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December 3, 2007

Dennis Ellis
Deputy of Policy
Colorado Attorney General's Office
1525 Sherman St., 7th floor
Denver, CO 80203

**Sent via fax: (303)866-5691 and certified mail**

Dear Mr. Ellis,

We are a group of community advocates, health care providers, nonprofit attorneys, and concerned citizens who are writing to express our serious concerns regarding a proposed transaction that will affect two hospitals serving the Denver Metropolitan area. Your office has previously received correspondence regarding this matter from the Board of Directors of Exempla, Inc., the healthcare system whose operations are sponsored by the Sisters of Charity of Leavenworth Health Systems (SCLHS) and the Community First Foundation (CFF). Representatives of the staff of Lutheran Medical Center (LMC), one of the hospitals at issue in this transaction, have also expressed their concerns.

We write to you independently, as a group which includes members who depend on the health care resources at stake, to express our concerns regarding (1) the enormous and unprecedented diversion of charitable assets away from health care in this community and (2) the severe impact of this transaction on the quality of and access to health care services in the metropolitan Denver area, including Jefferson and Boulder counties.

As described in detail below, CFF is seeking to transfer its interest in two hospitals to SCLHS. We urge you to recognize that the doctrine of *cy pres* applies to this transaction. This means that any transfer of CFF's interest in the hospitals must first be reviewed by a judge to ensure that any proceeds go, as near as possible, to provide health care services for the area previously served by the hospitals. While your office clearly has jurisdiction under Title 6, Article 19 (Transactions Involving Licensed Hospitals), we urge you to consider that the change in mission and diversion of assets caused by this transaction require district court approval before your office considers whether the transaction comports with the requirements of Article 19. Accordingly, we urge that you recommend to the court of jurisdiction that it refuse to allow this transaction to proceed because the board of directors of CFF has violated both the general Nonprofit Corporations statute and the Uniform Management of Institutional Funds Act.

Should the district court review this transaction and allow it to proceed without the requested review and protections to these affected communities, we would urge that you use every jurisdictional, statutory and common law power at your disposal to protect the public from the serious ramifications that this transaction will have on the quality and availability of health care for citizens throughout the Denver Metropolitan Area.[1] This would include employing all of the discretionary procedures for gathering relevant documentation from the entities and ensuring public input under § 6-19-203(2)(a).

## Background

To summarize, SCLHS and the Lutheran Medical Center Foundation (now CFF) entered an affiliation in 1997 under the auspices of, Exempla, Inc., to run their respective hospitals, St. Joseph and LMC. While designed to maximize their resources and gain the efficiencies of a partnership, the transaction was carefully structured to maintain each hospital's unique mission and identity. St. Joseph is a Catholic hospital run in accordance with the Ethical and Religious Directives for Catholic Health Care Services ("the Directives"), while LMC has no religiously based restrictions on the services provided. The partners developed and opened Good Samaritan Hospital in 2004, which likewise, is operated as a non-sectarian facility.

It is important to note that at the time of the 1997 transaction, all parties agreed that the respective religious and non-sectarian identities of the institutions were of the utmost importance. CFF's primary role as sponsor was to preserve the charitable "tradition" of LMC. It is inconceivable that the affiliation would have taken place had the parties not agreed to this.[2] In fact, the Attorney General of the State of New Hampshire was required to dissolve a similar merger between two entities that failed to adequately consider their respective missions. An article detailing that merger and its demise is attached.

Approximately a year ago, CFF and SCLHS made plans to transfer CFF's interest in the two hospitals to SCLHS in exchange for a reported $311 million. It is our understanding that over the course of the year, Exempla attempted to negotiate a deal that would have preserved access to all services currently provided by Good Samaritan and LMC, and that these efforts were rebuffed.

Despite the fact that $311 million dollars will be derived from the transfer of CFF's interest in two major health care resources in the affected communities, CFF refuses to commit the future use of these funds entirely too non-sectarian health care,[3] in violation of the primary historical charitable purpose for which those assets were accumulated. We urge you, after the required district court proceedings, to carefully review this transaction to ensure that the public interest is protected.

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[1] Participation by the undersigned organizations in this letter should not be deemed to be a waiver of the position that the district court is the appropriate venue.

[2] Your office received a letter on behalf of the LMC Medical Staff detailing this history and the parties' intentions dated November 26th.

[3] According to representatives from CFF, $90 million dollars would be used for "preventive health care."

## Impact on health care access and quality

Ownership of all three Exempla hospitals by SCLHS will result in not only St. Joseph Hospital, but also both Good Samaritan and LMC, being governed by Catholic health care restrictions, as expressed in the *Directives*. While most people are aware of the Catholic prohibition on abortion–which is not an issue in this transaction since the hospitals do not provide elective terminations–many are unaware of the broad impact of the *Directives*:

- The *Directives* prohibit all family planning services, referrals and counseling, including contraception, contraceptive counseling, tubal ligation and vasectomy. This prohibition also extends to counseling individuals with HIV and AIDS on the use of condoms to reduce transmission.

- Some hospitals have interpreted the *Directives'* prohibition on abortion to also prohibit treating women with ectopic pregnancies (non-viable tubal pregnancies) until they actually shows signs of infection, subjecting women to additional health risks, infertility and death.

- Some Catholic hospitals have also interpreted the abortion *Directive* to delay the treatment of women having miscarriages. While the standard treatment for placenta previa or ruptured membranes is to perform a uterine evacuation, some Catholic hospitals forbid this treatment until doctors can no longer detect a fetal heartbeat, often subjecting women to unnecessary blood transfusions, infections, infertility and death, despite the non-viability of the pregnancy.

- The *Directives* subject patients to fragmented care. A woman who has a cesarean section at a Catholic hospital and wishes to have a tubal ligation at the same time cannot do so. Instead, she must have the tubal ligation elsewhere, at a later date. Thus, she must undergo two separate surgeries, rather than combining the procedures as is medically advised.

- A rape victim who is treated at a Catholic hospital may be denied emergency contraception, the standard treatment to prevent pregnancy following rape. While Colorado law requires that a victim be given information about the medication, it does not require the provider to dispense it, direct her to another resource, or write a prescription (required for women 17 and under). The rape victim is forced to seek it elsewhere, often late at night, and after an incredibly traumatizing experience. Failure to provide EC in the emergency room as a standard part of treatment delays women's access to the medication, and greatly reduces its effectiveness, placing women at greater risk of pregnancy.

- The *Directives* prohibit the use of infertility treatments. This prohibition extends to counseling and referrals, so a person undergoing treatment for a fertility threatening disease, such as prostate cancer, would not be told of the possibility of storing and freezing sperm.

- The LMC-affiliated Estes Street Community Clinic, which serves homeless and uninsured adults and teens, may also come under the restrictions of the *Directives*. While the clinic currently provides the full spectrum of reproductive health care service, including

medically accurate sex education, a change in ownership would leave this needy population with no alternatives for critically needed health care.

- The *Directives* also limit patient access to clinical trials, since patients must be directed to use birth control in order to limit the potentially harmful effects of experimental medication and to remain in the trial.

- The *Directives* allow providers to ignore patient wishes for end-of-life treatment as specified in an advance health care directive or by a patient appointed proxy. This includes ignoring a patient's request not to be kept alive by artificial means when there is no medical probability the patient will ever regain consciousness as well as disregarding U.S. Supreme Court rulings that allow patients to refuse unwanted medical treatment.

- As a condition of admitting privileges, doctors may be required to sign a statement agreeing to abide by the *Directives* at all times, and not just when on Catholic hospital grounds. Such agreements severely limit access to the prohibited services in a wide geographic area beyond the Catholic hospital. Service restrictions may also be placed on any property leased or sold by the Catholic hospital.

- Because insurance plans and Medicaid limit where patients can receive treatment, patients whose provider networks include only hospitals and physicians subject to Catholic health care restrictions are left without options for the services, unless they are able to pay for them at providers who are outside of their health plan networks.

- The *Directives* can be revised at any time, so additional restrictions may be imposed on the hospitals in the future. The *Directives* would likely prohibit any new therapies derived from research on fetal stem cells.

- Finally, it is the Archbishop who has final say in how the *Directives* will be interpreted, thus allowing more restrictions on services at the hospitals in the future, even if assured otherwise by CFF.

## Applicable Laws

Nonprofit to Nonprofit Hospital Transaction Act

Under the Nonprofit to Nonprofit Hospital Transaction Act, § 6-19-203, the Attorney General may (but is not required to) review a transaction that will "result in a material change in the charitable purposes to which the assets of the hospital have been dedicated." While we believe that this transaction clearly meets this criteria and your office plays a vital role in its review, we would urge that your office defer jurisdiction to the district court since this transaction also implicates broader concerns for the institutions involved, as well as the communities they serve.

Furthermore, should your office eventually review the transaction, we would urge that you not allow the transaction to proceed because it does not satisfy the criteria for approval set forth in § 6-19-203. First, the parties to the transaction have not acted reasonably "in light of the

financial circumstances of the parties" as required by § 6-19-203(2)(b)(II). While we understand that SCLHS wishes to expand, there is no indication that any of the parties are in such financial straits that they must act hastily and in a way that reduces theses communities' access to healthcare.

Second, the parties have not made an attempt to "accommodate[e] the affected communities" with regard to the loss of health care assets generally and health care services specifically as required by § 6-19-203(2)(b)(III). CFF has not, for example, pledged to devote the proceeds of the sale to replacing health care services that will be discontinued at Good Samaritan Hospital and LMC as the result of Catholic restrictions that will accompany ownership by SCLHS. Furthermore, as set forth in greater detail below, given the loss of health care assets in the local area and the windfall incurred by CFF, the directors have breached their fiduciary duties and have advanced their own interests to the detriment of the affected communities. Even liberally construing the criteria set forth in the statute in favor of approving the transaction, the attorney general would be doing a great disservice to the public and offending the spirit of the statute in allowing this transaction to go forward.

Uniform Management of Institutional Funds Act

CFF has openly stated its intent to use these funds for charitable purposes other than health care, and has not sought a district court's determination that the charitable purpose for which these funds had been used has been frustrated. CFF has thus indicated its intent to violate the Uniform Management of Institutional Funds Act (UMIFA). UMIFA requires the board of a nonprofit organization to manage its funds to advance the organization's charitable purposes. In fact, in September 2007, the foundation changed its name from the "Lutheran Medical Center Foundation" to the "Community First Foundation," indicating its intent to further disassociate itself from the provision of healthcare in the Denver Metropolitan Area. While we do not doubt CFF's intent to use these funds for laudable charitable purposes, the law requires more.

Pursuant to the Nonprofit Hospitals Act, § 6-190-101(2), nonprofit hospitals explicitly hold their assets as trusts "deemed to be dedicated to the specific charitable purposes set forth in the articles of incorporation or other organic documents of the nonprofit entities that hold them in trust." The documents surrounding the 1997 affiliation constitute "organic documents" expressly stating the hospitals' nonsectarian charitable purposes. For this reason, UMIFA must first be applied, and the attorney general's office does not have primary jurisdiction over this transaction.

Under § 15-1-1109, before allowing the charitable funds obtained from the transfer of CFF's interest in the hospitals to be used for a purpose other than hospital based comprehensive healthcare, CFF is required to get donors' written consent. Presuming that CFF is unable to do so, (given the long history of the hospitals and variety of cash and in-kind donations) then it must establish before the court that its interest in the mission of the hospitals is "obsolete, inappropriate, or impracticable." This means that before this transaction can proceed, CFF must establish that it cannot continue its mission to support non-sectarian comprehensive

health care in West Denver. CFF must prove that there exists no viable option to continue providing the services currently available at LMC and Good Samaritan.

Even if the restricted use of the funds is found to be obsolete, inappropriate or impracticable (which we strenuously contend it is not) funds that are released from their restricted use by the district court still may not be used for purposes "other than educational, religious, or other eleemosynary purposes of the institution affected." Therefore even if CFF could establish that this specific mission is obsolete, inappropriate or impracticable, CFF would still be, at a minimum, required to generally further a health care mission with the assets it will gain from this transaction.

Additionally, § 15-1-1108 of UMIFA requires that the board of a charitable institution "exercise ordinary care and prudence under the facts and circumstances prevailing at the time of the action or decision, and in so doing they shall consider long- and short-term needs of the institution in carrying out its educational, religious, charitable, or other eleemosynary purposes . . ." Based on the letter your office received from members of the medical staff of LMC, it is apparent that this transaction does not benefit the hospitals or their interest in serving the affected communities' needs.

UMIFA requires that your office be notified and given an opportunity to be heard. Given our stated concerns, we would urge you to oppose the release of these funds from their intended charitable purposes. CFF has steadfastly refused to acknowledge its duty to use the proceeds of this transaction for health care purposes, indicating its clear intent to contravene the requirements of UMIFA.

Nonprofit Corporations Act

Because CFF stands to profit by $311 million dollars, and refuses to agree to use all of these foundation funds for health care, this transaction presents a conflict of interest as defined under § 7-128-501 of the Nonprofit Corporations Act. While the statute permits conflicting interest transactions if the conflicts are disclosed and approved of by disinterested directors, there are no disinterested parties here. All CFF board members have an interest in increasing the foundation's assets, prestige, and its ability to significantly influence the charitable landscape of the Denver area.

This transaction also presents a breach of the CFF board of directors' fiduciary duties, as set forth in § 7-128-401, which requires them to act: (a) in good faith; (b) with the care an ordinarily prudent person in a like position would exercise under similar circumstances; and (c) in a manner the director or officer reasonably believes to be in the best interests of the nonprofit corporation. As stated above, there is a clear conflict of interest posed by this transaction, as well as the substantial diversion of health care assets and the reduction in health care quality and access that will come with the proposed change in ownership.

And finally, CFF and SCLHS are violating the Nonprofit Statute because they are entering into this transaction without the approval of the Board of Exempla, Inc., the entity of which they are sponsors. A transaction of this magnitude clearly requires the Exempla Board's approval,

pursuant to § 7-123-103(d)-(f). As you are aware, the Exempla Board has opposed this transaction based on the impact it will have on health care access and the diversion of health care resources from the Denver Metropolitan Area. For this reason, the directors of both SCLHS and CFF have breached their fiduciary duties to the organization which they sponsor.

In addition to the jurisdiction provided under the Nonprofit to Nonprofit Transactions provision of the Licensed Hospitals Act, § 7-134-301 of the Nonprofit Corporations Act gives your office the authority to dissolve CFF in order to protect the public from the serious consequences of this transaction.

## Conclusion

CFF has cited a study it commissioned to show that there are adequate services in the affected communities to replace those that would be lost in this transaction, implying that if there are alternative providers then this transaction is permissible. This is patently false. Even if CFF could show that there are adequate services in the area, this still would not mitigate CFF's obligation to those who have supported these hospitals and the people who rely on them to provide comprehensive, high-quality, non-sectarian health care.

We thank you for your consideration of our concerns and urge you to act in the public interest in preventing the diversion of health care assets and the decline of health care services and throughout the Metropolitan Denver Area. If you would like to meet with coalition members to discuss this, or if you have any questions regarding our requests, please contact Ed Kahn, of the Colorado Center on Law and Policy at 303-573-5669 ext. 305.

Sincerely, Edwin S. Kahn, for
ACLU of Colorado
Colorado Chapter of Compassion & Choices
Colorado Center on Law and Policy
National Council of Jewish Women Colorado Section
The Colorado Religious Coalition for Reproductive Choice
The Freedom Fund
Compassion & Choices
The MergerWatch Project
National Women's Law Center
Mark Siman, former New Jersey Deputy Attorney General
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**Merger Failure: A Five-Year Journey Examined - Optima Health**

Julia L. Eberhart

In 1994, Catholic Medical Center and Elliot Hospital in Manchester, New Hampshire, merged to form Optima Health, a full-ownership, not-for-profit IDS. Initially, Optima Health was an economic success. A number of strategic miscalculations, however, led to the IDS's demise. First, Optima Health's leaders failed to fully consider the divergent cultures of the two hospitals, particularly with respect to their religious differences. Second, Optima Health's leaders did not anticipate the public's response to the organization's consolidation plan. And third, the consolidation was found to have changed the charitable missions of the two tax-exempt hospitals in violation of Federal laws regarding charitable trusts. The issues combined to undermine the commitment of the organization's leaders to the consolidation strategy, and Optima Health was dissolved.

In 1992, two hospitals in Manchester, New Hampshire--Catholic Medical Center (CMC) and Elliot Hospital--were experiencing a significant threat to their future viability. Managed care had come to New Hampshire, rapidly reducing patient days and occupancy at both facilities. In addition, the hospitals feared that expansion of the renowned Lahey Hitchcock healthcare system would cut into their market share.

CMC and Elliot were not-for-profit community hospitals of similar size that were longtime competitors. Given the market conditions, the two hospitals' boards began to question whether continued competition between the organizations was detrimental to their continued viability Based on an assessment of each hospital's unique strengths and their common capabilities, the boards determined that the best strategy would be to merge the two hospitals.

CMC and Elliot decided to create a full-ownership IDS with two flagship hospitals. In February 1994, after rigorous political, religious, and legal review, they formed Optima Health, an IDS offering a range of services, including ambulatory care, home health services, and long-term care. Optima Health's first concern was to effectively consolidate the services provided by the two hospitals.

Consolidation Approach

The full-ownership merger promised to create multiple economic advantages because such a model creates the cohesive structure required to execute significant organizational change. Premerger studies projected that operating savings of $150 million over a 10-year period could be achieved by consolidating administrative, support, and clinical services.

Administrative services were the first to be consolidated. An executive team was appointed, and duplicate positions were eliminated at both senior- and middle-management levels. Savings of $21.2 million dollars in salary and benefits over five years were projected to be realized from these actions.

Consolidation of support services also was projected to achieve significant savings. Optima Health's enhanced economic clout was used to renegotiate more favorable contracts for outsourced services, such as insurance, maintenance, and facilities management. Support-services consolidation was effected in food preparation, housekeeping, and other "hotel" services. Clinical-support services, such as radiology laboratory, respiratory therapy and pharmacy services also were consolidated. These consolidation efforts produced annual, nonsalary savings of more than $15 million dollars.

One year after the merger, Optima Health began the daunting legal and political process of consolidating CMC's and Elliot's medical staffs. By October 1995, this process was complete, and a medical staff executive committee had been formed with a single chairperson from each department. Many of the hospital-based private practices decided to take consolidation even further, with the emergency, pathology and radiology groups merging as well.

The third level of consolidation involved clinical services. Low patient volume at CMC for oncology and women's services made it fairly easy to relocate these services to Elliot Hospital. Only minor renovations were required, and management had already been consolidated. This step was followed by consolidation of all cardiac catheterization services at CMC.

At this point, to support future consolidation recommendations, Optima Health leadership adopted a process for forecasting the Manchester community's future acute care needs. A utilization-forecast committee researched the use of hospital services in markets with various levels of managed care penetration. The committee's finding was that managed care could be expected to continue growing in New Hampshire and that acute care utilization would further decline.

The forecasts suggested that acute care services could be accommodated in one acute care hospital in Manchester. After a comparative review of both facilities, it was determined that Elliot Hospital would be best suited to house the acute care services and that CMC should be converted to an ambulatory care service facility.

By all accounts, the Optima Health merger had achieved unprecedented success prior to this decision. Merger savings had exceeded expectations, and market share was at an all-time high. The IDS had achieved the scale necessary to successfully compete against large organizations and was negotiating to bring additional hospitals and other continuum-of-care facilities into its fold. Moreover, the full-ownership model created efficient decision-making processes at the board and executive levels.

Unanticipated Problems

While the merger was successful from an economic perspective, the decision to consolidate acute care services at Elliot Hospital raised political and cultural issues that ultimately led to the demise of Optima Health. Elliot was the best choice for locating the consolidated acute care services, but some building renovation was required to accomplish this objective. Therefore, Optima Health filed a certificate of need (CON) request with the state to gain approval for the renovations.

As Optima Health's plan became public through the CON process, opposition emerged at many levels. A grassroots group called Save CMC was formed to protect CMC from the changes proposed by Optima Health. Save CMC expressed concern that Optima Health's changes would make it impossible for CMC to fulfill its traditional commitment to religious health care, which was partially dependent on the hospital's ability to continue providing acute care services.

At the CON public hearing in July 1996, Save CMC presented statements made by Optima Health's leadership when soliciting support for the merger in which the public was assured that both hospitals would continue their acute care missions. The media provided Save CMC with the forum it needed to spread its concerns.

Over time, Save CMC developed a political as well as a public following. Nonetheless, the state's CON board voted in favor of Optima Health's application, finding the economic case for acute care consolidation compelling. Construction began in 1997.

Save CMC intensified its opposition, winning increased political support. In November 1997, several legislators implored the New Hampshire attorney general to investigate the Optima Health merger. The investigation was to focus on the business practices of Optima Health, its status as a charitable trust, and its failure to communicate honestly with the public.

In December 1997, the attorney general agreed to investigate, and in March 1998, the attorney general issued a report

indicating that the Optima Health merger had, indeed, violated cy pres doctrine, in that the proposed plan for CMC significantly changed the hospital's original charitable mission. Under the laws of charitable trusts, a tax-exempt organization is not permitted to make such a mission change without adherence to a specific process. Optima Health, it was found, had not followed this process.

To address this issue, special independent boards were appointed for each hospital to review the attorney general's findings and report back to the attorney general's office. Construction was halted.

About the same time, the public debate assumed a religious focus when word leaked out regarding a late-term abortion scheduled at Elliot Hospital. Save CMC rallied around this ethical issue, and the new focus of debate began to influence the leaders involved with the hospitals' special boards. The special board members discovered they had different views regarding how Catholic religious and ethical doctrines should be applied to Optima Health. Under such intensified scrutiny, it became clear that this issue had not been adequately addressed before the merger.

In February 1999, the special boards recommended the reestablishment of the two Optima Health hospitals as independent facilities. These recommendations were made in spite of a report produced by Ernst & Young in September 1998 that indicated that this reversal would result in annual operating losses of $19.6 million in five years. Criticism of the Ernst & Young report led the attorney general's office to commission a second report by Arthur Andersen. The Arthur Andersen report, issued in October 1998, concluded that two acute care hospitals could operate successfully. The New Hampshire probate court was appointed to oversee the dissolution process.

The Dissolution Process

The dissolution process began with the appointment of new boards of directors and CEOs for the two hospitals. The CEOs then quickly built separate management teams, and the hospitals resumed competition with each other. These steps were accomplished with little difficulty, and the public seemed to return easily to their traditional preferences for one hospital or the other.

The transition, however, was much more difficult for Optima Health's employees and medical staff The full-ownership model complicated the process of unraveling CMC and Elliot Hospital because all assets were jointly owned and had to be divided. As a result, it took more than a year to separate Optima Health's departments. Information systems and laboratory services, were particularly difficult areas to separate because of the substantial infrastructure integration that already had been completed in those areas.

The other components of the IDS were divided between the two hospitals. To a large extent, those continuum-of-care components that were owned by a hospital before the merger were returned to sole ownership by that hospital.

In June 2000, Optima Health was formally dissolved, with the entire dissolution process reportedly costing $10 million. Yet contentious issues remain. The use of the expanded Elliot Hospital space--the project approved by the CON board in 1996--still is the subject of public debate.

The project was estimated to be 80 percent complete when construction was halted. Most of the expansion was intended for cardiac services, including cardiac surgery, which was to move from CMC. Cardiac surgery is regulated by the state's CON office. With the dissolution of Optima Health, CMC remains the only hospital in Manchester approved to provide cardiac surgery. Elliot Hospital contends that the CON approved in 1996 extends this right to Elliot Hospital.

The resolution of this issue has enormous implications for the Manchester hospitals because CMC's cardiac surgery program

long has been regionally renowned, with CMC surgeons being recognized as leaders in the field. To continue to be on the leading edge, CMC requires that the program retain its current patient volume and scale of operations. Moreover, CMC's cardiac program contributes the majority of the hospital's revenue and profits. Any redirection of this revenue and patient volume to Elliot could compromise the quality, breadth, and depth of CMC's program. Thus, at least in the short term, the cardiac surgery issue has created a discordant rather than a collaborative environment.

Lessons Learned

Several lessons have been learned from the failure of the Optima Health merger. First, although the problems the IDS faced initially were not cultural, ultimately it was the divergent hospital cultures that caused the dissolution. Indeed, the decisive factor in the demise of Optima Health was the disagreement between the two special boards. It was not made clear from the beginning to the two merging hospitals' executive leadership, boards, and medical staffs how CMC's religious and ethical directives would be interpreted for Optima Health. There can be no ambiguity on this issue when Catholic and secular institutions merge, particularly when they are adopting a full-ownership model. The lesson for all merging healthcare organizations is that cultural issues, whether or not religious differences are involved, should be reviewed carefully before moving forward.

The second lesson learned was that public opinion should be considered before moving ahead with significant plans that will affect the public. In Optima Health's case, failure to consider public opinion before announcing its plans to consolidate acute care infuriated the public, resulting in the formation of Save CMC.

The third lesson to be learned was that all issues related to the continued tax-exempt status of the merging organizations must be thoroughly reviewed before moving ahead with a merger. In Optima Health's case, the attorney general's report uncovered the findings relative to the cy pres doctrine. CMC and Elliot Hospital, as not-for-profit organizations, are charitable trusts of the state of New Hampshire. Their charitable status is tied to their charitable missions. Optima Health was not free to change these missions.

Conclusion

Had Optima Health considered any two of the foregoing issues, it might have succeeded. What is of particular interest, though, is that the factors that undermined Optima Health's success had an additive effect. Had the public not turned against Optima Health, the attorney general's office would not have investigated the merger and found that it violated the laws of charitable trusts, nor would the religious and ethical concerns have swelled. Healthcare organizations that are seeking to merge therefore need to understand the broader consequences of the decisions they make and, in particular, how those decisions are likely to affect their markets and the public that they serve unilaterally.

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