State Proposals to Partly Close Eleanor Slater Hospital Would Harm Vulnerable Residents

Gary Storrs, Labor Economist
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I reviewed information regarding the State of Rhode Island's proposals to close large parts of the Eleanor Slater Hospital and to essentially throw vulnerable residents into private-sector settings which are nominally "least restrictive," but may not be appropriate. These proposals would undermine a crucial safety net for a population which needs high levels of service and care, shift costs out of the state agency's budget without a clear cost comparison or acknowledgement of necessary oversight and monitoring costs, and undermine middle class jobs. The state should urgently and immediately reconsider its plans, which are moving on a fast track.

Resources Reviewed

For this review, I analyzed the following documents:

1. "Eleanor Slater Hospital Transition and Redesign" proposal by the consulting firm Alvarez and Marsal. An October 8 version very slightly changed a September 18 version.

2. "Eleanor Slater Hospital: Billing Issue and Status Update," September 29, 2020. This presentation appears to have been authored by the state's House Finance Committee staff.

3. "Eleanor Slater Hospital Proposed Reorganization" memo from Council 94 to state Senate Finance Committee members. I will briefly touch on some of this memo's themes.

4. "Proposed Closure of State-Run Group Homes, AFSCME Review," February 19, 2020. Although this document was nominally on a somewhat different subject, the proposals are conceptually related. I believe the union can and should argue that the proposals to close parts of Eleanor Slater hospital are *even more* ill-advised given that the state has already proposed shutting state-run group homes.

5. "Information for C94 on RI group home privatization," February 14, 2020, sent by Public Policy Analyst Mary Gable and compiled by Research Librarians Lindsay Shapray and Kendra Gale. This, too, is on the topic of group homes, but is clearly related. I have not summarized these findings, but private-sector facilities often have elevated turnover rates.

Alvarez & Marsal Presentation

At the top of the list, the Alvarez and Marsal presentation is interesting. First, A&M is not in any sense a neutral or disinterested consulting firm. A&M is deeply involved in promoting and evaluating privatization of healthcare and related functions in the United States, India, and possibly elsewhere. Its own description uses the euphemistic language of corporate restructuring:

> Privately held since 1983, A&M is a leading global professional services firm that delivers business performance improvement, turnaround management and advisory services to organizations seeking to transform operations, catapult growth and accelerate results through decisive action. Our senior professionals are experienced operators, world-class consultants and industry veterans who leverage the firm's restructuring heritage to help leaders turn change into a strategic business asset, manage risk and unlock value at every stage.[1]

The firm is also involved in efforts to introduce the private equity business model into healthcare.[2] The merits of that model are beyond the scope of this report, but suffice it to say that the introduction of private equity into healthcare has already had significant negative results for patients, insurers, and government health payors, such as a profusion of "surprise medical bills."[3] In any case, it is doubtful that A&M's stated motto for its private equity consulting – "Maximize every transaction's value. Avoid post-transaction surprises" (see footnote 2) -- is appropriate for the public sector in general or for highly vulnerable groups of patients and residents in particular. A&M's position on labor unions, at least in the European context, describes unions as obstacles.[4]

The A&M presentation and the state's proposals simply assume, without really offering any proof, that it will be "appropriate" to transfer ESH residents to non-institutional or non-public settings and that they will still receive the proper "level of care [LOC]." I would not under any foreseeable circumstances concede that the state or the consultants have proven this point. On the contrary, whether available private facilities are appropriate for severely ill or disabled residents, many of whom have lived in state facilities for long periods, remains an open question.

The A&M pitch is largely based on very substantial projected cost savings from closing parts of ESH, as well as significant amounts of federal funding which the firm argues would be newly available. As Council 94 pointed out in its recent memo (item # 3 above), "medical reimbursement issues [were] not created by patients or workers." Evaluating A&M's claims as to what would or would not be eligible for federal reimbursement may be a longer-term project, but it is problematic when the intricacies of funding sources determine crucial patient care outcomes.

Also, even potentially large savings to the state agency's budget do not occur in a vacuum. Some person or entity will have to pay for care even in non-state settings, and the state agency would be well-advised not to skimp on contract monitoring costs. As AFSCME's February group home review (item # 4 above) pointed out, "The Government Finance Officers

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[1] https://www.alvarezandmarsal.com/insights/alvarez-marsal-analyzes-challenges-and-opportunities-ahead-post-acute-care-sector.

[2] https://www.alvarezandmarsal.com/expertise/private-equity-services.

[3] See, for example, https://www.ineteconomics.org/uploads/papers/WP_118-Appelbaum-and-Batt-2-rb-Clean.pdf.

[4] https://www.alvarezandmarsal.com/insights/european-transformation-overcoming-labor-law-obstacles-when-change-essential.

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1625 L Street NW, Washington, DC 20036-5687
TEL (202) 429-1215 WEB www.afscmesearch.org

Association uses a standard assumption of between 10 to 20 percent of a contractor's bid for contract monitoring and administration costs."[5] Some very substantial costs would not disappear.

The A&M presentation acknowledges this fact, conceding that the very large estimated ten-year general fund savings estimate of $788 million "does not include the costs and savings incurred by tangential state agencies" (p. 11). Even the presentation's supposed success stories make clear that community placement is not problem-free and that substantial costs, such as the ongoing intervention and involvement of currently ESH-based social workers, will not disappear:

> A young woman with IDD and chronic pain was hospitalized with impulsive, disruptive and assaultive behavior. Her ESH team worked with a DD group home provider to develop an extensive behavior plan. Her social workers conducted several follow up visits to touch base in her new home. When her behaviors escalated, her ESH social worker was able to collaborate with the provider and provide reassurance to this young woman of her ability to live successfully in the community. Despite multiple setbacks, she has been able to remain in the community in the least restrictive setting that can meet her needs [p. 12].

This is a very ambiguous example. It clearly demonstrates that some current costs will remain or be shifted to other agencies or providers, and that cutting those costs would be unwise.

Neither the A&M presentation nor the House Finance Committee report seem to clearly indicate *where* current costs will go, or *who* (what agency, community, or individuals) will bear these costs. Both documents point to significant savings, but do not appear to include an all-important accounting of how much can really be saved, and how any savings will be realized. I would certainly question whether large cost savings or budget savings can be realized without substantially eroding or even eliminating the intensive support services needed by ESH residents.

The A&M presentation's comparison of per-person treatment costs at ESH and in the community puts fiscal year 2019 ESH per-resident costs at a high $549,528; it further claims that these costs will increase to $658,943 under the enacted fiscal year 2020 budget. However, this extremely inflated cost estimate is the result of a simple calculation of total budgeted costs divided by caseload, *even though the presentation acknowledges* that the higher fiscal year 2020 figure "included a one-time UHIP payment of $14.6M" (p. 15). The House Finance Committee document (item # 2 above) describes this amount somewhat cryptically as "$14.6 million to clean up an outstanding Medicaid receivable from an issue with UHIP." It is far from clear that a one-time payment involving the state's Unified Health Infrastructure Project should be included in estimating per-resident expenses at ESH. Including this payment in the estimate is misleading.

It gets better (or worse, depending on one's perspective). The UHIP project was an example of unsuccessful contracting out, described as a "debacle" by the media and involving repeated failures by Deloitte Consulting. A 2019 *Providence Journal* account of UHIP is telling:

[5] R. Gregory Michel, "Cost Analysis and Activity-Based Costing for Government," Government Finance Officers Association, 2004.

> As to why the Raimondo administration decided to extend the contract instead of suing or replacing Deloitte, [state DHS director] Hawkins said: "From my perspective, ending this in a lawsuit would put the operations of DHS at risk," jeopardize benefit payments to close to a third of the state's population, and potentially "result in a protracted legal case which would cost the state a lot of money."[6]

This is hardly a ringing endorsement of privatization, and in fact shows its dangers. I recommend aggressively questioning A&M's extremely high per-resident cost estimate for ESH.

After presenting what is arguably an artificially inflated cost figure for ESH, the A&M presentation discusses non-state costs, stating that "Community placement Medicaid rates range between $16,800 - $290,285" (p. 16). A table shows a wide range of options, from assisted living at the low end to "SBD individuals (ENLOC)" at the high end. The abbreviation is not explained.

The fact that assisted living, offering relatively limited services, is included in a cost comparison for the care of severely disabled or mentally ill residents is questionable. In any case, the A&M presentation does not demonstrate that lower-cost alternatives to ESH are clinically appropriate for residents requiring close monitoring or significant assistance with daily activities.

Summary

This report reviews the A&M presentation and other materials on partly closing ESH, finding them misleading or uninformative in several ways. A&M is hardly a disinterested party. The savings the consulting firm projects are very large and depend to some degree on issues of federal reimbursement, which this report does not comprehensively explore. Further research on those issues is possible. As Council 94 argued, pressing financial issues were not caused by staff.

The A&M report and the state's proposals do not clearly indicate *what* costs can truly be eliminated, nor do they quantify *who* is expected to pay ongoing costs (other than potentially the federal government), what oversight costs will remain, or how significant cost-cutting will affect quality of care. The A&M presentation also uses a highly questionable aggregate estimate of per-person costs at ESH, as opposed to far less costly but possibly inappropriate alternatives. *These sources do not show that available options are appropriate, and there is every reason to doubt it.*

[6] https://www.providencejournal.com/news/20190315/uhip-debacle-ri-to-extend-contract-as-deloitte-agrees-to-more-concessions.

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