STATE OF CONNECTICUT

Office of Health Strategy

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IN THE MATTER RE -	:	Docket No:
	:	22-32586-CON
Certificate of Need Application	:	
Acquisition of Imaging Equipment	:	April 19, 2023

- x

HELD BEFORE: ALICIA NOVI, ESQ.

Hearing Officer

(Held remotely via Zoom Videoconferencing)

A P P E A R A N C E S

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Also Present:

From Yale New Haven Health:

Jeryl Topalian, Director, Strategy & Regulatory Planning
Keith B. Churchwell, MD, President YNHH
Rob Goodman, MB BChir, MBA, Chief of Radiology, YNHH

(Hearing commenced: 9:30 a.m.)

HEARING OFFICER: Good morning, everyone. It is 9:30. I'm going to go ahead and ask Ms. Fentis if she can start the recording now.

All right. As you have all just been informed, your taking part in this hearing today and your staying in this room will be your consent to being on camera for this hearing. All right. We will go ahead and get started.

It is 9:30 on April 19, 2023. This is the Yale New Haven Hospital CON hearing for Docket No. 22-32586-CON. And this is -- I'm going to go ahead and read the instructions for the hearing. If I look down during this part, it's because I'm reading off paper. I do apologize.

Good morning, everyone. The Yale New Haven Hospital, the applicants in this matter, seek a certificate of need for the acquisition of imaging equipment to Connecticut General Statutes, Sections 19a-638(a) or -- sorry, 638(a)(10), specifically, acquisition of imaging equipment for -- acquisition of imaging equipment including two MRI units, two CT scanners, and two PET CT scanners to be located in the towns of Hamden, Guilford, New Haven, and North Haven.

Throughout this proceeding, I'll be interchangeably referring to Yale New Haven Hospital as "YNHH" for brevity

purposes.

Today is April 19, 2023. My name is Alicia Novi. Dr. Diedre S. Gifford, executive director of the Office of Health Strategy, designated me to serve as hearing officer in this matter to rule on all motions and recommend findings of fact and conclusions of law upon completion of the hearing.

Section 149 of the Public Act 21-2, as amended by Public Act 22-3, authorizes an agency to hold public hearings by means of electronic equipment. In accordance with this legislation, any person who participates orally in an electronic meeting shall make a good-faith effort to state their name and title at the onset of each occasion that such person participates orally during an uninterrupted dialogue or series of questions and answers.

I'm going to add to that for the purposes of this hearing today to help our court reporter. If you have a name that might be difficult to spell, if you could spell it the first one or two times that you speak so that she can get the correct spelling of your name as well.

All right. We're going to ask all members of the public to mute the device they are using to access the hearing and silence any additional devices that are around them.

This public hearing is held pursuant to Connecticut

General Statutes Section 19a-639(a)(f)(2) of the General Statutes. It provides that HSP may hold a public hearing with respect to any CON application submitted under Chapter 368v. This notice of hearing is being issued pursuant to that statute, although, this will be a discretionary hearing that is not governed by the contestant's case section, case provisions, found in Chapter 54 of the General Statutes, the Uniformed Administrative Procedures Act or UAPA, and the Regulations of Connecticut State Agencies, or RCSA, Sections 19a-9 through 24. The manner in which OHS conducts these proceedings will be guided by those statutes and regulations.

The Office of Health Strategy is here to help me in gathering facts related to this application and will be asking the applicant witnesses questions. I'm going to ask each staff person assisting with questions today to identify themselves with their name, the spelling of their last name, and OHS title.

MR. LAZARUS: Good morning. Steven Lazarus, L-A-Z-A-R-U-S. I'm the certificate of need program supervisor.

MS. FAIELLA: My name is Annie Faiella, last name F-A-I-E-L-L-A, and I am a planning analyst.

HEARING OFFICER: Thank you. Also present is Faye Fentis, a staff member for our agency who will be assisting

with hearing logistics and will gather the names for public comment later today.

This certificate-of-need process is a regulatory process, and as such, the highest level of respect will be accorded to the applicant, members of the public, and our staff. Our priority is the integrity and transparency of this process. Accordingly, decorum must be maintained by all present during these proceedings.

This hearing is being transcribed and recorded, and a video will be made available on the OHS website and its YouTube account. All documents related to this hearing that have been or will be submitted to the Office of Health Strategy are available for review through our certificate of need portal, which is accessible on the Office of Health Strategies' CON web page.

In making my decision, I will consider and make written findings accordance with Section 19a-639 of the Connecticut General Statutes.

Lastly, as I previously stated, and as Zoom has notified you in the course of entering the hearing, I wish to point out that by appearing on camera in this virtual hearing, you are consenting to being filmed. If you wish to revoke your consent, please do so at this time. All right. So, nobody has left, so we'll go ahead.

The CON portal contains the prehearing table of

record in this case. At this time -- I'm sorry, at the time of its filing on Tuesday, exhibits are identified in the table from A through K. The applicant is hereby noticed that I am taking administrative notice of the following documents: One, the Statewide Health Care Facilities and Services plan; two, the Facilities and Services inventory; three, the OHS Acute Care Hospital Discharge Database and the All-Payer Claims Database claims data.

I may also take administrative notice of the Hospital Reporting Systems, the HRS financial and utilization data, and also prior OHS decisions, agreed settlements, and determinations that may be relevant in this matter.

For the applicants, can you please identify yourselves for the record at this time?

MS. FELDMAN: My name is Joan Feldman. I'm a partner with Shipman & Goodwin, and I'm here representing Yale New Haven Hospital.

With respect to your table of the record, I don't know if this is the appropriate time for me to object to one of the exhibits.

HEARING OFFICER: We will -- why don't we go ahead and go -- which exhibit are you objecting to?

MS. FELDMAN: I'm objecting to Exhibit K, and I would like the opportunity to explain my objection.

HEARING OFFICER: Okay. Why don't we -- we will put a pause on that for the moment. We'll go through the -- we'll go through the rest of my opening, and after you make your opening statement, we can go into the exhibit.

MS. FELDMAN: I would prefer to object to the exhibit before I make my opening statement, if that's possible.

HEARING OFFICER: It will require a back and forth, and I would prefer to get those onto the table. We may have questions. We may have -- we may need to meet with the -- with the -- sorry, with the analyst. So I would prefer to just -- we know that you have an objection. I'll note the objection. I'll note it throughout your opening statement, but I do believe I want to give them a chance to hear it after you make your opening.

MS. FELDMAN: Well, I'd like to make my objection before I make my opening comments, as they are related.

HEARING OFFICER: Okay.

MS. FELDMAN: Typically, the hearing officer will ask whether or not the applicant has any stipulations to the table of record; and I just want to be clear that we do not agree with the table of record as it relates to Exhibit K, and I want to state my reasons for the record as to why that is our position.

HEARING OFFICER: I understand you do not agree

with it. I noted that you do not agree with it. We will be making a statement about that.

MS. FELDMAN: Okay. Sorry. Fine, fine. All right. That's fine.

HEARING OFFICER: Yeah. So, let's go on to Attorney Feldman. Do you have any other -- sorry. In addition to the exhibits listed in the table of record, a public comment file may be added, which will be updated from time to time.

Attorney Feldman, do you have any other exhibits that you would like to enter at this time?

MS. FELDMAN: No, I do not. Well, actually -- no.

HEARING OFFICER: We'll proceed in the order established in the agenda for today's hearing. I would like to advise the applicants that we may ask questions related to the application that you feel have already been addressed. We do this for the purpose of ensuring that the public has knowledge of your application and your proposal and for the purpose of clarification.

I want to assure you that we have reviewed your application countless -- sorry, your application and completeness responses and pre-filed testimony, and I will do so many times before making a decision. We are asking these questions because we would like the public to have knowledge of what you are -- of what you are testifying to,

to provide them with more information and to make a complete record for any decisions that will be made later.

So, if you could you could answer, even if you are pointing to a document that's already in record and speak to the document instead of saying, It's already been answered, and Exhibit A, Page 4, that would be helpful. That will also help the public get a better understanding of what you are testifying to.

As this hearing is being held virtually, we ask that all participants, to the extent possible, should enable the use of their video cameras while testifying or commenting during the proceeding. All participants should mute their devices and should disable their camera when we go off the record or take a break. Please be advised that although we will try to shut off this hearing recording during breaks, it may continue. If the recording is on, any audio or video that is not disable will be accessible to all participants during this hearing.

Public comment taken during the hearing will likely go in the order established by OHS during the registration process; however, I may allow public officials to testify out of order. I or OHS staff will call each individual by name when it is his or her turn to speak.

Registration for public comments will take place at 2:00 p.m. and is scheduled to start at 3:00 p.m. If the

technical portion of this hearing has not been completed by 3:00 p.m., public comment may be postponed until the technical portion is complete. The applicant's witnesses must be available after public comment as OHS may have follow-up questions based on the public comments.

All right. So, at this point, I would like to go ahead, and let's go ahead and take a quick pause. I would just like to meet with my analyst before we go into the objections that you do have to Exhibit K. I'm going to ask that we take a three-minute break and come back at 9:45.

MS. FELDMAN: I suggest before you take the break that I be provided five minutes to state my objection so that when you meet with your analyst, you have a better understanding of our position.

HEARING OFFICER: Let me meet with them first.

MS. FELDMAN: Okay.

HEARING OFFICER: And then I will know if I need to -- and then we'll go into your objection.

MS. FELDMAN: Okay.

HEARING OFFICER: Before your objection so that I feel that I can make any sort of ruling that I need to make at the time. Okay?

MS. FELDMAN: Right, because I do believe it's fundamental to this entire hearing.

HEARING OFFICER: I understand, but I would like to

meet with them first. So I will take three minutes.

(Recess 9:43 to 9:46.)

Welcome back at 9:46. Thank you, everyone. Faye, go ahead and begin recording. As you've just been notified by the Zoom voice, we have begun recording again; and your staying in this hearing is your consent to being recorded.

All right. So at this point, we'll go ahead, and if you would like to start with your objections.

(Off-the-record discussion.)

All right. So I would now like to go back to the applicant.

MS. FELDMAN: Thank you, Hearing Officer. My name is Joan Feldman. I am counsel for Yale New Haven Hospital, and I am objecting to the inclusion of Exhibit K, labeled "OHS Need Calculations." And we object to the use of that exhibit as a basis for any decision that's made in this proceeding.

First of all, it's untimely and very irregular. We received this by happenstance. Typically, we would receive notice from the office to counsel letting them know that there's a new document that's been uploaded to the portal,

but we became aware of this document, Exhibit K, being loaded to the portal 24 hours prior to today.

This application was submitted almost nine months ago, and we're first hearing of this exhibit and these proposed guidelines 24 hours prior to the hearing today. Relatedly, it violates the hearing officer's March 16, 2023 order, which is Exhibit G on the portal. Let me explain why.

Someone from OHS, we don't know who, added Exhibit K to the table of record yesterday, as I said, one day before the hearing. We were not informed. The March 16, 2023 order requires parties and participants to pre-file in written form all testimony that it proposes to offer at the hearing. The order required Yale to do this by April 5, 2023 because Yale New Haven Hospital is the only party. And in that very notice, we are informed that, if we are going to seek a continuance, we have to do it five days prior to the hearing.

Since this exhibit was submitted yesterday, we can't even file for a continuance. The order does not contemplate or allow a submission but some unknown person from OHS. As far as we know, Yale -- OHS has not made such a submission before such as this.

The March 16, 2023 order states, quote, "All persons providing pre-filed testimony must be present at the

public hearing to adopt their written testimony under oath and must be available for cross-examination for the entire duration of the hearing."

Exhibit K is not signed by anyone. It's not pre-filed testimony. We had no opportunity to cross-examine the author of the exhibit. This is fundamentally unfair.

For these reasons, Exhibit K is untimely, irregular, and in violation of the March 16, 2023 order. Second, it violates our common-law rights to fundamental fairness and the due process clause of the United States and Connecticut constitutions.

Relatedly, we must object to the notice of hearing, Exhibit E, insofar as it purports to state today's hearing and any eventual decision is not a contested hearing or a final decision that may be appealed for being in violation of constitutional and statutory provisions in excess of the statute -- the agency's statutory authority may, upon unlawful procedure, effected by an error of law, clearly erroneous in view of the evidence, arbitrary, capricious, and characterized by abusive discretion or unwarranted exercise of discretion.

HEARING OFFICER: I'm sorry. I just want to pause you for a second. Are you saying you also object to Exhibit E, as in "elephant," which was the notice of hearing, the original hearing officer?

MS. FELDMAN: Yes, yes. Yes, with respect.

THE HEARING OFFICER: And what is your objection to that document?

MS. FELDMAN: That it's not a contested case.

HEARING OFFICER: Okay. Well, there was a second re-designation of a hearing officer.

MS. FELDMAN: Correct.

HEARING OFFICER: And I have very much stated that while this is not a contested case in my opening statement that this will be guided by UAPA law, that this is a discretionary hearing. So, do you still want to object to E?

MS. FELDMAN: Yes.

THE HEARING OFFICER: As I have made representations that this is -- and corrected that?

MS. FELDMAN: Well, I'm not sure what you mean by "guided by the UAPA," and whether or not that leads us to the conclusion that this is a contested case. As you know, there is a pending case before the Connecticut Supreme Court, and we want to preserve our right to an appeal based on the outcome of this hearing.

HEARING OFFICER: Let me repeat for you what I stated in my introduction. This is a public hearing held pursuant to Connecticut General Statutes, Section 19a-639(a)(f)(2) of the Connecticut General Statutes that

provide that HSP may hold a public hearing with respect to any CON application submitted under Chapter 368v. This notice of hearing is -- or sorry. This is being issued -- although this will be a discretionary hearing that is not governed by the contested-case rules found in Chapter 54 of the General Statutes of the Uniform Administrative Procedures Act, or UAPA, and the Regulations of Connecticut State Agencies, RCSA, Sections 19a-9 through 24, the manner in which OHS conducts this proceeding will be guided by those statutes and regulations.

So, I am and I did state in my opening that while this is not a contested hearing, we will be guided by those regulations. So, I am now stating that this is an (f)(2) hearing, as I did in the opening.

MS. FELDMAN: Yes. I'm going to have to preserve my objection to that.

HEARING OFFICER: All right. Keep going with your objections.

MS. FELDMAN: Okay. So, we became aware of the hearing more than 30 days after the application was deemed complete. As you know, we only have 30 days after an application is deemed complete to request a hearing, which, as I understand the agency's historical position that unless the applicant, you know, requests a hearing pursuant to Subsection E, they don't have -- it's not considered a

contested case, which means they're precluded from any sort of appeal to the courts.

So, I also want to explain to you why this is important. We prepared our application based on the statutorily mandated criteria in Section 19a-639, Subsection (a) 1 through 12. Connecticut General Statutes Section 19a-639(a) Subsection 8, requires OHS to consider, quote: The utilization of existing health care facilities and health care services in the service area of the applicant, end quote. A 2012 OHS publication explains how to do this calculation. And --

HEARING OFFICER: I'm sorry. Did you go back to --

MS. FELDMAN: I'm objecting to Exhibit K.

HEARING OFFICER: Okay. You didn't actually state that you went back to K.

MS. FELDMAN: Well, I'm back on K.

HEARING OFFICER: All right.

MS. FELDMAN: A 2012 OHS publication explains how to do this calculation, and this methodology has been in place and relied upon by the agency where there's significant precedent and reinforced by a work group in which Mr. Lazarus was the facilitator as recent as 2020. Yale New Haven Hospital relied on the statute and longstanding and time-tested methodology.

Exhibit K purports to ignore and change the

statutory requirement of Subsection -- Section 19a-639(a)(8) as well as OHS's longstanding practice applying the statutory requirement in favor of a new approach that considers utilization statewide rather than utilization in the service area.

There was no public comment, no notice, no explanation from OHS as to why this is being done. Had Yale New Haven Hospital known in advance, we would have exercised our statutory right to request a hearing under Section 19a-639(a) Subsection (e), which states, quote:

"The unit," OHS here, "shall hold a public hearing on a properly filed and completed certificate need application if an individual representing an entity with five or more people submits a request in writing that a public hearing be held."

So this would have guaranteed Yale New Haven Hospital basic due process and fundamental fairness protections under the Uniform Administrative Procedure Act.

OHS waited to issue its notice of hearing, Exhibit E, which says this hearing is a discretionary hearing. This occurred 30 days ago, March 15th, when the application was deemed complete on January 13th. At that point in time, the period for the applicant's request for discretionary hearing had already passed. The apparent purpose of doing this gives the appearance that it was done in an attempt to deny

the hospital basic due process and fundamental fairness protections.

Since we only learned of Exhibit K yesterday morning, we are still trying to fully understand how harmful this will be for our patients. Had Yale New Haven Hospital known that OHS would change the approach so fundamentally, Yale New Haven Hospital would have had the opportunity to change its application, to change its pre-filed testimony, to change its statement of issue responses, to change its completeness response.

Had others known that OHS would have changed this approach to utilization, we're confident that there would have been interveners and significant public testimony at the very least from Yale New Haven Hospital patients. This is clearly, very clearly, illegal rulemaking.

In all, Yale New Haven Hospital must object. OHS may not wait 30 days after a notice of completion to request the discretionary hearing and then submit an exhibit that purports to ignore and change the statute governing the hearing and the practice that has been in place for more than a decade.

For these reasons, Exhibit K should not be considered insofar as it is or may be, Yale New Haven Hospital must have the right to cross-examine whoever was involved with the creation of the document referred to as

Exhibit K.

HEARING OFFICER: Okay. Thank you. I want to ask that -- so just for clarity purposes because that was a little confusing, you objected to two exhibits because you originally stated you had one objection, but then in reading that document, you objected to two. So I am going to restate for the record that you object to both E and K. Is that correct?

MS. FELDMAN: Correct.

HEARING OFFICER: Okay. It wasn't stated originally when you said, I object to K, I would like to make an objection. Then you verved into E, and then you went back to K.

MS. FELDMAN: Right.

HEARING OFFICER: So, I wanted to make sure we have that stated correctly on the record.

MS. FELDMAN: Right. I mean, the problem with Exhibit E is in part in terms of whether or not this is a contested case. So, in my objection to K, I wanted to make that statement because of all of the reasons set forth in my objection as the basis for why this should be a contested case. So that's --

HEARING OFFICER: I just wanted to make sure we have on record that you've made two objections to two exhibits, not the original one objection you put forward.

MS. FELDMAN: Right.

HEARING OFFICER: All right. At this time, I am going to take a brief 15-minute recess. We will be back at 10:20, and I will see you all then. Thank you very much.

MS. FELDMAN: Okay. Thank you.

(Recess: 10:06 to 10:22 a.m.)

HEARING OFFICER: Okay. Good morning. If we could have Ms. Fentis please start the recording again. We were just notified by the Zoom voice that we are now recording again, and your staying in this hearing is your -- you will be consenting to being recorded. If you do not want to be recorded, please go ahead and exit hearing at this time.

All right. Nobody has left the recording.

So, Attorney Feldman, I am going to allow you to -- what I would like to do with your objections is I'm going to allow you to brief your objections on both of them. I am going to give you two weeks until May 3rd to go ahead and submit that; and at that time, I'll make a ruling. So if you would like to go ahead and submit a brief until May 3rd, we will give you that time.

MS. FELDMAN: Thank you.

HEARING OFFICER: All right.

MS. FELDMAN: I will.

HEARING OFFICER: So at this point, we will go ahead to opening statement.

MS. FELDMAN: Okay. All right. This Joan Feldman on behalf of Yale New Haven Hospital speaking.

As you can see from the application that's been submitted by my client, demand by Yale New Haven Hospital patients for advanced imaging substantially exceeds capacity resulting in significant delays for patients.

As you also know, Yale New Haven Hospital is an academic medical center where every single day, there is innovation. Many of these innovations help advance care for our patients and serve as solutions and adaptations for others in the state and in the nation and internationally.

Whether it is targeted treatment or new types of imaging, the demand for advanced imaging far exceeds our current capacity. However, because of limited equipment, patients have to wait for their advanced imaging studies beyond that which is in their best interests or that which is consistent with industry standards for the delivery of high-quality care. There should be no delay. Rather, advanced imaging equipment should be available to meet the needs of our patients. We have no interest in acquiring imaging equipment that cannot be used and that will sit by idle.

For a variety of reasons mentioned in our pre-filed

testimony, Yale New Haven Hospital has taken a very conservative approach with respect to incrementally adding imaging equipment for general use. And other than imaging equipment for specialties, for instance, our neonatal ICU, Yale New Haven Hospital has not added advanced imaging equipment for general use since 2009. Not having this very important equipment will undoubtedly result in increased waiting time for our patients, delays in diagnosis and treatment, and poorer outcomes. If, as we think and believe, OHS is invested in curbing hospital costs, delays are not conducive to either patient satisfaction, good patient outcomes, and lower costs.

Let me take this time to remind OHS as to the standards for determining the, since 2012 and reinforced in 2020 by the OHS imaging work group facilitated by Mr. Lazarus. Under Section 2, Chapter 5 of the Statewide Facilities and Service Plan for 2012, the standards for acquisition of CT MRI and PET CT are as follows: Identify the primary service area; identify existing services of the applicant and other providers in the primary service area; provide capacity of existing services identified in the primary service area; explain the likely impact on existing services in the primary service area; provide actual and proposed hours of operation for the services and provide a three-year projection of utilization with reasonable

assumptions, okay, and demonstrate need as described above.

We have done all of that plus some. We see no different -- we see no different -- we see no reason for any other analysis than that which is set forth in the statute and the guidelines.

Under the guidelines and under the statute, utilization rate per capita means the number of scans per thousand population as determined by data collected and published by the Office of Health Strategy. There's nothing in that language that authorizes OHS to change or modify the definition. In fact, there is a biannual survey inventory of imaging providers. It does not state in that inventory language that OHS can unilaterally decide that the standards or the assessment must be done on a statewide basis.

In addition, in the calculations that we see before us today, for instance, in Exhibit K, and tipped the hand of OHS with respect to how they would review our application seems to treat all scanners as the same.

All scanners are not equal. As you see from the inventory, there are a variety of different types of scanners; and they are not for general use. Some of them are for a select patient population, some of them are for research, some of those are for orthopedic patients or by orthopedic surgical groups. All scanners are not equal.

To use the statewide rationale calculation to look

at service need is absolutely irrelevant and arbitrary and has no relationship to actual need that we have set forth in our application. It only makes sense to look at what the need is in the primary service area, as the majority of the text that I just read provides.

Notwithstanding, in Exhibit K, OHS in Footnote 2 says, "As its basis and authority for looking at a statewide calculation which drastically reduces the need of analysis," quote, "it stands to reason." If you look up that term in the Oxford dictionary, "it stands to reason" means that it's obvious or logical. Neither of that is the case here. This is not obvious, it is not logical, and it's a gross departure from the precedent that OHS has created.

In addition, the OHS guidelines provide that in determining need, other factors should be taken into consideration. One, capabilities of the proposed advanced imaging equipment; the ability to serve underserved populations; the impact of avoiding delays and timely diagnosis and treatment; the use of the scanners for research or innovation; the ability of the applicant to make radiation dose exposure decisions.

For hospitals only, unique patient populations' specific clinical needs, complexity of the scanning procedures impact on access due to lengthy procedures. Thus, the formula which groups all scanners equally is very

flawed. By any objective measure there is need. We are not going to serve the patients of this state if we come up with hypothetical, arbitrary formulas that ignore the real need and demand set forth in our application by applying arbitrary and irrelevant calculations for the purpose of extinguishing what is real need and demand.

I'd like to turn to Dr. Churchwell, who is Yale New Haven Hospital's CEO, so he may provide some comments.

HEARING OFFICER: All right. Is he going to be offering an opening statement as well or are you rolling right into your testimony?

MS. FELDMAN: He is going to be providing pre-filed testimony. He's going to provide some comments.

HEARING OFFICER: So, hold on before we start with his pre-filed testimony. Dr. -- I'm sorry --

MS. FELDMAN: Churchwell.

HEARING OFFICER: No, no. I meant to speak to you -- I was going to call you Dr. Feldman by accident.

MS. FELDMAN: That's okay, that's okay.

HEARING OFFICER: Attorney Feldman, if you could just state your two witnesses, and I'll just swear them in right now.

MS. FELDMAN: Sure. And you might -- it may be -- we have other people here who might have the necessary expertise to answer any questions that OHS has.

HEARING OFFICER: We'll swear them in at the time they're needed.

MS. FELDMAN: Okay. Fine. Yes. Dr. Keith Churchwell, the CEO of Yale New Haven Hospital and Dr. --

HEARING OFFICER: Can you spell his last name for the court reporter?

MS. FELDMAN: Sure. C-H-U-R-C-H-W-E-L, first name, "Keith."

DR. CHURCHWELL: Two Ls at the end, L-L.

MS. FELDMAN: Sorry, Doctor.

DR. CHURCHWELL: That's all right.

MS. FELDMAN: First name, Keith; middle initial "B."

HEARING OFFICER: Okay. And if you want to just take the other name and then spell it as well.

MS. FELDMAN: Dr. Thomas R. Goodman.

HEARING OFFICER: That is G-O-O-D-M-A-N? Is that correct?

MS. FELDMAN: Correct. Do you want his title?

HEARING OFFICER: Yes.

MS. FELDMAN: It's in the pre-file.

HEARING OFFICER: Yes. No. I'm just having you state them for the record for the court reporter so that she can get them as well.

MS. FELDMAN: Got it. Thank you.

HEARING OFFICER: And his title?

MS. FELDMAN: Sorry?

HEARING OFFICER: Title for Dr. Goodman.

MS. FELDMAN: Oh, you did want his title. I thought you said no.

Well, he's very distinguished. He is the chair of the department of radiology and biomedical imaging at Yale New Haven Hospital, and he has a number of other titles, but for the purpose of this application, I think that will suffice.

HEARING OFFICER: All right. I'm going to swear you in at the same time. I will ask you to say yes individually, if you don't mind. If you could please both raise your right hands.

(The witnesses, Dr. Churchwell and Dr. Goodman, were duly sworn by the hearing officer.)

HEARING OFFICER: All right. And I believe the front person is Dr. Churchwell, and the back person is Dr. Goodman. Is that correct?

DR. CHURCHWELL: That is correct.

DR. GOODMAN: That is correct.

HEARING OFFICER: All right. Thank you. I will note for the record that you have both been sworn in.

Okay. If you would like to go ahead into Dr. Churchwell's testimony.

DR. CHURCHWELL: Well, good morning. My name is Dr. Keith Churchwell, and in my capacity as president of Yale New Haven Hospital, Joan gave me a promotion; I really appreciate that, Joan, but I'm president of Yale New Haven Hospital. It is my pleasure to have this opportunity to present to you some of the reasons why this application is so critical to Yale New Haven Hospital, which I will actually abbreviate by "YNHH" going forward.

First I would like to adopt my pre-filed testimony.

HEARING OFFICER: Thank you.

DR. CHURCHWELL: Thank you. As a cardiologist and having played a senior role in the development of the cardiovascular care plan for Yale New Haven Hospital in the past, I have a common interest with Dr. Goodman in delivering the highest quality of care here with our advanced imaging, especially in the field of cardiology. However, in the interest of time, my testimony today will be brief and will focus on the importance of adequate advanced imaging capacity as it relates to the delivery of timely, high quality and cost-effective care, patient care, of Yale New Haven Hospital and the impact of advanced imaging delays will likely have on all the communities that are served by

Yale New Haven Hospital. Many underserved will be limited in their ability to travel and to times -- and their ability to actually get timely access to care.

Dr. Goodman will soon present to you a discussion relating to the empirical evidence demonstrating a direct correlation between delays in advanced imaging and an increased cost in the health care system, and more importantly, less favorable patient outcomes.

As president of one of the largest hospitals in the country, academic medical centers in the country, that delivers tertiary and quaternary care to our communities, these delays in advanced imaging directly impact YNHH's ability to operate as efficiently and effectively as it could and should. When there is a bottleneck in the YNHH emergency department -- not if, but when -- due to delays in accessing advanced imaging, if Yale New Haven Hospital outpatient advanced imaging locations cannot absorb appropriate decanting from the main hospital, if outpatients are delayed in returning to work for treatable injuries or cancer diagnoses are delayed, affecting staging and prognosis, we cannot meet responsibilities to our patients that are part of the values and the mission that YNHH is committed to uphold.

While some may question the need or utilization of advanced imaging at YNHH, I can assure you that utilization

is not driven by financial incentives or the need to increase our diagnostic volumes. In actuality, we're trying to service our existing patient volumes; and the longer in the delay of the advanced imaging, it leads to a greater cost of care for this hospital and for many hospitals across the country.

Advanced imaging is an essential component to diagnosis and treatment, and utilization of advanced imaging is driven from improvements in scanning technology that allow more cost effective, less invasive, and less costly care. In fact, YNHH works to follow the American College of Radiology and the American Society of Nuclear Cardiology appropriateness criteria guidelines to ensure that the scanning is appropriately being employed in the most cost effective and clinically effective manner.

As you may know, Yale New Haven Hospital has invested in doing all that it can to enhance patient satisfaction, improve patient outcomes, and reduce the low -- reduce the cost of health care.

I am actually one of the executive sponsors of System Access Initiative to improve access and accessibility across our whole health system. And at this time, a significant barrier to our efforts is not having the needed advanced imaging equipment directly related for this -- for our ability to effectuate advanced care for patients.

There is direct evidence that increased delays with respect to accessing advanced imaging directly correlates with missed appointments, which presumably also have had a correlative relationship with patient outcome and prognosis.

In a 2018 study performed on behalf of the American College of Radiology, the researchers found the longer wait times for advanced imaging, the more likely the patient would miss -- will miss the appointment.

Of further interest is the finding that underrepresented minorities are at increased risk for missing appointments. In this particular study, Hispanic, Asian, and Medicaid patients had a higher incidence of missed appointments. It is therefore my strong belief and opinion that it is the responsibility of Yale New Haven Hospital to do everything in its power to avoid long delays for all of its patients, including this marginalized patient population, ultimately defraying costs for all, including the State of Connecticut Medicaid program.

Finally, and most importantly, I would like to address the impact that the delay in diagnosis and treatment has on our patients. Aside from the delays causing economic impact with respect to our patients returning to work, delays also contribute significantly in the patient's anxiety related to waiting for a diagnosis or undergoing treatment. No one should have to wait as long as patients

currently do to receive the care that they deserve. No one should want that outcome.

For all these reasons, I respectfully request that OHS approve the above-referenced application.

Thank you for taking time to listen to me. I'm happy to answer any questions that you may have.

HEARING OFFICER: Okay. What I'm going to do is I'll have both of your witnesses testify first, and then we will go to questions from OHS.

MS. FELDMAN: That's fine. Thank you.

HEARING OFFICER: All right.

DR. GOODMAN: So, my name is Rob Goodman, chief of radiology at Yale New Haven Hospital.

HEARING OFFICER: I'm sorry. A little slower. You said that was the chief of radiology at Yale New Haven Hospital?

DR. GOODMAN: That is correct.

HEARING OFFICER: Okay. Just for the court reporter, so we can make sure she gets that.

All right. Go ahead with your testimony.

DR. GOODMAN: Thank you. Good morning, Attorney Novi, and good morning everyone at OHS. My name's Rob Goodman. I am chief of radiology at Yale New Haven Hospital, and it's my pleasure to give you my thoughts on this application.

Firstly, I want to adopt my pre-filed testimony with the proviso that there's a typo where it says "chest MRI." It should say "chest CT."

HEARING OFFICER: Okay. And what page was that on?

MS. FELDMAN: I am going to have the -- I don't think the pre-filed testimony is paginated, but I will -- we submitted a corrected version to Mr. Lazarus, so you have it.

HEARING OFFICER: Okay. I will upload the corrected version.

MS. FELDMAN: Thank you.

HEARING OFFICER: We'll make sure that we get the corrected version up on the website, and that will go as Exhibit L. Is that okay with you, Attorney Feldman?

MS. FELDMAN: Yes. Thank you.

HEARING OFFICER: Okay.

DR. GOODMAN: Thank you. So it's been my privilege to, as the chief of radiology at Yale New Haven Hospital to help build a world-class imaging facility here in the heart of Connecticut. And as part of that service, we provide a wide spread of imaging options to our patients, including services that patients cannot get anywhere else in the region, including services that patients cannot get anywhere else in the state. Because of that, I take great pride in providing that service for the population of the state of

Connecticut.

I think it's important to emphasize that imaging in today's health care environment isn't just taking a picture. Imaging is now something that is integrally related to health care as a whole. Imaging is now important in preventing disease. If I see an adenoma on an abdominal CT and it's removed, I've prevented that patient getting colon cancer.

Imaging is involved in disease detection. We tell what is going on. Imaging is involved in disease diagnosis. We tell our patients and our providers what we feel the cause of a problem is. Imaging is involved in prognosis. We tell our providers and our patients if the cancer is getting better or if it's getting worse and need to talk about different treatment options.

And more recently, imaging has become involved in disease therapy and treatment and determining treatment options and delivering treatment to patients. And because of that, I feel strongly that it is vital that we harness this power and deliver it in a timely and effective manner to the people of Connecticut.

The people of Connecticut currently are hampered with access to this high-quality service at Yale New Haven Hospital because of the inadequate provision of scanners. You've heard already that we have not requested any

additional CONs at this hospital in 14 years, and I run my scanners now everyday. I run my scanners all evenings. I run my scanners on weekends, and many of our hospital scanners are now working overnight as well. Despite this, I still have a third next available appointment time for MRI of 59 days.

I cannot provide greater access without additional scanners. The delays that our patients and our providers encounter are obviously unconscionable, and I appeal to Connecticut State for Health Strategy to help with this.

I'd like to finish by reading a letter that I received this week:

"Dear Dr. Goodman, I am hoping you can assist me or point me in the direction where I can get assistance.

"I referred a patient, "DB," for an MRI for nausea, anorexia, significant continued weight loss, and an elevated CA 19-9. My main concern is to rule out pancreatic cancer. He was told the first available appointment for an MRI was June 21st."

I received this letter this week.

"This is an unreasonable time frame for the type of illness we are considering and the symptoms he is experiencing. He is losing three to five pounds per week and is weak from malnutrition.

"At this point in time, the patient is so

despondent, he is considering palliative care. This is unnecessary simply because he is unable to obtain timely testing and appointments.

"Again, can you please find a way to help me expedite this study?"

This is not from a colleague in the hospital. This isn't from a faculty member. This is from a community provider trying to do the best she can for her patient.

I receive letters like this almost every week, and I think they illustrate the problem that we are asking you to help us with. Thank you.

HEARING OFFICER: Okay. Attorney Feldman, do you have any additional questions for your witnesses?

MS. FELDMAN: No, I do not.

HEARING OFFICER: Okay. All right. So, I will take a brief recess so that our analysts can get their questions together for your witnesses. If we need to bring in other people who are better able to ask -- to answer those questions, we will swear them in at the time they're answering the questions, get their name, including spelling and title on the record at that time.

All right. So we will take a -- let's take a 15-minute break. We will be back at 11:02 for analysts' questions, and we will do our best to make sure that your doctors can keep to their schedules for today.

MS. FELDMAN: Thank you.

HEARING OFFICER: Thank you, everybody.

(Recess: 10:48 to 11:02.)

HEARING OFFICER: All right. It is 11:02. I am going to ask our OHS -- as you were just informed by the Zoom voice, we are recording this hearing, and your participation in this hearing is your consent to being filmed. If you would like to revoke that consent, you may leave at this time.

All right. So, at this point, we will begin with OHS questions. Before I do, I will just state that I can visibly see both Dr. Churchwell and Dr. Goodman are present and available. We will begin with OHS questions.

Annie, would you like to begin with your questions.

MS. FAIELLA: Yes. So, this is Annie Faiella. So, I will be begin the first of the questions.

In the first completeness letter on Page 427, when asked about the utilization calculations and census, the applicant provided an example along with steps on how they calculated utilization rates. However, the PSA town population table -- however, in the PSA town population table, the applicant did not use all of the PSA towns they had listed in the application on Page 23. Can you explain

why that is?

MS. FELDMAN: I'm going to ask -- no. I think, Jeryl, can you take that? Okay. Just state your name for the record and title?

MS. TOPALIAN: So, my name is Jeryl Topalian. Last name is spelled "T" as in "Thomas," "O," "P" as in "Peter," A-L-I-A-N.

HEARING OFFICER: I can't see this person. If you can have them move slightly closer. That way we can see them. Otherwise -- Hi. State your name again, please.

MS. TOPALIAN: My name is Jeryl Topalian. First name is J-E-R-Y-L, last name is T-O-P-A-L-I-A-N; and I'm the director of regulatory planning for Yale New Haven Health Systems.

(The witness, Jeryl Topalian, was duly sworn by the hearing officer.)

HEARING OFFICER: All right.

MS. TOPALIAN: So, in our initial application and in response to the completeness letter, we used a definition of service area that were the towns contiguous to the site that we were proposing the equipment on.

And then subsequent to that, when we received

follow-up questions for the response to issues prior to the hearing, both of those questions related to the service area. And so, we redid the calculations of need using all of the towns defined in the service area definition that OHS provides, which is, you know, 75 percent of discharges at the site. And we provided that in our response to issues for each of the sites, which also showed need in each site for each piece of equipment.

MS. FAIELLA: Thank you. My next question is in the pre-filed testimony, the applicant states that there are eight hospital-based CT scanners in the Guilford PSA location and nine in the Hamden PSA location. However, OHS Table 9 says that there are 10 for Guilford and 11 for Hamden. Could you please explain?

MS. TOPALIAN: I don't know how to explain that. We used the OHS table -- we used the OHS tables.

MS. FAIELLA: So, our OHS table also shows that there was eight hospital-based CT scanners in the Guilford PSA, and then the applicant showed that there was -- sorry. Ours showed that there was ten for Guilford, and the applicant showed that there was eight; and two of those scanners were not -- that weren't being accounted for were Yale scanners in both Guilford and in Hamden.

MS. TOPALIAN: This is in response to MRIs; correct?

MS. FAIELLA: CT scanners.

MS. TOPALIAN: If we can have a minute.

HEARING OFFICER: Sure.

MS. TOPALIAN: Sorry. My apologies.

HEARING OFFICER: No, that's okay.

MS. TOPALIAN: In the subsequent testimony that we provided, we counted the scanners similar to what OHS has in the response to issues. And the two that we didn't include in our calculation of need, one is used for biopsies, and one is the portable, yes, portable, a mobile, that is used for specialty unit testing. So, it's used for a very limited specialty population. It's not a standard diagnostic general CT.

HEARING OFFICER: You're muted. You're muted, Annie.

MS. FAIELLA: Thank you. Give me just two seconds real quick. I just want to pull up the table because I do believe that Yale's scanners are all combined into one number rather than being separated out.

MS. TOPALIAN: Those two are separated.

MS. FAIELLA: Oh, they are. Okay. Perfect.

MS. TOPALIAN: One has 22 scans, and I don't remember the other one, but it's a much lower number; and it's given separately than the combined number of the other eight.

MS. FAIELLA: Okay. Thank you. So, I'll move on to my next question.

Dr. Churchwell and Dr. Goodman have testified today regarding the importance of getting scans done in a timely fashion. Does the applicant know if there are delays in getting scans done at other providers within the PSA?

MS. FELDMAN: Why don't you take it, Dr. Goodman?

DR. GOODMAN: This is Rob Goodman again. We are not privy to what the wait times are for other scanners in the region, but what I can say is that the other scanners are not of the same quality or standard of the studies that we provide at Yale New Haven.

Also, referring patients to other scanners within the [inaudible] area breaks the continuity of care for us to be able to provide patient care.

MS. FAIELLA: Will the break in continuity of care, though, increase or decrease the time of -- that it would take to get the scan done, if it would increase the time -- or like if it would -- if it -- if you keep a patient inside and get their scan done by Yale, would that take longer than referring them out and getting a scan done that way?

DR. GOODMAN: If a patient comes to Yale with a scan done from an outside entity, more often than not we have to repeat that study because it's substandard quality or it isn't giving us the answer that's required, which

delays patient care.

And so, again, it's not appropriate for referring outside to address delays in getting access to imaging health care.

DR. CHURCHWELL: This is Dr. Churchwell. We don't have access to their scheduling. We don't have access in terms of what resources they have to actually do the type of scanning that we need. What standardly will happen, if we actually have an outside scan performed, we have to actually redo the scan, as Dr. Goodman talked about. We also have to do a second assessment of the scan. And we've had multiple incidences where, actually, because of that communication or because that was not the scanner that we needed or the specialized protocol, we have to redo it or actually have to -- we're missing information, which ultimately leads to overall delay in terms of the protocol in the pathway of care.

DR. GOODMAN: This is Dr. Goodman again. The studies that are performed at the outside scanners are often read by general radiologists. At Yale New Haven, we have subspecialist radiologists that provide the high-quality interpretation that helps with rapid and effective delivery of health care.

MS. FAIELLA: So, as a follow-up, about -- are you aware of how many scans that have been referred out and need

to be repeated? Like what percentage would need to be repeated by Yale?

DR. GOODMAN: We have data from, national data, that shows that studies that are not performed in academic health systems are of substandard quality 30 percent of the time; and the diagnosis is inaccurate if the study is substandard.

MS. FAIELLA: Is that Yale's data?

DR. GOODMAN: No. That's national data.

MS. FAIELLA: Do you have Yale's data that you could provide?

DR. GOODMAN: I know that when we double read studies that are performed on that site, center, we change the diagnosis approximately 25 percent of the time.

DR. CHURCHWELL: This is Dr. Churchwell. That's one of the reasons that's part of the standard protocol. For outside studies, we actually have a double read. We have our specialist radiology to do the over-read for any outside study because of that incidence of actually misinterpretation and the need for reevaluation.

MS. FAIELLA: So am I correct to understand that there's about 25 percent -- if a patient is referred out to get a scan, 25 percent about would need to get rescanned?

DR. GOODMAN: Rescanned or have the wrong diagnosis. But, again, we don't control the referral

pattern of our providers. They can refer wherever they want to. We're not -- we're not referring our providers to outside entities. Our providers do what they want.

HEARING OFFICER: I have a question. You're saying that your providers can do what they want. So, you are not -- you're not saying that a Yale New Haven Hospital-affiliated doctor cannot, if they're not finding an appropriate wait time at your hospital, that they can't refer that patient to somebody -- or they can refer that patient to a different facility that may have a shorter wait time? Is that what you're saying?

DR. GOODMAN: They absolutely can refer to an outside facility. But again, I refer you to the letter that I read out. The referrer wants their scans done at Yale New Haven Hospital.

HEARING OFFICER: But if they're going to have to review them anyway because your hospital does a second review coming in, how likely is it that, if a Yale doctor referred somebody to a, maybe a clinic with a shorter wait time and was able to receive a faster scan and then has a specialty doctor review those scans, how likely would it be that that patient would be misdiagnosed for a long period of time?

MS. FELDMAN: I guess I would like to object to the question in that the application demonstrates that we have

patients to select and choose. Patient choice is essential to all of us as to where we receive our health care services.

So our patients come to us. What the anecdotal information is with respect to our experience when we do have the occasion of reviewing a scan done elsewhere, it's not that we're reviewing every scan done elsewhere; it's just the ones coming to us that we get to review. But the demand is basically determined by both the patient and the referring physician because it is an academic medical center, and presumably, patients are interested in getting the highest quality of care.

So, I'm not really sure where the questioning is going about the percentage of patients that we review their scans and they're incorrect. This is based on our knowledge and experience.

Plus, with respect to recruiting physicians, one of the biggest attributes and advantages is that all ancillary services for the most part are provided by Yale physicians, Yale radiologists; and that's what makes Yale special because you know --

HEARING OFFICER: Joan, I can't quote anything that you say --

MS. FELDMAN: Okay. Okay.

HEARING OFFICER: -- in my decision. If you would

like your -- if you would like that to be something that we could consider in a decision, I would recommend having -- I'm sorry, Attorney Feldman; I shouldn't have called you "Joan" -- coming from the doctors might be a better answer.

MS. FELDMAN: Okay. If you could note my objection to the question.

HEARING OFFICER: Yeah. Okay.

DR. CHURCHWELL: This is Dr. Churchwell again.

As within an academic health system environment, there is a -- there is a real attempt in terms of integration of care. We don't think about our radiologists or our imaging service as a separate and distinct entity along the pathway of care. They are actually alongside our oncologists or our cardiologists or our endocrinologists. In thinking about what is appropriate, what is the right test, the interpretation of the test is going to have an impact in terms of the overall pathway of care.

The utilization of outside resources as part and parcel is actually what we don't think and I think would lead to actually enhancement of care, it would lead to delays in care. It would actually lead to, actually, at times, misinterpretation of actually what should be the right and proper diagnosis and the right and proper treatment and not a true integration in terms of information that we have actually worked assiduously to, to actually to

bring forward along with our electronic health record system, along with our imaging capability that actually coalesces our diagnosticians to actually bring the best diagnosis, best recommendations, and thinking with the patient the best pathway in terms of how we're actually going to think about the next stages for that patient in terms of the care we're going to deliver.

So, it's really not -- in terms of thinking about a solution of actually adding, of using an outside agency within the confines of this institution and the patients that we serve, that only leads to, that would only lead to a persistent sort of joker in the deck in regards to not only the time element, but also the opportunity to actually be able to integrate that data appropriately with the right conversations and the right pathways in terms of care.

DR. GOODMAN: And as the chief of radiology for the hospital, I would feel very uncomfortable encouraging the population of Connecticut to use inadequate imaging equipment that is performed incorrectly and read incorrectly for our population.

MS. FAIELLA: So, then, we've been talking about referral patterns and things such as that. Would it be possible as a late file to get the referral patterns that Yale has been then doing out of Yale for CT, MRI, and PET CT scans outside of Yale?

DR. CHURCHWELL: I just want to be clear. Do you want the number of patients that we, within this particular health system, we send out to actually have diagnostic scans performed at other institutions?

MS. FAIELLA: Yes.

DR. CHURCHWELL: Is that what you're asking?

HEARING OFFICER: Can you restate your question?

MS. FAIELLA: It's referrals out. So, if someone is at Yale Hospital getting services done, how many patients do you send out into [signal interruption] to get a CT, MRI, and PET CT scan?

DR. CHURCHWELL: Dr. Churchwell. We can -- we might be able to find that data. I kind of doubt it because we work very hard to actually avoid that at this particular point. It is not a policy of ours to actually work in that particular direction.

We might have a rare patient who actually will come to us to say that they want to have a test done at another facility. We have to honor that particular request, but in terms of the integrated matter that we actually think about the development-of-care plan, it is assumed by the vast majority of our patients, if not almost -- I can't think of actually an example of where that would be a pathway that we would use. We work to actually integrate our diagnostic capabilities from an imaging standpoint along the path --

along this particular journey for patients in terms of evaluation and treatment.

MS. FELDMAN: Can we please ask to be muted for one minute so we can be more responsive?

HEARING OFFICER: Yes. Okay. Joan? Or attorney Feldman, I'm sorry. Attorney Feldman, if you would -- would you mind a five-minute break so that you can discuss this answer, and then we can take a break as well? Oh, you're muted. Sorry.

MS. FELDMAN: Okay. Five minutes is fine. Thank you.

HEARING OFFICER: You can grab your answer. I just will quickly meet with the OHS staff, and we will be back. Thank you.

MS. FELDMAN: Great.

(Recess: 10:24 to 10:28.)

HEARING OFFICER: All right. It's 11:28. The Zoom voice just told us we are now recording again.

All right. Attorney Feldman, would you guys like to answer?

MS. FELDMAN: Yes, please.

DR. GOODMAN: This is Rob Goodman. We believe that it's the referrer's choice as to where they refer their

patients for their imaging. We don't control the quality, as I've told you, or the techniques of the sites. We leave that to the referrer and their patient to determine if they want to take a Yale New Haven Hospital or have the scan done at an alternative site.

MS. FAIELLA: I have no further questions.

HEARING OFFICER: All right. I have a few questions. I had some questions about the PSAs for the MRI, for the two MRIs that are requested in Guilford and North Haven. How are you determining that they are different PSAs when they are about 17 to 21 miles apart from each other?

MS. TOPALIAN: Jeryl Topalian again. The way that we determine the PSAs was as directed by OHS. OHS directs that you perform a service area definition that requires the site to determine 75 percent of the towns that make up the discharges from that site.

So, as you saw, in our definition, we provided, in the main application, we provided in Table 2 the service area for each of the sites that was determined by 75 percent of the discharges for that service, the service we are asking for at the site for those towns. There was, as you saw, overlap. Some of the towns were included in both service areas.

HEARING OFFICER: So, knowing that there's overlap, would you -- can you explain why there would be a need for

two in the same service area, then?

MS. TOPALIAN: We included those when we did the assessment of all of the scanners in the areas. We included -- each assessment was done including all of those towns.

HEARING OFFICER: Was it also including the two new requested scanners as well or -- I'm trying to understand why a service area that may include both locations where you'd like to put scanners needs two scanners instead of maybe one scanner.

MS. TOPALIAN: So, what you're saying, why one in North Haven and why one in Guilford?

HEARING OFFICER: Yes. Correct.

MS. TOPALIAN: Because we, including the ones in Guilford and the ones in North Haven, the towns that overlap, need was demonstrated for a scanner at each site, at each service area.

HEARING OFFICER: Okay.

MS. TOPALIAN: Based on the volume of the scan, the capacity of the formula used by OHS in Chapter 5 of the 2012 -- yeah -- OHS facilities plan, we performed our analysis that way for each site for each type of equipment.

HEARING OFFICER: All right. I'm going to switch -- I'm going to switch gears a little bit on Bates Page 39, Tables T and U. You have a 16.15 percent black and African American population, but you only have a 7.5 utilization

rate. How do you plan to address this gap in utilization among non-white patients?

DR. CHURCHWELL: This is Dr. Churchwell. So, I think we have a number of initiatives that actually are pointing towards direct -- directly of thinking about how we address the needs for the underserved and underrepresented population, not only in New Haven, but in the greater New Haven community. I think that is not only an imaging issue; that actually is a global issue in terms of the delivery of care for patients within our population.

So, we have a number of constituencies, both at -- within the school and also within the hospital and the health system that are addressing this issue in terms of outreach and in terms of understanding the need for those within the organization.

I also think about the timely access of care for those who are actually -- that are impacted and to ensure that we are connecting our patients with the right individuals within our organization from a clinical standpoint and that we are following them along the journey in terms of pathway.

We have made investments, despite the significant economic impact of the pandemic, for the idea of the opportunity around patient navigation for our core patients, actually who we take care of and actually darken our doors.

That I think is actually one opportunity and one aspect of how we're going to be able to tie our patients' needs and do a greater degree of assessment of how we can actually address those needs from a clinical standpoint and the utilization of a resource standpoint to actually improve those overall numbers.

HEARING OFFICER: Jeryl?

MS. TOPALIAN: Just to add to that, Yale New Haven Hospital is a safety net provider, and other providers don't necessarily accept Medicaid patients. Yale New Haven Hospital will accept all patients, regardless of ability to pay. And we have provided as part of this application be, you know, charity care applications and the amount of charity and free care provided there.

HEARING OFFICER: On Page 8 of the supplemental form, Table C-3 for fiscal year 2023, can you check the costs on that and tell me if those are correct? Looks like there is a typ -- an error.

MS. TOPALIAN: Are you referring to the page number or the Bates number?

HEARING OFFICER: I'm sorry. This one, there was no Bates number on it. It was Table 3 for the PET CT scan, the average cost per scan per commercially insured patients. It looks like one number was transcribed. I just wanted to make sure that was correct, especially fiscal year 2023.

MS. TOPALIAN: Sorry. Can you repeat the question?

HEARING OFFICER: Sure. Table C-3 is called "PET CT Average Cost of Scan Per Commercially Insured Patient." And under the projected for year 2023, I just want to have you look at that and let me know if that is a typographical error.

MS. TOPALIAN: Are you talking about the $2,093?

HEARING OFFICER: Yes, 2065. The year before, the costs are $2,605; and then they either go down significantly or we just transcribed the numbers --

MS. TOPALIAN: Yeah. That was a typo. I believe that was corrected in the completeness response.

HEARING OFFICER: Okay.

MS. TOPALIAN: Yeah, it is a typo. It should be 2605 in each of those three -- in each of those three years, 2065.

HEARING OFFICER: So the cost stays the same in fiscal year '22 and '23 and goes up slightly in 2024?

MS. TOPALIAN: Correct.

HEARING OFFICER: Okay. All right. And Exhibit 3 -- sorry. Exhibit C on Page 3, you state, "Population data is useful in needs-based analysis if the exact number of scans is not known."

So, I have a question. Approximately how many scans are done per person per appointment?

DR. CHURCHWELL: Alicia, let's try that again. How many -- This is Dr. Churchwell. I apologize.

How many scans are done?

HEARING OFFICER: So, let's break it down. I'll ask it in different way.

For MRI patients, approximately how many scans would an MRI appointment usually entail?

DR. CHURCHWELL: Well, for each appointment, there would be one scan performed. Is that what you're -- it could be based upon what actually we're looking for.

An example could be that it could be a MRI of the chest pending abdomen based upon the particular diagnosis. In that particular setting, we would do imaging of the chest and the abdomen with information derived for evaluation. So in a sense, that could be two types of scanning performed for one particular event; right? It all depends upon exactly what the preliminary diagnosis or the diagnosis is, what we're actually looking for, and the issues that need to be evaluated, whether it's metastatic disease we're singularly looking, actually, for the evaluation of cardiomyopathy; right? So I'm sure there is a degree of variation that will occur in terms of the number or the type of scan performed at that particular setting.

DR. GOODMAN: Dr. Goodman, if I might add some additional thoughts about that.

I would ask whether it's [inaudible] service or I think in general the number of scans that are performed on each patient per appointment is really just over one, according to average, 1.1.

HEARING OFFICER: Okay. And is it possible that sometimes a patient could be referred for both a CT scan and an MRI or --

DR. GOODMAN: Rarely. Rarely.

DR. CHURCHWELL: In this day and age, that would be very rare.

HEARING OFFICER: And, then, just some follow-up last questions.

Dr. Goodman, the studies referenced in your testimony spoke to wait times for someone who presents at a hospital or ER. What would -- can you correlate that to an outpatient setting, those studies to an outpatient setting?

DR. GOODMAN: The wait -- sorry, the wait times for a hospital-setting appointment compared to an outpatient setting?

HEARING OFFICER: Yes. You -- Exhibits B, C, and D were -- were talking about delays as particular for length of hospital stay, for hospital admissions. How would those relate to outpatient settings, such as the request from Yale?

MS. FELDMAN: Can we get a minute?

HEARING OFFICER: Sure.

MS. FELDMAN: Thank you.

(Pause.)

Hearing Officer Novi, would you please, one more time? We wanted to make sure we have the right person who could answer the question, but if you could restate it, that will be very helpful.

HEARING OFFICER: Sure. In Dr. Goodman's testimony, Exhibits B, C and D, these studies address radiological delays as independent predictors of the length of hospital stay. How do these studies relate to a non-emergency outpatient imaging request?

MS. FELDMAN: Say your name.

MR. ALEXA: My name is Daniel Alexa. Last name is spelled A-L-E-X-A. I'm the executive director of System Radiology Operations.

HEARING OFFICER: I'm just going to quickly swear you in.

(The witness was duly sworn by the hearing officer.)

HEARING OFFICER: Thank you. All right. Go ahead.

MR. ALEXA: So, if I'm understanding everything correctly, when we say that there's, like, a 59-day and

third next available, that is pertaining to outpatient exams for patients trying to call to get in to have an exam done as an outpatient referral.

So, what that can do, the longer that a patient has to wait to get an exam, that will delay the subsequent care that they will have if they do have to get admitted to the hospital or have further care that is done.

HEARING OFFICER: All right. So, what would -- you said that's the third appointment. Would there -- what is the "third appointment"? Can you explain that to me?

MR. ALEXA: Okay. Yeah. So, the third next available appointment is kind of an industry benchmark to determine wait time and backlog. So that's the median third next available appointment to get the MRI, you know, across our outpatient locations.

HEARING OFFICER: So it is possible that there could be a first available appointment that would be sooner, but...

MR. ALEXA: Yes.

HEARING OFFICER: Okay. All right.

MR. ALEXA: That's just a standard benchmark that we use, essentially.

HEARING OFFICER: I'm sorry. I could not hear that.

MR. ALEXA: The reason we use a third next -- and

I'm not going to get into all of the science behind it -- but, you know, a first next can be due to a cancellation that happened, you know, tomorrow. You know, somebody -- so, that's why we try to use third next as the true benchmark of what the wait looks like.

HEARING OFFICER: Okay. All right. Thank you. That's it for my questions.

Joan, would you -- do have any -- I'm sorry. I do apologize. Attorney Feldman, do you have any questions that you would like to redirect back to any of your witnesses around the table?

MS. FELDMAN: Yes. I'm going to direct this question to the doctors. It's getting back to the question related to the fact that there is capacity in the PSA in some settings which may or may not be appropriate settings for patients to receive their advanced imaging. In terms of how we can best deliver our health care at Yale New Haven Hospital, I'd like you to, one or both of you, explain why the concept of a hospital receiving a request to schedule imaging, that it's not the practice of health care in health care settings, in particular, academic medical centers, that the hospital would redirect the patient outside of their system to receive imaging. Can you address that?

DR. GOODMAN: Yes. As a hospital imaging department, we do not have the ability to make appointments

for patients at other sites, nor do we want to encourage making appointments, patients' appointments, at other sites because of the reasons I mentioned before; and, see, it may not be what the referrer or the patient wants.

MS. FELDMAN: So, if the patient is told they're not going to be able to get an appointment until June, like the letter you read earlier, that patient's referrer who orders the test, he or she can refer that patient to another site, presumably?

DR. GOODMAN: She can.

MS. FELDMAN: And the fact that some of these sites are maybe below capacity, what does that tell you as a radiologist in terms of the desirability of the referrer sending their patient there for a study?

DR. CHURCHWELL: Well, it may mean that that particular site may not have the imaging equipment or the modality to actually do the type of procedure that's necessary for the patient. There are -- many of them are -- can be general or very, very specific, like an orthopedic site that does not really align to actually figuring out or evaluate the patient, given the diagnosis that their internist or their subspecialist is actually trying to evaluate.

You know, we can't really comment truly on the capabilities of the expertise there. We do know the type of

-- and many times, the imaging modality that they have, which is actually concentrating many of the times actually on a particular disease state, whereas from our standpoint, it's, you know, we have multiple issues that we're actually trying to resolve.

And there could be a significant amount of specialty that is actually correlating, especially within our cancer center, in our cardiovascular center, and within our endocrine center that we're actually looking for that we have put in place with our imaging modality here to actually evaluate and evaluate at an expert level.

DR. GOODMAN: I would add that I believe that we all have to trust that the provider is motivated to do the best they can for their patient. And if they want to image their patient somewhere else, they should do that. But if they feel that they want to have the imaging done at Yale New Haven Hospital, they should be allowed to be able to do that as well.

And there are certain categories in these areas that these other providers cannot satisfy. They cannot do patients who need anesthesia; they cannot do patients with pacemakers; they cannot do pediatric patients; they cannot do studies that require gamma knife treatment for brain tumors. We are the only entity in this region that provides that. These patients have to come here.

MS. FELDMAN: Dr. Goodman, can you talk a little bit more about, in your pre-filed testimony, you gave many examples of how a lot of the scanning that is done at Yale New Haven Hospital is not done elsewhere in terms of targeted care and treatment. Can you talk a little bit about that?

DR. GOODMAN: Yeah. There's been an innovation of imaging, and the indications for imaging continue to grow every year; and we at Yale New Haven want to be able to satisfy that need for our referrers and our patients for this progressive care.

So, we are now doing PET CT scans for patients to get their cancer therapy from our nuclear medicine department. We're doing patients who have prostate cancer, where we are treating the prostate cancer without the need for any surgery. We're doing this with MRI; MRI is killing prostate cancer cells.

We are providing, as I just said, imaging for patients who have pacemakers, MRI where they are unable to get that service elsewhere, which is another service that was started at Yale New Haven Hospital.

It's these types of progressive imaging techniques that we are providing our patients and the patients come to us for.

MS. FELDMAN: I have no further questions.

HEARING OFFICER: All right. At this time, let me just -- OHS, do you have any additional questions? Are you done?

MR. LAZARUS: We're all set. Thank you.

HEARING OFFICER: Attorney Feldman, I know that your witnesses both have prior commitments, so I would like to offer you the chance to, if anything were to come up in public comment that you would like a witness to respond to, we will give you time to have a written response from your witnesses.

MS. FELDMAN: Thank you very much.

HEARING OFFICER: Okay. So at this time, we will take a -- we will take a break. Public comment signup will begin at -- sorry.

MS. FELDMAN: Will I have an opportunity to make closing remarks?

HEARING OFFICER: Yes. I was about to say that. So, public comment signup will be from 2:00 to 3:00. We'll have public comment, then you can make closing remarks. We can address anything you would like to have a late file for at that point. And then directly following public comment will be closing statements.

MS. FELDMAN: Thank you.

HEARING OFFICER: All right. So I will come back at 2:00. If you'd like to come back for a brief description

of how the public can sign up, you can come back. You don't need the witnesses, obviously. I'll come on briefly to explain public signup and then 3:00 p.m., we'll come back for public comment.

MS. FELDMAN: Presumably, if there are no witnesses signing up, there will be no 3:00 p.m.?

HEARING OFFICER: If there are no witnesses, we will proceed directly to closing statements.

MS. FELDMAN: Okay. Very good. Thank you.

HEARING OFFICER: All right. Thank you very much and have a nice day. I appreciate your witnesses' availability this morning, Attorney Feldman.

MS. FELDMAN: Thank you.

HEARING OFFICER: Thank you.

(Recess: 11:53 to 2:00.)

HEARING OFFICER: All right. It is two p.m. I'm going to go ahead and ask Faye to go ahead and start the recording. We were just notified by the Zoom voice we are now recording this hearing again. If you do not consent to being on camera, please -- you can revoke that consent at this time by leaving the hearing.

All right. Good afternoon, everybody. Thank you for coming back. I can see the applicant's counsel is

present. It's two p.m. We will -- I will inform you all that you can sign up for public comment, which will take place at three p.m. by placing your name into the chat. OHS HSP, the host, will be taking those names. That is our paralegal, Faye Fentis. She will be signing you up, and she will take names and she will give me those names in the order in which you signed up.

We may limit testimony to three minutes or less, depending on the amount of people that show up. But public comment will begin at 3:00, so after you give your name to Ms. Fentis, you can come back at 3:00 p.m.

Anything that you would like to add, Attorney Feldman? You're on mute.

MS. FELDMAN: No, thank you.

HEARING OFFICER: All right. We will see everybody at three p.m. If you would like to sign up, again, please add your name in the chat and give your name to OHS HSP, which is our paralegal, Faye Fentis. Thank you.

(Recess: 2:03 to 3:00.)

HEARING OFFICER: All right. I'll go ahead and ask Ms. Fentis -- Zoom has now alerted us we are recording this hearing again.

It is 3 p.m. on April 19, 2023. Ms. Fentis, have

we had anyone sign up?

MS. FENTIS: We have not.

HEARING OFFICER: Okay. So at this point, we will go ahead and go directly to our closing statement from our applicant. If you would like to go ahead and take yourself off of mute and begin your closing statement.

MS. FELDMAN: Thank you very much.

HEARING OFFICER: Oh, actually, before we do that, I just want to remind everybody, for those who are joining us at this time, this is the afternoon portion of today's hearing, a CON application filed by Yale New Haven Hospital on Docket No. 22-32586-CON.

The technical portion was held this morning, and this is the closing statements.

MS. FELDMAN: Thank you very much. And I make my closing remarks in a respectful manner to the OHS staff.

The proposed new methodology to use a statewide calculation, as more particularly described in Exhibit K, should that be included in the record and be the methodology, whether it's included in the record or not, the methodology that OHS decides to utilize, it will cause a complete disruption in the delivery of health care in the state of Connecticut.

Patients will be harmed by substituting demonstrated actual need with hypothetical formulas that

have no relevance to actual need.

OHS, unfortunately, based on this new methodology, is headed onto a slippery slope where the government is engaged in the practice of medicine versus providing some level of deference to the clinicians who are best positioned to demonstrate real and substantial patient need.

Interestingly, a denial of this proposed application to acquire two MRIs, two PET CTs and two CTs will negatively impact patient access, especially for Medicaid patients and other marginalized populations who are already disadvantaged by way of not being able to timely access health care.

Ostensibly, this is the same population that I view OHS as a watchdog for. If racism is a public health crisis in Connecticut, this undoubtedly does not help.

Hearing Officer Novi, what we have here with this new methodology will constitute a de facto moratorium on advanced imaging equipment in the state of Connecticut. That cannot be. Because we have proven in our application, our pre-filed testimony, our responses to the hearing issues, and our responses to the completeness questions, the actual demand by patients to receive advanced imaging at Yale New Haven Hospital, there's no doubt that up until yesterday, with only one round of completeness questions, that OHS on some level agrees that the demand or need has

been proven.

Accordingly, we respectfully request that OHS approve the acquisition of the proposed advanced imaging equipment and that it not reverse course. This will have dramatic results for providers in this state, but most importantly patients.

Thank you for allowing me to have that time to provide these closing remarks.

HEARING OFFICER: All right. Thank you, Attorney Feldman. I just want to remind you that we will give you until May 3rd to submit a brief on your objection. Is that adequate time for you to get the brief in?

MS. FELDMAN: Yes, that's fine. I don't want to jump ahead, but I didn't know if you were going to request any late files.

HEARING OFFICER: I'm going to go ahead and ask if -- ask the OHS staff, Ms. Faiella, do you have a late-file request?

MS. FAIELLA: I do not.

HEARING OFFICER: So, we don't have any late-file requests from OHS, so it looks like the record will stay open for your brief. And since we did not have any public comments, you will not need to submit any response from your witnesses who came earlier today.

MS. FELDMAN: I would like to ask the hearing

officer, since there seemed to be, you know, some lack of understanding or confusion regarding our submission with respect to the primary service area or methodology for calculating demand, if we could submit a late file with some additional narrative that walks through the analysis and evidences the fact that there's no duplication, that the demand is actually there, and be responsive to some of the questions that Ms. Faiella had presented to us earlier this morning.

HEARING OFFICER: I'll go ahead and allow that as well.

MS. FELDMAN: Thank you.

HEARING OFFICER: So, we'll bring that in. I believe that will -- the brief will be out, and the late file for that will be in.

MS. FELDMAN: Okay.

HEARING OFFICER: And is the same time period agreeable?

MS. FELDMAN: Given that there is another very significant CON proceeding that our staff is working on next week, I would respectfully ask if we can have additional time, perhaps another week.

HEARING OFFICER: You know, why don't we make them all due on the same day, and we will push them all up three weeks.

MS. FELDMAN: That's fine.

HEARING OFFICER: So we will have our due date of May 10th.

MS. FELDMAN: Perfect.

HEARING OFFICER: Okay? For both of your late files. I would rather have you turn everything in at once than have two separate due dates. I do understand that you are -- you know, it's a very busy time period for your client; and we want to make sure that everything can get turned in in a timely fashion.

MS. FELDMAN: I appreciate that.

HEARING OFFICER: All right. With that, anything else? Any OHS staff? Anything else from the staff? Does not look like it. All right.

Attorney Feldman, I would like to thank you for your time today and for your witnesses' time today. It is now 3:08 p.m. This hearing is now adjourned.

And I would -- the record will remain open until closed by OHS, and we have a due date of May 10th for your two late files.

Thank you.

MS. FELDMAN: And in turn, we thank you and the OHS staff for your time and patience today and for attention to this very important matter.

HEARING OFFICER: All right. Well, have a good day

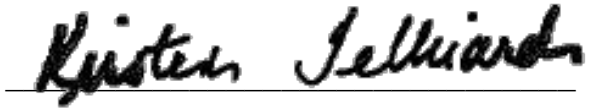
everybody.

MS. FELDMAN: Thank you.

(Hearing adjourned: 3:08 p.m.)

CERTIFICATE

I hereby certify that the foregoing 72 pages are a complete and accurate computer-aided transcription of my original stenotype notes taken of the hearing, which was held in re: Office of Health Strategy Public Hearing for CON Application by Yale New Haven Hospital, via Zoom videoconference technology, on April 19, 2023.



Kirsten Telhiard, LSR #391