organization, Adventist imposes no religious-based restrictions on medical procedures and services.*

While Adventist Health states that they impose no faith-based restrictions on medical procedures and services, Adventist Portland's policy related to induced pregnancy terminations at its acute care hospital does appear to impose some restrictions:[131]

> *Adventist does not permit direct termination of pregnancy "on demand" by the patient or as a method of birth control. Any person seeking admission to the facility for a direct termination of pregnancy must be notified by the facility of this policy.*
>
> *Adventist Health has adopted a practice of not admitting patients seeking direct termination of pregnancy as described above. However, medically indicated termination of pregnancy may be considered in the course of treatment of a patient who is pregnant at Adventist Health only when:*
>
> *a. The attending physician believes in good faith that the life or health of the patient or unborn fetus is in imminent danger or continuing the pregnancy would threaten the patient's and/or unborn fetus survival or potentially causes harm, morbidity, or mortality.*
>
> *b. If other situations arise that are consistent with the principles stated in the preamble, the chairman of the Facility's Governing Board shall appoint a subcommittee of the board who, in consultation with the Facility's Ethics Committee, will evaluate and decide on a case-by-case basis the request for a medically indicated termination of pregnancy in the course of treatment of the patient who is pregnant.*

Adventist Health's policy on induced termination of pregnancy applies to Adventist hospitals. In response to OHA's follow-up questions, Adventist Health stated it does *not* direct physicians/providers on induced termination of pregnancy at outpatient and other clinical sites. Adventist's policy also states that for all clinical sites, (acute care, emergency care and ambulatory settings), Adventist Health does not direct physicians/providers on contraception, Plan B, hormonal therapies for any purpose, or birth control.

Adventist Health and MCMC have provided multiple assurances that access to reproductive health services from MCMC will not change because of the transaction. However, given Adventist Health's current policy language and concerns expressed by members of the public (see **Public Comments**), OHA has applied conditions to its approval of the transaction to ensure that the Entities keep their commitments and continue to make existing services available.

End-of-life services

Adventist Health has publicly stated that the organization does not participate in providing death with dignity services. The organization's FAQs state:[132]

> *After careful consideration, Adventist Health has chosen not to participate under the "death with dignity" legislation in any of the states in which we have operations. This means that no Adventist Health employees, independent contractors, or other persons or entities may*

participate in activities under any death with dignity law while on the premises of an Adventist Health facility, or while acting within the scope of any employment or contractual relationship with Adventist Health. If a patient requests assistance under a death with dignity law, a referral may be provided.

In keeping with our mission, we believe our providers have an obligation to openly discuss the patient's concerns, unmet needs, feelings and desires about the dying process. Our goal is to help our providers pursue the underlying causes regarding the patient's questions and help the patient understand the range of available options, including comfort care, hospice care and pain control. We encourage all providers to respond to a patient's query about life-ending medication with openness and compassion. Ultimately, our goal is to help patients make informed decisions about end-of-life care.

Adventist Health's systemwide policy further states:

If a terminally ill patient requests assistance under a Death with Dignity Law, every reasonable measure that might help to alleviate the underlying causes for the request shall be explored. […] If a terminally ill patient admitted to Adventist Health continues to request assistance under the End of Life Option or Death with Dignity Act(s), a referral will be facilitated, as applicable.

Given these statements and policies, OHA has applied conditions to its approval of the transaction to ensure that the Entities continue to make available any end-of-life services currently offered at MCMC.

Rural Health Disparities

MCMC serves a large rural population. There are large and widespread disparities in health care access and outcomes between Oregon's rural and urban populations. People living in rural and frontier areas have lower life expectancy compared to rural residents, higher suicide rates, and higher rates of chronic conditions such as arthritis, diabetes, and high blood pressure.[133]

Adventist Health positions itself as a health system with deep expertise in providing health care services to rural populations. MCMC has cited this as one reason for choosing to affiliate with Adventist Health versus other systems. The Notice states:

Adventist Health has a long history of expanding access to care in medically underserved areas and is one of the nation's largest providers of rural healthcare services.

The Notice also mentions "expansion of MCMC's rural health clinics and rural health clinic services" among anticipated uses of the capital commitment. If Adventist Health is successful in implementing these plans, there is potential for the transaction to reduce disparities in care between rural and urban communities. Conversely, any further service reductions or closures at MCMC would further deepen urban-rural disparities in health care access and outcomes for people in Oregon.

Public Comments

OHA held a public comment period from January 24, 2023 through February 8, 2023 and received 50 written public comments. Public comments related to this transaction are posted to the HCMO website.

Public comments for the Adventist-MCMC transaction are reproduced below for reference only. Where applicable, OHA has used public comments to inform its analysis of the transaction. OHA expresses no views on the substance of the comments and their inclusion in this report does not constitute an endorsement by OHA of the views expressed therein.

Commenters were split in their support for the transaction, with many voicing that the transaction is needed to maintain and rebuild services in the region, while others opposed the transaction as likely to cause harm. Key themes from comments are summarized below.

Lack of providers

Many commenters mentioned that MCMC has struggled to recruit and retain providers. Some comments shared stories of delays in care, such as long waits to see primary care providers.

Closures and reduction of services

Related to a lack of providers, some commenters described the challenges related to closed and reduced services, including delaying care, waiting longer for appointments, and having to travel longer distances to receive care. One comment highlighted research findings that rural hospitals may be more likely to lose access to certain services after consolidation.

Concerns about faith-based restrictions

Some comments raised concerns about a faith-based organization (Adventist Health) gaining control of a secular hospital (MCMC). Commenters noted that the next closest hospital is also run by a faith-based organization. Many comments raised concerns about how some populations may be treated at a faith-based hospital and the potential that services, such as reproductive health, gender-affirming care, and death with dignity care, may be reduced or eliminated.

"Please recruit good doctors and support them so we can establish a good relationship with them and keep them here so people don't have to travel to Gresham or Portland for medical services."

"MCMC has a history of losing doctors and other staff, which has been a detriment to our community. They are or have closed specialty clinics in Hood River, the chemo center at Celilo, and a large part of Water's Edge Including the cardiology clinic. Our communities deserve local care."

"There has been talk of MCMC building a new hospital where it might be more easily accessible than the current one. That does make sense and seems necessary, however, I would ask that you please first build a strong foundation as a healthy and viable professional organization within the community, establish trust with the people of our community before beginning to build a physical structure."

"Something needs to change. We have no doctors. Anything would be better."

"Some community members are concerned about current MCMC leadership/Board and may not be reassured by their retention in the acquisition."

Leadership and local control

Some commenters expressed concerns about MCMC being controlled by a large health system that is based out of state and that may not consider local needs. Several commenters expressed a lack of confidence in MCMC's current leadership and board.

Need for support from a larger system

Several comments acknowledged the reality faced by independent rural hospitals and argued that support from a large health system is crucial to the success of MCMC. Commenters highlighted national staffing and workforce challenges and the impact of the pandemic on independent hospitals.

Rural health care needs

Several commenters shared experiences with rural health care, including the challenges of serving a large geographic area with a low population, staffing concerns, the need to travel to get care, and health inequities.

Cost and quality concerns

Several comments raised concerns about the potential for increased costs, citing research showing that health care consolidation can result in price increases. One commenter also raised concerns about declining quality for MCMC if the transaction goes through.

"There are many people in our community (LGBTQIA2S+, BIPOC, those accessing reproductive healthcare, those accessing end-of-life care) who feel uncomfortable or even unsafe in Christian/Catholic faith-based settings and deserve to have access to a secular option for healthcare."

"The Dalles needs a strong local hospital. It should provide access that is safe and responsive to the needs of the whole community. Allowing a purchase and monopoly by a large, distant, corporate institution moves us away from that ideal."

"With the national challenges surrounding all industry especially healthcare with staffing, recruitment, burnout, etc. small independent rural hospitals are struggling. Having an affiliation with a larger organization is better in today's new normal."

"Because we are rural, we suffer huge inequities in health care. It's easy not to know that The Dalles is actually the hub for a bi-state area known as the Columbia River Gorge that currently serves 7 counties: Wasco, Wheeler, Sherman, Gilliam, Hood River, Klickitat and Skamania … over 10,000 square miles of mostly rocks and sage brush."

Conclusions

Based on preliminary review findings, **OHA approved the transaction with conditions on April 13, 2023.** For legal requirements of the approval, see the Order in the Matter of the Proposed Material Change Transaction of Adventist Health and Mid-Columbia Medical Center, dated April 13, 2023.

The transaction was approved with conditions, per ORS 415.501(6)(a), because OHA determined that:

- The transaction is in the interest of consumers and is urgently necessary to maintain the solvency of MCMC.

OHA's approval criteria are specified in administrative rules for the Health Care Market Oversight Program (OAR 409-070-0055(2)) and are consistent with Oregon law. Below is a summary of the main reasons, based on the findings described in this report, why OHA considers this criterion satisfied.

Approval Criteria

The transaction is in the interest of consumers and is urgently necessary to maintain the solvency of MCMC.

The transaction will not lead to horizontal consolidation and thereby restrict competition. Adventist has committed to maintaining substantially all MCMC's facilities, services, and programs, including existing reproductive and end-of-life services. Adventist and MCMC maintain that the affiliation will enhance MCMC's ability to attract and maintain physicians and expand services for local communities. MCMC is facing significant financial challenges, and there are solvency concerns for the hospital if the transaction is not completed. Adventist will assume MCMC's current financial obligations and has committed to investing $100 million of capital in MCMC over the next ten years.

Approval Conditions

OHA's approval of this transaction requires the Entities to comply with certain conditions. These conditions focus on maintaining access to care and informing OHA about Adventist Health's spending of the $100 million capital commitment. For legal requirements related to conditions, please refer to the Order. OHA's approval conditions are summarized as follows:

Access conditions

1. For ten years following the closing date of the transaction, Adventist and MCMC shall use commercially reasonable efforts to continue to operate and maintain MCMC as a licensed general hospital.
2. For ten years following the closing date of the transaction, Adventist and MCMC shall use commercially reasonable efforts to continue to operate and maintain existing MCMC facilities, services, and programs at or above current service levels.
3. For ten years following the closing date of the transaction, Adventist and MCMC shall use commercially reasonable efforts to maintain existing MCMC services at current levels and maintain referral policies for reproductive health care services, gender affirming care, and Death with Dignity Act services.
4. For ten years following the closing date of the transaction, Adventist and MCMC shall maintain participation in public health care coverage programs, including Medicaid.

5. Within one year following the closing date of the transaction, Adventist and MCMC shall have used commercially reasonable efforts to restore medical oncology services at Celilo Cancer Center.
6. MCMC and Adventist shall not significantly reduce, restrict, or terminate facilities, services, or programs described in 1-5 unless they have requested and obtained OHA's approval for such changes.
7. If unplanned provider departure(s) at MCMC result in significant temporary reductions, restrictions, or terminations of the facilities, services, or programs described in 1-5, MCMC and Adventist shall notify OHA in writing within five business days, including documentation to support the need for such temporary changes.

Capital investment conditions

8. Adventist shall invest $100 million (the "Capital Commitment") in MCMC under the terms of the Affiliation Agreement.
9. Within five business days of the completion of a Capital Investment Plan, detailing how the Capital Commitment will be spent, Adventist and MCMC shall share the plan with OHA.
10. Within five business days of the completion of the Urgent Capital Needs Plan, Adventist and MCMC shall submit a copy of this plan to OHA.

Annual reporting condition

11. For ten years following the closing date of the transaction, Adventist and MCMC shall submit an annual report to OHA describing compliance with approval conditions and spending of the $100 million Capital Commitment. Adventist and MCMC shall share a public version of the annual report on MCMC's website.

Post-Transaction Monitoring

As required by statute, OHA will conduct follow-up analyses at minimum one, two, and five years after the transaction is complete. These analyses will assess the impact of the transaction on access to care, quality of care, affordability, and health equity. They will include follow-up on concerns or observations noted in this report. As part of these activities, OHA may request additional information from the Entities. OHA will publicly publish findings and conclusions from follow-up analyses.

Acronyms & Glossary

Acronyms & Abbreviations

APAC	Oregon's All Payer All Claims database
CAH	Critical Access Hospital
CEO	Chief Executive Officer
CMS	Centers for Medicare and Medicaid Services
DCBS	Department of Consumer and Business Services
DCOH	Days Cash on Hand
DOJ	Department of Justice
DRG	Diagnosis Related Group
ED	Emergency Department
EMR	Electronic Medical Record
HAI	Healthcare Associated Infections
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCMO	Health Care Market Oversight
HDD	Hospital and Emergency Department Discharge database
HHI	Herfindahl-Hirschman Index
HPSA	Health Professional Shortage Area
LLC	Limited Liability Company
MCMC	Mid-Columbia Medical Center
MDC	Major Diagnostic Category
OAR	Oregon Administrative Rule
OHA	Oregon Health Authority
OHP	Oregon Health Plan
OHSU	Oregon Health & Science University
ORS	Oregon Revised Statute
PSA	Primary Service Area
RHC	Rural Health Clinic
RRC	Rural Referral Center
SCH	Sole Community Hospital

Glossary

Competition: A situation in a market in which firms or sellers independently strive to attract buyers for their products or services by varying prices, product characteristics, promotion strategies, and distribution channels.

Concentration: A measure of the degree of competition in the market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for individual firms.

Consolidation: The combination of two or business units or companies into a single, larger organization. Consolidation may occur through a merger, acquisition, joint venture, affiliation agreement, etc.

Health equity: OHA defines health equity as follows:

Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, age, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.

Appendix A: Commitments in the Affiliation Agreement

Area	Adventist Health Commitments	MCMC Responsibilities
	•	
Maintenance and expansion of clinical services	• Continue to operate MCMC as a hospital. • Continue to operate substantially all existing MCMC facilities, services, and programs, subject to any changes overseen by the Corporate Board and Community Board. • Consult with Community Board prior to any elimination or material reduction in facilities, services, or programs. • Develop a Clinical Services Growth Plan to expand the breadth and depth of services provided by MCMC (including tertiary & quaternary services and as needed, off-campus sites).	• Work with Adventist Health to develop Clinical Services Growth Plan. • Community Board will provide input to Adventist Health on any material service reductions.
Clinical affiliations	• Together with MCMC, develop a Clinical Affiliation Plan to maintain, enhance, or replace each legacy MCMC relationship/affiliation. • Ensure any replacement programs provided by Adventist Health are at least on par with those currently offered by MCMC. • Ensure that access and quality of service is maintained for any modified or replaced program. • Minimize disruptions to patients, physicians, and employees associated with any transitions.	• Work with Adventist Health to develop Clinical Affiliation Plan.
Charity and community care	• Ensure that MCMC continues to provide support to and participate in community-based health programs at levels reasonably consistent with previous years, if Adventist Health assesses these programs to be sufficiently effective and financially viable.	• Adopt Adventist Health policies on charity care (financial assistance). • Allow patients on financial assistance as of the closing date to finish their treatment course under the financial arrangement that existed pre-closing.
MCMC's Current Medical staff	• Make available Adventist Health resources, programs, and services for physicians and advanced practitioners to MCMC medical staff members	• Retain general structure of medical staff of the hospital, including existing medical staff bylaws and officer selection process

Area	Adventist Health Commitments	MCMC Responsibilities
		• Maintain existing employment relationships for MCMC-employed physicians and advanced practitioners in good standing. • Maintain medical staff privileges at the hospital for medical staff members in good standing.
Recruitment	• Provide recruitment assistance to MCMC, including sharing expertise from recruitment efforts in the Portland market and experience with provider recruitment into rural communities. • Support recruitment and retention efforts driven by MCMC's executive leadership team and Community Board (see MCMC responsibilities). • Provide access to Adventist Health Physician Services (AHPS) including relationships with 5,200 providers.	• Use commercially reasonable efforts to recruit and retain quality physicians and advanced practice providers across specialties to serve the needs of the MCMC service area. • Implement specific initiatives, including surveying provider needs and provider satisfaction, developing a recruitment & retention plan, developing a post-hire support program.
MCMC Employees	• Retain all employees of MCMC entities who are in good standing for at least 180 days following closing ("180-day retention period). This does not apply to the MCMC executive leadership team. • No reduction in compensation or benefit levels, and no substantial changes in positions or employment terms during the retention period. • MCMC employees will retain their current years of service for of eligibility and vesting in MCMC benefit programs. • When switching to Adventist Health benefit programs during the plan year, MCMC employees will be credited for expenses incurred under corresponding MCMC benefit programs during the applicable plan year.	• MCMC employees must pass all pre-employment screenings applicable to Adventist Health employees. • MCMC employees may not engage in any conduct that is grounds for termination under applicable law or policies of Adventist Health.

Source:
Affiliation Agreement between Adventist Health System/West and Mid-Columbia Medical Center, March 1, 2023, available at https://www.oregon.gov/oha/HPA/HP/HCMOPageDocs/006-Adventist-MCMC-Affiliation-Agreement-Public-Version.pdf.

Appendix B: OHA's Review

OHA performed a preliminary review of the transaction to assess its potential impact on Oregon's health care delivery system. The review explored impacts in four areas (domains): cost, access, quality, and equity. OHA's analysis followed the guidelines and methods set out in the HCMO Analytic Framework published in October 2022.[134] The framework is grounded in the goals, standards and criteria for transaction review and approval outlined in OAR 409-070-0000 through OAR 409-070-0085.

Background Research and Literature Review

OHA conducted background research to understand more about MCMC, Adventist Health, the circumstances surrounding the transaction, and factors affecting health care access in the Columbia Gorge region. OHA consulted publicly available sources, including press releases and media reports; audited financial reports; entity websites; state agency, professional association, and third-party entity reports; and reports commissioned by local, state, and federal governments.

Requests for Information

OHA made several information requests of the Entities to clarify and supplement information in the Notice. Public versions of the Entities' responses are posted to HCMO's website.

Public Input

OHA accepted comments on the transaction from January 24th through February 8th, 2023, via email to hcmo.info@oha.oregon.gov. OHA notified subscribers to HCMO program updates of the opportunity to provide comments.[12] To solicit comments from communities potentially impacted by the transaction, OHA conducted limited email outreach to local community organizations, public health agencies, CCOs, Tribes, and local news organizations.

Analysis

OHA's analysis assessed the current state of the Entities involved in the transaction, related industry trends, and the likely impact of the transaction on the delivery of health care services in Oregon. The table below describes the types of analysis OHA typically performs in each domain and OHA's approach for this review.

Domain	Analysis
Cost	Analyses under the cost domain explore how the transaction may affect the prices patients and payers (e.g., insurers, employers, and governments) pay for health care services in Oregon and overall spending on health care services for Oregonians. Prices and spending for health care services may be affected by the degree of competition between providers offering similar services. The cost domain may also include analysis of the financial condition of the entities. For this review, OHA analyzed financial data to assess MCMC's financial condition and this would be impacted by the transaction. OHA also considered potential price impacts from consolidation among hospitals.

[12] Anyone can sign up to receive updates by clicking on the "Subscribe to Program Updates" button on HCMO's website.

Domain	Analysis
Access	Analyses under the access domain explore how the transaction may affect the range of services available in the market, types of providers and provider-patient ratios, characteristics of the patient population, and any barriers to access, including transportation burdens and limitations by insurance type. Consolidation and change of ownership in the health care market can impact the range and type of services offered in the service area. Changes in population demographics can alter demand for some services and shifts in the labor market can impact availability of specific provider types, potentially affecting the financial viability and profitability of offering certain health care services in a region. For this review, OHA analyzed the volume of inpatient, primary care, and specialty care services provided by MCMC, and characteristics of MCMC patients. OHA considered how the transaction may improve access by enhancing financial and recruitment resources available to MCMC.
Quality	Analyses in the quality domain explore how the transaction may affect patient outcomes and the experience of care. Consolidations and ownership changes in health care can impact clinical practice, including staffing ratios, time spent or number of visits with patients, timeliness of care, and the patient's experience of care, all of which can have adverse effects on patient outcomes. Analyses in the quality domain consider current indicators of quality and assess potential impacts of the transaction on quality of care. For this review, OHA analyzed MCMC's performance on measures of patient safety, patient experience, hospital readmissions, and other commonly reported quality indicators.
Equity	Analyses in the equity domain explore how the transaction may affect the Entity's ability to assess for and equitably meet the needs of the population it serves. Consolidations and ownership changes in health care can disproportionately impact availability of health services for populations who already experience health inequities, including people of color, low-income families, and residents of rural areas. Equity-focused analysis considers the entities' ability to serve a patient population that is representative of the community in which they operate. OHA also looks for evidence that the Entity is actively identifying and addressing inequities in access to or quality of care across their patient population. For this review, OHA analyzed data on community investments (community benefit spending) for MCMC, Adventist hospitals, and other hospitals. OHA also assessed potential impacts of faith-based restrictions on access to reproductive services, gender-affirming care, and end-of-life services.

Data Sources

All Payers All Claims Data

The Oregon All Payer All Claims Database (APAC) houses administrative health care data for Oregon's insured populations. It includes medical and pharmacy claims, non-claims payment summaries, member enrollment data, billed premium information and provider information for Oregonians who are insured through certain commercial insurance, Medicaid and Medicare. Information about APAC is available on OHA's website.

American Community Survey Data

The American Community Survey (ACS) is an ongoing, nationwide survey conducted by the US Census Bureau. The survey generates data about a variety of topics like occupation, housing, education and demographics. For this report, OHA used 2020 ACS 5-Year Estimate data. Additional information about the ACS can be found on the US Census website.

CMS Overall Hospital Quality Star Rating Data

The Center for Medicare and Medicaid Services (CMS) Overall Hospital Quality Star Ratings provide consumer-facing information about hospital performance in the areas of mortality, safety of care, readmission, patient experience, and timely and effective care. CMS considers performance on dozens of measures to assign a rating of one to five stars, with five stars signifying the best rating. This rating can be used to compare hospitals nationwide. Additional information about the rating system can be found on the CMS website.

Community Benefit Data

The Community Benefit dataset is comprised of self-reported data on community benefit from Oregon's 60 acute care hospitals. The community benefit data is reported to the Oregon Health Authority by the hospitals 240 days after the end of their fiscal year. The Community Benefit dataset is updated once a year. These data are collected, maintained and analyzed by OHA's Hospital Reporting Program and are available on OHA's website.

Healthcare Associated Infections Data

CMS reports data on infections that occur while a patient is in the hospital. Many of these healthcare-associated infections (HAI) can be prevented when hospitals use CDC-recommended infection control protocols and so HAI rates are measure of hospital quality. High HAI rates may indicate lower quality care. Additional information about HAI data can be found on the CMS website.

Hospital CAHPS Data

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is a national survey of the experience of patients discharged from inpatient hospital care. The survey measures how well hospital staff communicate with patients and respond to their needs, cleanliness and the overall satisfaction of the patient. CMS publishes HCAHPS results on its Hospital Care Compare website. Additional information about the survey can be found on the HCAHPS website.

Hospital and Emergency Department Discharge Data

The Hospital and Emergency Department Discharge database (HDD) houses records of every discharge from an acute care inpatient hospital or emergency department in Oregon. Data include diagnosis and procedure codes, how much was billed, and length of stay. These data are collected, maintained and analyzed by OHA's Hospital Reporting Program and are available on OHA's website.

Hospital Financial Data

Oregon's hospitals are required to provide information on annual financial performance to the Oregon Health Authority. Specifically, hospitals must submit an audited financial statement and FR-3 form for each fiscal year that includes information on revenues, expenses, margins, and uncompensated care. These data are collected, maintained and analyzed by OHA's Hospital Reporting Program and are available on OHA's website.

Hospital Readmission Medicare Penalties

Through its Hospital Readmission Reduction Program (HRRP), CMS penalizes hospitals with excessive rates of readmissions by reducing the amount a hospital receives for providing care to patients covered by Medicare. Penalties may reduce payments by up to 3%. Higher penalties indicate higher readmission rates. In this report, OHA has used hospital penalty data as a proxy measure of hospital quality. Additional information on these penalties can by found on the CMS website. Recent hospital penalty rates have been published on the KHN website.

Leapfrog Hospital Safety Grade Data

The Leapfrog Hospital Safety Grade is a rating generated by the Leapfrog Group to measure a hospital's performance in keeping patients safe from medical error and preventable harm. It uses 30 performances measures from CMS, hospital surveys and other data to award acute-care hospitals with a single letter grade (A,B,C,D,F) in the fall and spring of each year. More information on the Leapfrog methodology can be found on their website.

Population-to-Provider Ratio Data

The Health Care Workforce Reporting Program (HWRP) estimates the number of direct patient care providers in Oregon using data from 17 health licensing boards. These numbers are published as ratios of the number of people living in a county to the number of providers working in that county. In this report, OHA has used this ratio as a measure of access with lower ratios indicating better access. More information on this measure is available on the HWRP website.

Unplanned Hospital Visit Data

CMS reports data on rates of hospital readmission and emergency department visits following inpatient stays as well as unplanned visits following outpatient procedures as a measure of hospital quality. Additional information on these measures can be found on the CMS website. Measurement periods for the measures are included in the table below.

Measure	Measurement period start date	Measurement period end date
Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction	7/1/2018	6/30/2021
Excess Days in Acute Care after Hospitalization for Heart Failure	7/1/2018	6/30/2021
Excess Days in Acute Care after Hospitalization for Pneumonia	7/1/2018	6/30/2021
Facility 7-Day Risk Standardized Hospital Visit Rate after Outpatient Colonoscopy	1/1/2019	12/31/2021
Admissions for patients receiving outpatient chemotherapy	1/1/2021	12/31/2021
Emergency department (ED) visits for patients receiving outpatient chemotherapy	1/1/2021	12/31/2021
Hospital visits after hospital outpatient surgery	1/1/2021	12/31/2021
Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	7/1/2018	6/30/2021
30-Day All-Cause Unplanned Readmission Following Coronary Artery Bypass Graft Surgery (CABG)	7/1/2018	6/30/2021
Chronic Obstructive Pulmonary Disease (COPD) 30-Day Readmission Rate	7/1/2018	6/30/2021
Heart Failure (HF) 30-Day Readmission Rate	7/1/2018	6/30/2021
30-Day Readmission Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty	7/1/2018	6/30/2021
30-Day Hospital-Wide All-Cause Unplanned Readmission Rate	7/1/2020	6/30/2021
Pneumonia 30-Day Readmission Rate	7/1/2018	6/30/2021

Appendix C: Reporting Methodology

Healthcare Associated Infections Methodology

CMS publishes Healthcare Associate Infection (HAI) data for six infections associated with inpatient hospital procedures and considered to be largely preventable:

- Central Line-Associated Blood Infections (CLABI)
- Catheter Associated Urinary Tract Infections (CAUTI)
- Surgical Site Infections related to colon surgery (SSI-Colon)
- Surgical Site Infections related to abdominal hysterectomy (SSI – Abdominal hysterectomy)
- Methicillin Resistant Staphylococcus aureus bacteremia infections (MRSA)
- Clostridium difficile infections (C.diff)

For each hospital, CMS publishes the number of procedures associated with each infection performed in the study period, the number of infection cases identified among those procedures, and a Standardized Infection Ratio (SIR) used to compare hospitals. To generate infection rates for MCMC, OHA divided the number of observed infections in the CMS data for MCMC by the number of total related procedures at MCMC during the study period. OHA then multiplied the result by 100 to express a rate of infection per 100 procedures or 100 patient days (or by 1,000 to express the rate of infection per 1,000 device days for the CLABI and CAUTI measures). For all measures, lower rates are better and a rate of zero is ideal. To generate infection rates for the state, OHA summed the total number of infections and the total number of relevant procedures performed at Oregon hospitals and used the same method noted above to generate a statewide rate.

Additional information about HAI data as well as the datasets used in the report can be found on the CMS website.

Market Share and Consolidation Methodology

Consolidation, or concentration, is a measure of the degree of competition in a market; highly concentrated markets are generally characterized by a smaller number of firms and higher market shares for individual firms. When a transaction involves health care entities offering similar products or services (a “horizontal” transaction), the level of concentration in the market and the change in concentration resulting from the transaction is useful as an initial screen for potential anticompetitive effects.

OHA measured market concentration using the Herfindahl-Hirschman Index (HHI), a measure commonly used by federal and state antitrust enforcement agencies.

HHI is calculated as follows:

$$HHI = (S_1^2 + S_2^2 + S_3^2 + \cdots S_n^2)$$

Where S1 is market share (in percentage points) of firm 1 and n is the total number of competitors in the market. By summing the squared values of market shares, the HHI gives greater weight to firms with larger market shares. For this analysis, OHA measured market shares as a percentage of inpatient discharges in 2019-2021 for residents of Oregon zip codes within MCMC’s primary service area, aggregating hospitals to the system level were applicable.

Transactions occurring in concentrated markets and those involving a significant change in concentration are more likely to have adverse effects on competition and lead to price increases.

For horizontal transactions under preliminary review, HCMO will use the HHI thresholds specified in the U.S. Department of Justice and Federal Trade Commission Horizontal Merger Guidelines summarized in the table below.

HHI Thresholds:

Post-transaction HHI	HHI Change	Level of Concern
> 2,500	> 200	High (if both). Presumed likely to enhance market power:
> 2,500	>= 100 and <= 200	Moderate (if both). Potentially raises significant competitive concerns and often warrants scrutiny.
>= 1,500 and <= 2,500	>= 100	Moderate (if both). Potentially raises significant competitive concerns and often warrants scrutiny.
< 1,500	< 100	Low (if either). Unlikely to have adverse competitive effects and ordinarily requires no further analysis.

U.S. Department of Justice and the Federal Trade Commission, Horizontal Merger Guidelines, August 19, 2020, available at https://www.justice.gov/sites/default/files/atr/legacy/2010/08/19/hmg-2010.pdf.

PSA Definition Methodology

To define the inpatient primary service area (PSA) for a facility, OHA follows four steps:

1. Summarize Hospital Discharge Data (HDD) for the three most recent years of data by patient zip code.
2. Rank the zip codes in descending order of discharge volume.
3. Identify contiguous zip codes that account for at least 75% of discharges. To do this, OHA starts with the facility's zip code, adding zip codes to the map based on discharge volume rank. Zip codes that are not immediately contiguous with the facility may be permanently excluded from the PSA, or only temporarily excluded until interim zip codes are added that fill in the geographical gap. Continue to add zip codes until the total discharge count from zip codes contiguous with the facility constitutes 75% of the hospital's total discharges. Adding a new zip code that then pulls in previously excluded zip codes can result in a PSA discharge volume over 75%. This identifies the contiguous, volume-driven PSA.
4. Add zip codes that are fully encompassed by the zip codes identified in step 3. This may result in a PSA discharge volume over 75%.

When zip codes outside of Oregon make up a defined PSA, OHA excludes those zip codes in its transaction analyses, which may result in analyses that use less than 75% of a facility's discharge volume.

Below are the zip codes identified for the Mid-Columbia Medical Center PSA and related PSAs referenced in this report.

Mid-Columbia Medical Center PSA

Located in Wasco County, zip code 97058.

Zip codes identified in contiguous, volume-driven PSA selection (82.2% of discharges.):

- WA: 98620, 98635, 98617
- OR: 97058, 97021, 97063, 97037, 97823, 97812

Added zip codes fully encompassed by PSA above (totaling 88.4% of discharges):

- WA: 98613, 98673
- OR: 97050, 97065, 97039, 97029

Oregon zip codes in the PSA account for 73% of patients discharged from MCMC.

Providence Hood River PSA

Located in Hood River County, zip code 97031

Zip codes identified in contiguous, volume-driven PSA selection (75.8% of discharges):

- WA: 98610, 98672, 98648
- OR: 97031, 97014, 97041, 97058

Added zip codes fully encompassed by PSA above (totaling 84.7% of discharges):

- WA: 98605, 98651, 98639, 98623
- OR: 97040, 97044

Oregon zip codes in the PSA account for 61% of patients discharged from Providence Hood River.

Adventist Portland PSA

Located in Multnomah County, zip code 97216.

Zip codes identified in contiguous, volume-driven PSA selection (76.2% of discharges): 97213, 97220, 97230, 97024, 97060, 97216, 97233, 97030, 97206, 97266, 97236, 97080, 97222, 97086, 97089, 97267, 97015, 97045, 97023, 97055

Added zip codes fully encompassed by PSA above (totaling 78.1% of discharges): 97009, 97022, 97268, 97286, 97027

Adventist Tillamook PSA

Located in Tillamook County, zip code 97141

Zip codes identified in contiguous, volume-driven PSA selection (76.2% of discharges): 97141, 97136, 97131, 97107

Added zip codes fully encompassed by PSA above (totaling 82.5% of discharges): 97130, 97147, 97118

Profitability of Type B Hospitals

To measure profitability across Oregon's Type B hospitals, OHA computed a simple average of operating margins in each year based on audited financial statement information in OHA's Hospital Financial Data (See **Data Sources**).

Oregon's Type B Hospitals

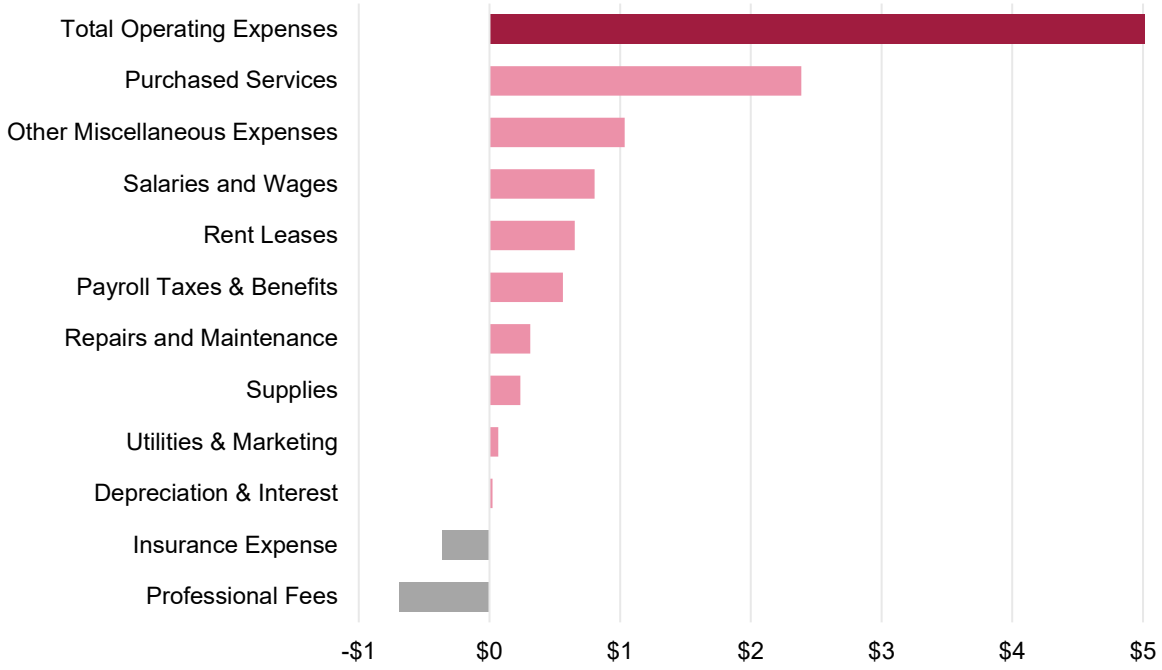
Asante Ashland Community Hospital
Columbia Memorial Hospital
Coquille Valley Hospital
Legacy Silverton Medical Center
Lower Umpqua Hospital
Mid-Columbia Medical Center
PeaceHealth Cottage Grove Community Hospital
PeaceHealth Peace Harbor Medical Center
Providence Hood River Memorial Hospital
Providence Newberg Medical Center
Providence Seaside Hospital
Salem Health West Valley Hospital
Samaritan Lebanon Community Hospital
Samaritan North Lincoln Hospital
Samaritan Pacific Communities Hospital
Santiam Memorial Hospital
Southern Coos Hospital & Health Center
St. Charles Medical Center - Madras
St. Charles Medical Center - Prineville
St. Charles Medical Center - Redmond
Willamette Valley Medical Center

Appendix D: Supplemental Data

Changes in MCMC's Operating Performance from 2021 to 2022

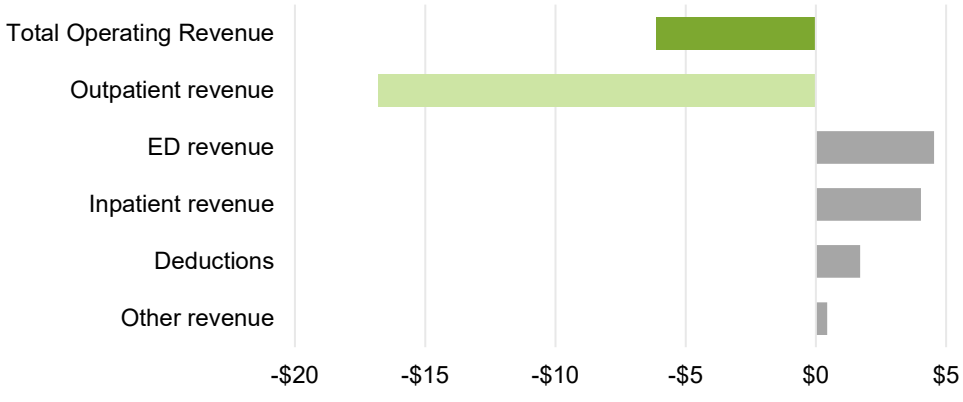
Of the $5 million increase in MCMC's **total operating expenses** from 2021 to 2022, purchased services and other miscellaneous expenses accounted for more than half ($3.4M).

Operating expenses, **change** in millions from 2021 to 2022



A $17 million decrease in MCMC's outpatient revenues from 2021 to 2022 drove the $6 million year-on-year decline in **total operating revenue**.

Operating revenues, **change** in millions from 2021 to 2022



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