Decision

Applicant(s): Hartford HealthCare Corporation
100 Pearl Street
Hartford, CT 06103

Manchester Memorial Hospital, Inc.
100 Pearl Street
Hartford, CT 06103

Docket Number: 25-32843-ECON

Project Title: Emergency Certificate of Need (E-CON)
Transfer of Ownership of a Health Care Facility (Hospital) in Bankruptcy Protection and any Subsidiary or Group Practice Thereof

I. Project Description

Hartford HealthCare Corporation (HHC), via its subsidiary Manchester Memorial Hospital, Inc. (HHC MMH) and one or more other HHC subsidiaries (HHC and HHC MMH together referred to herein as the "Applicants"), seeks to acquire certain of Prospect ECHN, Inc. d/b/a Eastern Connecticut Health Network's (PECHN) assets and PECHN affiliated entities' assets (collectively, the "Parties").[1] The transaction includes, but is not limited to, the assets of Prospect Manchester Hospital, Inc. d/b/a Manchester Memorial Hospital (Prospect MMH) and its Rockville campus formerly known as Rockville General Hospital (RGH), certain PECHN joint ventures, the PECHN components of Prospect CT Medical Foundation, Inc., as well as other affiliated entities as more particularly described in the Parties' Asset Purchase Agreement (APA) (all of which is hereinafter referred to as the "Proposal").[2] The capital expenditure associated with this transaction is the purchase price of $86.1 Million, but total anticipated costs over the integration period are $311,800,000.[3]

II. Provisions of Law

On March 3, 2025, Ned Lamont, Governor for the State of Connecticut, signed House Bill No. 7067, through which Public Act No. 25-2 was enacted. For any hospital in the state that has filed for bankruptcy protection, Section 1 of this law provides a pathway by which the Office of Health Strategy (OHS) may complete an expedited, emergency Certificate of Need (CON) review ("E-CON") of a potential purchaser requiring approval from, or already approved by, the bankruptcy court (the "E-CON Law").

[1] Exhibit ("Ex."; plural, "Exs.") C – Application, p. 000005 (hereinafter, page references shall not include the prefatory 0's)
[2] Ex. C – Application, p. 5
[3] This includes the purchase price of $86.1 Million. Ex. C – Application, p. 2

CON applications, including those reviewed under the E-CON process, are decided on a case-by-case basis and do not lend themselves to general applicability due to the unique facts of each case. Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board*, 309 Conn. 727, 728-29 (2013).

III. Factual Background

On or about January 11, 2025, Prospect Medical Holdings, Inc. (PMH) and certain of its subsidiaries filed for Chapter 11 bankruptcy protection to effectuate a transaction process for certain of its assets and liabilities.[4] The bankruptcy proceedings are being overseen at the federal level by the U.S. Bankruptcy Court for the Northern District of Texas.[5] Prospect CT, Inc. (Prospect CT) is the Connecticut subsidiary of PMH, and Prospect CT includes two (2) Connecticut-based hospital systems: PECHN, which is comprised of MMH and its Rockville campus, and Prospect Waterbury, Inc. d/b/a The Waterbury Hospital, as well as certain affiliated entities and joint ventures associated with each of the hospitals.[6] The latter hospital system and its various subsidiaries and affiliated entities are not part of the transaction at issue in this E-CON matter.[7]

On September 12, 2025, ECHN Holdings (now HHC MMH) entered into an APA with PECHN concerning the transfer of assets of certain PECHN assets to HHC MMH. And on October 16, 2025, it was determined that HHC MMH was the exclusive bidder for the PECHN assets. Thereafter, on October 24, 2025, the judge in the bankruptcy proceeding indicated that she would be approving the proposed sale. On October 28, 2025, the Court issued a written order approving the sale, and on the same date HHC and HHC MMH (the "Applicants") submitted the instant E-CON application.[8]

The E-CON Law permits OHS to engage the services of one or more third-party consultants, at the sole expense of an E-CON applicant, to analyze "the anticipated effect of the hospital's transfer of ownership on access, cost and quality of health care in the affected community" and "any other issue arising from the application review process."[9] The E-CON Law also requires that any decision on the application include "an assessment of the effect on health care market concentration and health care access for Medicaid recipients."[10] Accordingly, OHS contracted with Arnold Analytics LLC for these purposes,[11] after which a report was prepared and issued (the "Report").[12]

[4] Ex. C – Application, p. 5
[5] Ex. C – Application, p. 5
[6] Ex. C – Application, p. 5
[7] Ex. C – Application, p. 5
[8] Ex. C – Application
[9] E-CON Law, Section 1(b)(5)
[10] E-CON Law, Section 1(c)(5)
[11] Ex. F – Letter re: Confirmation of Recent Engagement
[12] Ex. Y – Report

Lastly, the E-CON Law permits the agency to hold a public hearing at its discretion provided it does so within certain parameters.[13] That hearing was held on November 18, 2025.

IV. Discussion and Analysis

Pursuant to the E-CON Law, OHS must issue a final decision on an E-CON application and such decision must "articulate the anticipated effect of the hospital's transfer of ownership on access, cost and quality of health care in the affected community, including an assessment of the effect on health care market concentration and health care access for Medicaid recipients."[14] Additionally, this same section requires that OHS "consider the effect of the hospital's bankruptcy on the patients and communities served by the hospital and the applicant's plans to restore financial viability."

Each of these specific subjects are addressed in detail below. However, generally speaking, the Proposal appears not only likely to preserve the continued existence of a hospital in the service area, but also to lead to improvements in access, cost, and quality. All noted deficiencies and identified material risks based on the statutorily prescribed criteria for an E-CON are addressed via the imposition of certain enumerated conditions set forth in a separate section below.

a. Access

The Applicants have established that the anticipated effect of the transfer of ownership on access to health care supports approving the E-CON application, subject to the imposition of certain enumerated conditions set forth below.

Most significantly, MMH is a financially distressed hospital and HHC MMH was the only bidder in the bankruptcy proceeding.[15] Accordingly, if this transaction were not approved, MMH and its Rockville campus would likely close, creating a gap in access to both inpatient and outpatient services. In fact, Prospect has a history of closing hospitals, most recently a string of hospitals in Pennsylvania including Delaware County Memorial Hospital (2022) and Springfield Hospital (2022), and after filing for bankruptcy, Taylor Hospital (April 2025) and Crozer-Chester Medical Center (May 2025).[16] By contrast, HHC has not closed a hospital, and instead states that it has a history of strong investment that has enhanced access at struggling hospitals. For example, HHC asserts it invested $200 million in St. Vincent's Medical Center (SVMC) and $72 million in Charlotte Hungerford Hospital (CHH).[17] Here, other than the $86.1 million purchase price, HHC plans to invest an additional $225.7 million into MMH over the next three (3) years.[18]

[13] E-CON Law, Section 1(b)(4)
[14] E-CON Law, Section 1(c)(1)
[15] Ex. A – Application, pp. 9, 12, 35
[16] https://pestakeholder.org/news/prospect-hospitals-in-pennsylvania-to-close-layoff-2651-workers/ (last accessed December 4, 2025)
[17] Ex. C – Application, pp. 10, 17; Ex. Y – Report, p. 17
[18] Ex. C – Application, p. 12; Ex. Y – Report, p. 17

Beyond pure capital investment, it is clear that the Applicants are focused on ensuring continuity of care, having developed what appears to be a comprehensive integration plan.[19] In fact, the Applicants attest to having initiated Phase I of the integration plan the day after the APA was signed.[20] Regarding Phase II, the Applicants make a number of assertions regarding the initiatives they anticipate extending to MMH, which if fully implemented would preserve, expand or enhance access to health care services in the MMH area. For example, the Applicants assert they:

- will extend 24/7 virtual primary care, urgent care and chronic care to the area;[21]
- will establish GoHealth Urgent Care centers in the area;[22]
- will cross-credential and share hospitalist and intensivist providers across HHC hospitals;[23]
- will recruit new providers to address service gaps in the MMH area;[24]
- will extend HHC Institute models to the MMH area;[25]
- have identified certain areas for investments in inpatient and outpatient behavioral health services, including expansion of inpatient mental health services by reopening an empty 30-bed unit at the Rockville campus;[26]
- have identified certain areas for investments in expansion of vascular and orthopedic surgical services, and development of an inpatient rehabilitation unit (IRU) in the MMH area;[27]
- will invest in specialty health services including oncology and diagnostic imaging services in the MMH area;[28] and
- will likely seek to expand other ambulatory services currently offered in the area.[29]

As a result of the aforesaid, the Applicants expect that the communities will regain trust in MMH, including services at the RGH campus, and they will return to accessing care more locally.[30] This, in turn, is expected to allow more of Hartford Hospital's (HH) patient census to seek care in the community hospital, in particular those who do not require quaternary care, thereby increasing access for the more intensive levels of care at

[19] Ex. C – Application, pp. 7-9
[20] Ex. C – Application, p. 460; Hearing Recording at 40:34 – 45:10. Note that OHS has not received a copy of the hearing transcript from the court reporter, so references to specific portions of the hearing record are made using time stamps to sections of the video recording available at the following link: https://www.youtube.com/watch?v=42338gs066w.
[21] Ex. C – Application, pp. 8, 13
[22] Hearing Recording at 1:09:50 – 1:12:15
[23] Ex. C – Application, p. 9
[24] Ex. C – Application, pp. 7-8, 12, 16-17 (CHH and SVMC)
[25] Ex. C – Application, pp. 8, 589-612
[26] Ex. C – Application, pp. 8, 12
[27] Ex. C – Application, pp. 8, 12
[28] Ex. C – Application, p. 8
[29] Ex. C – Application, p. 12
[30] Ex. C – Application, pp. 9, 12; Ex. M – CMIR Related Records

HH.[31] These conclusions are supported by an analysis conducted using both OHS and HHC data.[32]

HHC has not terminated or reduced hospital service lines or scope of services, nor have there been any reductions in clinical staffing levels or staffing models, at any of the hospitals it has acquired within the last ten (10) years.[33] However, the Applicants indicate that there have been instances of hospital service relocations.[34] Additionally, HHC recently terminated labor and delivery ("L&D") services at Windham Hospital, which it acquired in 2009.[35] Prospectively, the Applicants have affirmed their intention to sustain emergency department and inpatient behavioral health services at the RGH campus consistent with requirements outlined in the Agreed Settlement in Docket No. 20-32405-CON.[36] The Applicants report that they may consolidate or relocate services post-acquisition, and while they expressed an expectation to, and interest in, expanding existing services offered under the MMH license, they have stopped short of fully committing to maintain all existing services.[37]

Many of the Applicants' assertions regarding their intention to preserve, expand and enhance access – while likely true and sincerely held – lack sufficient, necessary supporting documentation and evidence to ensure compliance therewith. Given the foregoing considerations and the importance of access to health care services, OHS imposes Conditions 1 through 8 set forth below.

b. Quality

The Applicants have established that the anticipated positive effect of the transfer of ownership on quality of health care supports approving the E-CON application, subject to the imposition of certain enumerated conditions set forth below.

Changes in Leapfrog Group safety grades are indicative of the positive impact a HHC acquisition can have on a financially-struggling hospital. Since joining HHC, SVMC's grade has improved from a "D" to an "A."[38] CHH's grade improved from a "C" to an "A," though it has since dropped slightly to "B."[39] These improvements coincided with what HHC reports as a $200 million investment in SVMC and a $72 million investment in CHH post-acquisition.[40] According to the Leapfrog website, MMH currently holds a "C"

[31] Ex. C – Application, pp. 9, 12; Ex. M – CMIR Related Records
[32] Ex. Y – Report, p. 19
[33] Ex. C – Application, p. 17
[34] Ex. C – Application, p. 17
[35] *See* Docket Nos. 08-31178-CON (acquisition); 20-32394-CON (termination of L&D); 22-32517 (civil penalty regarding termination of L&D)
[36] This matter concerned PECHN's request to consolidate MMH and RGH under one hospital license (MMH), which earlier this year resulted in an approval with conditions.
[37] Ex. C – Application, p. 11; Hearing Recording at 1:33:14 – 1:34:32
[38] Ex. C – Application, pp. 10, 16-17
[39] Ex. C – Application, pp. 10, 16-17
[40] Ex. C – Application, pp. 10, 17; Ex. Y – Report, p. 17

grade,[41] so there is similar room for improvement to that in HHC's prior transactions, at least in Manchester,[42] which could be achieved via the Applicants' planned capital investment of $225.7 million over the next three (3) years.[43] Importantly, OHCA[44] imposed a number of conditions on the transfers of ownership of both SVMC and CHH when granting those hospitals CON approval, and it is possible, if not likely, that at least some of the demonstrated quality improvements were due in part to compliance with those conditions.

Beyond the Leapfrog grades, though, HHC has also received a number of quality-related accolades at its existing hospitals.[45] Moreover, there have been no criminal investigations and all licensure inspections with any findings were resolved with plans of correction,[46] and there don't appear to have been any adverse private credentialing or accreditation actions taken against HHC or its affiliates within the past five (5) years.[47]

According to the Applicants, all HHC hospitals and ambulatory surgery centers currently participate in HHC clinical quality and safety counsels and adopt the best practice standards and protocols, and this will be extended to the acquired facilities.[48] The Applicants have also confirmed that they plan to upgrade the acquired entities to Epic electronic health record software likely within one (1) year of closing the proposed transaction.[49]

Nevertheless, recent peer reviewed literature generally does not provide support for the notion that hospital mergers and acquisitions lead to an increase in quality because the reduced degree of competition due to a merger reduces incentives to invest in quality improvement.[50]

Given the foregoing considerations and the importance of ensuring patient health and safety, OHS imposes Conditions 1 and 2 set forth below.

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[41] https://www.hospitalsafetygrade.org/h/manchester-memorial-hospital (last accessed December 3, 2025)
[42] RGH declined to participate. https://ratings.leapfroggroup.org/facility/details/07-0012/rockville-general-hospital-vernon-ct (last accessed December 3, 2025)
[43] Ex. C – Application, p. 12; Ex. Y – Report, p. 17
[44] OHCA became the Health Systems Planning Unit when OHS was created in 2018.
[45] Ex. C – Application, pp. 13-14. HHC is "Number one in the Nation" for mitral valve surgery based on data from the Society for Thoracic Surgeons ("STS"), "Best in the Nation" for Kidney Transplant and "Best in New England" for Infection Prevention. HHC hospitals have also been recognized by U.S. News and World Report as among the best in the country (High Performing) for Orthopedic Care, Pneumonia care, Hip and Knee Replacement, Chronic Obstructive Pulmonary Disease (COPD) care, Cardiovascular care, urological care, and cancer care. HHC is also the recipient of the American Hospital Association's 2025 Quest for Quality Prize.
[46] Ex. C – Application, pp. 18-19
[47] Ex. C – Application, p. 19
[48] Ex. C – Application, pp. 13-14
[49] Ex. C – Application, pp. 7-8, 14.
[50] Ex. Y – Report, p. 16

c. Affordability and Cost

The Applicants have established that the anticipated effect of the transfer of ownership on affordability and cost of health care supports approving the E-CON application, subject to the imposition of certain enumerated conditions set forth below.

Because the Applicants have established that the Proposal is financially feasible (*see* discussion in Section IV(f) below), it is unlikely that the anticipated capital expenditures associated with this Proposal will result in significant costs being passed onto patients. With this as a foundation, the Applicants go on to explain the various strategies and initiatives they anticipate extending to the to-be-acquired assets in order to increase affordability and control costs.

The Applicants assert that HHC participates with multiple public and private payers to improve population health, reduce the rate of unnecessary cost or utilization growth, improve access to primary care, and address the social determinants of health.[51] They further assert that through HHC's aligned programs, diverse value-based arrangements, care models and initiatives, there has been an overall improvement in quality and access to affordable health care across HHC's facilities.[52] Furthermore, the Applicants expect to offer the following initiatives to improve cost-effectiveness:

1. **Population Health**: bringing PCTMF physicians to HHCMG will bring additional lives under the HHC umbrella, allowing for enhanced population efforts.
2. **Uniform EHR**: will lead to more efficient delivery of health care, avoidance of duplication of services (and therefore unnecessary costs), and a reduction in long term maintenance costs.
3. **Standardization of Clinical Care**: provides the opportunity to reduce costs by enhancing outcomes, such as length of stay and readmissions.
4. **Cost-Effective High-Quality Care**: HHC's ambulatory network allows for the transition of care to the most appropriate and cost-effective setting. Additionally, the Applicants expect that their initiatives aimed at improving access will result in patients in the MMH area regaining trust in their community hospital, which is lower intensity and less resource intensive than HH.
5. **System Efficiencies**: HHC's past integration experiences position it to avoid unnecessary delays and failed initiatives, resulting in more cost-effective operational and clinical outcomes.[53]

Assuming MMH adopts the HHC system's Financial Assistance Policy, which the Applicants assert it will, such policy is significantly more generous than the existing PECHN policies.[54] Moreover, there have been no civil or criminal investigations,

[51] Ex. C – Application, pp. 13-14
[52] Ex. C – Application, pp. 13-14
[53] Ex. C – Application, pp. 14-15; *see also* Section IV(a) above.
[54] Ex. C – Application, p. 18. The Policy authorizes discounts for uninsured and underinsured patients from families with an income between 250% to 550% of the federal poverty level (FPL), while the PECHN hospital financial assistance policy provides for a sliding-scale discount covering households with a gross

citations, violations, enforcement actions or charges against the Applicants relating to improper or unlawful billing practices within the past five (5) years.[55]

Notwithstanding, inpatient and outpatient prices at MMH and perhaps even HH may, and indeed are even likely to, increase post-transaction as a direct result of the large, estimated changes that are anticipated in market concentration (*see* discussion immediately below in Section IV(d)).[56, 57] There are a few reasons to anticipate such price increases even though such increases were not seen following the CHH and SVMC transactions. First, HHC's market concentration was lower in the aftermath of those transactions, when it had fewer hospitals under its umbrella than it is today. Second, this transaction is different from the acquisitions of CHH and SVMC – most significantly, MMH is much closer to HH than either CHH or SVMC.[58] And third, OHCA and OHS imposed conditions on CHH and SVMC that were designed to control the costs of health care.[59]

Given the foregoing considerations and the importance of the affordability of health care, OHS imposes Conditions 7 through 10 set forth below.

d. Market Concentration

An assessment of the effect of the Proposal on health care market concentration supports approving the E-CON application, subject to the imposition of certain enumerated conditions set forth below.

Looking at the State of Connecticut as a whole provides a useful starting point for discussion. The formation of the HHC system began in 1998 with the affiliation of Hartford Hospital with MidState Medical Center.[60] Since then, HHC has acquired and/or affiliated with Windham Hospital, Natchaug Hospital, William W. Backus Hospital, The Hospital of Central Connecticut, CHH and most recently, SVMC.[61] In addition, HHC has

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annual income between 125% (where free care ends) and 400% of the FPL guidelines. The HHC Policy discounts can be as high as 75% of the patient's account. In addition, HHC provides "free care" or a 100% discount on covered services for patients whose gross annual family income falls at or below 250% of the FPL guidelines. This free care policy reaches more patients than the policies of the Prospect MMH hospital, which provide 100% discounts only to patients with gross annual family incomes of 200% of the FPL and 125% of the FPL respectively. Ex. C – Application, p. 18

[55] Ex. C – Application, pp. 18-19

[56] Ex. Y – Report, pp. 13-15

[57] *See* Section IV(d) below for a discussion regarding market concentration.

[58] Ex. Y – Report, p. 15

[59] *See* Docket No. 16-32135-CON (CHH) and Docket No. 18-32271-CON (SVMC)

[60] Ex. C – Application, p. 16; https://portal.ct.gov/-/media/ohs/ohca/hospitalstudy/midstatepdf (last accessed December 9, 2025); https://members.midstatechamber.com/news/member-news.asp?MemberID=6135&NewsID=1272&fromPage=0#:~:text=Since%201987%2C%20CQIA%20has%20recognized,date%20such%20news%20events%20occurred (last accessed December 9, 2025); https://midstatemedical.org/about#:~:text=MidState%20Medical%20Center%20is%20part,most%20comprehensive%20health%20care%20network.&text=Your%20browser%20can't%20play%20this%20video.&text=An%20error%20occurred.,HealthCare%2C%20Connecticut's%20largest%20healthcare%20system (last accessed December 9, 2025).

[61] Ex. C – Application, p. 16

significantly expanded its state-wide ambulatory network and affiliated system-wide medical foundation.[62] By one metric, HHC is already the largest health care system in the state. HHC currently has seven (7) general acute care (GAC) hospitals. The system with the second most GAC hospitals in the state, Yale New Haven Health System ("YNHHS"), only has four (4), so HHC will have double the amount that YNHHS has upon closure of this transaction.[63] In terms of bed capacity, HHC will overtake YNHHS as the largest system once this transaction closes (2,889 licensed inpatient beds for HHC > 2,556 licensed inpatient beds for YNHHS).[64] Based on FY2024 data, YNHHS is likely to continue to edge out HHC in percentage of inpatient discharges at least in the short term.[65] The same goes for operating revenue as well.[66]

Analyses more specific to local market concentration paint a different picture. The proposed transaction leads to a significant increase in local market concentration, for both inpatient and outpatient surgery services, regardless of whether viewed from MMH's primary service area (PSA) or HH's PSA.[67]

Given the foregoing considerations, the potential impact of market concentration on prices, and the importance of the affordability of health care, OHS imposes Conditions 7 through 9 set forth below.

e. Medicaid Access

An assessment of the effect of the Proposal on health care access for Medicaid recipients supports approving the E-CON application, subject to the imposition of certain enumerated conditions set forth below.

The communities served by MMH are recognized as high-need areas, with medically underserved populations and shortages of health care professionals, including primary care and mental health.[68] The percentage of admissions that are for Medicaid patients at MMH (18.5%) is roughly in line with that of other hospitals in the Hartford area, but

[62] Ex. C – Application, p. 16
[63] Ex. Y – Report, pp. 4-6; *see also* OHS' Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2023, p. 35 (https://portal.ct.gov/-/media/ohs/reports/ohs-annual-report-on-the-financial-status-of-connecticuts-hospitals-fy2023.pdf) (last accessed December 6, 2025).
[64] Ex. Y – Report, pp. 4-6. YNHHS will continue to have 2,556, but HHC will add 401 beds to its existing 2,488 beds.
[65] Ex. Y – Report, pp. 6-7. Combining HHC's and MMH/RGH's percentages results in 31.3%, which is less than YNHHS' 33.2%.
[66] OHS' Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals for Fiscal Year 2023, pp. 37, 73 (https://portal.ct.gov/-/media/ohs/reports/ohs-annual-report-on-the-financial-status-of-connecticuts-hospitals-fy2023.pdf) (last accessed December 6, 2025). In FY2023, HHC had a total operating revenue of $5,998,649,000 while YNHHS had a total operating revenue of $6,429,214,000. Adding MMH's ($221,976,082) and RGH's ($34,313,670) to HHC results in $6,254,938,752, which was $174,275,248 less than YNHHS.
[67] Ex. Y – Report, pp. 7-12
[68] Ex. C – Application, pp. 15-16

seems low when one considers the underserved population in its PSA.[69] HHC's Medicaid percentage is 19.4.[70]

Prospect MMH is currently a for-profit entity, but the Applicants will file for tax-exempt status for MMH to bring it in line with HHC's other non-profit hospitals. The Applicants anticipate that the Proposal will allow HHC to both maintain and enhance the scope of services provided (*see* Section IV(a) above), which will ensure that the needs of those more vulnerable populations continue to be met.[71]

In addition, as required by the Connecticut Department of Social Services' Medicaid Provider Enrollment Agreement,[72] HHC does not discriminate against any patients based on payer source, including Medicaid patients.[73] The Applicants assert that as a tax-exempt health system, it is the mission of HHC to serve all without regard to the ability to pay and that all provider entities within HHC participate in Medicaid.[74] The Applicants also assert that MMH will adopt HHC's Financial Assistance policy.[75]

Nevertheless, given the considerations regarding access generally as described in Section IV(a) above and the potential for those to impact the Medicaid population specifically, OHS imposes Conditions 1 through 6 set forth below.

f. Effect of the Hospital's Bankruptcy on Patients and Communities and the Applicants' Plans to Restore Financial Viability

Consideration of the effect of PECHN's bankruptcy on the patients and communities served by PECHN, and the Applicants' plans to restore financial viability, supports approving the E-CON application, subject to the imposition of certain enumerated conditions set forth below.

Regardless of one's views on private equity in healthcare, it is no secret that Prospect's ownership of MMH and RGH, and the subsequent bankruptcy, has had a negative effect on patients and communities. As described in the Office of the Attorney General's draft complaint, Prospect and its owners borrowed heavily on the hospitals to pay a half-billion-dollar dividend, then covered the loan with a sale-leaseback agreement, selling the hospitals' physical plants to a real estate investment trust (REIT) (Medical Properties Trust, Inc. [MPT]) that leased the property back to Prospect in exchange for unsustainable annual lease payments.[76] This is common practice when private equity, such as Leonard Green & Partners'-owned Prospect, takes ownership of health care

[69] Ex. Y – Report, p. 18
[70] Ex. Y – Report, p. 18
[71] Ex. C – Application, pp. 15-16
[72] https://www.ctdssmap.com/ctportal/portals/0/staticcontent/publications/enrollment_agreement.pdf (last accessed December 6, 2025)
[73] Ex. C – Application, pp. 15-16
[74] Ex. C – Application, pp. 15-16
[75] Ex. C – Application, p. 18
[76] Ex. C – Application, pp. 484-524; Ex. U – Public Comment (Attorney General)

facilities.[77] And it is likely these and other similar practices can be directly linked to a lack of investment in MMH that allowed for the cyberattack in August 2023, a decline or at least lack of improvement in quality and safety, and ultimately the bankruptcy.[78]

In contrast, HHC is not backed by private equity and the proposed transaction will not result in HHC having a future relationship with a REIT such as MPT at MMH.[79] Moreover, it is clear that the Proposal is financially feasible for the Applicants. HHC maintains strong investment grade ratings of "A" from S&P and "A+" from Fitch with Stable outlooks.[80] Commensurate with its ratings, balance sheet and leverage metrics, HHC has sufficient ability to fully fund the purchase price through equity (operating cash and investments) or debt (outstanding undrawn lines of credit or bridge financing).[81] The Applicants assert that additional funding for capital investments will be generated both by HHC-specific capital investments and MMH-generated revenue.[82] And perhaps most importantly, the Proposal includes the buy-back of the real estate on which the hospitals reside, removing MPT from the picture and bringing full control of the real estate assets back into Connecticut.[83]

All of this – when combined with the Applicants' tentative plans post-acquisition – supports the conclusion that they will restore MMH's financial viability in both the short-term and long-term.

V. Conditions

The E-CON Law permits OHS to impose "any condition on an approval of an emergency certificate of need application," provided that (1) "any such condition is consistent with the purposes of sections 19a-630 to 19a-639f, inclusive, of the general statutes"; (2) the unit weighs "the value of imposing such condition in promoting the purposes of sections 19a-630 to 19a-639f, inclusive, of the general statutes with the cumulative burden of imposing such condition on the applicant and any other transacting parties in the hospital's transfer of ownership"; (3) for each condition, OHS includes "a concise statement of … the legal and factual basis for such condition, and … which criterion of health care cost, quality or access in the affected area that the unit

[77] Ex. C – Application, pp. 484-524; Ex. U – Public Comment (Attorney General); https://www.grassley.senate.gov/imo/media/doc/profits_over_patients_budget_staff_report.pdf (last accessed December 6, 2025)
[78] Ex. C – Application, pp. 484-524; Ex. U – Public Comment (Attorney General); https://www.grassley.senate.gov/imo/media/doc/profits_over_patients_budget_staff_report.pdf (last accessed December 6, 2025)
[79] Ex. A – Application, pp. 10-11
[80] Ex. C – Application, pp. 19-20; Ex. Y – Report, p. 20
[81] Ex. C – Application, pp. 19-20; Ex. Y – Report, p. 20
[82] Ex. C – Application, pp. 19-20; Ex. Y – Report, p. 20
[83] Ex. A – Application, p. 11

intends such condition to promote"; and (4) each condition is "reasonably tailored in time and scope."[84, 85]

For the specific reasons articulated at various points in Section IV above, OHS imposes the following conditions:

1. **[Access and Quality]** Within nine (9) months of the closing date, HHC MMH shall complete an initial community health needs assessment (CHNA), as described in 26 C.F.R. § 1.501(r)-3.
    a. In addition to the requirements listed in 26 C.F.R. § 1.501(r)-3, HHC MMH shall:
        i. Hold at least one (1) community meeting for the initial CHNA open to any member of the general public who wishes to share comment on the CHNA prior to its publication. Such community meeting may be held in-person, virtually, or in a hybrid meeting fashion;
        ii. Publish notice of any meetings open to the public on its public internet website and provide such notice to OHS to publish on the OHS website;
        iii. Address the needs of the communities for both the community surrounding the RGH campus and for the community surrounding the MMH main campus;
        iv. Submit the final CHNA to OHS for posting in the CON portal under this docket; and
        v. Submit the final implementation strategy, as described in 26 C.F.R. § 1.501(r)-3(c) to OHS once completed consistent with that subsection.
2. **[Access and Quality]** Within nine (9) months of the closing date, HHC MMH will provide OHS with an initial assessment of the condition of MMH/RGH and its operations and a strategic integration plan for (1) incorporating MMH/RGH into the operations of HHC and (2) improving quality, access, and affordability of healthcare in the MMH/RGH communities with definable benchmarks. To the extent that such benchmarks are not required to be reported on elsewhere in this document, HHC MMH shall report within one (1) year of closing and annually thereafter for four (4) additional years on achievement of its stated benchmarks and measures.
3. **[Access]** For a period of three (3) years from closing the transaction, HHC MMH shall provide notification to OHS within thirty (30) days of the effective date of any

[84] E-CON Law, Section 1(c)(2)
[85] Individuals who submitted public comment have requested that OHS impose several conditions on the Applicants. *See* Exs. R, T – X. Specifically, it was requested that OHS require the Applicants to: (1) fully fund and assume pensions; (2) honor all collective bargaining and employment contracts, including all provisions; (3) release all physicians from their non-compete agreements; (4) implement and maintain an open medical staff policy; and (5) re-open closed inpatient and ICU services at the Rockville campus. Requests (1)-(4) would exceed the scope of OHS's authority as articulated in Public Act No. 25-2. Request (5) is contrary to the intent of the MMH-RGH consolidation, and even if that were not the case, would undermine HHC's efforts to restore the financial viability of the facilities and improve quality, accessibility, and affordability of health care.

decision to reallocate inpatient beds or relocate outpatient services between the MMH and RGH campuses.

4. **[Access]** HHC MMH shall maintain a 24/7 Emergency Department in the town of Vernon for a period of at least three (3) years from the close of the transaction.
5. **[Access]** HHC MMH shall maintain the full complement of inpatient behavioral health services currently provided under the combined MMH-RGH license, provided that HHC MMH may relocate such inpatient behavioral health beds within thirty (30) miles of the RGH campus. The relocated inpatient behavioral health beds may not be substituted for existing inpatient behavioral health beds presently located at the other location or in existence at the other location at the time of relocation.
6. **[Access]** HHC MMH shall maintain or enhance the services offered under the MMH license. HHC MMH shall not terminate any service offered under the MMH license until at least the later of (1) three (3) years from the closing of the transaction or (2) ninety (90) days after the publication of the second CHNA under 26 C.F.R. § 1.501(r)-3. Further, any proposed material reduction in service shall require prior approval of OHS. In seeking such approval, HHC MMH shall provide an analysis of utilization patterns, staffing for the services referenced for reduction, a data supported assessment of community need for such service, a rationale for reduction of the service, and evidence that HHC MMH has employed reasonable efforts to sustain the service without reduction. This condition shall not apply to (A) the outpatient laboratory services, provided such services continue to be furnished pursuant to contract with HHC MMH, or (B) the MMH hospital outpatient department (HOPD) urgent care services, provided such services continue to be delivered in the MMH PSA.
7. **[Cost and Access]** HHC MMH shall adopt all existing payer rates for MMH in place at the time of closing the transaction.
8. **[Cost and Access]** All payer contracted rates for HHC MMH shall continue to be negotiated separately from each other hospital. HHC MMH shall continue to abide by Connecticut General Statutes ("C.G.S.") § 38a-477i and shall neither include nor seek to include any all-or-nothing clause, anti-steering clause, anti-tiering clause, or gag clause in any healthcare payer contract.
9. **[Cost]** For any contracted price increases negotiated to take effect after the closing date for commercial payor contracts whose rates will take effect in the three years following the close of the transaction, HHC MMH shall not contract for a price increase[86] in excess of the average of (1) the Health Care Cost Growth Benchmark Target[87] and (2) the Consumer Price Index for Medical Care in New England, all urban consumers (CPI), not seasonally adjusted.[88] This price

[86] For purposes of this condition, a price increase means an annual rate trend increase, provided that rates may be redistributed on a rate trend neutral differential basis for all such services at the hospital. The rate trend neutral differential basis is calculated based on the weighted average rate increase across all services billed by the hospital under that payer contracted rate. Therefore, the price growth constraint, once applicable, limits the growth of the annual rate trend for each payer contract.
[87] C.G.S. § 19a-754f *et seq*.
[88] The CPI shall be determined by taking the difference between the published CPI for December of the immediately preceding calendar year and published CPI for December of the year prior to that, measured

constraint shall not take effect until the average commercial prices across all commercial payer contracts is equal to, or in excess of, 262% of the Medicare rate for the same set of services.

10. **[Cost]** HHC MMH shall not convert any of the existing ECHN or MMH outpatient, non-hospital physician offices or other facilities or providers, nor any future acquisition of such providers, to hospital-based status for billing or reimbursement purposes for a period of three (3) years from the closing date of the transaction. The purpose and intent of this condition is to ensure that new and existing off-campus non-hospital providers continue to bill as non-hospital entities and will not bill for hospital facility fees or under a hospital fee schedule. This condition shall not prevent any such conversion or establishment of a HOPD site under a hospital license if necessary for HHC MMH to achieve any cost savings provided no hospital facility fee is billed to the patient or responsible payer.

Nothing in this Decision shall be construed to limit the authority of any other state agency including, but not limited to, the authority of the Office of the Attorney General and the Department of Public Health, on matters that include, but are not limited to, licensure determinations.

VI. Conclusion

Based upon the foregoing, the Emergency Certificate of Need application for HHC MMH to acquire certain assets of PECHN, as well as imaging equipment owned by Prospect MMH, PECHN's medical foundation, and ownership interests in three joint ventures held by PECHN and its affiliates, is **APPROVED WITH THE ENUMERATED CONDITIONS**.

The foregoing constitutes the final order of the Office of Health Strategy in this matter.

By Order of the Office of Health Strategy

Amy Porter
Acting Commissioner

12/10/25
Date

at the time of the negotiated increase, provided, however, in no event shall the CPI be less than zero percent (0%). The CPI is published monthly by the U.S. Bureau of Labor Statistics on their website.