STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH STRATEGY

RADIOLOGY ASSOCIATES OF HARTFORD, P.C. AND EASTERN RADIOLOGY AFFILIATES, LLC

ACQUISITION OF IMAGING EQUIPMENT

DOCKET NO. 19-32322-CON

FEBRUARY 27, 2020

10:00 A.M.

DEPARTMENT OF PUBLIC HEALTH
470 CAPITOL AVENUE
HARTFORD, CONNECTICUT

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. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Strategy, in the matter of Radiology Associates of Hartford, P.C. and Eastern Radiology Affiliates, LLC, Acquisition of Imaging Equipment, held at the Department of Public Health, 470 Capitol Avenue, Hartford, Connecticut, on February 27, 2020 at 10:00 a.m. . . .

HEARING OFFICER MICHEALA MITCHELL: Good morning. Can everyone hear me well? Everyone is nodding.

This public hearing before the Health Systems Planning Unit, identified by Docket No. 19-32322-CON, is being held on today, February 27th of 2020 to consider Radiology Associates of Hartford, P.C. and Eastern Radiology Affiliates, LLC’s application for the acquisition of a 3T MRI and 64-slice CT scanner at its proposed Bloomfield location, and, also, for the transfer of ownership of three existing CT scanners and two existing MRI scanners owned by Radiology Associates of Hartford at other locations to Eastern Radiology

Affiliates, LLC.

This hearing is being convened pursuant to Connecticut General Statute 19a-639a and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Micheala Mitchell. I have been designated by Victoria Veltri, who is the Executive Director of the Office of Health Strategy, to serve as the Hearing Officer for this matter.

The staff members assigned to this case are Brian Carney and then, also, Jessica Rival. The hearing is being recorded by Post Reporting Services.

At this time, I just want to make sure that, whenever I say HSP, that you know that that is the Health Systems Planning Unit.

I'm going to ask all of the people that are going to comment or render testimony that, if you opt to use any acronyms, that you define the acronym first, as well.

In making its decision, we will consider and make written findings concerning the principles and guidelines that are set forth in Section 19a-639 of the Connecticut General Statutes.

Specifically, we are going to consider whether there's clear public need for the proposed transaction, whether the Applicant has satisfactorily demonstrated how the proposal will improve quality, accessibility and cost effectiveness of healthcare delivery in the region, and whether the Applicant has satisfactorily demonstrated that the proposal will not negatively impact the diversity of healthcare providers and patient choice in a geographic region.

The Applicants, Radiology Associates of Hartford, P.C. and Eastern Radiology Affiliates, have been designated a party in this proceeding, and, additionally, Jefferson Radiology has been designated as an Intervenor with full rights, and that means that Jefferson Radiology will be permitted to Cross-Examine the Applicant's witnesses.

At this time, I'm going to ask staff to read into the record those documents already appearing in HSP's Table of Record in this case. All documents have been identified in the Table of Record for reference purposes.

MR. BRIAN CARNEY: Good morning. At this time, I would like to enter into the record Exhibits A through CC.

We also have two additional records to add, Exhibit DD, the Applicant's request to strike, and Exhibit EE, ruling on the motion to strike.

HEARING OFFICER MITCHELL: I'm going to start with the Applicants. Are there any objections to the inclusion of these documents into the record?

MS. MARY MILLER: No.

COURT REPORTER: I'm sorry. You need to have a microphone in front of you.

MR. ADAM ROSE: For the sake of efficiency, we combined really two documents in one. We styled the document that was filed last night as a rebuttal and a request to strike, and, so, we understand that the request to strike has been denied, but we want to make sure that the rebuttal and the points that were made is being allowed into the record and considered.

HEARING OFFICER MITCHELL: All right. And, then, Attorney Volpe?

MS. MICHELE VOLPE: Yeah, hi. Michele Volpe, legal counsel for Intervenor, Jefferson Radiology.

We're objecting to the motion in the record that's been labeled DD on the rebuttal and motion to strike, specifically because Applicants filed it at 10:30 last night. It's nearly a 30-page document, some

of which in the rebuttal is irrelevant to these proceedings. Specifically, one of the exhibits.

The Intervenor has been denied their right to offer a rebuttal to the rebuttal that's been presented, and we also want to have on the record the fact that Applicant has had in excess of a month to put forth additional testimony and supplements to their application, and we think that we are in a jeopardized position having to respond just receiving this this morning.

The other point we want to make is that Applicants reference the Statewide Health Plan as being old. The Statewide Health Plan is updated regularly and yearly and has been updated in the last three times since the 2012 submission.

And we would also propose that Applicants have had our testimony since Monday. We voluntarily submitted our pre-filed testimony earlier than this office required as part of their ruling, so they've had additional time, and I don't think it's reasonable to allow the Applicants to have more time than the statute and the administrative proceedings allow.

The administrative law makes it clear, you know, when the filings for the Applicant have to be made,

and, in this specific CON proceeding, Applicants have had more time than most Applicants, on account of the delay in the hearing, and also have had additional time than was required with our pre-filed testimony, as evidenced by the fact that we offered it early on Monday.

MR. ROSE: So this is Adam Rose, one of the attorneys for the Applicants today. I'm here with Mary Miller.

I want to be very clear that the document that I'd like to be considered is a rebuttal to the pre-filed testimony that was submitted in two parts, and we are talking a matter of days, and I think that document, itself, contains a lot of important information that pertains to the pre-filed testimony, and, so, as the Applicant is trying to just prove facts and make arguments, we understand that the role of Intervenor is to try to attack our application and our facts.

Cross-Examination is one way of trying to get the agency to understand, you know, peel back the layers and understand what's really behind the statements and facts in the testimony.

However, as the length of the document shows, it was so exhaustive that, in lieu of having to cover every single one of the misstatements or statements

of law, we wanted to have a written document that could be considered by everyone in a timely manner.

I have no issue with Intervenors in writing responding. Our goal is to have the agency flesh out the arguments and have everything, without turning it into a, you know, Cross-Examination session today.

HEARING OFFICER MITCHELL: Let me ask. Attorney Rose, are your witnesses prepared to present that rebuttal through their testimony today?

MR. ROSE: So our pre-filed testimony has our affirmative arguments, as to why the application should be approved, but, related to misstatements made by Dr. Foxman in his testimony, the Applicants are aware of those, but they haven't catalogued them, and I'm not sure where in the testimony portion of the proceeding they would have an opportunity to go through and catalogue those, which is why the --

You know, the rebuttal document, itself, again is, if we could ask, if you want, we could restyle that as additional testimony of the Applicants and then file it, and, so, they don't have to read the document into the record today.

HEARING OFFICER MITCHELL: Any response on that? I'm sorry. I'm sorry. Just one moment.

MS. MILLER: Another option, of course, is, if it would work better for you procedurally, is I do believe that the President of RAH would be happy to adopt it as his testimony, but that seemed more logical to me, again, than reading it point-by-point, and, if you have questions on it, could obviously answer the questions about them then.

That might be more logical for the record as late-filed testimony.

MS. VOLPE: So, first of all, everything that's being proposed is inconsistent with the Administrative Procedures Act, and, you know, we would -- the Applicants have the burden of proof.

They have their time allotted this morning. They could use that time how they deem appropriate. I don't think it's reasonable to allow a late file from 10:30.

I know that this Commission, this Office, doesn't take into account precedent, but it is inconsistent, and it would be highly unusual to allow that type of filing to come in at that time period.

If this Office is going to permit even portions of that filing to come in, we would ask that we have an opportunity to submit a filing refuting and

rebutting those and that the proceedings be closed after our filing is submitted, so there isn't allowance for further rebuttal.

I agree with my colleague, Rose, that we are here to get at the truth and the facts and apply them to the law, which every Applicant is held to the same standards under the CON statute, and that's all we're trying to ensure today, so, again, I think it's unusual to not allow -- to allow filings that are inconsistent with the Administrative Procedures Act and the time period for filing or to turn a rebuttal into pre-filed testimony, which we would vehemently object to.

So if it is within your discretion, Hearing Officer Mitchell, if you are going to allow it, we would ask that we be afforded an opportunity to file a rebuttal and that, after that filing is done, that the proceeding, the record be closed.

MS. MILLER: I think it could be fair. We are rebutting essentially in lieu of Cross-Examination, in an effort to move this proceeding along, so, given that it was testimony, we're using it instead of Cross-Examination.

I think, if counsel wanted to file essentially Redirect, especially within a reasonable

amount of time, you consider the fact that that rebuttal was put together in a day, like a day or two to Redirect seems fair, and then to close after that.

MS. VOLPE: I don't know where the days come in, but I think it's up to the Hearing Officer to determine that.

MS. MILLER: Sure. Obviously, we did that within --

HEARING OFFICER MITCHELL: I don't want you guys to talk to each other.

MS. MILLER: My apologies, Hearing Officer Mitchell.

HEARING OFFICER MITCHELL: I want you to talk to me. It's okay. So here is what I am prepared to do. So I, after listening to both parties, I do believe that the Intervenor should have an opportunity to respond to the rebuttal, if I'm going to allow it to come in.

I'm going to allow it to come in. The motion to strike, again, was denied, but, in terms of the rebuttal, I'm going to allow that to come in.

We're going to allow the Intervenors the opportunity to respond to what is in the four corners of the document, in terms of responding to what they have asserted is either erroneous or inconsistent with what

you have submitted, and I will give three days on that, and that's three calendar days.

MS. VOLPE: Okay, so, if you're going to allow the four corners in, I guess one item we have to object to is an exhibit that was submitted, as it's completely irrelevant to these proceedings, and it's correspondence between Jefferson Radiology and the Division of Nuclear Materials.

I mean that's inappropriate for that to come in in these proceedings, so, if you're going to allow this to be part of the table, we ask that this not be part of the record.

HEARING OFFICER MITCHELL: Any response on that, Attorney Rose?

MR. ROSE: We will allow that. We'll just establish on Cross-Examination the ownership transfer of Jefferson. This was just used to prove that it's public records that Jefferson Radiology has transferred ownership. We'll establish it on Cross-Examination, so we're willing to do that.

HEARING OFFICER MITCHELL: Amenable to that, Attorney Volpe?

MS. VOLPE: Yes. So, just to be clear, so this will be taken out of the record and won't be made a

matter of --

MR. CARNEY: So Exhibit DD's sub Exhibit E, correct?

MS. VOLPE: Correct.

MR. CARNEY: Okay.

MR. ROSE: And, for the record, I found that on a Google search and just printed it from the internet.

MS. VOLPE: Yeah, and, for the record, Hearing Officer Mitchell, everything in our pre-filed testimony is a matter of public record for the Applicant.

Everything in our pre-filed testimony is from the Statewide Health Plan or from publicly-available data and information that's been filed with this agency.

HEARING OFFICER MITCHELL: All right, so, let me just make sure that I've got this correct. So we are going to, and I think, Brian, you indicated with her, so Exhibit E and DD, Attorney Rose, are you amenable to us excluding that, with the exception that we are going to acknowledge that that transaction took place?

MR. ROSE: Yes.

HEARING OFFICER MITCHELL: Is that what you said? Okay. I just want to make sure. Attorney Volpe?

MS. VOLPE: Yes, thank you.

HEARING OFFICER MITCHELL: Okay. And turning back just to the Table of Record, any other objections to anything in the Table of Record, Attorney Rose? Attorney Volpe?

MS. VOLPE: No. Just that our rebuttal will be added to the Table of Record.

HEARING OFFICER MITCHELL: Right. All right, so, what's going to happen now is that the Applicants will present a 10-minute overview of the proposed project by way of Direct testimony.

The Intervenor will then be allotted 10 minutes to provide its testimony. I'm going to allow for public comment directly thereafter.

It's my understanding that the Applicants have physician witnesses that cannot stay for the duration of the hearing, so we'll do that, and then, afterward, the Applicants are going to have the opportunity to Cross-Examine Intervenors. Intervenors are going to have the opportunity to Cross-Examine the Applicants. We will ask questions after the Cross-Examination has taken place.

Following questions, I will, then, turn it back over to the public, if there's any members of the

public that still want to make a comment.

At this time, I'm going to ask all of the individuals that are going to testify to raise their right hand for me, so that the court reporter can swear you in.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER MITCHELL: All right, so, before you testify, just make sure that you state your full name and, also, that you are adopting your pre-filed testimony.

At this time, I'm going to turn it over to the Applicants.

MR. MICHAEL TWOHIG: Good morning, Hearing Officer Mitchell and members of the Office of Healthcare Strategy. My name is Dr. Mike Twohig. I'm a physician shareholder in and President of Radiology Associates, P.C., which we'll refer to as RAH, or R-A-H, and Eastern Radiology Affiliates, LLC, which we'll refer to as ERA.

And I also serve as Chairman of the Department of Radiology at St. Francis Hospital and Medical Center, and I adopt my pre-filed testimony.

I intend to keep my remarks brief today, because we have a lot of information that has already

been submitted, and we at RAH respect your time.

I will be happy to answer any questions you have, though, and I'm very excited, very excited about what this will mean as we bring this type of change to the communities we serve.

Very simply put, the proposal addresses every single consideration with respect to acquiring new imaging equipment. The community need is demonstrated by existing MR and CT capacity in a service area, evolving demographic trends, increased advanced use of advanced imaging, as well as extraordinary growth that RAH has experienced in the last year.

The introduction of this equipment in Bloomfield will also serve to improve the quality of and access to advanced imaging while reducing costs as part of a clinically-integrated network to manage the total cost of care.

As you will hear from my colleagues and read in the materials we submitted, this proposal is critical to RAH's efforts with the physicians and hospitals we work with within a risk-bearing clinical entity to ensure the highest level of advanced imaging in the lowest cost setting, and I urge you to approve this application. Thank you.

DR. ANTHONY POSTERARO: Good morning, Hearing Officer Mitchell and members of the Office of Healthcare Strategy.

My name is Anthony Posteraro, and I'm a shareholder physician of Radiology Associates, P.C., also known as RAH, and I also serve as the Director for Cross-Sectional Cardiovascular Imaging and the Director of Nuclear Medicine at St. Francis Hospital and Medical Center.

I also serve on the Board of Directors of St. Francis Hospital and the Board of Directors of Southern New England Healthcare Organization, or SOHO.

I will also be brief in my remarks today, as I know you've read the materials we've submitted, and, for the record, I adopt my pre-filed testimony.

This application to acquire CT and MR equipment in Bloomfield and to transfer ownership of RAH's imaging equipment to Eastern Radiology Associates is an important part of RAH's strategy for best serving the needs of our clinically-integrated network in the communities we serve.

We propose to move advanced imaging out of the hospital setting into the community, in order to improve access in managed cost of care and to create a

more flexible model of financial -- to share financial risk associated with these efforts.

These efforts are critical in moving advanced imaging into a value-based care model, and we have demonstrated in our papers how our proposal is supported by existing capacity for service and transient utilization.

Our collective experience and passions, clinicians and business professionals stands behind this proposal after careful consideration and a great deal of work.

I can say with confidence this proposal reflects the right equipment in the right setting at the right time, and, as such, I urge your approval. Thank you.

MS. KATHLEEN SMITH: Good morning, Hearing Officer Mitchell and members of the Office of Health Strategy.

My name is Kathy Smith, and I'm the Practice Administrator for Radiology Associates of Hartford and Eastern Radiology Affiliates, and I adopt my pre-filed testimony.

I have come before you today to testify regarding my experience with managing RAH's current

imaging sites, which, except for Bloomfield, includes CT and MR services.

You have heard from my colleagues how RAH has been actively working with physicians and hospitals within the SOHO network to produce the most beneficial diagnostic information to support optimal patient care at the lowest financially-prudent cost.

These efforts have resulted in extraordinary growth over the past year in RAH's MRI and CT services, providing the need for those services to continue in their current locations, yet RAH and SOHO have also identified a need for an additional community-based MRI scanner and CT scanner to complement the services currently being provided at RAH's Bloomfield site.

The need for this equipment is based on the network's plans to further improve patient access and produce the best possible diagnostic information in a manner that can reduce cost of the services while providing the highest quality care to the patient.

RAH's proposal to achieve this goal through ERA is also supported by my analysis of the capacity and trends in the service area.

I feel confident sitting before you today

that our proposal provides for the right imaging platform to meet the needs of our network physicians and the communities that we serve.

Thank you for your time and consideration, and I urge you to approve this application.

HEARING OFFICER MITCHELL: Thank you. Anything additional, Attorney Rose?

MR. ROSE: I just want to say, very briefly, and I apologize that you guys have bore the brunt of it, we worked extraordinarily hard in trying to make everything crystal clear, point-by-point and organized for you, and I think each of these individuals have been breaking their back to articulate things.

You know, they're not professional witnesses, so, you know, be patient with some of their answers today. We're all a little nervous, because this is very important.

HEARING OFFICER MITCHELL: Got it. Anything additional?

MR. ROSE: No.

HEARING OFFICER MITCHELL: Attorney Volpe?

MS. VOLPE: Okay. Good morning, Hearing Officer Mitchell, Mr. Carney, Ms. Rival. We really appreciate the opportunity to be here today.

My name is Michele Volpe again, counsel for Jefferson Radiology, Intervenors in this proceeding. The pre-filed testimony and the remarks offered today establish that Applicants have not met their burden of proof on the CON before you.

Dr. Foxman is here today. He's going to provide some additional testimony on top of his pre-filed testimony to provide information and support on why the standards under the statute for the CON have not been met in this application, and I'd like to introduce Dr. Foxman now, who will adopt his pre-filed testimony.

DR. ETHAN FOXMAN: Thank you. Good morning, all. My name is Dr. Ethan Foxman, and I am President of Jefferson Radiology. I adopt all my pre-filed testimony.

Before I turn to my prepared comments, I would like to say good morning to Dr. Twohig and his colleagues and share that my colleagues all hold Dr. Twohig and his colleagues in high regard for their professionalism and dedication to patient care, and I know that the discussion today is focused on a different sphere, which is matters of the CON.

I'll return to my prepared comments. Jefferson Radiology has been providing radiology services

to the Greater Hartford Area for over 50 years.

We have been before this agency's predecessor, OHCA, numerous times, and I thank you for the opportunity to speak to you again today.

I am here to respectfully request that OHS deny RAH's application. The request to acquire a 64-slice scanner in Bloomfield, the request to acquire a 3.0 Tesla MRI in Bloomfield, and the request to transfer the technical component of all its MRI and CT scanners to ERA do not meet CON requirements.

My pre-filed testimony offered detailed analysis of a significant failure of RAH, R-A-H, to satisfy its burden of proof.

This morning, I will address some of the major elements of the CON statute that RAH has failed to meet. These elements are, one, to properly identify the service area and the patient population to be served; two, there's no clear public need for either a CT or MRI scanner; three, there is no improved quality, accessibility and cost effectiveness of healthcare delivery from the desired equipment; four, the project is not financially-feasible and is a costly duplication of services; five, there's no clear public need to transfer the technical component from RAH to ERA, and this request

does not identify who the investors are or the terms of their ownership.

I'll address each of these five areas of concern. First, the service area. RAH fails to properly define its service area. We have a Statewide Health Plan, which tells us how to define a service area, which RAH has ignored.

Clear public need, community need is what is required, and RAH has failed to address community need by virtue of its contrived service area.

By its own admission, RAH is only using a subset of its service area. Moreover, that subset is based on a referral network of S-O-H-O, which I believe was introduced previously, the acronym. Neither of these are in accordance with the Statewide Health Plan.

By manipulating and limiting its proposed service area, RAH fails to account for the excess capacity in the market. RAH bases this entire need on that of the Southern New England Healthcare Organization, SOHO, yet does not incorporate SOHO's full service area.

By way of example, my supplemental pre-filed testimony identifies a significant number of additional MRI standards that must be considered.

Two, there is no clear public need for

either CT or MRI scanner. RAH does not address how the CON serves the community. RAH's in-network contrivance is not a determinant of need.

RAH is requesting this equipment for its own subset of covered lives as a matter of convenience and contrivance to capture ancillary revenue.

Networks, such as SOHO, primarily serve commercial payer agreements. This convenience does not address community need or Medicaid and low income personal need.

Where is the consideration for the rest of the community? What need is being met, other than the in-network referral capture? Network need does not equate to clear public need.

Three, there's no improved quality, accessibility and cost effectiveness of healthcare delivery from the desired equipment.

Accessibility is not improved by adding MRI and CT scanners to an area that already has excess capacity. RAH's Avon CT scanner, a town one over from Bloomfield, has historically been underutilized.

Furthermore, RAH cannot substantiate an argument for greater access for Medicare patients. RAH suggests it will have an overall Medicaid patient base of

12 percent when its existing standard in Avon is under two percent.

What factors support a 10 percent jump in Medicaid patients for the same service area? The Medicaid population in towns do not support it. This difference has not been explained.

RAH has failed to prove there will be improved access for CT, as there are multiple CT scanners in the Applicant's service area that are below the statewide healthcare facilities and service plan volume requirements.

A new CT scanner in the Applicant's purported service area was just approved by this agency mere weeks ago.

RAH has failed to carry its burden, but there will be improved access for MRI. There is already substantial capacity in RAH's subset of the service area, much of which is outpatient-based imaging, including open bore and 3T outpatient MRIs. Looking at the additional service area towns we've identified, there are over 40 MRIs available.

Four, the project is not financially-feasible and is a costly duplication of services. RAH presents information that the proposed scanners will meet

narrowly-focused Z-specific imaging needs, such as specific needs in MS, cancer and liver disease. These specific subset of patients are small, and their healthcare needs and comorbidities are significant.

Outpatient imaging equipment requires significant volume to remain cost effective. How can it be feasible for RAH to focus its services on these subset of patients while maintaining cost effectiveness? In fact, it does not appear that RAH will focus its services on these patients.

When reviewing the Applicant's Table C, where the stamp and body type is identified, the 3T MRI breakdown of scans is unchanged from the Applicant's historical data.

How does the 3T serve any additional function if it is proposed to serve the same type of patients?

Five, there's no clear public need to transfer technical component from RAH to ERA, and this request is not ripe for review.

Finally, RAH's request for moving its equipment to ERA is not ripe for review before this agency. The CON is completely void of any information, other than RAH is setting ERA up for investors.

Who are these investors? What will their ownership structure be? Are they even located in Connecticut? Are these owners good? Are these owners of good standing in the healthcare industry? Will the new owners require changes to the financial assistance policies? Will the new owners move equipment? Will the new owners shut down locations?

This is just a small sampling of questions that remain unanswered that show RAH is asking for approval on a transfer of imaging equipment without any supporting information.

On behalf of Jefferson Radiology, I respectfully request that OHS recognize the significant failures of RAH to uphold its burden of proof and this application be denied in full.

Thank you for your time, and I'm happy to answer any questions you may have of me.

HEARING OFFICER MITCHELL: Thank you. Anything else, Attorney Volpe?

MS. VOLPE: We would add that the Applicants -- we appreciate Attorney Rose's comments that they've worked very hard.

We all want providers and institutions to survive and thrive in Connecticut. All we ask is that,

to the extent that they feel they need this equipment, that they present it to this office in a manner that every other Applicant is required to do, and that is to follow the statutory provisions and comply with the Statewide Health Plan when it comes to defining the market and the service area and that it be consistent with the definition, as provided in the Statewide Health Plan, and not some contrived service area to support a really commercial-based in network analysis.

We would also add that their CON application was completely void of the Statewide Health Plan analysis. They tried to correct it in their pre-filed testimony, but, again, if you're not applying the Statewide Health Plan utilization imaging capacity to an appropriate service area, no matter what your numerator and denominator are, it's not going to be correct.

So we would dispute that, if you utilize an appropriate service area and apply all the providers in the service area, they proposed additional 2019 numbers, again, in a vacuum.

You can't -- there is a reason that all providers are required to submit their data and information and utilization to the State, and they're not falling under their own utilization for purposes of the

Statewide Health Plan.

By their own admission, they're falling into the category of all providers in the service area and the 85 percent, so you have to look at all MRIs. You have to look at all CTs in the service area in the market.

They have, and I'm going to close, but, as Dr. Foxman just noted, they have a CT that is well below the threshold one town over and within which this Commission has relied on a certain mile radius always historically, even though you don't rely on precedent, of a 10-mile radius.

If you relied on a 10-mile radius, the amount of imaging capacity and availability, there is excess capacity. There's excess capacity at Jefferson's equipment in this service area, so, again, we would argue that they may deem that they have need.

We would ask that they go back and present their need in a new CON in a format that's consistent with the law in the CON statutes and the regulations required.

Thank you for the opportunity today.

HEARING OFFICER MITCHELL: At this time, we're going to go forward with public comment.

(Whereupon, public comment was given.)

HEARING OFFICER MITCHELL: Back on the record. Okay, we're back on the record.

So, at this time, I just want to double check and make sure there are no additional public comments.

So we're going to move on to the Applicant's Cross-Examination of the Intervenors. I'll turn it over to you, Attorney Rose.

MR. ROSE: Hi. So this is Adam Rose, counsel for the Applicants.

I'm going to start with a couple of questions, and then my colleague, Mary Miller, is going to do most of the heavy lifting, but I just wanted to clarify a couple of things for the record.

Dr. Foxman, I just want to ask very succinctly is there a clear public need for a shift to risk-bearing value-based reimbursement?

DR. FOXMAN: Understood. I'm thinking through that question, and the thought in my head is that is an extraordinarily broad question, which is probably going to occupy public thought and debate over a period of many years and have many dimensions of thought threaded into that.

I just don't see that as a simple yes/no question, nor do I see myself in the capacity as a practicing radiologist and for the professional seats that I sit in as someone who could comment on something as broad as that.

I think that society is trying to figure out all the dimensions of that.

MR. ROSE: Okay and, in your testimony, you have focused on the fact that part of the application includes moving Radiology Associates of Hartford's equipment into a wholly owned subsidiary, ERA, and I just want to -- I want to confirm that you know that the 100 percent owner of ERA is Radiology Associates of Hartford. Are you aware of that fact?

DR. FOXMAN: My personal understanding of ERA is that it is still -- it's essentially an entity, which is awaiting transfers of ownership, and in the future would therefore be constructed as such that additional owners and members could participate in that entity and be a partial owner of that entity, along with potentially RAH, if, in fact, RAH puts modalities and assets into that entity.

MR. ROSE: Okay, so, I just want to confirm. You do understand that Radiology Associates of

Hartford, as part of this application, is the sole owner of ERA, yes or no?

DR. FOXMAN: In the current state, that's my understanding, yes.

MR. ROSE: Okay and, so, can a professional corporation, such as Radiology Associates of Hartford, sell 100 percent of its side to anyone that they want within the parameters of law and not have to get permission, Certificate of Need permission?

MS. VOLPE: I'm going to object to that.

HEARING OFFICER MITCHELL: On what basis?

MS. VOLPE: The fact that he's asking him a legal question. He's asking a doctor of radiology whether they could add shareholders to a professional corporation.

HEARING OFFICER MITCHELL: I'm going to allow the question, only because it was brought up that there was a possibility that there could be some additional buyers. I'm going to allow it, if you know. If you know the answer, you can answer.

DR. FOXMAN: So please refresh me, you know, because trying to follow the legal --

MR. ROSE: I'd be happy to rephrase. In September of, roughly, September 27, 2017, did Jefferson

Radiology, P.C. own MRI and CT equipment?

DR. FOXMAN: I'm trying to follow that, in terms of a rephrasing. I think we just went to another sphere. If you're asking in September of 2017 if Jefferson Radiology, P.C. owned equipment, is that right?

MR. ROSE: Yeah, or prior to then, or at that point.

DR. FOXMAN: Yes.

MR. ROSE: Okay and, on September 27, 2017, did 100 percent of the Jefferson Radiology Professional Corporation stock get sold to Curtis Pickert, who is now the sole shareholder of Jefferson Radiology, P.C.?

DR. FOXMAN: Sure. Yeah. A lot of that is in the public record for multiple reasons with the State Attorney General, with this agency.

Just to be very clear, Jefferson Radiology had membership interest. The membership interest was previously held by multiple radiologists over a period of time. Some would buy in. Some would buy out. They'd retire out. They'd buy in as junior partners.

And then the physician you mentioned is a physician under a friendly physician model that basically made Jefferson Radiology an affiliate of MEDNAX

Radiology, which is still in the process of setting up a multi-regional radiology network.

MR. ROSE: Okay and when you made that 100 percent sale of the stock of Jefferson Radiology --

MS. VOLPE: I'm going to object again.

HEARING OFFICER MITCHELL: On what basis?

MS. VOLPE: On the basis that Jefferson isn't in this proceeding today, and the action of Jefferson and its affiliation with MEDNAX or Hartford Hospital through CIP has been the review of this office on numerous dockets, has been before this agency for approval on CONs, on determinations, has been before the Attorney General's Office in filings, and everything is a matter of public record.

If they have questions, it's outlined in detail in the CON filings, so I don't see how it's relevant, and if we're going to talk about models and what was done with Jefferson and its affiliations and trying to compare it to RAH, we're comparing apples to oranges, because those applications, which you're referencing, were very detailed.

We identified who all the investors were, we identified who the governance was, and this application is completely void of that.

HEARING OFFICER MITCHELL: I'm going to ask you to respond to her objection.

MR. ROSE: Very simply, I'm trying to establish that, whether you're a Professional Corporation or a Limited Liability Company, if you own equipment, you can transfer 100 percent of the shares with respect to the equipment and not go and get a Certificate of Need.

You don't have to, then, go and appear before the agency and get a Certificate of Need to sell your stock, and that's evidenced by the fact that Jefferson did not have to get a Certificate of Need for MEDNAX to acquire that imaging equipment by virtue of selling 100 percent of the stock, and this is relevant to the proceeding, because, in the same way that Jefferson can sell its stock, RAH can sell its stock.

RAH is just moving the equipment into a wholly owned subsidiary, which is a better model to partner with other legal entities.

And I think the confusion that's caused by Dr. Foxman's testimony -- and I wanted to see whether he understands the principles at play, because they are legal in nature.

Attorney Volpe is correct, that some of these questions are legal, but one of our objections was

that Dr. Foxman's testimony actually is making legal arguments, so I'd like to just confirm and conclude this line of questioning with whether the sale of 100 percent of Jefferson Radiology, P.C.'s stock, even though it had imaging equipment, did that require a Certified of Need for MEDNAX to acquire that imaging equipment by virtue of buying the stock?

MS. VOLPE: And, again, I'm going to object that it's inappropriate. If you have a model that you want to put forth for your client and provide a determination to the State and let them review it and determine if it's appropriate, you should do it.

I mean that isn't what you've done in the CON application. You haven't provided a set of facts to support why you don't need a CON to do what you're doing. You're actually here before asking for a CON, so the fact that my client went through the regulatory process and analyzed the law and presented it to this office and the Attorney General in a way that allowed them proceed, you can avail yourself of the same thing. That's what we're saying.

You just haven't picked the appropriate forum or the appropriate way to do it. If you feel it can be done, do it. You haven't done it in this

application, and now you're trying to cure it by asking my client to opine on a legal analysis for a transaction they did years ago.

MR. ROSE: Yeah, this isn't an objection, by the way, so --

HEARING OFFICER MITCHELL: Yeah, I'm going to interject.

MR. ROSE: -- if you --

COURT REPORTER: I can only record one person.

HEARING OFFICER MITCHELL: Yeah, and I'm also going to interject. Let me just ask. What were you going to say in response?

MS. MILLER: I was going to request that she address you, Hearing Officer Mitchell, instead of us.

HEARING OFFICER MITCHELL: Yeah. I think she was just looking over there. Let me just say, so, the reason that you're going down this line of questioning is that, at this point, what is in the CON application is basically the acquisition of the two pieces of equipment for the new location in Bloomfield, and, then, also, the acquisition of the existing equipment by ERA.

I'm just kind of like summing it up, but,

basically, what it sounds like to me is we're talking about something that could potentially happen down the road, but is something that is not before this Office currently.

MR. ROSE: Yeah, and I think that's the confusion. What's before this Office today is whether ERA --

HEARING OFFICER MITCHELL: Could possibly.

MR. ROSE: -- is -- whether ERA can acquire imaging equipment, and if the question is, well, who owns ERA, it's RAH, and the fact that RAH could sell interest later exists both as a P.C. -- it exists today, it exists tomorrow, it's immaterial.

HEARING OFFICER MITCHELL: So I'm just going to make a statement that we're just going to stick to what's in the application before us.

You know, in terms of the CON statutes, when there is a transfer of ownership sometimes of radiology practices, you know, the acquisition of equipment or the, you know, transfer of equipment kind of eludes us, because of how the statutes are written, so that's understood, so I just think that we can maybe move on with the next line of questioning. Does that sound fair to both parties?

MS. VOLPE: Yes. Thank you.

HEARING OFFICER MITCHELL: Fair?

MS. MILLER: Good morning, Dr. Foxman. As I discussed with your counsel earlier, it is my intent to keep this Cross-Examination brief out of respect for your busy schedule, everyone's busy schedule here, so, because of that, I'm going to be doing a little bit of jumping around.

If you get confused by what my questions are and want me to repeat anything, I'm happy to do that. It may not seem like they're entirely connected. I do promise I don't have a line of questioning that goes on for more than about four or five questions, so we'll get to a point, but just to warn you. It's for everyone's benefit, I believe.

In your pre-filed testimony, you attempted to discredit RAH's projection that 8.1 percent of its Bloomfield CT patients would be on Medicaid, right?

DR. FOXMAN: That's correct. Could you show me or actually direct me to where you're referring, and I can turn to that page?

MS. MILLER: Sure. Take a moment. Page 13, Dr. Foxman. You do have the page now, Dr. Foxman?

DR. FOXMAN: Yes, I do.

MS. MILLER: So and you did that, and you can probably see right in your testimony, by pointing to the fact that only 1.7 percent of RAH's Avon CT patients are on Medicaid, is that correct?

DR. FOXMAN: That's correct.

MS. MILLER: So is it your position, then, that the towns of Avon and Bloomfield have identical patient populations?

DR. FOXMAN: They have similar patient populations.

MS. MILLER: Okay and Jefferson has CT scanners currently in both Avon and Bloomfield, is that correct?

DR. FOXMAN: That's correct.

MS. MILLER: Would you say that you see the same amount of Medicaid patients in Bloomfield and Avon?

DR. FOXMAN: My recollection of that is we see similar percentages.

MS. MILLER: Did you check the data, to your recollection, based on actually checking those numbers before filing the pre-filed testimony?

DR. FOXMAN: Yes. So when I say that, we prepared this statement with reference to our data.

Those sorts of numbers and things, in terms of knowing the precise number today, while I sit here, is something I have to refresh my memory on. That's what I meant by that.

MS. MILLER: Okay. You cited a report in your pre-filed testimony. It was just in the footnote. It was put out by the Department of Social Services regarding the people it serves. Do you recall that footnote?

DR. FOXMAN: Correct.

MS. MILLER: So that report states that DSS serves 7,264 Bloomfield participants, and that was in 2018, versus the 1,942 participants it served in Avon.

Based on that report that you cited, do you see that the percentage of Medicaid patients in Bloomfield might be higher than the percentage in Medicaid patients in Avon?

DR. FOXMAN: The way I understand that is we're talking specifically about Medicaid patients and that the Department, DSS, actually has noted that the population of Medicaid patients has actually diminished in the Bloomfield market.

MS. MILLER: But isn't it true they diminished from essentially 7,400 to 7,200, Dr. Foxman?

DR. FOXMAN: Correct. That's right.

MS. MILLER: Okay, so, it's still much higher than the 1,900 in Avon, correct?

DR. FOXMAN: The raw number is higher, yes.

MS. MILLER: Turning to page two of your pre-filed testimony, if you'd like the reference, you chose to compare RAH's fiscal year 2018 CT volumes to the Statewide Health Plan capacity I noticed, and you did not use the more recent fiscal year 2019 volumes that RAH provided, is that correct?

DR. FOXMAN: That is correct, yes.

MS. MILLER: You did have access to those numbers from RAH, though, didn't you?

DR. FOXMAN: Yes, we did have access to those numbers.

MS. MILLER: RAH had stated in fiscal year 2019 that it did 9,212 scans, and that's total for its Avon, Enfield and Glastonbury CT scanners. Do you have any reason to doubt the truth of that statement?

DR. FOXMAN: Sure. The way we understand that is that those are self-reported numbers. The numbers that we actually take reliance on are the numbers that are reported to the State, and we take reliance on

numbers that are reported by all organizations, so, in interpreting a service area, anyone who wants to interpret that service area needs the full compendium of everyone's reported data, and the data that we always look at is the data reported to the State, not a self-reporting of data. That has not been part of the normal reporting process via the State.

MS. MILLER: So your concern is that the growth seems to be incredible? That's the sense I got from your testimony, but let me know if that's not your concern.

DR. FOXMAN: There is some figures in here that were self-reported that show very significant growth.

MS. MILLER: Did you compare it with Jefferson's growth during that time period?

DR. FOXMAN: I have an awareness of Jefferson's growth during that time period, an awareness of just what the marketplace and our patient population sees with growth and what is organic growth and what would be expected growth, and when I see numbers that are significantly high, as my testimony is sorted out, that raises questions around allocation, some sort of one-off transition, but, again, it's hard to react to self-

reported single data without a full compendium of data, and my testimony I think made that clear.

MS. MILLER: And, so, you were saying you were searching for context. Did you compare it with Jefferson's growth in those same towns during that time period?

DR. FOXMAN: I have an awareness of Jefferson's growth in general, because it's the practice that I live and work in.

MS. MILLER: Did it grow during that time period?

DR. FOXMAN: Jefferson Radiology has multiple dimensions to Jefferson Radiology.

MS. MILLER: The CT scanners in Avon, let's take that, for example. Has that increased for you in the past year, fiscal year 2019?

DR. FOXMAN: Yeah. The CT scanners that we have in Avon have excess capacity. Our MRI in Bloomfield has excess capacity, and that excess capacity has actually increased.

MS. MILLER: For the MRI in Bloomfield?

DR. FOXMAN: Correct.

MS. MILLER: The CT scanner in Avon, did it increase in fiscal year 2019?

DR. FOXMAN: Did its capacity increase?

MS. MILLER: No. Did you get additional CT scans in fiscal year 2019 versus fiscal year 2018?

DR. FOXMAN: So ’18 versus ’19.

MS. VOLPE: So you’re asking for 2019 numbers.

MS. MILLER: No. He said he had an awareness. I mean he had made very clear in his pre-filed testimony that he finds the growth of RAH’s Avon CT scanner. It grew to 59 percent capacity from 43 percent. He stated that he found that growth incredible and there was no context.

Of course, Jefferson has their own scanner right in Avon, so I thought maybe he checked to see what the context was, and if Jefferson also grew quite a bit in 2019, that would tell us something about the reliability of RAH’s numbers.

MS. VOLPE: I think, in his pre-filed testimony, which speaks for itself, that he’s pointing out the 59 percent capacity being still below the Statewide Health Plan assessment.

I think that’s, when you’re reading the context of that, that’s what the reference is.

MS. MILLER: Well I --

HEARING OFFICER MITCHELL: Hold on one second. Was that an objection to the question?

MS. VOLPE: Yes.

HEARING OFFICER MITCHELL: Okay. Any response to the objection?

MS. MILLER: Oh, well, he actually seems to be doing more than that. He seems to be questioning the entire fiscal year of 2019 numbers, and we, of course, the fiscal year 2019 numbers are considerably higher, and, so, for him to -- for anyone at Jefferson, rather, to say that they presented this body with out-of-date information and then they used that to say that RAH is at 61 percent capacity, when, in reality, looking at the fiscal year 2019 data, they're at 82.99 percent capacity, but, if Jefferson's position is that the 2019 data is not reliable, I just wanted to explore why it's not reliable, because that seemed to me to be their position.

They didn't want to hear our 82.99 percent. They wanted to stick at 61.

MS. VOLPE: He'll respond to why 2019 is not reliable.

HEARING OFFICER MITCHELL: I think it's a fair question.

MS. VOLPE: Yeah. He'll address why the 2019 is not reliable.

MS. MILLER: So, again, your Avon growth, then, was it similar?

(Multiple conversations)

HEARING OFFICER MITCHELL: I was going to say let me just allow you. I'm going to allow you to just ask the question again, and then you'll answer.

MS. MILLER: Okay, great. So in 2019, your Avon CT scanners, did they increase the number of scans from fiscal year 2018, if you know?

DR. FOXMAN: That specific data point is not something I know sitting here today.

MS. MILLER: Okay, so, you said it was incredible growth that RAH had, their Avon CT scanner in 2019. Your testimony was that you didn't believe that growth, but you didn't compare it to Jefferson's CT scanners before filing that testimony, is that correct?

DR. FOXMAN: Yeah. No. So I'll catch up with a lot of sort of the comments/questions that were just relayed out here.

MS. MILLER: Those were not questions, sir. I mean if you don't have an answer to the question I posed, that's fine. You don't just get to testify.

You're responding to my questions, sir.

MS. VOLPE: Well --

HEARING OFFICER MITCHELL: Hold on. Hold on. No. You guys are not going to argue across the floor. Let me just ask. Is there a specific question that you want him to answer?

MS. MILLER: No. I believe, actually, that covered it. He didn't compare it to anything. I think I can move on.

HEARING OFFICER MITCHELL: Okay.

MS. MILLER: Thank you. You stated in your pre-filed testimony that there were two advanced imaging providers in Bloomfield, but that one of those providers, Connecticut Valley Radiology, dissolved, is that correct?

DR. FOXMAN: That's correct.

MS. MILLER: Did Jefferson provide Connecticut Valley Radiology or any of its physician shareholders with any compensation or payment in any form, in order to encourage that dissolution?

MS. VOLPE: How is this relevant?

HEARING OFFICER MITCHELL: You're making the objection on the basis of relevance?

MS. VOLPE: Correct.

HEARING OFFICER MITCHELL: You can respond.

MS. MILLER: The implication of the testimony is that Connecticut Valley Radiology dissolved, because of low numbers. That is what my reading of it was. I think it would be what anyone's reading of it was, and that could be a reason they dissolved, or they could have also dissolved, because Jefferson paid them to leave, or say paid off debts owed by their physician shareholders.

If they did, then I believe the implication is something that needs a little more context, because that gets to -- I think the mention of Connecticut Valley Radiology really gets to the question of do you need two providers in Bloomfield or not?

HEARING OFFICER MITCHELL: I don't want to go too far down that line of questioning.

MS. MILLER: That's the one question I have.

HEARING OFFICER MITCHELL: I'm going to allow it. Yeah?

DR. FOXMAN: I have to sort that out.

MS. MILLER: I can read it back to you, if that's helpful.

DR. FOXMAN: I think I'm good.

MS. MILLER: Okay.

DR. FOXMAN: Yeah, thanks. So CVRG, Connecticut Valley Radiology Group, was a group that essentially had less and less volume and went -- reached a point where its volume was not financially-sustainable. Their volume numbers have been reported.

MS. MILLER: I think we're getting a little further away from my question, though. Did Jefferson provide compensation?

MS. VOLPE: That --

HEARING OFFICER MITCHELL: Hold on.

MS. VOLPE: -- response that she should let him answer the question.

HEARING OFFICER MITCHELL: And I do want to hear what he has to say.

MS. MILLER: That's fine. If you want to hear it, Hearing Officer Mitchell, that's absolutely fine.

HEARING OFFICER MITCHELL: Thanks.

MS. MILLER: Go ahead.

HEARING OFFICER MITCHELL: Go ahead.

DR. FOXMAN: Yeah, sure. So it's no secret, actually, that CVRG had, Connecticut Valley

Radiology Group, basically had diminishing volume in its offices. They reached a point where they were far below a break even in sustainability, and their entity was in distress. The physicians reached out to us.

I believe those physicians actually, despite -- those physicians came into Jefferson Radiology. Some of them were partners. It was a small number. Two doctors, actually, at the time, and -- it may have been more. I can't remember. It was a while ago.

And, essentially, their volume numbers were low, and there was some transaction of dollars going back and forth, but then those physicians, I believe, even had to use a lot of their own funds to decommission their offices, what the finance folks would call off balance sheet obligations, you know, returning an office to the leaser, literally pulling equipment out and disposing of it, and it basically was a financially non-viable entity, and, in my mind, I mean there's no secrets here.

This is public information. They just were not sustainable when they came into Jefferson.

MS. MILLER: And did Jefferson provide them with some sort of compensation of any kind or a

payment of any kind? Was debt paid off, for example?

MS. VOLPE: Well how is that relevant?

MS. MILLER: That was the question I was permitted to ask.

HEARING OFFICER MITCHELL: So let me just -- so we are asking -- you're objecting on the basis of relevance, and what is the relevance?

MS. VOLPE: He answered the question.

MS. MILLER: He said that, which I already knew --

MS. VOLPE: It was low volume.

MS. MILLER: It was low volume.

MS. VOLPE: -- sustainable.

HEARING OFFICER MITCHELL: Stop talking to each other, please.

MS. MILLER: I'm sorry, Hearing Officer Mitchell. The relevance is that, while there's low volume, they were also given a financial incentive to dissolve. It's not just the low volume, and that adds to the relevance. It's just a yes or no question.

I don't know if they were given any additional financial compensation.

HEARING OFFICER MITCHELL: I'm going to allow the answer, and I think maybe you did answer.

DR. FOXMAN: I'm happy to answer. There's no secrets here. So I don't remember precise details. I didn't walk in today to do that, but, really, the incentive to them was to have a go-forward employment as a radiologist in that community, so they joined our group and they dissolved their practice, essentially because it was my recollection they were doing some like two or three scans a day.

That's way below break even, so the incentive, if that was the fact, you know, I understand what you're asking, is that we said join our group, and you can practice radiology with us.

MS. MILLER: Thank you. I appreciate it. Again, in your pre-filed testimony, you stated that you were concerned, because RAH, in your words, omitted two CT scanners from its application, is that correct?

DR. FOXMAN: That's correct, yes.

MS. MILLER: And you're aware that neither of those CT scanners appeared on the 2016 inventory?

DR. FOXMAN: I believe that's correct.

MS. MILLER: And are you also aware that that was the only inventory available to RAH at the time it filed its application?

DR. FOXMAN: I would not know what

inventories were available to RAH when they did their homework, if you will, to file the application.

MS. MILLER: Okay. Assuming that you did only have the 2016 inventory available, then it wouldn't be fair to expect RAH to include those two scanners at the time of the application only, correct?

DR. FOXMAN: My understanding is, and this is something I've seen many practices do over the years, is you consult what's publicly available, and there's data in the CON filings, and if that data was available publicly in the CON filings, which I think it probably was, that's an opportunity for someone to come across that information and include it in their application. I think that's almost standard practice.

MS. MILLER: You are aware, though, that those two CT scanners were included in RAH's needs analysis that it submitted in response to the issue response questions?

HEARING OFFICER MITCHELL: Do you know? Do you know whether or not?

DR. FOXMAN: Yeah. As I understand it, they were submitted in a different component of this application process.

MS. MILLER: Another critique, and this

was right in the same part of your testimony, I think page four, you criticized RAH for omitting a scanner that was approved on January 29th of this year, and I was wondering what you thought it was omitted from.

MS. VOLPE: Where are you specifically referencing?

MS. MILLER: I'm looking at page four. So it looks like in the middle of page four, if that helps. You explain that, "Moreover, the Office of Health Strategy approved a 256-slice on the main campus of Hartford Hospital, and this has not been included in the Applicant's analysis," and then you have a footnote that explains that was just approved on January 29th of this year, so you say it's not included in the analysis, but I'm wondering where exactly you felt we should have included it.

DR. FOXMAN: My understanding is the pre-file was filed after the January 29th date, and, as I said just a moment ago, things that are in the public record by virtue of reporting to this agency are items that are available for anyone, who wants to come forward and make a representation about the community and what CT scanners are available or have been approved.

MS. MILLER: Did you, and you may not, did

you realize that the original date of this hearing was supposed to be January 28th, the day before that approval?

DR. FOXMAN: My understanding is the January 29th date, yes, is a date one day after the approval, but I also have an understanding that the approval process may have been underway for a long time prior to January 29th, so January 29th wasn't the unveiling of all the publicly-available information.

MS. MILLER: Are you aware, with regard to that specific CT scanner, that the projected volume for 2020, and that was in the Certificate of Need decision that you're talking about, was 17,733, which I calculated as roughly 148 percent of capacity?

DR. FOXMAN: I don't, sitting here today, I don't know details like that, but I can accept that, if you're telling me that, that it must be in the application.

MS. MILLER: Okay. Moving on, but kind of in the same vein, you also stressed a Hartford Hospital CT scanner in Avon in your testimony. Do you remember talking about that scanner?

DR. FOXMAN: Yes.

MS. MILLER: By that, did you mean the CT

scanner at the Helen & Harry Gray Cancer Center?

DR. FOXMAN: Sure. Just to be very clear, just like any hospital organization, there's cancer centers and programmatic organizations, which are much larger than just one CT scanner and one component of the Radiology Center, so I don't know precisely if that scanner was attributable to the Helen & Harry Gray Cancer Center, which is a larger programmatic effort within Hartford HealthCare, and that level of I'll say, you know, structure of their cancer center is something that, you know, without exactly knowing that, I wouldn't want to say yes or no to.

MS. MILLER: So when you decided to reference the Hartford Hospital CT scanner in Avon, you didn't look back to the inventory to check what it was associated with?

DR. FOXMAN: Our information here is just referencing what's in the public data and the filings, and, then, if a hospital, whether it be Hartford, or UConn, or any hospital, is in their public records also conceptualizes that CT scanner as part of some other, you know, disease center process or programmatic process, that's just something I wouldn't have awareness of.

MS. MILLER: Okay, so, just referencing

the inventory, I'm reading it here, and it says, Hartford Hospital's Helen & Harry Gray Cancer Center, Avon, in Avon, radiation simulation only, and, so, that, I believe, that is the only Hartford Hospital CT scanner I'm seeing in Avon, so is that what we're talking about?

MS. VOLPE: Just if I may, Hearing Officer Mitchell, I'm not sure what counsel is reading from, and my client doesn't have the benefit of it, but, irrespective, I mean I'm just trying to follow where the line of questioning is going, if there's actually a question, but I'm not sure what she's referring to. We don't have the benefit of that in front of us.

I think my client answered the question, that there's an office in Avon, a location that has equipment in Avon. Whether it's specifically tied to a specific cancer center, I think he's already answered that question.

HEARING OFFICER MITCHELL: So you're looking at the inventory?

MS. MILLER: I am. This one is the 2018 inventory.

HEARING OFFICER MITCHELL: Okay and, so, the purpose of the line of questioning is that it's with the Cancer Center and it's just for a specific type of

use?

MS. MILLER: Yes. As the inventory notes, it says radiation therapy only. Radiation simulation therapy only.

HEARING OFFICER MITCHELL: Okay. I'm going to note that and whether he knows it's a fact. You can move on.

MS. MILLER: Okay, thank you. We've gotten into this in some degree, but this is in a slightly different vein.

You had expressed concern with RAH's request to transfer its existing equipment into Eastern Radiology Affiliates, LLC, or ERA, is that correct?

DR. FOXMAN: That's correct, yes.

MS. MILLER: And, if I'm understanding, at least one of your bases is the fact that the investors of ERA are not known, correct, future investors, as we discussed before?

DR. FOXMAN: Yes, that's correct.

MS. MILLER: Because you admitted earlier that you do understand that, currently, the sole member is RAH, correct?

DR. FOXMAN: My understanding right now is ERA is perhaps a formulated LLC or vehicle, which

contains no equity at this point, and that was setup by RAH, yes.

MS. MILLER: Okay, so, has Jefferson transferred its equipment to a different entity?

MS. VOLPE: I'm going to object.

HEARING OFFICER MITCHELL: On what basis?

MS. VOLPE: That we've covered this already with Attorney Rose's Cross.

HEARING OFFICER MITCHELL: Any response?

MS. VOLPE: And that it's all a matter of public record, again, in the filings before this office, the Attorney General, their entire application. All of the transaction with respect to Jefferson has been subject to review by this agency and others in the State.

HEARING OFFICER MITCHELL: Any response?

MS. MILLER: Yes. I actually have two very simple questions. It might be easier to have them in the record versus reading all of the many, many, many documents that revolve around Connecticut Imaging Partners.

I think having the answers to two yes or no questions on the record may actually be easier for the decision maker in this case.

HEARING OFFICER MITCHELL: You're going to

move on to the question?

MS. MILLER: Yes, absolutely.

HEARING OFFICER MITCHELL: All right, so, I'm going to sustain the objection.

MS. MILLER: Well I apologize. I actually have one -- I have a question in this vein, but it's only one question.

HEARING OFFICER MITCHELL: Ask it.

MS. MILLER: Okay, so, during the transfer process that we were just referencing, was Connecticut Imaging Partners required to list all of its potential future investors, or did it only need to explain that it was essentially a joint venture between Jefferson and I believe Hartford Hospital? You can correct me if I'm wrong on that.

DR. FOXMAN: Sure. So I want it to be very clear. I think it's all public record. There's nothing that I want to be unclear today.

Connecticut Imaging Partners was established as a joint venture entity for a single MRI I believe 10 to 15, maybe 15 years ago.

Jefferson Radiology placed another CT scanner in that hospital joint venture I want to say around 2010, and then Jefferson Radiology went to this

agency, went through all the, you know, the process of asking if it could transfer additional imaging equipment into that Connecticut Imaging Partners joint venture with Hartford HealthCare, and a number of those, a number of CTs and MRIs were put into that joint venture, and, so, the joint venture is just increased size.

It's a Hartford HealthCare, initially Hartford Hospital, then Hartford HealthCare, and Jefferson Radiology joint venture.

I think it's been well-known in the community. It's public record, so I just want it to be clear and facts on the table that's straightforward.

MS. MILLER: And, so, is it your position that that was distinct from what we're doing here, and that's why you need more information about what we're doing here? Is that what I'm understanding by your explanation?

DR. FOXMAN: When you say doing here, you mean like --

MS. MILLER: Right, so, you would ask -- I'm sorry to interrupt.

DR. FOXMAN: No, no problem. You're just saying, by doing here, we're standing up ERA and then allowing assets to be placed into it?

MS. MILLER: Correct. So you're making a distinction, because, you know, because of what you just explained. You found that process to be somewhat distinct to what we're doing here, and, because you're finding it to be distinct, that's why you think the ERA question we should be able to tell you today what all of our future investors are? Am I understanding that correctly?

DR. FOXMAN: Again, I just want to be very clear, facts on the table in my mind. I did hear something stated earlier by your colleague. Sort of it's apples-to-apples, not a change, but, entities, I have an awareness that moving to an entity that's an LLC or some other entity that may not have been a conventional traditionally-formed physician entity, and moving into that entity it's done for a reason.

And the reason it's done is to open the door in the future to further investors, other entities, and, you know, if the entity is constructed in such a manner, it can be essentially a way of getting a blanket approval for future investors to move in.

It's a way that, in my opinion, someone could even sidestep the spirit of my multi-year interaction with this agency, which is put the facts on

the table. It's clear it may be approved. It might not be approved, but there's an approval process. There's guidelines. There's metrics. There's multiple parties across the state, who have prospectively setup the rules of the road, not for the benefit of Jefferson, not for the benefit of any radiology group, or a clinic, or any emerging clinically-integrated network, but really just for the benefit of the State of Connecticut, and we play by those rules, and it's in my testimony.

MS. MILLER: At what point do you feel would be the ripe time, I think as you put it, that it wasn't ripe, for RAH to come in and ask to transfer its equipment to ERA?

How many investors do you think ERA would need to have, because right now, remember, RAH is the only one, so at what point do you think we should be coming back and asking for permission, when it has two or three investors, or when those investors seemed kind of permanent? What would you setup at the ripe point?

MS. VOLPE: I'm going to object, because you're asking a question -- they're asking a question that's better addressed to this agency, and we can -- we're going off of what's in their CON application.

I mean their CON application specifically

says they haven't identified all their members in classes ownership, and they basically haven't submitted any documentation on the governance, control, membership interest.

It's completely void of the information that this agency looked to review and, in fact, which was actually in this application, that they're trying to make an analogy through this torturous Cross-Examination, but, again, I mean the facts aren't in the CON, so we're just responding.

Dr. Foxman is responding to what's in their CON, and it doesn't identify members or classes.

HEARING OFFICER MITCHELL: Go ahead and respond to the objection.

MS. MILLER: Absolutely. I was asking him where he thought the ripeness would kick in, because, in his testimony, he said that this is premature and not right.

I was surprised to see that. That's odd testimony to see from a doctor. It sounds much more like a legal opinion or a decision from a Hearing Officer, for example, so it did surprise me, but given that he thinks it's not ripe right now, ERA, again, solely-owned by RAH, so we know all of the members, it's just RAH, so I

thought maybe in his mind he thought there needed to be two members or three members.

I'm not sure what he's thinking, but he did say it wasn't ripe, so I was just curious. I guess I don't really need the information, but it did make me wonder.

HEARING OFFICER MITCHELL: I'm going to allow it.

DR. FOXMAN: Okay. Very good. So you're asking my opinion of when it would be ripe, if you will?

MS. MILLER: Right. Yes. Just that.

DR. FOXMAN: Right. I think elements that would need to come before this agency and be part of this discussion are review of the governance structure, a representation of internal discussions, perhaps SOHO's intent who those investors would be, and, actually, clarification in the formulation of that future LLC of yes/no, if this agency approves that transfer of ownership, yes or no, is that a blank check to bring anyone else in in the future, and what discussions have taken place, what's the strategy, what motivated this, what are the intentions?

When Jefferson Radiology went forward with expanding its joint venture, the joint venture that had

been in place for many years, not a new entity, a multi-year entity, it's pretty straightforward.

We're aligning more with our hospital. We want a joint venture with our hospital. It could have been denied, it could have been approved, but there is no question what the intent was, what the formulation of the governance was, who would have control.

All those things were clear, as opposed to standing up something, not representing what it's governance would be, what its structure would be, and potentially standing up something that means this agency would not in the future have any oversight, any direction, and my concerns, as I expressed by saying it's not ripe, is that's a big step to take.

That's a big step to take, and, to answer your question specifically, just very a straightforward common sense question should be answered before that's approved.

MS. MILLER: Okay, so, the investors wouldn't all have to necessarily have already invested, but you feel that there's more information that needs to come out?

DR. FOXMAN: The investors are probably people, who, down the road, would be solicited, have

discussions. Unless you know something I don't know, are the investors already lined up and standing up and waiting for this to happen?

The very fact that we're having this question it's a curtain, and behind that curtain no one knows what's there, and there might be something there that's not declared, or there might be something that materializes in the future, and there may be an intent to say, well, we just want to have, you know, the freedom, the latitude to make decisions in the future, and I would compare that with, because you asked about Jefferson Radiology, when we came forward, it might have been denied, it might have been approved, but there is no question that we are trying to put imaging assets into a joint venture at the hospital.

There is no mystery around that. There is no curtain. You could accept it, you could deny it, but we didn't put a curtain up and say please approve something, and we're just not going to like round out what's behind that curtain.

MS. MILLER: Okay.

MR. ROSE: Thank you. I just want to follow-up with a couple of things. So within a Limited Liability company model, you've recognized that there is

flexibility in investors.

I just want to confirm that Connecticut Imaging Partners is the sole owner of Farmington Imaging Center, is that correct?

MS. VOLPE: We'd have to look. I don't have the organizational chart on it. I don't know. I mean I know the State does, because it's on file, but I don't recall. I have to look at the organizational chart.

HEARING OFFICER MITCHELL: Do you know? Only if you know.

DR. FOXMAN: Yeah, I don't know precisely, and it's a matter of public record, and even when you are asking me your question, you said within a Limited Liability, I know, at that point, like that's where I need, you know, that's where I need a lawyer to basically precisely tell me who owns what, but, as I said, there's nothing to hide.

All these things carried forward with this agency in the public record.

MS. MILLER: Switching gears kind of completely, but I did warn you about that, are you aware that, at this point, Anthem Blue Cross, UnitedHealthcare and Cigna have all implemented policies to steer

outpatients away from hospital-based imaging and towards lower cost community-based imaging providers?

DR. FOXMAN: Yes, there's a general public awareness of payers doing that, but I would also say the payers, themselves, have made representations there's additional dimensions to that around how they steer patients.

MS. MILLER: Is it a fair summary to say that they would actually prefer the high cost hospital imaging be used only when it's medically necessary?

DR. FOXMAN: A statement, which is caveated when it is only medically necessary, is something that generically I think everyone would stand behind.

MS. MILLER: So you would concede that there is some need for ambulatory 3T MRIs, then?

DR. FOXMAN: You're asking generically?

MS. MILLER: Generically. I mean I know your position on Bloomfield right now, but there is some need for that they exist in the community you would agree with?

DR. FOXMAN: You mean the community, define the community, etcetera, but --

MS. MILLER: Oh, yes.

DR. FOXMAN: In general, there can be a need for a 3T MRI in a community, yes.

MS. MILLER: Versus in a hospital-based setting?

DR. FOXMAN: Again, we're speaking with sort of hypotheticals and, you know, what's the community, what's the hospital, what are the patients, and I was really prepared to talk about this specific application, but asking a sort of a generic question the answer is going to be yes in certain circumstances, no in others.

MS. MILLER: Okay. I noted that, in your pre-filed testimony, so getting back to being more specific, you did list 12 hospital-based CT scanners as part of your proof of the ample choice of CT scanners within RAH's proposed service area, is that correct?

DR. FOXMAN: Yes, that's correct.

MS. MILLER: And don't you think it might be more fair with regard to this application to really be focusing on the community-based imaging providers in the proposed service area, not the hospital-based scanners?

DR. FOXMAN: No, I don't think so. I think this agency has set ground rules, which have been commented on by multiple parties over multiple years and

reviewed in multiple instances, and I think the question today is to take reliance on those guidelines and not divert or redefine to something new.

MS. MILLER: But if we were going to focus on community-based imaging providers, I believe you listed Jefferson as the only such provider in Bloomfield, is that correct?

DR. FOXMAN: Well the Statewide Healthcare Plan doesn't make the distinction between hospital and, quote, "community-based," and my opinion is part of that reason is what can be hospital-based could be a scanner on the campus of a hospital, which has the look and feel of an ambulatory center; easy parking, easy registration.

I come across people, who will paint all hospitals as busy inner-city tertiary environments, where it's impossible for a patient to have an experience as in a community. That's not true generically.

In fact, I know many instances in Connecticut where that is not true, so you're asking me to make black and white distinctions between a hospital-based and community-based, with I believe an undertone that a hospital could never be accommodating to a patient community, has unique things that could not happen in a hospital, and I just feel that's way too generic, and I

point back to the Statewide Health Plan, and it does not make a distinction between those two entities.

MS. MILLER: Now I know, Dr. Foxman, you don't actually have it in front of you, but I would like to point out, really for your benefit, because I wouldn't want you to make a mistake in your testimony, that the 2018 inventory certainly breaks up the scanners by hospital-based, hospital-owned satellite, non-hospital for their three categories, and I know you didn't know that probably, but I am pointing that out to you.

MS. VOLPE: I'm going to object.

HEARING OFFICER MITCHELL: On what basis?

MS. VOLPE: On the basis that, for need analysis, you apply imaging capacity and availability, irrespective of in and out, so I'm not -- whether or not they're inpatient or outpatient is irrelevant when you're applying the need analysis and what the capacity and excess capacity and availability is in a market, in a primary service area that's defined in accordance with State requirements, whether it be the definition in the Statewide Health Plan or any other recognized definition that this agency has utilized or its predecessor, OHCA, has utilized in defining a primary service area.

So I'm objecting to the line of

questioning on whether it's inpatient or outpatient, its capacity, its imaging capacity, and that's how it's been looked at since its inception.

HEARING OFFICER MITCHELL: Any follow-up?

MR. ROSE: Yeah, I'd like to respond to that. So with respect to CT scanners, there's actually different capacity numbers that apply to hospital versus non-hospital, so the number of scans that the plan identifies for non-hospital is 4,000 and it's 12,000 for hospital, so you can see there is a difference, and you have to take that into account when you're producing your needs methodology.

And, so, the inventories are broken up in these categories, so this is a well worn path of distinction.

HEARING OFFICER MITCHELL: What Attorney Rose has actually said it's accurate on the CT side. Is there any response on that?

MS. VOLPE: Yes, but you're still looking at total available capacity versus total available volume, and they haven't set it out in their CON or in their pre-file, and they have a CT in their primary service area that's underutilized, so I'm not sure what the line of questioning is.

I mean if we can get back to a -- they're offering testimony in their Cross-Examination, so, I mean, that's what's happening. We're not really asking questions. I think the pre-file speaks for itself.

MS. MILLER: So my question -- I think we're getting a little confused, because the question I actually posed to Dr. Foxman was is it true that Jefferson is the only community-based imaging provider in Bloomfield, and his answer kind of went a little astray, but my question still is is Jefferson the only community-based imaging provider in Bloomfield, and if he wants me to define community-based imaging provider for him to help him answer that question, I'm happy to, but that's actually the question.

MS. VOLPE: I object.

HEARING OFFICER MITCHELL: I'm going to allow that question, and we're going to move on. Are you the only community-based?

DR. FOXMAN: Sure. Yes, we are.

MS. MILLER: Okay and, so, you stated in your testimony that Jefferson had 3,934 CT scans in fiscal year 2018, is that correct?

DR. FOXMAN: Yes.

MS. MILLER: Okay, so, by your own

admission and your own testimony, Jefferson, the only community-based imaging provider in Bloomfield, had a 106 percent utilization rate in fiscal year 2018, is that correct?

DR. FOXMAN: That's correct, with the understanding that Bloomfield is not the service area, but, in the town of Bloomfield, that's Jefferson's numbers.

MS. MILLER: Thank you. Thank you, Hearing Officer Mitchell. I don't have any further questions for this witness.

HEARING OFFICER MITCHELL: All right.

MR. ROSE: One moment. Can I confer one second?

HEARING OFFICER MITCHELL: Yes.

MR. ROSE: Maybe we'll end it. I just wanted to see. Okay. All right.

MS. MILLER: We are all set, Hearing Officer Mitchell. Thank you.

HEARING OFFICER MITCHELL: All right. I'm going to throw it out there for both parties. Do you guys want to break for a half hour for lunch, or do you want to continue on?

MS. MILLER: I don't know how long the

Cross-Examination is planned, so it kind of hinges on that for me.

HEARING OFFICER MITCHELL: It's up to you.

COURT REPORTER: Attorney Volpe, if you could just turn your microphone?

MS. VOLPE: Sure. Sorry. Michele Volpe. We don't have a lot of Cross. I think, if you would indulge us, I'd like to at least address the Cross, as it relates to ERA, since there's been a lot of discussion on that. Maybe, while it's still fresh in everyone's memory, we can --

MR. ROSE: Is she offering testimony? I'm sorry.

MS. MILLER: Would you like to break it up? Is that what you're asking?

HEARING OFFICER MITCHELL: I think she wants to continue. Am I misspeaking?

MS. VOLPE: Actually, I'll defer to whatever the Hearing Officer would like. What would you want to do?

HEARING OFFICER MITCHELL: If you guys want to continue, we can. I just want to make sure that no one, you know, feels like they want to stop.

MS. MILLER: Oh. I'm good, but if there's

going to be three hours of Cross --

DR. POSTERARO: Sorry to interject.

MS. MILLER: A short break would be good either way, I think.

DR. POSTERARO: Grab a glass of water.

HEARING OFFICER MITCHELL: Not a problem.

MS. MILLER: We can break.

HEARING OFFICER MITCHELL: Short break?

MS. MILLER: Short break.

HEARING OFFICER MITCHELL: Okay, so, we'll break for 15 minutes. You guys can get a snack.

(Off the record)

HEARING OFFICER MITCHELL: We're back on the record. So I'm going to turn it over to Attorney Volpe for Cross of the Applicants.

MS. VOLPE: Hello. I'm going to allow, if it's okay with Hearing Officer Mitchell, that I can ask a question, and you can decide among you who is most appropriate to address it.

MS. MILLER: That's fine with us.

MS. VOLPE: And I'll make reference to where things are in the application, and whoever feels most comfortable in addressing it is fine by me.

HEARING OFFICER MITCHELL: Okay.

MS. MILLER: Hearing Officer Mitchell, would it be helpful for the record that they identify themselves each time before answering?

HEARING OFFICER MITCHELL: I'm going to defer to the court reporter. Do you need people to identify themselves each time that they make a response?

COURT REPORTER: No. I think I'm good.

HEARING OFFICER MITCHELL: Got it.

COURT REPORTER: They just have to make sure that they pass the microphone to whoever is speaking.

HEARING OFFICER MITCHELL: All right. Thank you. All right, we're all set.

MS. VOLPE: Thank you. So there's been a lot of discussion about ERA today, based on what's in the application, some of the information we've tried to present.

So, on Bates page number 16, you state that ERA will be a disregarded entity of RAH, until RAH identifies the most appropriate members in classes of membership, so my questions deal with that statement. Who would like to -- Hi, Dr. Twohig. How are you?

DR. TWOHIG: Good. How are you?

MS. VOLPE: Nice to see you.

DR. TWOHIG: Yeah, likewise.

MS. VOLPE: Long time. Okay. My question is has RAH identified any potential members?

DR. TWOHIG: No. At this point, no.

MS. VOLPE: So no sense of who the proposed members might be?

DR. TWOHIG: Well, as you know, I mean we have more from St. Francis Hospital into a larger national entity, and we want to have ERA as a vehicle, a legal structure, to give us the flexibility to work with other colleagues regionally, locally and nationally.

MS. VOLPE: Okay, so, out-of-state, are out-of-state investors would they be permitted to participate?

DR. TWOHIG: Again, it would be whatever the most appropriate relationships are to improve care, improve access and patient outcomes.

MS. VOLPE: Okay. Have you spoken with out-of-state investors regarding participation in the ERA?

DR. TWOHIG: Continue to have lots of conversations, you know, across I'd say appropriate type of potential colleagues, mostly centered around Trinity.

MS. VOLPE: Okay, so, can an individual

invest, like a person, or is it just entities and corporations?

DR. TWOHIG: I don't think that the project is that refined.

MS. VOLPE: Okay, so, I hear you say the project is not refined. Are there governance documents that have been created?

DR. TWOHIG: No.

MS. VOLPE: So nothing for this Commission to review what the governance structure would be?

MR. ROSE: I object.

HEARING OFFICER MITCHELL: On what basis?

MR. ROSE: This is a wholly owned subsidiary, which is --

COURT REPORTER: I'm sorry. Attorney, if you could just --

MR. ROSE: Oh, I'm sorry. This is Attorney Adam Rose. So a Limited Liability Company has what's called membership interest, and when you have a sole owner, for tax purposes it's literally -- it's a disregarded entity, its financials go on the parent company's financials, and when you only have one member, I can tell you who is governing it. It's not a secret.

It's one member, so I think there is a

whole package of ideas here that I think, unfortunately, a (coughing) of a shortcut of corporate law, which is just, if you have a wholly owned subsidiary, LLC, it is an alter ego of the parent.

HEARING OFFICER MITCHELL: Response?

MS. VOLPE: Yeah. That may be, Attorney Rose, but, Hearing Officer Mitchell, that's not the application that's before this agency.

I mean they're putting in a transfer, and they're, by their own admission in the CON, saying they haven't identified who the members will be, how they'll own, what the governance structure would be, how they would be invested, how they would divest, and there's been a lot of discussion today, trying to make an analogy to a joint venture with CIP, which, in that review by this agency and its predecessor, all of the organizational documents we'll put in.

The agency knew who the members were going to be that time and forever, based on the governing documents, and there was full transparency with the corporate structure, the instruments allowing participation, how they were governing, how much was invested, what they were going to own.

What's before the agency today and the

reason we're objecting to his objection is that they, by their own admission, they haven't identified who the parties are going to be, yet they're asking this office to give a blanket approval, because, right now, it's a disregarded entity.

That was why Dr. Foxman alluded in his and specifically stated in his pre-file that it's not ripe for review.

I mean, if they want to form a joint venture between RAH and St. Francis and come in for approval, maybe that might get approved.

MR. ROSE: So I think this is getting overly complicated. Today, Radiology Associates of Hartford operates this equipment, and they can make whatever decisions they think is in the best interest as radiologists for the disposition of the equipment and use of that equipment, and RAH is going to control this wholly owned subsidiary.

This wholly owned subsidiary is going to be an alter ego of RAH, so there's no trick here. RAH continues to make all decisions with respect to the disposition of that equipment.

MS. VOLPE: But how does this Commission know that? There's no documents provided, and there's

nothing in -- the application is completely void of that. You're asserting that now. I'm going to withdraw the question, okay? I'm going to withdraw that question.

HEARING OFFICER MITCHELL: I'm just going to ask, just so that we make this clear, do the Applicants know at this time who the potential members are going to be in ERA?

DR. TWOHIG: It's RAH shareholders.

MR. ROSE: I mean ERA exists today.

HEARING OFFICER MITCHELL: Right.

MR. ROSE: I'm their corporate lawyer, so I'm just giving you the information, but, so, we have setup ERA already with the Secretary of State, and it is a sole member. RAH, as a corporation, is that sole member.

HEARING OFFICER MITCHELL: Right.

MR. ROSE: And, Dr. Twohig, I think one of the first things that he did is he identified that this group has been in so many conversations locally, regionally and nationally.

There is no -- I'll let Mike say it, Dr. Twohig say it, but there is -- no one is sitting in the wings that we know right now, like, oh, the second we get approval, somebody is going to be that member, but

there's always conversations. It's actually the culture of this group to always be in conversations, trying to understand who is interested in partnership, and setting up a Limited Liability Company, if one of those things does bear fruit in the future, just allows for that partnership to happen without selling the stock in the Professional Corporation the same way Jefferson did.

MS. VOLPE: But we would also assert that that's without regulatory approval. I mean that's the whole point. You're not bringing a set of facts, asking for a ruling.

By your own admission, you said that needs to identify the most appropriate members in classes of membership. It hasn't happened, so, again, here's my question.

Have specific economic rights been determined for proposed membership?

DR. TWOHIG: Can you repeat that?

MS. VOLPE: So economic rights, so has it been decided how new members would come in, how they would leave?

MR. ROSE: Again, this is a corporate law issue. We've said, time and again, that RAH 100 percent owns this. One hundred percent of the economic rights of

ERA are with RAH, and, so --

MS. VOLPE: I would object. That's not --

HEARING OFFICER MITCHELL: Let me let him finish his thought. Let me let him finish his thought.

MR. ROSE: This is as easy as you think it is, and there have been other entities in the State that have literally just moved their equipment from PCs to LLCs, and then those LLCs got determinations to sell their interest to whoever they want, and the agency has taken the position that that after activity is unregulated, but, today, the Applicant before you that is ERA is an alter ego of RAH, and, so, nothing has been defined.

If we had something defined that involved other parties, we would tell you. We would not withhold that from you, and that does not exist today.

MS. VOLPE: And I would assert that, if we're going to look at history and precedent of these types of transactions, that this office and its predecessor did not even allow a single member LLC owned by a radiologist to take that equipment and transfer it to another entity wholly owned by him. That wasn't even permissible.

MR. ROSE: I object. That's an incorrect

statement.

MS. VOLPE: It isn't. I represented that client. I can give the docket number and show where it was.

MR. ROSE: What you are referring to, Michele, and I'm sure you're going to agree with me, is a determination from the agency, saying that that can't be done without a Certificate of Need.

What you're saying right now, which I'm correcting, is that that determination said, no, you just absolutely can't do it, and those determinations are why we're here today.

The agency said, if you even are a solely-owned PC and you want to transfer to an LLC, you have to get a CON. Do you agree that you were actually speaking about --

MS. VOLPE: Yes, and you have to disclose who the owners are, and you're purporting to put an infrastructure in place that just is going to allow, without the agency having reviewed any of that, noting that it could be some out-of-state investor that now is controlling the ownership and upgrades of imaging equipment in this community. That's precisely what this office has been formed, to try to make sure there's

always access.

What if they decide they want to -- I mean you're asking for approval of something that isn't without disclosure of the organizational documents. I've never known this Commission to give approval without seeing governing documents, who the investors are, how they come in, how they go out, who has control.

I mean control is the operative question, so I'm going to -- I'd like to ask my questions and get them answered, to the extent that they can be.

HEARING OFFICER MITCHELL: Well I'm going to say that -- I'm going to interject and just say that, in terms of what you're asking about what their future plans are, if this was approved, that I'm going to acknowledge that we don't have the governance documents, etcetera, and I'm just going to ask that we move on, and we'll figure out how to go forward at the end of the hearing, whether or not we need that information or whether or not we make the decision without it.

MS. VOLPE: Okay. So in the application on Bates page 17, you stated that the ERA proposal is similar to the CIP transaction, so you're familiar with the CIP transaction?

DR. TWOHIG: Um-hum.

MS. VOLPE: Okay.

MR. ROSE: Can we have a moment to actually find the page and the statement? So I'm on page 17. If you can just direct me to where?

MS. KATHLEEN TOMMASO: It's right at the bottom of the page.

MS. VOLPE: The very last five lines.

MR. ROSE: And, so, what are you saying this says, because I think it's inaccurate.

COURT REPORTER: You need to be into a microphone.

MR. ROSE: Oh, I apologize. If you could repeat how you're characterizing this language?

MS. VOLPE: Well I'm reading from your application on page 17, and it says, "As we note, that the imaging equipment formerly owned by Jefferson, which is similarly organized as a Professional Corporation and is the radiology practice that supports the Hartford HealthCare Partners Network, was recently transferred to Connecticut Imaging Partners, which is a Limited Liability Company."

MR. ROSE: Yeah, so, those are all true statements. We've made no analogies, as you alleged.

MS. VOLPE: Okay, so, since -- you're

familiar with the CIP transaction. Are you aware that the transaction fully disclosed to OHS in exacting detail, including identifying the owners and all the transaction documents, were provided to OHS? Are you aware of that?

MS. MILLER: I am going to raise an objection to this. I feel that we spent a lot of time -- on relevance. We spent a lot of time this morning, talking a lot about how the CIP transaction was not relevant, and, so, I would just generally object to our witnesses being asked about the CIP transaction that Jefferson wasn't testifying on, because they would obviously be much more familiar with their own transaction than we are with their transaction.

HEARING OFFICER MITCHELL: I'm going to take official notice of that transaction for the purpose of this hearing, and I will note that there was a disclosure, so you don't have to ask them. It was in there.

MS. VOLPE: Okay. Thank you. Okay. I'm going to ask some questions on SOHO, so I don't know if that's best directed to Ms. Smith.

MS. SMITH: Probably best to Dr. Posteraro.

MS. VOLPE: Okay, great. So on page 18 of the CON application, it's the first sentence of the last paragraph.

MR. ROSE: Page 18?

MS. VOLPE: Yes.

MR. ROSE: Yup.

MS. VOLPE: First sentence of the last paragraph, it says, "As the exclusive St. Francis Healthcare Partners network partner for radiology, RAH/ERA worked with network stakeholders to identify the Bloomfield location as a strategic gap in network coverage." So who are those stakeholders?

DR. POSTERARO: Thank you. Just in regards to the question, just looking over this, because this isn't from my pre-filed testimony, but, when we talk about RAH/ERA worked with network stakeholders to identify the Bloomfield location as a strategic gap in care in regards to St. Francis Healthcare Partners, which was the predecessor organization for SOHO, are we talking about clinical stakeholders?

MS. VOLPE: Any for now. I mean who --

MR. ROSE: I can explain that, and I just want to clarify, because the vernacular is just different. So the various members within St. Francis

Healthcare Partners, who had contributed to discussions around the need for this equipment, and who you've been working with and all the people that have testified today, etcetera.

DR. POSTERARO: Okay, yeah, because, you know, we've been, you know, discussing things, but when we think -- St. Francis Healthcare Partners is a clinically-integrated network, which really has been a collective contracting vehicle since that began about 25 years ago, back in the era of capitation, you know, sort of helping primary care docs, began really in the St. Francis community, and it was at a time when primary care docs were dealing with a total cost of care model, where they would be bonused or non-bonused, based upon how much cost it look to take care of their patient population that the insurers would attribute to them.

MS. VOLPE: It's not my question. I appreciate that, but my question is who, like who are the stakeholders?

DR. POSTERARO: These people are the stakeholders, the actual clinicians that are taking care of covered populations.

MS. VOLPE: Okay. The clinicians. Okay and did that -- on that analysis with the stakeholders

for the Bloomfield location, was there any work product that was produced to show, oh, we have a gap here in Bloomfield?

MS. MILLER: I'm going to object to the way she just characterized that. So far, what she has heard from Dr. Posteraro is that it was half of an explanation of what the need was in the area around St. Francis, and she's just characterized it as an analysis, as though it was done just before, and without actually letting him explain who everyone involved was, so I get that there's probably a point that she's getting to.

MS. VOLPE: I'll ask my question again, if you'd like, specifically. Was there an analysis done to identify the Bloomfield location?

DR. POSTERARO: Really, you know, at the community level, looking at our providers and our patient population around north into Hartford and Bloomfield, much of that came from internal discussions, as looking at where the needs analysis was for patient care.

A lot of it stems from looking at the 2016 Statewide Facilities Plan Supplement with internal discussions, you know, at St. Francis, which, you know, as you know, needing to partner with outside entities to improve care in the north end within the state and form

these larger networks of care to value-based care models.

Now Trinity looked at the north end and Bloomfield area as an underserved area, based on a facilities map, and said we need to look at closing some of these gaps, and imaging services was one of the areas that we identified, in addition to multiple other ones, being a part of that network.

You know, we based the decision that, if there was a strategic place RAH needed to expand into, was into this area.

MS. VOLPE: And why, if there was this analysis done that you just testified to, why wasn't that provided to OHS for their review?

COURT REPORTER: I need you on the microphone.

MR. ROSE: Sorry. I'm not good at this. Okay, so, sorry, this is Adam Rose. So with respect to putting together the application, it was a function of what are the questions asked, and what do we think the answers are?

MS. VOLPE: So there is no -- you decided to omit any analysis on how the Bloomfield location was arrived at in your application?

MR. ROSE: So this is about, I don't know,

1,000 pages, and, so, we did not volunteer another, you know, thousands of pages related to everything that we could think of, but the agency did give us completeness questions, based on their review of what's in here and what they thought we should provide in addition, and we provided that, as well as the responses to the issues.

MS. VOLPE: Okay and in selecting the Bloomfield location, did that analysis that you did, but didn't provide, did it quantify leakage from your network as part of it?

MR. ROSE: Kathy?

COURT REPORTER: You need a microphone.

MS. SMITH: Sorry. We did discuss with SOHO Health leakage that has occurred. We can see that leakage by zip code. We cannot define where that leakage went to, what other imaging services, provider inpatient, outpatient, or emergency visits.

We don't have that detail, and we only have it from Medicare shared savings contracts. I believe three, but I would have to confirm that. Three Medicare shared, so it's not the complete picture of potential leakage.

MS. VOLPE: So would patients -- for these contracts with SOHO, are patients restricted --

MS. SMITH: No.

MS. VOLPE: -- in who they go to for imaging?

MS. SMITH: No.

MS. VOLPE: Okay and, in the application, and this is, again, addressed to whoever is appropriate, it's readily stated a number of times that RAH is the exclusive provider for professional radiology. Is that true? I mean, obviously, it's true. You would agree?

DR. POSTERARO: Currently, you know, SOHO, you know, as you can see SOHO has just emerged over the last couple of months as a regional entity with the formal transfer, you know, in becoming a regional entity.

At the time of this filing, you know, RAH was the only radiology group in St. Francis Healthcare Partners, and, as you can see, we're now a much larger entity that's going through the, shall I say, the integration process, you know, working to kind of build a similar culture, like you've seen with all these providers that come in, stretching out to Waterbury and stretching out to up to Springfield, covering a larger geographic area, and, you know, we're continuing to on board and bring in other providers that want to engage in clinically-integrated care and move in a progressive

direction with where healthcare is going nationally and locally here in the state.

MS. VOLPE: Okay. Can RAH contract with other healthcare providers outside of St. Francis SOHO network?

MR. ROSE: Yeah. When you say can and contract, these are incredibly broad. Can you narrow that question?

MS. VOLPE: Well you're exclusive, so could you -- can the radiologist provide services to another network, or would that jeopardize their exclusivity?

MR. ROSE: So I don't want to disclose any proprietary or confidential information that's in the group's contracts, but we've already stated that Radiology Associates of Hartford has a contract with St. Francis Hospital, as well as a contract with Johnson Memorial Hospital, both of which are part of Trinity, and those contracts are exclusive, in that those hospitals can't use outside radiology providers. This is very common.

And it's also, I will -- without disclosing anything confidential, I will just say it's very common for those contracts to come with non-

competition restrictions and not readily available.

MS. VOLPE: I just want to point for the record that counsel is testifying. I mean we're allowing it, because this is a --

HEARING OFFICER MITCHELL: I'm only laughing, only because you did it a little bit, too. I don't mean to be improper.

MS. VOLPE: On an objection I did.

HEARING OFFICER MITCHELL: It seemed like a clarification. I don't know if there was anybody better situated to answer that question. I will let you respond to that, Attorney Rose.

MS. MILLER: May I actually ask a question? So, in terms of the questions, if they have to do with, I guess, questions of corporate structure or questions about their contracts, actually Attorney Rose is in the best position to do it, because he is their corporate attorney.

If it would be helpful to have him sworn, I can obviously continue to be the attorney here, but, I mean, those sorts of questions will lend themselves, actually, to those answers.

HEARING OFFICER MITCHELL: I know. You know, this is an administrative proceeding, so it's not -

- you know, it's slightly more relaxed than if we were in court, but I will just say that I don't know if there was.

You can correct me if I'm wrong. It sounds like I'm not, based upon what you just told me, but it sounds like he's probably the only one that had the answer to that question.

MS. MILLER: Well it's going to be that specific about the exclusivity in their contract. I mean we just want to make sure we're giving you correct information.

HEARING OFFICER MITCHELL: Right, right, right.

MR. ROSE: Yeah, and --

MS. VOLPE: I'll move on to my next question.

HEARING OFFICER MITCHELL: She's going to move on.

MR. ROSE: Okay, thank you.

MS. VOLPE: And this is for Dr. Twohig. Does St. Francis direct RAH where to geographically locate its scanners?

DR. TWOHIG: No.

MS. VOLPE: So you make that determination

solely? RAH makes that determination?

DR. TWOHIG: No.

MR. ROSE: She's asking legal questions around the --

MS. VOLPE: No, I'm not. I'm asking if the hospital goes to him and says, hey --

HEARING OFFICER MITCHELL: I'm going to allow it. I'm going to allow it.

MS. VOLPE: That's not a legal question.

MR. ROSE: Yeah, but I'd like to answer it, because --

MS. VOLPE: And it's addressed to Dr. Twohig. I mean it's a simple question. I asked if St. Francis basically makes a strong suggestion on where you should place your scanners.

DR. TWOHIG: Well strong suggestion is a very broad --

MS. VOLPE: Well why don't you tell us what impact, if any, they inject into your decision-making?

DR. TWOHIG: Well I think it's always, as we've mentioned and as you heard very clearly through testimony from the community today, we don't work in a vacuum. We're not an imaging island.

We believe in the changes that are undergoing in medicine and really being accountable as an organization for the total cost of care.

The reason I bring that up, just like that, we don't work in a vacuum. In this case, we don't work in a vacuum. When you say stakeholders, we talk to our stakeholders, including the hospital, where is it optimally positioned to provide the best integrated care in a fashion that a patient can avail themselves of all of the opportunities in that medical home environment and get the best possible outcome?

So we don't make an independent decision, but we aren't coerced or forced into it, but, rather, it's a collaborative decision that really has the patients' outcome as its sole guiding force.

MS. VOLPE: And did representatives from St. Francis assist in the compilation of this application? Did they provide assistance to RAH?

DR. TWOHIG: I wasn't involved in all the components of it, so I will have to ask for some --

HEARING OFFICER MITCHELL: Hold on. Is there any witness that has any knowledge about how the application was prepared?

MS. SMITH: The application was prepared

by myself, in conjunction with Alexis, who RAH has hired as a consultant, to help us put the application together with Attorney Rose, and we did not rely on -- I'm trying to recall if we relied on input from folks at St. Francis.

To the extent that we asked for leakage data, that wasn't incredibly helpful. No. The answer is no.

MS. VOLPE: Just to follow-up to that, your consultant, is that an independent consultant, or consultant with --

MS. SMITH: She's an independent consultant.

MS. VOLPE: Okay. Not affiliated with the network?

MS. SMITH: She's not affiliated, no.

MS. VOLPE: Or the hospital?

MS. SMITH: No.

MS. VOLPE: Okay. There's a lot of talk about risk sharing arrangements in SOHO, and does RAH disclose, if it's in a risk sharing arrangement with -- to its patients?

MR. ROSE: Objection, relevance.

MS. VOLPE: Well I think it's very

relevant. The crux of your application is the fact that you need more in-network SOHO. That's how you're defining a service area, not inconsistent with the Statewide Health Plan, but narrowly based on a compilation of where SOHO is drawing patients from, so I think it's very relevant.

HEARING OFFICER MITCHELL: Is this about financial feasibility or something different? I just want to make sure I understand.

MS. VOLPE: It has to do with whether or not patients have choice and, you know, different access. If they're doing this for purposes of a risk arrangement, are patients going to still have choice, or are they going to be required to be directed to --

HEARING OFFICER MITCHELL: I'm going to allow that question. Anybody know?

DR. POSTERARO: Well, you know, I'm just to ask that, you know, it's a bit of a nuanced question that gets into sort of like healthcare structure and payment structure, so if I may please explain?

When you talk about risk sharing, historically, the relationship between a payer and a provider, which is the level that SOHO sits, that interfaces with patients, either on a federal level, or

a, you know, state level, or private payment level, every interaction that a patient has with a system where service is provided needs to be broken down into a procedural category. There needs to be a number or something that attributes a value to this.

So you'll go see a doctor, that doctor will see you, and then that visit, that 15-minute, 20-minute, whatever visit, there's a charge dropped for it.

People have surgery. There's a charge dropped for it. You know, you get an imaging procedure, there's a charge dropped for it.

Over the years, we've had to kind of break it -- we try to break it down to get as specific as possible, but how much effort for whatever resources, economic resources, that are associated with it?

We're going now on a state and national level when they talk about pay per value and, you know, some of these changes is, and I may be over-simplifying this, but, basically, adding up the total value, you know, the total cost of each one of those individual things and attributing that as a total packet, as a unit, as the total cost of care.

You know, historically, people, patients are just going to do whatever, and they contract at

whatever level with a provider, and the charges get dropped, and that would be the care provided.

What's happening now is, you know, the payers and the government, and certainly since the passage of the, you know, the MACRA legislation, the government, you know, we're now forced in some fashion to engage in value-based arrangements, where all those charges that happen to a patient are added up at the end, and the reason it has to be done this way is because that's how the machinery works.

So when you talk about like a risk sharing arrangement, it's all at the contracting level, and when you end up taking a risk, you know, financial risk, which is where, you know, frankly all our contracts are going now, that is the level when you say risk arrangement, and, you know, you end up in a system where providers come together to accept risk for that.

HEARING OFFICER MITCHELL: I'm going to interject, only because I think I -- so we've all read the application and everything, and I think we understand those payment, you know, arrangements, agreements.

I just want to make sure that her question, about how this is communicated to patients, so that they know and they have choice about their care,

like how does that happen, or does that happen at all?

DR. POSTERARO: It happens at the level that they end up signing on for an insurance policy or product, and the term we use is a narrow network, and that's the level that SOHO, you know, St. Francis Healthcare Partners existed and SOHO now exists.

That entity representing all of us, which are contracts all set together, we, RAH, has never had an independent contract in the last 25 years.

I've never had to negotiate with a payer. It's all been done by this legacy machine that's existed since the time of, you know, capitation, the '90s, to really help our primary care providers, you know, who are in that environment. That's what it is. I apologize if I've taken too long on this.

MS. VOLPE: Okay. Just in the interest of time, because I don't want to -- I mean I want to make sure we finish today, but my colleague, Kate Tommaso, who has an appearance filed, has some questions. You can use this one.

MS. TOMMASO: Thank you. All right. My questions are going to revolve around the CT and the MRI, the capabilities and type of scanning. I don't know who may be appropriate to answer that, so I'll just direct

them generally.

RAH has three existing CT scanners, correct?

DR. TWOHIG: Yes.

MS. TOMMASO: And all three of those scanners have been upgraded recently, in the past year, correct?

DR. TWOHIG: Yes.

MS. TOMMASO: And they've all been upgraded to the same exact CT machine, correct? They're all the SOMATOM go.Up 64-slice. That's in the application.

DR. TWOHIG: Yes.

MS. TOMMASO: Okay and the new scanner that you're proposing is also that same exact scanner, correct?

DR. TWOHIG: Correct.

MS. TOMMASO: All right and you call this? In your application on Bates page 23, it's noted that this is the same class and configuration. The proposed scanner is the same class and configuration that RAH has chosen to upgrade for its existing units, the Avon, the Glastonbury and Enfield, so would it be correct that the proposed Bloomfield CT scanner and the existing three CT

scanners have the same exact capabilities?

DR. TWOHIG: Yes.

MS. TOMMASO: So a patient, who is coming to RAH, could receive the same scan on any three of its existing scanners now, correct?

DR. TWOHIG: Yes.

MS. TOMMASO: And it could receive that same scan on the proposed CT scanner, correct?

DR. TWOHIG: Yes.

MS. TOMMASO: And there's no functionality in the new proposed CT scanner that is above and beyond what is in RAH's existing CT scanner, in terms of class and configuration, as what's used in the CT, or, excuse me, the CON application?

DR. TWOHIG: Yes.

MS. TOMMASO: Okay, so, there's no new or novel aspect to this new CT that is new to RAH's world of CT technology?

DR. TWOHIG: I'm sorry. Could you repeat the question?

MS. TOMMASO: Sure. So would it be accurate to state that there's no new or novel aspect to the proposed CT scanner that benefits patients above and beyond what is currently offered at RAH's existing CT

scanners, in terms of technology?

DR. TWOHIG: It's not a simple yes or no question, since it's the same technology, but it would be in a different, a completely different area.

MS. TOMMASO: So even though it's in a different location, it's still the same exact scanner that RAH has currently threefold?

DR. TWOHIG: Correct.

MS. TOMMASO: Okay.

DR. TWOHIG: In RAH, yes, but not in a local competition.

MS. TOMMASO: But, at RAH, it is the same exact scanner?

DR. TWOHIG: In RAH, yes, but not with a local.

MS. TOMMASO: All right. And in any of those scanners in the past years, has there been excess capacity in the existing CT scanners? I think you put this in your application, so, in the past years that you've disclosed in your application, it would be correct to say that there's been, historically, there's been capacity available at all of those three CT scanners?

MS. SMITH: Yes, that is correct.

MS. TOMMASO: I have a few questions on

the MRI, so I don't know.

DR. TWOHIG: Yes.

MS. TOMMASO: All right, so, RAH has two existing MRIs, and they're both 1.5T?

DR. TWOHIG: Yes.

MS. TOMMASO: Okay and it looks like you have a relationship with Siemens. Most of your equipment or all of your CT are Siemens machines?

DR. TWOHIG: A lot of the equipment tends to be Siemens.

MS. TOMMASO: Okay and, so, has Siemens or any other I guess MRI manufacturer approached you to upgrade your existing 1.5s to a 3T?

DR. TWOHIG: No.

MS. TOMMASO: Have you ever considered upgrading one of your 1.5s to a 3T?

DR. TWOHIG: Sure.

MS. TOMMASO: Okay and why was that upgrade not -- why didn't you go through with an upgrade for one of your existing machines if you have considered it?

DR. TWOHIG: I think we're looking for the optimal location, and I think, again, from public testimony, you heard very clearly, as to the benefits to

the community, whether it's a migration of cases from the costly hospital setting to an ambulatory setting that frees up time for the emergency room, things we don't usually think about, but the emergency room suddenly is able to provide their care quicker. We know that improves outcomes and saves lives.

The GI, a lot of our GI doctors and hepatologists, are located in the Bloomfield area, and it allows for their close proximity of care again to have that continuity of care provide a quicker, better outcomes, better patient experience, better or in a more cost effective setting, and our M.S., our Mandell Center, 3,400 patients, one of the largest in the country, right down the street, so there's proximity, and it certainly allows for a free flow of patient care to be one-stop shopping, where they can come in, get imaged, go to their report.

What better thing for a patient, who may be neurologically impaired, than to have that all available in a close medical neighborhood; get their scan and only have to make one trip, especially when they have, you know, underlying neurologic problems, so it addresses the needs of the total patient population, with patient outcome and patient experience as its prime goal.

MS. TOMMASO: So would it be your testimony that an M.S. patient does not have the ability to get the scan that they need in the area currently?

DR. TWOHIG: They can -- there is a 3 Tesla magnet at the hospital. It's more costly. As we know, it's over capacity, and, you know, to be honest, it's nice to be able to -- somebody, I think you mentioned it, Dr. Foxman, earlier, parking and access and ambiance, especially what we heard from Dr. Wade.

They're on a chronic surveillance. They get scanned every year. It's nice to be able to come into an environment that is welcoming. Not that a hospital isn't, but an office certainly has -- is setup a little different.

It's a relaxing place, and it can really have a healing presence to it.

MS. TOMMASO: So would it be accurate to say your testimony is that there's an element of patient convenience, and that's driving a lot of this?

DR. TWOHIG: No. I would say that it's not that simple, and it shouldn't be boiled down to convenience. Convenience is an understatement that really doesn't understand the patient experience.

If you're simply labeling the humanity

you're trying to provide to a patient as convenience, you don't understand medicine really.

I mean it's trying to make that patient throughout their -- as they come through a very difficult disease process, to make them as comfortable as possible. Can you label that as convenience? I don't.

MS. TOMMASO: Okay.

DR. TWOHIG: I'm sorry. I'm a little passionate about that, but I have direct -- and we know we're forward-facing in radiology these days, direct interaction with patients, and I'm very cognizant of that.

MS. TOMMASO: All right. Has RAH ever considered relocating one of its current MRI scanners to address this need gap that it's found in the Bloomfield market?

DR. TWOHIG: No.

MS. TOMMASO: Okay.

MS. VOLPE: Do you know that you can do that without regulatory approval?

DR. TWOHIG: I'm very aware of that, yes.

MS. VOLPE: Okay and you know you can upgrade to a 3T one of your 1.5s without regulatory approval?

DR. TWOHIG: Very aware of that, as well, yes.

MS. TOMMASO: All right. I have a few questions on the proposed breakdown of scans for the 3T scanner. One is that, in the application, there is a basis for the proposed scans for the 3T, and that's based on the historical volume of RAH over the past years and I think, in part, of the annualized data for 2019, is that correct?

MS. SMITH: Yes.

MS. TOMMASO: Okay, so, also in the application, it sets forth that the 3T can be used for a significant number of scans that a 1.5 cannot be used for, correct?

MS. SMITH: Correct.

MS. TOMMASO: So when you based your numbers on your 1.5T capacity, did you take into consideration the fact that you're now moving to a new type of machine, a 3T that's going to see all of these new types of patients that RAH currently cannot see?

MS. SMITH: We did.

MS. TOMMASO: And has that number been determined by RAH what that difference is?

MS. SMITH: As best as one can project.

MS. TOMMASO: And, so, there was a number associated with that difference?

MS. SMITH: We had a projection that we calculated into that, a projection that is submitted into the application.

MS. TOMMASO: So the specific difference between utilization on your current 1.5Ts, which see, I would imagine, your plethora of outpatients for basic needs, basic MRI needs, is your basis for your 3T, but there is a difference that you've calculated to incorporate the patients that you will now be able to see on the 3T?

MS. SMITH: If you can just give me one moment, please?

MS. TOMMASO: Sure. Did you have an answer?

MS. SMITH: Yeah. We processed your question.

MS. TOMMASO: Sure. Sorry. It was lengthy.

HEARING OFFICER MITCHELL: She just needed to break it down a little bit.

MS. SMITH: So what we looked at was we did not -- we took a look at our charges on our 1.5

billing for the exams that we're performing today on the 1.5 Tesla magnet, and we looked at, with the additional software, that the radiologist had specified on the new 3T magnet. We did not define exactly how many cases would be added to that, but we did look -- let me correct that. I'm sorry.

We did look at the current 1.5 volume of charges, and we looked at with the additional software that we had spec'd out and added those two together to come up with these projections. So the page reference to that is OHS 090. All right, so, that's on Table C. We have to get to the Bloomfield page, but Table C.

MS. TOMMASO: So RAH did not calculate the number of patients that it could not see on a 3T currently and add those into its projected utilization?

MS. MILLER: Can you ask that again, without the double negative, just to make sure?

MS. TOMMASO: Sure. Did RAH calculate the exact number of patients or percentage of patients that it cannot see, because it does not have a 3T?

MS. SMITH: No.

MS. TOMMASO: Okay.

MS. VOLPE: We have one last question and then we're done. The question is why wasn't the

Statewide Health Plan used in defining your primary service area? Why didn't you use the definition in the Statewide Health Plan, or in, sort of a two-part question, or in any recognized service area composition that's traditionally before this agency?

MR. ROSE: Objection. So, in terms of snuck premises, you know, the whole question is loaded with things, like why didn't you follow the plan?

MS. VOLPE: Okay. I'll rephrase it, if you'd like.

MR. ROSE: Yeah. Thank you.

MS. VOLPE: Did you utilize the definition in the Statewide Health Plan for defining your primary service area?

MR. ROSE: Could you read for me that definition?

MS. VOLPE: Sure. Primary service area means that geographic area by town for the service location in the application consisting of the lowest number of contiguous zip codes from which the Applicant draws at least 75 percent of its patients for this service.

MS. MILLER: Just as a follow-up question to the definition you just read, is your understanding,

since you're asking the question of us, that that's a service area of imaginary people or a service area of surrounding?

MS. VOLPE: No. It's a service area of the Applicant, which is RAH, and it's 75 percent of the contiguous zip codes of the patients of RAH.

MS. MILLER: Versus the actual --

MS. VOLPE: Not RAH's, not SOHO, or it's RAH in as the Applicant.

MS. MILLER: And it's RAH in a certain location? So, for example --

MS. VOLPE: No. It's RAH in all of its offices.

MS. MILLER: I'm trying to understand the position just for the question.

MS. VOLPE: Well, I mean, if you're not sure how to define a primary service area for purposes of the CON application, that's a problem, because it's clear --

MS. MILLER: Well, no. I think --

COURT REPORTER: You can't talk over each other.

HEARING OFFICER MITCHELL: Wait. Wait. Wait, wait, wait.

MS. MILLER: My apologies.

HEARING OFFICER MITCHELL: So I don't want you to talk about what you feel the definition might be. Can you just, so Attorney -- Attorney Rose is raising his hand.

I just want to make sure. So I think the question is -- just so you know, OHS has a question on that, as well. So we generally look at the need methodology in a way that kind of like looks at the entire state, like, you know, the state per capita, and, so, we're going to ask you a question about that, so I think that this kind of is derived from the fact that the methodology that you provided to us is very different, and I don't want to speak for you.

MS. MILLER: No. This is a good transition.

HEARING OFFICER MITCHELL: So I think that the question is how did you come up with your primary service area if you used the definition -- did you use the definition that was in the Statewide Healthcare Facilities and Services Plan, and then how did you apply that to come up with the methodology that you provided us?

MS. MILLER: Thank you. That is not a

question that we have an objection to. I appreciate that.

HEARING OFFICER MITCHELL: But I just want to make sure. Am I mischaracterizing it?

MS. VOLPE: If it will help, in the interest of these proceedings, we can conclude our Cross and turn it over to the Department's questions, with this being the first one, because this is we feel very important and would like an answer to, as well.

HEARING OFFICER MITCHELL: Okay.

MR. ROSE: Okay, so, I want to start, because part of this really gets down to the notion that somehow we came up with towns to monkey with numbers to manufacture the results that support our proposal, so I do want to start by saying, and I think everybody here can all attest, that nobody looked at towns and then scanners and capacity and then said, oh, let's take out this town and that town, and now, look, we've got capacity according to the plan standards, so all of these folks, you can all say aye, we all attest that nobody did that before they defined the towns.

HEARING OFFICER MITCHELL: Can one of your witnesses speak to it more than you? I just want to be sure.

MS. SMITH: So in creating a service area, we took an analysis, detailed analysis of all of the RAH charges for all of the zip codes, and we're able to define the service area based on the charges, where of those patients, and it's based on where patients are, their address.

MS. VOLPE: Okay, but, when you define a service area as an Applicant, normally you include the population where you have existing services.

A FEMALE VOICE: Are we still on Cross-Examination?

MS. VOLPE: Well, I mean, this was in a question that I just want to make sure that we have the ability on this one question and continue to follow-up to get the answer.

HEARING OFFICER MITCHELL: Actually, we weren't, but I'm going to allow that question, though.

MS. SMITH: But this is new equipment, so we don't -- there is -- RAH does not have new equipment in the new service location.

MS. VOLPE: Right, but they're an existing provider, right? They're an existing provider in an area, and they're the Applicant. I think they're an existing provider in this service area, maybe not in your

narrowly-defined PSA, but in the State definition of a primary service area, RAH is a provider.

MS. SMITH: That is correct.

MS. VOLPE: Right, so, as a provider, why did you not include in equipment and towns and zip codes from where RAH is providing services?

MS. SMITH: When we looked at our analysis and we went through previous CON submissions, there are other CON submissions for new services that calculate the primary service area different ways.

MS. VOLPE: None of which have prevailed, I would add. I mean that’s not -- I mean, if you have a service area and you’re a provider, this isn’t a new service for RAH. You have imaging equipment, so it’s not analogous. This is not a new service.

HEARING OFFICER MITCHELL: So let’s just take a moment. Do you guys need to talk to your witness? Let’s just take two minutes. We’ll go off the record. I just want to let you guys confer, so that we can get clarity on the record, okay? Thanks.

(Off the record)

HEARING OFFICER MITCHELL: All right, so, I know that I had turned it back to you, Attorney Volpe. Did you want to just re-ask the question?

MS. VOLPE: Sure. Why didn't you use the definition in the Statewide Health Plan for purposes of defining your primary service area in the application?

MS. MILLER: I'm a little sad we're back on that. If --

COURT REPORTER: If you can just grab that microphone?

MS. MILLER: I think that's what we're trying to get at.

HEARING OFFICER MITCHELL: Okay.

MS. MILLER: Whether or not it's a violation, one way or the other, is, honestly, for you guys to decide, but we'll tell you exactly what we did, to the extent that that's going to be helpful, and I think that will get at everyone's question, I hope, at this point.

HEARING OFFICER MITCHELL: Can I just interject? Did you think, when you were doing it, that you were doing it accurately?

MS. SMITH: One hundred percent.

HEARING OFFICER MITCHELL: Okay, so, tell us what you did.

MS. SMITH: So I took an extract of all of the RAH billing data, five patient address zip code, and

analyzed that to create 80 percent of that volume to create the ERA service area.

MS. VOLPE: Okay, so, how can that be, when you have imaging equipment in Enfield and Glastonbury and you don't include that volume or those zip codes in your service area?

MS. SMITH: For ERA or for Bloomfield?

MS. VOLPE: Well Bloomfield isn't the Applicant. For defining your service area.

MS. MILLER: There's two different parts to this application, and I think you may be getting confused. We used two different service areas, one for the ERA part and one for the new Bloomfield location, of course, a location that does not exist, so it was actually done two different ways, and I'm worried there may be some confusion.

MS. VOLPE: Well I don't know that there's a distinction in your service area by virtue of your three-part CON. I never saw that.

HEARING OFFICER MITCHELL: So what I'm going to say is we're going to -- we're actually going to table this discussion until OHS asks its questions, because I think we were going to ask for a late file on this, and we may ask you to re-do it, but let's move on.

I'm just going to turn back to Attorney Volpe. Anything else that you wanted to ask on the issue?

MS. VOLPE: Well, on the PSA, I guess just you put Suffield in your primary service area to utilize equipment in Avon. Why wouldn't residents of Suffield use the equipment right next door in Enfield?

MS. SMITH: Avon?

MS. VOLPE: You have equipment in Avon, Enfield and Glastonbury. You've defined your service area to include Suffield. Why wouldn't patients from Suffield go to your CT scanner in Enfield? Why would they travel down to Bloomfield?

HEARING OFFICER MITCHELL: Let me just ask. Do you recall putting --

MS. SMITH: It is in there, and I can't tell you why patients go. Do they go, based on where they work? I can only tell you from where we bill.

HEARING OFFICER MITCHELL: So, like you said, based upon where your charge is?

MS. SMITH: That's correct.

HEARING OFFICER MITCHELL: All right. I'm just going to -- I actually am going to go ahead and we're going to hold off on the discussion of the mean

methodology just for a few moments, and then we're going to -- I think we're going to just take a super quick break, because I think that some of the questions that the Applicants asked the Intervenors and the Intervenors asked the Applicants may have disposed of some of our questions, but then, at the end, then we will ask for some late files on the mean methodology, just to make sure that everything is consistent. That sound good?

MS. MILLER: That sounds great.

HEARING OFFICER MITCHELL: All right, so, just like maybe two or three minutes for Jessica, Brian and I to confer, then we'll come right back on the record. Thanks.

(Off the record)

HEARING OFFICER MITCHELL: Back on the record. So we're going to start with some hearing questions. My colleague, Jessica Rival, is going to begin.

MS. JESSICA RIVAL: Hello. In Exhibit L, a letter submitted to Representative William Petit and forwarded by Representative Petit to OHS, Dr. Twohig writes that the traditional method of determining need that would historically support approval of a Certificate of Need for new imaging equipment has largely focused on

counting scans.

We emphatically believe that this method of determining need is outdated. Could you explain what you meant when you said that the method is outdated?

COURT REPORTER: Microphone, please?

DR. TWOHIG: Can you hear me now? It really centers around a lot of what we've been discussing today with the shift in the paradigm from a purely fee-for-service model and, you know, the inherent sort of need for additional market share and additional volume as we go into a risk-bearing contracting, and it really focuses on patient outcome and trying to control the total cost of care, so that was really with an eye towards the future and knowing that that is going to become a more common model in the near future.

MS. RIVAL: Okay.

MR. CARNEY: Can I just do a follow-up? So would you think, then, that it's possible that there would be quite a few, say, more additional scans in that whole process, you know, for like whatever, lung screening, that may sort of have a larger upfront cost, but thereby reducing overall cost of care to the patient long-term?

DR. TWOHIG: Exactly. And that's very

interesting you asked about lung scan, and one that we have seen been addressed here quite a bit today, the tremendous growth, year ‘19 over ‘18 in our CT volume, and a lot of it is attributed to coronary calcium scoring, which is a test to look at the coronary arteries, look at the structural heart disease, identify people early, so they can be treated early, and that’s an excellent question about the overall cost of care.

Some money, seed money upfront, but tremendous savings for the overall cost of care by identifying it earlier, and to make that, to highlight the value of that, we have been extremely aggressive at RAH, and I think it accounts for a lot of the growth.

Extremely aggressive in our price point for coronary calcium score, and we charge $99, and, as far as I know, that is the lowest price that we can find anywhere, and the reason to do it is recognizing how important it is, to your point, Mr. Carney, to get people in earlier and, you know, not only have an impact on their life, but hopefully effectuate a decrease in cost of care.

MR. CARNEY: Thank you.

MS. RIVAL: Could you describe what you believe will be the best alternative to counting scans to

establish need as it relates to the CON approval for imaging?

DR. TWOHIG: Well I think that is still obviously very important. Capacity is a critical issue, but, in addition, I think it's an eye towards alternative payment models and understanding that patient choice, I know that doesn't come up too often, but patient choice is critical, and that, if there are systems that are functioning different, you know, significant differences between the systems, that a patient has an opportunity to avail themselves to one or the other.

And much to the point of in radiology, in the setting of radiology, taking an aggressive stance towards key critical screening tests and trying to create novel ways to be able to have more patients take advantage of them, and, in particular, a vulnerable population, so strategically picking locations that are near vulnerable populations, bus lines, anything that affords those patients the opportunity for greater interaction.

You know, it's interesting. Radiology in a lot of settings has become an entree in for people, now that we've become more active in screening. It may be the first time that they come into the healthcare system,

and I think we have to have that forward-thinking approach and say how do we ensure that we can provide that access and do so where people really need it?

MS. RIVAL: Okay. Again, for you, Dr. Twohig. On page five of the pre-filed testimony, it states, in relevant part, that, given there currently is no RAH MRI or CT scanner located in Bloomfield, the SOHO network is suffering leakage with respect to patients, who use the CIP services purely out of convenience.

I know we touched on this a little bit before, but is there any way we could, you know, get to what you mean by leakage, get that definition on the record?

DR. TWOHIG: Sure. Patients migrating outside of our network, out of our contracting network.

MS. RIVAL: Okay and would anybody have information on the percentage of SOHO patients that have been lost to CIP, due to lack of in-network MRI and CT scanners in Bloomfield?

MS. SMITH: We can try to quantify it. I'm not sure. Again, in the leakage data that we looked at, it was limited by the MSSP payers, and it wasn't specific to any one imaging site, so I'm not sure that we can give you exactly what you're looking for.

MS. RIVAL: Okay. Are you able to give any percentage of what the patients that are receiving services are part of this SOHO clinically-integrated network?

MS. SMITH: Could you repeat that? I'm sorry.

MS. RIVAL: Sure. What percentage of the patients are those that are receiving services as part of SOHO's clinically-integrated network?

MS. SMITH: I don't have that number off the top of my head. It would be an estimate.

MS. RIVAL: Okay.

MR. CARNEY: What would your estimate be?

MS. SMITH: I would estimate greater than 75 percent.

MS. RIVAL: Thank you. On page six of the pre-filed testimony, it states that the underserved area of Bloomfield and Hartford might not be willing to travel to Avon, Glastonbury, or Enfield to receive their imaging services.

Since the Town of Avon is included in the proposed service area for the new equipment, you had stated previously that you had not considered moving any equipment to the new Bloomfield site. Could you tell us

why?

DR. TWOHIG: Sure. It's really a twofold answer to that, but Avon, the CT has been at, with 2019 numbers, 59 percent capacity, but had 36 percent growth year '19 over '18, due to some of the I think novel screening tests that we've employed, as well as the upgrade of our existing equipment, so I see and would anticipate that that type of growth that it's extremely well-received by the public, and that type of growth will continue or even expand, and that, when you have expansion in screening, there will be additional imaging, as people, you know, become familiar and know where the site is.

Avon serves the Farmington Valley, and it's its own environment and location. The other services there, ultrasound and mammography, are extremely busy, and it's, again, affording the patients that opportunity to have all services available.

Bloomfield is a different entity. Geographically, their patient population is different as we serve Bloomfield and a lot of the north end of Hartford.

You know, it's on the bus line. It's readily accessible, so the vulnerable populations are

easy to access it.

The local providers are overcapacity, and, as we heard through the public commentary, it allows for not only the service of the M.S. center with all those patients, but, again, to decant patients away from the hospital, and it saves money in a less-costly environment, opens up services, and you heard from Dr. Wolf and Dr. Brunell from our E.R. that decreased turnaround time to get those studies done increases patient outcomes, patient experience, so it's an entire process that looks to me as just a win/win/win down the road, where patients do better in the hospital, they do better in the community, appropriate triage of patients to a less-costly setting, savings to the overall cost of care, and done so with ready access by local population.

MS. RIVAL: Thank you.

MR. CARNEY: Can I just follow-up quickly? So what you're saying is, basically, right now, it's sort of at middling capacity, but you've seen some significant growth, and you anticipate continued growth in that area.

Also, being that it's in the same service area, though, and you're saying that sort of Bloomfield is a very ideal location, would it not be plausible that people from the Avon area would be willing to go over the

mountain in the other direction and receive their services at Bloomfield, if that's really and truly the ideal location to serve underserved and, you know, underserved population?

DR. TWOHIG: Yeah, no, absolutely. I find it interesting they call it a mountain, and, having grown up in --

MR. CARNEY: I live there. I'll disclose. Right near that.

DR. TWOHIG: Well having grown up in Massachusetts, as we were talking about earlier, it's a relatively small mountain, yet it seems to be an impenetrable barrier, especially once you hit winter, if we're ever going to have winter again, but especially when you hit winter.

So I do think not only is it geographically separated, but we're not just servicing Avon, as you know, but communities west of there, north of there, south of there, so the distance has increased exponentially.

You know, for comparison, I mean not that you ever want to make comparisons, but our partners across town have offices in Farmington, Avon, Bloomfield, and, you know, there is a need to accommodate these

various communities.

Sometimes, I'm amazed at how what an obstruction a thing as a mountain or a river can do for patients to travel to critical imaging or critical medical facilities.

MR. CARNEY: Okay. Thank you, Doctor.

HEARING OFFICER MITCHELL: So this is also for you, Dr. it's Twohig?

DR. TWOHIG: Twohig, yes.

HEARING OFFICER MITCHELL: Got it. On pages three and four of your pre-filed testimony, you discuss the proximity of the Bloomfield site to St. Francis Hospital, and you talk about how the ease of access will allow for potential migration of hospital-based CT volume to the ambulatory setting for those patients, whose acuity does not require a hospital level of care, and, so, I think the question that I have is whether you can describe in detail your plans to facilitate the shift in volume to the proposed ambulatory setting in Bloomfield, because I don't think we have a clear picture of how that looks.

DR. TWOHIG: Sure. I think, by all the things we heard from the public testimony, from our ER docs, our GI docs, neuro, all these folks, they will send

out patients to the hospital currently for non-urgent outpatient imaging, whether it's on our 3 Tesla magnet, which we know we have at the hospital, which is over capacity 268 percent, or the CT, or the MR, you know, the MR setting.

It will be a natural migration. I'm not sure how much we have to facilitate. It will be a natural migration as services become available and as integrated, you know, clinically-integrated networks really have more involvement in the delivery of cost-effective care in a setting that, frankly, and sometimes we know it's not quite as bad, but, frankly, is a much more welcoming setting out in the community that it will just be a natural migration, that physicians will use that close proximity office and, with that, free up the services at the hospital for the more high acuity cases out of the emergency room, out our Intensive Care Unit.

And, with all that, the system as a whole will see tremendous savings, because CTs are done quicker, abscess drainages are quicker, patients are treated quicker, diagnosed and treated, and cost savings, better outcomes.

HEARING OFFICER MITCHELL: Can you talk a little bit about the benefit and quality of care to

patients having the proposed equipment in network for people, who are SOHO patients?

DR. TWOHIG: I'm sorry. Could you repeat that?

HEARING OFFICER MITCHELL: So can you identify benefits and quality of care to patients, to SOHO patients, as a result of being a part of that, I guess, clinically-integrated care model?

DR. TWOHIG: Absolutely. I mean it really is on multiple levels. It goes between multi-disciplinary conferences, developing protocols, working through complex clinical situations, doing the more mundane operational things that you were just alluding to, deciding, as teams of subspecialists, caregivers, nurses, transporters, what is the best environment?

How do we optimize that for the patient? How do we optimize the patient experience? So, from the patient's standpoint, that is one way, but, also, the equipment, as we heard from Dr. Wade. You know, the 3 Tesla scanner out in the community be able to do that for our M.S. patients, our neuro-oncology patients.

We have a very active neuro-oncology service, and we've invested in a very sophisticated neuro-oncology software package that allows us to do

follow-up brain tumor analysis out in the ambulatory setting, so those are just a few examples.

In CT, we talked about it with the calcium, coronary calcium scoring, where we would be able to investigate early for structural heart disease and help either, as we heard from Dr. Jilad(phonetic), that we can -- they are taking our data from that and working with optimizing the patients' medications to hopefully avoid more invasive procedures, like surgeries, and just have medical management optimally treating what was previously undiagnosed coronary artery disease, so those are a few examples of both the CT and the MR of how the patient experience and patient outcomes will be significantly enhanced.

HEARING OFFICER MITCHELL: Thank you.

DR. TWOHIG: Thank you.

HEARING OFFICER MITCHELL: This question is for Dr. is it Posteraro?

DR. POSTERARO: Posteraro.

HEARING OFFICER MITCHELL: Posteraro. Sorry about that. So in your pre-filed testimony on page 23, you state that the 3T MRI that's owned by Farmington Imaging Center is not configured to meet the needs of your network clinicians.

Can you talk a little bit more about that statement?

DR. POSTERARO: Let me find the page. I'm sorry, 23?

HEARING OFFICER MITCHELL: I think it was page 23. I think we re-paginated them.

DR. POSTERARO: Okay. I got it. My friends here have it. Got it. I guess, you know, it's a, just to get to some of the nuance, sort of the global concept, you know, my intent wasn't going to be pejorative or anything.

It was specifically to the best of our knowledge, because we work with neuro disease management teams to develop applications to serve our, I guess, for lack of a better term, from a business perspective, our internal customers, so the providers here within our network, primary care docs, specialists, cardiologists, GI, some of our cancer teams, they're our internal customers that we, you know, work with the patients within our network, you know, to generate diagnostic information.

The value of that information is in making a diagnosis. Think of medicine as two wings. There's treatment and diagnosis, which a lot of technology we

work with is becoming increasingly integral to managing that.

Whenever we look at a need for internal customers, it comes down to specifically what are the clinical situations and questions that they need to answer, and how do we budget and, you know, deploy equipment to be able to generate that kind of information, and I would ask you to think about a piece of imaging equipment as like you'd think about a Swiss army knife.

So it's a tool. You can get some tools that have more blades and things on them. You can get some that have less, but you try to choose the Swiss army knife. It's going to do what you need it to do, and that comes down into how you actually package and configure and talk to companies, like Siemens or General Electric, to, you know, what you intend to do with it.

So our process would specifically, I guess, at the hospital, you know, there's increase in need for a cardiac MRI to evaluate structural heart disease.

This is becoming, for my cardiologists, the standard that they manage patients with arrhythmias and cardiomyopathies. It's to the point where, pretty

much, 15 years ago, when I started and we began doing this, it was a relatively novel thing and something that we would do at the hospital.

We may do one or two, you know, one or two a week, but now it's becoming extremely frequent, so now I need to configure this tool, the MRI, with the proper software, coils, packages to accomplish that clinical need in the community.

When you buy an MRI, you know, and you deploy it, it isn't that each MRI is equal. It has to actually be budgeted and configured with the packages and software put into it to accomplish that.

You know, other applications for, you know, our cancer center, particularly radiation oncologists, increasingly, we're using MRI to follow patients, who have locally-treated disease with a cyber knife and stereotactic radiotherapy in structures, such as the brain and, particularly, the pelvis in this case with rectal tumors, you know, malignancies, where your earliest ability to detect is the tumor coming back or where it is is using some MR sequences that are relatively recently developed and are optimally done on this tool, so we just make sure that we've linked up the clinical, you know, figured out what the clinical needs

are, where the patients are, and it's part of the care redesign process, configured the right way and the right place for them to serve the network and our care teams.

HEARING OFFICER MITCHELL: Thank you.

MR. CARNEY: Okay. This question is probably going to be for you, Ms. Smith, so it relates to data. Your pre-file on page 45, I noticed the indication of a significant increase in both CT scans and MR volume in fiscal year 2019.

Our Executive Director is especially interested in how scans are being used by type. Can you explain sort of, provide an explanation for why this growth has occurred?

MS. SMITH: Sure. A couple of reasons. As Dr. Twohig has alluded to, we've seen a tremendous growth in the cardiac calcium score CT exams that we've done.

The other area that we've experienced tremendous growth is in the CT lung screening program. We started that program in 2017 as an accredited site for the American College of Radiology.

Once those patients, who have a 30 pack a year history of smoking, have one scan, they'll be followed. Just like a mammography patient would be

followed for breast imaging, lung patients are followed, as well.

So we've seen an increase in that volume of scans as those patients are enrolled in the program.

MR. CARNEY: So you do like a base assessment, and then you --

MS. SMITH: That is correct, and they would have either a short-term follow-up, or a longer-term follow-up, depending on the outcome of their scan.

We've seen organic growth. St. Francis opened an infusion center on the second floor of our building in our Glastonbury office, so we've seen an uptick in that office specific to oncologic imaging, an increase in growth in worker's comp imaging. Does that help?

MR. CARNEY: Yes. We're going to ask for a late file, as well, I think, to sort of break that down for us.

MS. SMITH: Sure.

MR. CARNEY: Another concern for our leadership, and this would be for whomever wants to take the question, but, historically, there have been concerns about potential correlation between excess capacity and the overutilization of imaging equipment.

Explain why the projected increase in the growth of CT and MRI scans at RAH is reflective of need or demand for services, as opposed to excessive or medically-unnecessary use.

DR. TWOHIG: So I think we discussed that, you know, sort of around the edges, but a lot of it has to do with screening, self-screening procedures, such as coronary calcium scoring, lung nodules, some worker's comp, and I think, with a more active screening program, as we discussed, I think, overall, you're more likely to see an overall decreased cost of total care, so, although there may be an uptick in the number of cases, a lot of these are strategically positioned price points to be as inclusive as possible, realizing the significant population health benefit.

MR. CARNEY: Okay. Dr. Posteraro, you had something to add?

DR. POSTERARO: The danger of maybe adding some other context, because sometimes I wear a slightly different hat in the organization, but I think, you know, where we're going and actually already, frankly, already are here, is looking at how we're taking care of patients on a sort of globally-budgeted process, and, you know, just by virtue of a Medicare-shared savings contract, you

know, we're actually taking financial risk on that, it's becoming increasingly incumbent on the organization to not over spend, so this internally creates, if you will, a buttress to have to figure out am I doing too many scans? Am I doing too less scans?

If I'm going to do, like Mike is saying, that extra screening scan, there's going to be a benefit that comes out, which gets to the whole heart of care redesign, so we're really in the stages of this internal organization, but the person, who is ultimately, if you talk about a cost, you know, financially responsible increasingly, is the actual providers at that network level, because the way our contracts are now and are going to increasingly, after a year, they close, and each one of those charges is added up for the patients, who are under that contract, and if we go over point, we pay it back.

MR. CARNEY: So there's a disincentive for you to over utilize or over prescribe imaging in your paradigm versus the old fee-for-service?

DR. POSTERARO: I would say very, very, very much so, and we had a lot of active discussions about that, because, in the end, you know, if we don't do it right, we're all -- everybody within our network is

collectively cutting a check back to CMS.

MR. CARNEY: Okay. All right. I also have a couple of questions for the Intervenors.

So new equipment is being proposed to come into the Bloomfield area, so I'd like to know if you could describe what equipment you currently have for MRI and CT scanners located in Bloomfield, as follows.

So I'd like to know the age of the equipment, sort of the technical specs of the equipment. Do you anticipate replacing any of that equipment in the near future, and how your equipment, you know, compares on a quality basis compared to the proposed equipment that RAH is suggesting. Can you do all the things that they're wanting to do with their new equipment or provide that service?

DR. FOXMAN: Sure. So I'll just -- pardon me. I'll provide you sort of a matter-of-fact assessment or representation of where we are.

So, in the Bloomfield office, there's a Hitachi open MRI, Oasis model. It's a 1.2 Tesla high field open MRI.

That MRI is designed for patients, who are claustrophobic, large body habitus, so, often times, there's a sense of, well, the higher the Tesla the better

the MRI, but, actually, low field MRIs and open MRIs occupy a certain niche around patient needs, and, years ago, our thought was, not just in Bloomfield, but in the actual service area, that was something that was needed by that patient population.

I don't know the age of that scanner. That scanner I believe went through or has been represented in public documents related to this agency, and it would have its age as several years old. It was considered top line open MRI at that time.

MR. CARNEY: How long are they usually effective for, Doctor?

DR. FOXMAN: Generically, an MRI, it depends.

MR. CARNEY: It depends who you ask.

DR. FOXMAN: Yeah, exactly. I saw one MRI go 18 years in service in our service area. That wasn't our MRI. I think that was a little beyond things. Five to seven years I think is generically for an MRI considered, you know, whether it's depreciation lifetime, or sort of replacement cycle lifetime, installed modality basis.

If they're refreshed around five to seven years, that's considered, you know, progressive. Ten

years is acceptable.

MR. CARNEY: Thank you.

MS. VOLPE: Just to add, there is discussions on adding and increasing capacity right in that same service area for imaging. There's always discussions on adding.

MR. CARNEY: In your internal discussions?

MS. VOLPE: Internal.

DR. FOXMAN: The CT scanner is a General Electric BrightSpeed. It's a 16-slice scanner, with ACE or dose reduction technology.

I don't know the age of that scanner, but it's within our replacement cycle, so we have an installed modality base refresh plan, and our plan usually moves equipment out at about five to seven years, and this is within our refreshment cycle, and, so, I think we find that the 16-slice scanner with the ACE or dose reduction very satisfactory. I use the word satisfactory in this context, but it covers imaging short of cardiac imaging, where there's motion.

We actually thought hard about this scanner. This was several years ago. Again, in consideration of Bloomfield as one of the suburban locations relative to the Hartford Metropolitan service

area in general.

It's population density put a lot of consideration into like where are the major medical centers? Where are their sort of specialty facilities located, and we thought, again, within the primary service area, this standard is doing good work for the patients.

MR. CARNEY: Okay. How does the cost of your imaging services that you're providing in Bloomfield compare to RAH for MRI and CT scans?

DR. FOXMAN: Yeah, I'll take a shot at that. I actually don't know what other providers are getting paid, and I believe that probably, depending on the insurance carrier and all sorts of things, there isn't like a single set point.

I can share that we have been in an integrated delivery system since 2013. I understand from today that SOHO is about three months old.

The discussion today around streamlining of care, etcetera, is very familiar ground, and the risk-based models of payments is very, very familiar ground, so I actually don't know what other providers around the state get paid, but I know we've been in risk-based models, and it's not new, and I'm presuming that, you

know, as a pretty well developed integrated delivery system, you know, probably what we get is going to be similar to what other integrated delivery systems get.

That's just me speculating. I think that information is blinded for me.

MR. CARNEY: I think we're going to probably ask for a late file sort of related to that.

MS. VOLPE: From us on fees?

MR. CARNEY: On average cost, yes. It's very important to our leadership, unequivocally.

MS. VOLPE: Yeah. I think we can certainly attest that they're market-based. I am worried about two competitors, direct competitors in a market sharing fees.

MR. CARNEY: We can do it confidentially if that's a problem or issue, but, like I said, I know that our Director would want to get a compare average cost for that type of service for its patients.

MS. VOLPE: Okay and a lot of it is based on the payer.

MR. CARNEY: Payer mix. Yes, I'm aware of that.

MS. VOLPE: Yeah, so, it's, you know, whatever ConnectiCare is paying for a scan is what you're

going to get, and I don't know and I don't want to speak for it either, because I don't know, but I think it's probably not advanced to the level where the SOHO or even the integrated network is saying, okay, now we're going to pay you, provider, a fee.

I think it's still based on the commercial payer fee schedule, you know, on a fee schedule and not based on, you know, saying, oh, we're going to -- SOHO is taking or Hartford Hospital Network is taking the risk up here, and we're going to decide now we're paying RAH or Jefferson $1,000 for an MRI scan. I mean that is really an advanced level of risk.

I think -- and I guess I will say, if you're going to require us all to put in our fees, I mean it is a bit cause for pause on that, because we are competitors. We're not really supposed to be sharing.

I mean, you know, there is some concern on that front, but it is market-based.

MR. CARNEY: The Applicant has provided us with that information.

MS. MILLER: We have no concern about it being confidential, you know, however they feel comfortable, but we agree of the importance of the data, and we're happy to share updated numbers, if that's

helpful.

MS. VOLPE: Okay. I mean to the extent we can provide a fee schedule, we will.

DR. FOXMAN: And I can share this. I know there's a fee schedule and then there's charges and collections.

MS. VOLPE: That's a good point.

DR. FOXMAN: Yeah, so, I mean, there's multiple ways of representing, where we can provide what is required.

MS. VOLPE: Excellent point. What would you like, Mr. Carney?

MR. CARNEY: Yeah. I'd like you to provide something similar to what we've asked of the Applicant. Exhibit C of the completeness response, pages two and three, they've provided an average cost of CT and MRI scans.

MS. VOLPE: So not a fee schedule. Just a cost?

MR. CARNEY: Correct. For commercially-insured patient and cost, as defined as total dollar amount paid by the insurer, plus patient out-of-pocket cost, deductibles, co-pays.

MS. VOLPE: Okay, sure.

HEARING OFFICER MITCHELL: I think, to make it easier, so that everyone knows what they need to provide, I'll issue an order for the late files. I'll do that.

MS. VOLPE: That would be great.

HEARING OFFICER MITCHELL: Either later on today, when I go upstairs, or early in the morning, so that everybody knows what we need, so you don't have to worry about whether or not you got your notes right.

MS. VOLPE: Okay.

HEARING OFFICER MITCHELL: Yeah.

MR. CARNEY: Okay.

MS. MILLER: One just kind of comment about timing with the late files.

HEARING OFFICER MITCHELL: Yup.

MS. MILLER: I do know that, immediately following this, we will lose both Ms. Smith and Dr. Twohig for about a week.

Luckily for them, they'll be on vacation, so we would really appreciate just some additional time, especially that it's critical for our numbers, to be able to get anything like that together for you.

HEARING OFFICER MITCHELL: So I'm amenable to giving two weeks. I don't have a problem with that,

as long as it's, you know, okay.

A lot of times, the Applicants come in, and they really want to get their decision, you know, as soon as possible, yeah.

MS. MILLER: No, that's great. And, obviously, we understand it would extend the decision time, too. That's not a problem.

HEARING OFFICER MITCHELL: Two weeks. Okay.

MS. VOLPE: Sure.

HEARING OFFICER MITCHELL: All right.

MR. CARNEY: Want to start on the late files?

HEARING OFFICER MITCHELL: Yeah. We'll just kind of go over what we had discussed, putting in the order for the late files.

So the first thing surrounds the need methodology, and we wanted the Applicants to provide a detailed summary about how you came up with the proposed service area, how you derived that.

And before I do that, I just want to make sure that we also get into the record, too, Attorney Volpe, the definition that you read for PSA, was that in the Statewide Healthcare Facilities and Services Plan?

Was it the 2012 one?

MS. VOLPE: It was, yes.

MR. CARNEY: Was it in a particular section, like inpatient?

MS. VOLPE: It's in the imaging.

MR. CARNEY: Imaging section?

MS. VOLPE: Yes. It's in section two, chapter five, Imaging and New Technology, page 60.

HEARING OFFICER MITCHELL: Thank you. Yeah, you can go.

MR. CARNEY: Okay. Second thing we would like, there's been a lot of discussion, obviously, about machines, where they are, how many there are, volumes, what should be included, what should not be included, so, to me, I think it would be a good way to do it, to have both of you submit -- I'll read it.

Provide updated tables to include all CT and MRI scanners that currently exist within the proposed service area, which I have right now defined as Avon, Bloomfield, East Granby, Farmington, Granby, Hartford, Simsbury, Suffield, West Hartford, Windsor and Windsor Locks, and their associated volumes, and I would prefer that you use the most recently-available completed year, for a complete year, so if you have 2019 as available,

either side, that's going to give us the most updated information.

I think that's fair. That's what's going on right now, you know, out there in the world, and not based on, not based on like three months and extrapolated, because maybe they're a really good three months.

MS. VOLPE: For all providers or just -- you mean all providers in that service area?

MR. CARNEY: Yeah. We're looking for the machines. We're looking for the CT and MRI machines in that service area that's been defined.

MS. VOLPE: The service area the Applicants put in?

MR. CARNEY: Correct. Yup. And then the associated volumes. Again, full years, most recent that you have available to you. No extrapolating. And footnote any existing equipment that you believe should be excluded from the analysis and a footnote that shows a basis for your exclusion.

I read something. One was like 22 years old and a .3 Tesla or something. I'm not probably sure that we would, you know, want to include that, but I'd like to see it in writing. I'd like to see it in

comparative, you know, a comparative analysis.

We can put them side-by-side, and we can determine, you know, is this fair? Is this the accurate representation of the number of machines, the number of scans, the capacity, and for us to come up with a hopefully good answer, as to, you know, where we're at, as far as capacity in the service area.

MR. ROSE: So I have a question that was raised by Dr. Foxman in pre-filed testimony, pointing to the fact that there's a new 256-slice scanner to service the Hartford Hospital Emergency Department that was just approved on January 29th.

We've noticed that they have proposed numbers or projected numbers for 2020. Obviously, it's a new scanner. And, matter of fact, in the 2018 inventory, Hartford HealthCare just rolled up all of its volume and didn't actually distinguish between hospital-based CT, so that table actually paints a better picture of their volume.

Can we use the 2020 projected that form the basis of their recent approval?

MR. CARNEY: It seems reasonable to me if it's a new machine, but we have no data for how much it's being used. I'm not really sure how we can sort of --

how can we use it if we don't have the data to go along with it, per se? I don't know.

It's a tricky question. Again, I think maybe, if you put it in writing, you give your explanation, as to why it's a yea or why it's a nay, and we'll weigh those two things, or our decision-maker will actually weigh it.

MS. VOLPE: But it's Hartford Hospital. It's not us. And we're talking about 2019 numbers maybe that haven't even been provided.

The only thing, obviously, we're going to produce any late files this office wants to see. I'm just struggling with the benefit to seeing a narrowly -- the service area with -- I mean we have it right here, of sort of what the imaging is in these few towns, like how the relevancy, in terms of capacity, when we're not including equipment in one town over, which is half the service area could be serviced by.

I'm not understanding the logic and why we're reproducing this.

MR. CARNEY: Well, because, for one thing, we have two different sides that are saying two different things. The number of machines, whether they're added, or not added, are all throughout the whole application

and responses. I'd like to see it side-by-side.

MS. VOLPE: Just for their service area the way they define it?

MR. CARNEY: Well, for now, because we're going to verify that we agree with that and that that's accurate. That's the first file that Micheala, Attorney Mitchell, has asked for. We have to go by something, and, generally, it's the PSA. I mean what else would we go by?

MS. MILLER: For fiscal year 2019, just to clarify, obviously, RAH has its own data, what information are you kind of expecting from Jefferson for fiscal year 2019? Because I know they have access, I'm sure, to some information, but, like we've heard from counsel, it hasn't been -- some of it hasn't been verified.

I know that they don't necessarily own their own equipment anymore, and, so, I wanted to have your expectation clear, in terms of what they're going to be producing for fiscal year 2019.

MR. CARNEY: I mean, to me, if they have the information and they want to provide it, I think that would be -- that's fair. I mean, if we're going to allow you to provide something that's helping you, then we

should allow them to provide the most, you know, up-to-date volume information, so it would be scan volumes for CT and MRI, just like you're providing, and we'll look at that.

We'll look at, you know, the volumes that are being produced and the capacity, and then we'll do the math and see how it works out.

MS. MILLER: And, to be clear, we would like their most recent data. That was more what I was clarifying.

MS. VOLPE: We're not the only provider in the service area, though. I mean we're not going to have St. Francis' data. We're not going to have Hartford Hospital's data, so, I mean, we'll do it, but, again, if we're applying the recognized legal needs analysis, you know, I think we only get so far with just us.

MR. CARNEY: Well we can have three tools. We have both of you in the room here, and we have the inventory. I don't have any other data that I can go to, so I'm not sure how else I could, you know, gather the information to evaluate it accurately and effectively.

MR. ROSE: Yeah. To clarify, so Jefferson Radiology is a professional practice, provides the reads for clinical -- for Connecticut Imaging Partners and has

also intervened, based on their minority interest in that entity, so we would expect that they would be able to use that position.

MS. VOLPE: We intervened, based on Jefferson Radiology, which is what we're intervening on.

HEARING OFFICER MITCHELL: So you have access to the data?

MS. VOLPE: We'll look, and we'll, yeah, what we have we'll provide.

MR. ROSE: Okay, so, you will provide CIP data?

MS. VOLPE: We'll provide whoever were a provider in this limited service area for. I mean we have, for us, we have two MRIs and three CTs, and I think that's inclusive of -- it doesn't include -- I'm sorry. You have two MRIs. We have six MRIs, six CTs. We include a CT with BIC and MRI with BIC.

MR. ROSE: Okay, so, you're also going to produce FIC's data?

MS. VOLPE: But we have Hartford in the service area, so that would mean all of Hartford Hospital's imaging, which, if it's not CIP or FIC, I don't know, we'll have to see if we can --

MR. CARNEY: Inventory, right?

MR. ROSE: Yeah, so, I think that's a good point. I think that's a good point, because one of the difficulties that we had is, well, I recognize that Hartford Hospital, when they did the inventory, they aggregated everything, and, so, we went back to St. Francis, trying to get updated data. It is difficult to break out, so I'm okay saying we'll just rely on the older -- they don't have to go back to Hartford Hospital. We don't have to go to try to pull data out of, but I think the reality is that they can pull CIP data and FIC data like that.

MS. VOLPE: I mean we'll see what we can do. I mean, even in their like filing last night and their rebuttal, they readily admit that the Applicants tried to update the St. Francis data, but, unfortunately, ran into difficulties extracting the data in a format that is broken out consistently, so I think we're all going to have that issue.

MR. ROSE: No, we agree on that, so you don't have to get the Hartford Hospital data. We'll rely on what's publicly reported by them.

MS. VOLPE: Well we're going to get what we can get. If we can get it, we're going to get it, and we're going to provide it.

MR. CARNEY: Okay. Agreed. Agreed. Agreed. Excellent.

HEARING OFFICER MITCHELL: This has been a very spirited hearing.

MR. CARNEY: I'm just trying to look for the truth. I need to look at both things as accurate as they can be, and it's not tricky, and it's hard. The data is not always available as readily as we would like it, all for the same year, all nice and packaged.

HEARING OFFICER MITCHELL: So, one, I just want to thank everybody for their time and their patience with the questions and with one another. I know everybody is trying to zealously represent their clients, and I appreciate that.

I'm going to issue an order. It probably will not be until tomorrow morning, to be quite honest. I'll give everybody two weeks to respond in writing, and then, for Attorney Volpe, who wants to respond to the rebuttal, to Attorney Rose's rebuttal, which was submitted last night, then we're going to get that back in three business days, so that's going to be on Tuesday. Sound good, everybody?

MS. VOLPE: Yes.

HEARING OFFICER MITCHELL: So we'll

adjourn. I'll issue the order, and then, immediately following the receipt of the information from both the Applicant and the Intervenors, we will go ahead and close the hearing on that date. The Order will have everything in it.

Does anybody have any closing remarks, Brian reminded me of? I'll start with the Applicants. Attorney Rose, do you want to do closing remarks? Your co-counsel?

DR. TWOHIG: I just wanted to thank everybody for a very, you know, thorough day here, and I really feel that our application speaks for itself, and I'm just thrilled to be able to present it.

It's the first time I've been down here in quite a while, and I really think we have a unique project, and the opportunities are endless for our patients that we serve, and I thank you for your time in reviewing our application.

HEARING OFFICER MITCHELL: Thank you.

MR. ROSE: And, if you don't mind, I just want to follow-up, and I will be brief, I promise.

There's so much that has been sort of dust up in the air, and I just hope that what sort of cut through is that the folks that appeared here today they -

- first, you guys see the papers, and you read all this stuff, but these guys are who they say they are, and I think all the public comments from -- I mean this is a very clinically-integrated group.

This is their radiology practice, these are their plans, and that's not an excuse to get equipment approved that shouldn't be approved. That's only in addition to all of the traditional measures being satisfied.

HEARING OFFICER MITCHELL: Thank you. Attorney Volpe, did you have a closing?

MS. VOLPE: I think Dr. Foxman would like to say a few, and then I'll say a few remarks.

DR. FOXMAN: Very good. So just a few closing thoughts. I opened today by saying, you know, the high regard we hold for our colleagues across the table, and, of course, nothing has changed today, knowing that our discussion has just been about a CON matter.

I also opened by saying that Jefferson Radiology has been before this agency many times, and, when we've done so, we know that there are certain rules of the road, and we've always tried to clear those thresholds and have a very appropriate and compliant story to tell.

I can't remember if we've ever been an Intervenor, and maybe we have, and there's a reason we're here today in what I find to be personally an awkward position, but it boils down to this.

We feel that there are some simple rules of the road, and there's a methodology for defining a service area. There's a methodology for defining a need and threshold for capacity, and that methodology and many of my colleagues and myself have participated in those discussions over the years.

Everyone from around the state gets together. There was the 2012, '14, '16 and '18 discussions around what is a primary service area, and that's important, because, if Jefferson Radiology said we've aligned with an integrated system, and we did in 2013, and we are telling you that that system does X, Y and Z, trust us, our service area now doesn't include X, Y and Z geography.

We could locate it anywhere we want it, based on that representation, and so could anyone else, and I really truly believe the heartfelt sentiments around these are my patients, this is what I see, but I also know that, at this level of discussion and consideration and evaluation for the state, we all know

that there's a reason why OHS is here, why we've had those meetings in 2012, '14, '16 and '18 to define all these things, so that, at the end of the day, those definitions are not for a radiology practice. They're not for a hospital. They're not for a system.

Therefore, the State of Connecticut and the patients in the State of Connecticut, and there's good examples of when consideration of those priorities are side stepped and when things like, and I feel weird saying this, like leakage, which is a corporate priority, or things like our thoughts about a service area, or our internal strategy, that can be applied in many different ways, and I think there's a lot of genuine and honest and caring thought behind that, but when we come to this body, we say that we don't set the rules.

We don't change the rules. We work with them, and we really feel there's thresholds and consideration, which is a process that's going to evolve over the years with all kinds of stakeholders at the table.

If this matter had been represented that the primary service area has the need, there's capacity issues, the numbers speak for themselves, which is what most CON applications look like to us, we wouldn't be

sitting at this table today.

The other item that we see is around what I said before, is sort of a creation of an entity, which I appreciate that they created. It's, you know, a standalone entity, a disregarded entity, but there's a reason why people do things like that, and there's a plan and a forward momentum to that, and it might be the right choice, and it might be great. It might be the right decision, but when we have a similar situation in our world, all those facts are on the table, there is no mystery, and other entities have been in that role, too.

So our view of why we're here today, and I say this, because it's an awkward thing for me to be here today, is that there's a real process and a real set of guidelines, and they've come together through many, many people working together, and I think, actually, there's a clear pathway to putting in a CON and getting it approved, and it shouldn't -- I don't think that this hearing today should be a referendum on years of work.

I don't think it should be a referendum on a three-month-old integrated delivery system, or emerging clinically-integrated network now has a special reason why it has license to not do what everyone else has done.

We've been in a network like that since

2013 and never represented anything, other than we're going to work with what OHS or its predecessors put on the table as the rules of the road.

I really felt today like there was a lot of enthusiasm for -- I didn't know it was three months old. There's a lot of enthusiasm for SOHO. I've seen that enthusiasm in different organizations I've participated in, too.

There's a lot of genuine thought around helping patients. There's a huge debate in society around are narrow networks good, because they're seamless and integrated, and is leakage a good or bad thing, is that patient not having the benefit of that, or is that patient choice going between different systems?

Should systems win the confidence of patients, or do they retain patients, and I predict I will retire out of this world or out of this business with those questions still hanging in the air.

So there are a lot of outstanding providers in the State of Connecticut, my colleagues across the table included.

We all have to work together. There's no real different service areas. There's the patients of the State of Connecticut, and we have really considerate

and well thought through roles on how to approach this.

We are asking that we work with those rules of the road, and only because our view is that there is such a divergence from that today is why we are here as Intervenors.

That's not a statement on what SOHO might evolve into. That's not a statement on the great care that I know is delivered by many providers.

It is a statement that we really take this process seriously. We've always held ourselves to that standard. We feel that that's really the essence of what the discussion is today. Thank you.

MS. VOLPE: From applying the statutory requirements to this application and even the pre-file and all the time that's been allowed to sort of, through the issue list, to try to cure some of the deficiencies, I mean the Applicants have failed to satisfy the statutory requirements for a CON. It doesn't warrant approval for a CT, or an MRI, or a transfer of equipment.

As Dr. Foxman stated, I mean you really -- there are rules in place for how you determine need in a marketplace, and the starting point, the basic CON 101 is how are you defining your primary service area?

And there are definitions and rules for

how we do it, you know, as was discussed today. I mean if we just decide we're going to pick this set of towns and that's going to be the service area, I mean the Statewide Health Plan specifically requires that you look at, if you're an existing provider, what is the application. If you're not an existing provider, then you apply this standard.

So, yes, you have a choice between what we call 3A or B, but it's a determinant, based on who you are, you know, and what type -- are you a provider in the market, and how is the market defined?

I mean this agency has been, you know, especially with hospitals and looking at the primary service area, not just having allowed what someone's historical service area has been.

This agency has been a stickler by saying we're going to look at your discharge admissions, you know, and the 75 percent draw, and lots of great minds outside this room have spent years meeting and having committees and commissions to come up with the imaging and new technology guidelines, the rules, as Dr. Foxman talked about, that we all need to comply with, that we all need to follow.

We can't just decide we're going to pick,

you know, a few towns and decide that's our service area when you're already an established provider with equipment, you know, one town outside of that region, so that does not a primary service area make, and, from our perspective, when you start with that in, you get that out, you know?

I mean the numerators and denominators of all this capacity really are important, as it relates to what's in the marketplace, you know, and how the service area is defined.

We've already spent a lot of time on, you know, the ERA issue and that there are a lot of unanswered questions. Again, if it's a joint venture with somebody, this agency has always wanted to see who are the parties, what are the terms, what are the documents, how do you go in and out?

And I'll just close on with imaging equipment. Never have we seen an approval of, when you have a piece of equipment, like a CT, like they do in Avon, that is underutilized, nowhere near capacity, being allowed to get an additional CT in the -- even their narrowly-defined market by themselves, by their own admission, is not at capacity or anywhere near what the State determines as statewide capacity.

So we appreciate the opportunity to be here today. We know how much work these hearings are. We know -- we hate creating more work for the agency. We know how over-worked everybody is, because we're involved in a lot of those applications, but we really felt, as Dr. Foxman said, it was warranted. Everybody needs to play by the same rules, and we really appreciate all the time and attention that you've given to this in allowing us all this deference here today, so thank you.

HEARING OFFICER MITCHELL: Thanks. All right, so, with all that being said, we're going to go ahead and adjourn for today. I hope that you have a good evening, and I will be sending out something to counsel tomorrow.

MS. VOLPE: Thank you.

MR. ROSE: Thank you.

(Whereupon, the hearing adjourned at 2:56 p.m.)

RE: RADIOLOGY ASSOC. OF HARTFORD & EASTERN RADIOLOGY
FEBRUARY 27, 2020

AGENDA