Office of Health Care Access
Certificate of Need Application

Final Decision

Applicants:	**Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC**
Docket Number:	**07-31047-CON**
Project Title:	**Establish and Operate an Outpatient Surgical Services Facility in Middletown**
Statutory Reference:	**Sections 19a-638 and 19a-639, Connecticut General Statutes**
Filing Date:	**April 16, 2008**
Hearing Date:	**June 12, 2008**
Presiding Officer:	**Cristine A. Vogel, Commissioner**
Decision Date:	**July 15, 2008**
Default Date:	**July 15, 2008**
Staff Assigned:	**Alexis G. Fedorjaczenko Laurie K. Greci**

Project Description: Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC propose to establish and operate an outpatient surgical services facility at 512 Saybrook Road, Middletown, Connecticut, at a total capital expenditure of $8,669,100.

Nature of Proceeding: On April 16, 2008, the Office of Health Care Access ("OHCA") received the Certificate of Need ("CON") application of Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC to establish and operate an outpatient surgical services facility at 512 Saybrook Road, Middletown, Connecticut, at a total capital expenditure of $8,669,100. The Applicants are health care facilities or institutions as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

Pursuant to Sections 19a-638 and 19a-639, C.G.S., a notice to the public concerning OHCA's receipt of the Applicants' Letter of Intent was published in *The Journal Inquirer* (Manchester) on October 8, 2007. Pursuant to Sections 19a-638 and 19a-639, three individuals or an individual representing an entity with five or more people had until May 7, 2008, the twenty-first calendar day following the filing of the Applicants' CON application, to request that OHCA hold a public hearing on the Applicants' proposal. OHCA received no hearing requests from the public.

Pursuant to Sections 19a-638 and 19a-639, C.G.S., a public hearing regarding the CON application was held on June 12, 2008. On May 29, 2008, the Applicants were notified of the date, time, and place of the hearing. On May 31, 2008, a notice to the public announcing the hearing was published in *The Journal Inquirer*. Commissioner Cristine A. Vogel served as Presiding Officer. The hearing was conducted as a contested case in accordance with the provisions of the Uniform Administrative Procedure Act (Chapter 54 of the Connecticut General Statutes) and Sections 19a-638 and 19a-639, C.G.S.

OHCA's authority to review and approve, modify or deny this application is established by Sections 19a-638 and 19a-639, C.G.S. The provisions of this section, as well as the principles and guidelines set forth in Section 19a-637, C.G.S., were fully considered by OHCA in its review.

Findings of Fact

Clear Public Need
Contribution of the Proposal to the Quality and Accessibility of Health Care Delivery in the Region
Impact on the Applicants' Current Utilization Statistics

1. Middlesex Hospital ("Hospital") is a general hospital located at 28 Crescent Street, Middletown. *(February 28, 2008, Initial CON Submission, page 253)*

2. Middlesex Hospital Surgical Center (referred to as the "Existing Center"), the Hospital's existing outpatient surgical facility, is located at 530 Saybrook Road in Middletown. *(February 28, 2008, Initial CON Submission, page 34)*

3. The Hospital and Orthos Holding Company, LLC ("OHC") established the Middlesex Center for Advanced Orthopedic Surgery ("MCAOS"), a Connecticut limited liability company, as a joint venture to establish and operate an ambulatory surgery center. OHC is comprised of physician-owned holding companies of the orthopedic surgeons

affiliated with the Hospital. The Hospital and OHC each own a fifty percent (50%) membership interest in MCAOS. *(February 28, 2008, Initial CON Submission, pages 260 and 265)*

4. The Hospital and MCAOS (together referred to as "Applicants") propose to establish an ambulatory surgery center ("Proposed Center") at 512 Saybrook Road, adjacent to the Hospital's Existing Center. *(October 2, 2007, Letter of Intent, page 9)*

5. The Proposed Center will occupy approximately 12,200 gross square feet of space in a freestanding one-story structure. It will have three (3) fully equipped operating rooms and twelve (12) pre- and post-op bays. *(February 28, 2008, Initial CON Submission, page 19)*

6. The Applicants based the need for the Proposed Center on the following factors:
   - Providing appropriate space for orthopedic surgery, which is currently nearing capacity in the existing available space at the Hospital and the Existing Center;
   - Expanding the Hospital's overall surgical operating room capacity in order to meet the projected increases in surgical services demand; and
   - Enabling the Hospital to decompress and "right-size" some of its current operating rooms at the main Hospital campus.

   (February 28, 2008, Initial CON Submission, pages 7 and 34)

7. The Existing Center was purchased by the Hospital in order to handle its outpatient surgical volume. The Existing Center was built nearly two decades ago as a two-room facility. Approximately 6 years ago, the Hospital performed renovations in order to add a third, but smaller, operating room in order to alleviate scheduling difficulties, including cases being done in the evening to accommodate demand. The Applicants stated that none of the rooms will easily or efficiently permit the use of orthopedic technology, such as C-arm equipment. The Existing Center is limited to the current footprint; there is no additional space for expansion. *(June 6, 2008, Pre-Filed Testimony of Colleen Smith, page 3)*

8. The Applicants testified to the following regarding capacity at the Existing Center:
   - Orthopedic surgical utilization for the second quarter of FY 2008 was 85%.
   - Orthopedic surgery accounts for approximately 80% of total cases.
   - Other surgical utilization (made up of ENT, general surgery, and podiatry) for the second quarter of FY 2008 was 72%.

   (June 12, 2008, Public Hearing Testimony of Terry Reardon, M.D.)

9. The utilization percentage calculations assume each operating room is fully available every scheduled hour of every day and do not account for nuances such as rooms that are taken off line for maintenance and repair, cancellations, or the inability to schedule every minute due to block scheduling (2 blocks/operating room/day). The Applicants testified that surgeries are scheduled weeks in advance, emergencies are scheduled at night, and that the Existing Center appears to be at full capacity.
   (*June 12, 2008, Public Hearing Testimony of Paul Breslin, M.D.)*

10. The Applicants testified that the majority of the Hospital's operating rooms located at its main campus are also undersized. (*June 12, 2008, Public Hearing Testimony, Colleen Smith)*

11. Specifically, the Applicants indicated that development of the Proposed Center will allow the following initiatives to occur:
    - Right-size undersized areas of the Existing Center, allowing the Hospital to move appropriate cases from the Hospital-based ambulatory surgery program to its Existing Center; and
    - Right-size the Hospital-based operating rooms to accommodate the anticipated volume increase in specialty inpatient surgery (i.e., spine, total joint and bariatric surgery).

    (June 6, 2008, Pre-Filed Testimony of Vincent Capece, page 4)

12. The Hospital is developing strategic plans to increase its future inpatient surgical activity. The Hospital and the physicians have been actively recruiting additional physicians to accommodate the need in the areas of surgery identified by the medical staff, particularly spine procedures, total joint procedures, and bariatric surgery. *(June 6, 2008, Responses to OHCA's Interrogatories, page 2)*

13. The Applicants plan to recruit one additional orthopedic surgeon specializing in spine surgery, one additional general surgeon, and one additional bariatric surgeon. The Hospital intends to phase-in these recruits between 2010 and 2013. *(June 6, 2008, Responses to OHCA's Interrogatories, page 11)*

14. MCAOS' proposed service area will include the following towns:

Chester	Clinton	Colchester	Cromwell
Deep River	Durham	East Haddam	East Hampton
Essex	Haddam	Killingworth	Madison
Marlborough	Middlefield	Middletown	Old Saybrook
Portland	Westbrook		

(February 28, 2008, Initial CON Submission, page 7)

15. The Applicants stated that Middlesex Hospital is currently the only provider of surgical services within the proposal's service area. *(February 28, 2008, Initial CON Submission, page 6)*

16. The Applicants stated that declining utilization in the ambulatory operating rooms is due in part to some types of ambulatory procedures (endoscopy, epidurals, steroid injections, anesthesiology injections, and ophthalmology cases) being moved by physicians away from the Hospital and into other non-hospital outpatient facilities. *(April 16, 2008, Completeness Response, page 5 and June 12, 2008, Public Hearing Testimony, Colleen Smith)*

17. The following table reports the historical volumes for orthopedic, podiatry, and other outpatient procedures at the Hospital and the Existing Center for FYs 2005, 2006, and 2007:

Table 1: Historical Volumes for Ambulatory Operating Room Procedures

Location	Procedure Type	Fiscal Year			
		2005	2006	2007	2008*
Hospital	Orthopedic	375	403	424	495
	Podiatry	2	3	21	17
	Pain Management	22	4	1	5
	Other	3,382	3,170	2,819	3,018
	Subtotal	**3,781**	**3,580**	**3,265**	**3,535**
Existing Center	Orthopedic	2,559	2,543	2,656	2,713
	Podiatry	164	183	145	147
	Pain Management	539	508	130	85
	Other	949	938	782	823
	Subtotal	4,211	4,172	3,713	3,768
	Total	**7,992**	**7,752**	**6,978**	**7,303**

* Annualized; based on procedures performed between October 1, 2007 and March 18, 2008

(April 16, 2008, Completeness Response, pages 15 to 17 and July 8, 2008, Correspondence to Update FY 2008 YTD Volumes, page 2)

18. The Hospital and its Existing Center currently have 11 multi-use operating rooms available for inpatient and/or ambulatory surgery, along with two smaller-sized rooms that are equipped for cystology and ophthalmology procedures only. Total surgical utilization in minutes and percentage of capacity at the Hospital's four different categories of operating rooms, for FYs 2004-2007 are presented in the following table:

Table 2: Surgical Utilization of Hospital's Operating Rooms ("ORs")

	FY 2004	FY 2005	FY 2006	FY 2007
2 Hospital Limited Use ORs				
Number of Procedures	1,123	734	1,060	753
Minutes Utilized	79,832	51,777	75,113	54,969
% Utilization (1)	33%	22%	31%	23%
5 Hospital Inpatient ORs				
Number of Procedures	2,951	2,975	2,873	2,971
Minutes Utilized	427,257	431,387	425,160	436,138
% Utilization (2)	71%	72%	71%	73%
3 Hospital Ambulatory ORs				
Number of Procedures	3,640	3,781	3,580	3,265
Minutes Utilized	315,451	323,389	313,580	290,106
% Utilization (3)	88%	90%	84%	81%
3 Existing Center Ambulatory ORs				
Number of Procedures	4,015	4,211	4,172	3,713
Minutes Utilized	274,192	278,164	268,361	263,875
% Utilization (3)	76%	77%	75%	73%

(1) Based on 240,000 minute capacity (8 hours/day times 250 days/year times 2 ORs). Low utilization reflects the limitations of the rooms use and the extent of demand for these specialty procedures.
(2) Based on 600,000 minute capacity (8 hours/day times 250 days/year times 5 ORs).
(3) Based on 360,000 minute capacity (8 hours/day times 250 days/year times three ORs).

(February 28, 2008, Initial CON Submission, pages 27 and 36 to 37, April 16, 2008, Completeness Response, page 5 and 14 to 23 and June 12, 2008, Public Hearing Testimony)

19. The Applicants project the following number of procedures to be performed at the Proposed Center:

Table 3: Projected Number of Procedures for the Proposed Center

	FY 2010	FY 2011	FY 2012
Orthopedic	2,767	2,932	3,096
Podiatry	147	154	163
Pain Management	94	100	106
Total	**3,008**	**3,186**	**3,365**
Minutes of Surgery (1)	218,551	231,441	244,428
OR Need Calculated (2)	2.3	2.4	2.5
Number of ORs Required (3)	**3.0**	**3.0**	**3.0**

(1) Minutes of surgery calculated based upon the projected case volumes and the Hospital's actual FY 2007 minutes per case data for each service line.
(2) Calculated by dividing the projected minutes by total minutes available per OR when operating 8 hours/day, 5 days/week, and 50 weeks/year at 80% utilization.
(3) Number of ORs required at MCAOS is the OR need calculated, rounded up to the nearest full room.
(April 16, 2008, Completeness Response, page 4)

20. The Hospital stated that approximately 85% of the non-orthopedic ambulatory surgery cases that are now performed at the Hospital can be performed safely in the Existing Center. These procedures will be moved to the Existing Center after the Proposed Center has begun operating. The additional capacity at the Hospital's main campus will then be able to accommodate the projected increased need for inpatient operating room time based on the growth in more complex procedures, such as bariatric and total joint procedures. *(June 8, 2008, Response to OHCA's Interrogatories, page 1)*

21. The proposed addition of three operating rooms is based on the Applicants' calculation that by 2017, a total of 14 operating rooms will be needed in order to meet projected surgical services demand. The calculations used to arrive at this projection are included in the following table:

Table 4: Surgical Utilization Projected for 2017

	Minutes of Utilization Projected (1)	Target Utilization Rate	Total Minutes of Capacity Required	Total ORs Required (2)
Inpatient Surgery	536,249	80%	670,311	5.6
Ambulatory Surgery	804,016	80%	1,005,019	8.4
Total	**1,340,264**	**80%**	**1,675,331**	**14.0**

Note: This projected utilization excludes the two limited use ORs at the Hospital.
(1) Based on Thompson Healthcare projections. Using the actual average surgery procedure times at the Hospital and its Saybrook Road Surgical Center, the Applicants translated this projected annual surgical demand in 2017 into minutes of OR utilization.
(2) Assuming 8 hours per day of scheduled OR time, 5 days/week, 50 weeks/year.
(February 28, 2008, Initial CON Submission, page 40 and April 16, 2008, Completeness Response, pages 7 and 8)

22. The Applicants utilized the following methodology to arrive at ambulatory surgery projections for the proposed project:
    - A Thompson Healthcare "technology trends" projection of 50% was the most aggressive assumption;
    - The actual projection of 24% increase in demand by FY 2017 is the midpoint between no growth at all over FY 2007 levels and the "technology trends" projection;
    - For comparative purposes, a "constant use rate" projection shows an 18% increase in demand by FY 2017 if ambulatory discharges per 1,000 population by age group remain at the levels reported to CHIME in FY 2007.

    (February 28, 2008, Initial CON Submission, pages 18 and 38; April 16, 2008, Completeness Response, page 4; and June 6, 2008, Responses to OHCA's Interrogatories, page 5)

23. The following table reports the Hospital's expected ambulatory surgical volumes in FY 2010, without and with the establishment of the Proposed Center:

Table 5: Projected Ambulatory Surgical Volumes at the Hospital, FY 2010

		Hospital	Existing Center	Total
Without the Proposal:	Orthopedics	579	2,767	3,347
	Podiatry	26	147	173
	Pain Management	12	94	106
	Other	2,795	782	3,576
	Total	**3,413**	**3,790**	**7,202**
With the Proposal:	Orthopedics	579	692	1,272
	Podiatry	26	37	63
	Pain Management	12	23	36
	Other	1,013	2,563	3,576
	Total	**1,631**	**3,315**	**4,946**
Difference		**(1,782)**	**(474)**	**(2,256)**

(June 6, 2008, Responses to OHCA's Interrogatories, pages 3 and 4)

24. The Hospital has projected that with the recruitment of the additional surgeons, the spine surgery, inpatient general surgery, and the bariatric programs will be at 50% utilization in FY 2010 and at full utilization in FY 2011. The additional number of inpatient surgical cases will be 90, 240, and 415, in FYs 2010, 2011, and 2012, respectively. *(June 6, 2008, Responses to OHCA's Interrogatories, page 11 and Revised Financial Attachment 1)*

25. The hours of operation for the Proposed Center will be Monday through Friday from 6:00 a.m. to 5:00 p.m. with cases scheduled between 7:30 a.m. and 3:30 p.m. *(February 28, 2008, Initial CON Submission, page 9)*

26. The Hospital's Existing Center currently operates Monday through Friday from 6:00 a.m. until the last patient goes home; usually by 5:30 p.m. Procedures start at 7:30 a.m. and run until approximately 3:30 p.m. The Hospital's main operating rooms operate from 6:00 a.m. and have staff until 1:00 a.m. with outpatients usually scheduled to be

discharged by 6:00 p.m. *(February 28, 2008, Initial CON Submission, page 9)*

27. MCAOS will comply with all guidelines set forth by the Accreditation Association for Ambulatory Health Care. *(February 28, 2008, Initial CON Submission, page 13)*

Financial Feasibility of the Proposal and its Impact on the Applicants' Rates and Financial Condition
Rates Sufficient to Cover Proposed Capital and Operating Costs
Impact of the Proposal on the Interests of Consumers of Health Care Services and Payers for Such Services
Consideration of Other 19a-637, C.G.S. Principles and Guidelines

28. The proposal has the following major expenditure components:

Table 6: Major Cost Components

Major Medical Equipment (Purchase)	$2,205,000
Non-Medical Equipment (Purchase)	263,000
Construction/Renovation	5,173,100
Other Non-Construction*	1,028,000
Total Capital Expenditure	**$8,669,100**

* Development, Contingency, and Pre-Opening Inventory
(February 28, 2008, Initial CON Submission, page 18)

29. The construction expenditure consists of the following components:

Table 7: Construction Cost Components

Building Work	$4,014,800
Site Work	378,200
Architecture & Engineering	351,500
Contingency	214,300
Total Construction Costs	**$5,173,100**

(February 28, 2008, Initial CON Submission, page 19)

30. The Applicants propose to finance the project as follows:

Table 8: Project Financing

Contribution from Middlesex Hospital	$750,000
Contribution from Orthos Holding Company, LLC	750,000
Building Loan	5,173,100
Equipment Loan	2,210,000
Total Project Financing*	**$8,883,100**

* Includes $214,000 in capitalized financing costs.
(February 28, 2008, Initial CON Submission, page 22)

31. The Applicants anticipate that construction will commence in October 2008 and will be complete in September 2009, with DPH licensure planned for November 2009. Commencement of operations at the Proposed Center is projected to be January 1, 2010. *(February 28, 2008, Initial CON Submission, page 20)*

32. MCAOS is projecting the following incremental revenue and expenses with the proposal for FYs 2010, 2011, and 2012:

Table 9: MCAOS' Projected Incremental Revenues and Expenses

Projected Incremental:	FY 2010	FY 2011	FY 2012
Total Net Patient Revenue	$4,524,000	$5,363,000	$6,289,000
Total Operating Expenses	4,041,000	4,311,000	4,570,000
Gain/(Loss) from Operations	**$ 483,000**	**$1,052,000**	**$1,719,000**

(February 28, 2008, Initial CON Submission, page 29)

33. The Hospital is projecting the following incremental revenues and expenses with the proposal, including its strategic initiatives for increasing inpatient surgical volumes and shifting outpatient procedures from the Hospital to its Existing Center for FYs 2010, 2011, and 2012:

Table 10: The Hospital's Projected Incremental Revenues and Expenses

Projected Incremental:	FY 2010	FY 2011	FY 2012
Revenue from Operations	$(4,736,502)	$(4,655,533)	$(1,961,587)
Operating Expense	(573,330)	186,077	1,730,096
Gain(Loss) from Operations	$(4,163,172)	$(4,841,610)	$(3,691,683)
Orthopedic JV Income	181,125	454,875	776,125
Revenue Over/Under Expenses	**$(3,982,047)**	**$(4,386,735)**	**$(2,915,558)**

(June 6, 2008, Response to OHCA's Interrogatories, Revised Financial Attachment I)

34. The Hospital is projecting overall revenues over expenses to be $7,070,225, $6,758,863, and $8,324,413 in FYs 2010, 2011, and 2012, respectively. *(June 6, 2008, Responses to OHCA's Interrogatories, Revised Financial Attachment I)*

35. The Hospital's current asset balance as of December 30, 2007, was $94,685,000. *(February 28, 2008, Initial CON Submission, page 17)*

36. The following reflects the Hospital's overall payer mix based on Net Patient Revenue:

Table 11: Three-Year Projected Payer Mix with the CON Proposal

Payer	Current	FY 2008	FY 2009	FY 2010
Medicare	38.9%	38.9%	38.9%	38.9%
Medicaid	5.2%	5.2%	5.2%	5.2%
Champus and TriCare	0.6%	0.6%	0.6%	0.6%
Total Government	**44.7%**	**44.7%**	**44.7%**	**44.7%**
Commercial Insurers	43.4%	43.4%	43.4%	43.4%
Uninsured	7.5%	7.5%	7.5%	7.5%
Workers Compensation	4.4%	4.4%	4.4%	4.4%
Total Non-Government	**55.3%**	**55.3%**	**55.3%**	**55.3%**
Total Payer Mix	**100%**	**100%**	**100%**	**100%**

(February 28, 2008, Initial CON Submission, page 23)

37. The following reflects the Proposed Center's payer mix based on Gross Patient Revenue:

Table 12: Three-Year Projected Payer Mix with the CON Proposal

Payer Mix	2010	2011	2012
Medicare	22%	22%	22%
Medicaid	3%	3%	3%
Champus and TriCare	<1%	<1%	<1%
Total Government	**25%**	**25%**	**25%**
Commercial Insurers	74%	74%	74%
Uninsured	1%	1%	1%
Total Non-Government	**75%**	**75%**	**75%**
Total Payer Mix	**100%**	**100%**	**100%**

(February 28, 2008, Initial CON Submission, page 30)

38. The Hospital is a tax-exempt entity; MCAOS is a taxable entity. *(February 28, 2008, Initial CON Submission, page 23)*

39. The Operating Agreement for MCAOS states that "The Company shall be operated in a manner that furthers the charitable purposes of the Hospital and its Affiliates by promoting health for a broad cross-section of the community. Such purpose shall outweigh financial considerations. Further, the Company shall not operate in a manner that could jeopardize the federal tax-exempt status under § Code 501(c)(3) of the Hospital or any tax-exempt Affiliate…" *(February 28, 2008, Initial CON Submission, page 265)*

40. MCAOS will operate as a freestanding ambulatory surgery center for reimbursement purposes, and will be the billing entity for the proposed service. *(February 28, 2008, Initial CON Submission, pages 16 and 23)*

41. There is no State Health Plan in existence at this time. *(February 28, 2008, Initial CON Submission, page 6)*

42. The Applicants have adduced evidence that this proposal is consistent with their long-range plans. *(February 28, 2008, Initial CON Submission, page 6)*

43. The Hospital stated that it has undertaken energy conservation, group purchasing, and the application of technology to improve productivity and contain costs. *(February 28, 2008, Initial CON Submission, page 15)*

44. The Hospital's teaching and research responsibilities will not be changed by implementation of the proposal. *(February 28, 2008, Initial CON Submission, page 16)*

45. There are no distinguishing characteristics of the Applicants' patient/physician mix. *(February 28, 2008, Initial CON Submission, page 16)*

46. The Hospital and MCAOS have provided evidence that they have technical, financial, and managerial competence. *(February 28, 2008, Initial CON Submission, Attachment D)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for the proposed service on a case-by-case basis. Certificate of Need ("CON") applications do not lend themselves to general applicability due to a variety of factors, which may affect any given proposal; e.g. the characteristics of the population to be served, the nature of the existing services, the specific types of services proposed to be offered, the current utilization of services and the financial feasibility of the proposal.

Middlesex Hospital ("Hospital") is a general hospital located at 28 Crescent Street, Middletown. The Hospital and Orthos Holding Company, LLC ("OHC") established the Middlesex Center for Advanced Orthopedic Surgery ("MCAOS"), a Connecticut limited liability company, as a joint venture to establish and operate an ambulatory surgery center. OHC is comprised of physician-owned holding companies of the orthopedic surgeons affiliated with the Hospital. The Hospital and OHC each own a fifty percent (50%) membership interest in MCAOS.

The Hospital and MCAOS (together refer to as "Applicants") propose to establish an outpatient surgery center ("Proposed Center") at 512 Saybrook Road, Middletown. The Proposed Center will have three (3) fully equipped operating rooms and twelve (12) pre- and post-op bays. The Applicants based the need for the Proposed Center on capacity issues at Middlesex Hospital Surgical Center ("Existing Center"), the current array of Hospital operating rooms that are undersized, and the ability to increase its inpatient surgical demand within the areas of spine procedures, total joint procedures, and bariatric surgery.

The Existing Center, built nearly two decades ago, was purchased by the Hospital in order to accommodate its outpatient surgical volume. The Existing Center is limited to its current footprint; there is no additional space for expansion. The Applicants stated that none of the rooms will easily or efficiently permit the use of orthopedic technology, such as C-arm equipment. The Applicants stated that the Hospital's operating rooms at its main campus face many of the same challenges.

Currently, orthopedic surgical utilization at the Existing Center is 85% and overall ambulatory surgical utilization at the Hospital and Existing Center is about 78%. The Applicants testified that the statistical utilization does not account for time that the operating rooms are unavailable for surgeries. According to the Applicants, surgeries are scheduled weeks in advance, emergency surgeries are scheduled at night, and the Existing Center is functionally at capacity.

OHCA recognizes that the Applicants have an established patient base and concludes that establishment of the Proposed Center will improve the quality of and access to ambulatory surgical services in the region. However, OHCA is concerned that the need for three operating rooms at the Proposed Center is based, in part, on a strategic process that will not be fully realized upon implementation of this proposal.

The total capital expenditure associated with the proposal is $8,669,100. The proposed project will be financed with a $750,000 contribution from each of the Applicants, along with a building loan and an equipment loan. With the proposal, MCAOS projects incremental gains from operations of $483,000, $1,052,000, and $1,719,000 for fiscal years 2010, 2011, and 2012, respectively.

With the proposal and the implementation of its strategic initiatives, the Hospital projects incremental gains from operations of $639,165, $1,785,599, and $3,200,616 for Fiscal Years 2010, 2011, and 2012, respectively. Although OHCA remains concerned with the impact of the proposal to its surgical volume, the Hospital testified to the fact that they are implementing strategic initiatives to increase its inpatient surgical utilization. In the longer term, the combination of the proposal with the Hospital's strategic initiatives should enable the Hospital to remain a financially strong organization. In addition, the proposal will allow the Hospital to reallocate outpatient surgical cases to the appropriate setting and to perform renovations to its operating rooms on the main campus and at its ambulatory surgical center.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Middlesex Hospital and Middlesex Center for Advanced Orthopedic Surgery, LLC ("Applicants") to establish and operate a new outpatient surgical services facility at 512 Saybrook Road, Middletown, Connecticut, at a total capital expenditure of $8,669,100, is hereby GRANTED, subject to the following conditions:

1. The Applicants are authorized to establish and operate an outpatient ambulatory surgery center located at 512 Saybrook Road, Middletown. The Applicants are authorized to build and equip three (3) operating rooms, and to utilize two (2) of these operating rooms.

2. The procedures that may be performed at the Applicants' outpatient ambulatory surgery center in Middletown are limited to those within the following specialties: orthopedic; podiatric; and pain management procedures. Should the Applicant wish to perform surgical procedures within other specialties, the Applicants shall file with OHCA a Certificate of Need Determination Request regarding the intended or planned change in specialties to be performed at the center.

3. This authorization shall expire July 15, 2010. Should the Applicants' project not be completed by that date, the Applicants must seek further approval from OHCA to complete the project beyond that date.

4. The Applicants shall not exceed the approved capital expenditure of $8,669,100. In the event that the Applicants learn of potential cost increases or expect that the final project costs will exceed those approved, the Applicants shall notify OHCA immediately.

5. The Applicant must do the following within two months of the commencement date:
   a. Report the date of the commencement of operations at the new outpatient surgical services facility to OHCA, in writing; and
   b. Provide a copy its license from the State of Connecticut Department of Public Health to OHCA.

6. The Applicants shall provide OHCA with utilization reports for the new outpatient surgical services facility on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1. Each quarterly report shall include the name and telephone number of the person that OHCA may contact for data inquiries. In addition to basic data analyses, OHCA will use the submitted data to assure that residents of Middletown and the surrounding towns have appropriate access to the facility.

7. The Applicant shall request approval to utilize the third operating room by filing with OHCA a Certificate of Need Determination Request regarding the intended or planned utilization of the third operating room.

8. Should the Applicants intend or plan any change or ownership by either Applicant, terminate any services, or change the location of the outpatient surgical facility at 512 Saybrook Road, Middletown, Connecticut, the Applicants shall file with OHCA a Certificate of Need Determination Request or Letter of Intent regarding the intended or planned change in ownership, termination, or location.

Should the Applicants fail to comply with any of the aforementioned conditions, OHCA reserves the right to take additional actions as authorized by law.

All of the foregoing constitutes the final order of the Office of Health Care Access in this matter.

By Order of the
Office of Health Care Access

Signed by Commissioner Vogel on July 15, 2008

_____ _____

Date Cristine A. Vogel
Commissioner

CAV:lkg:agf

Attachment 1

Outpatient Facility Encounter Data Layout
(For Institutions)

DATA RECORD TYPE 1					
#	**Description**	**Field Name**	**Data Type**	**Start**	**Stop**
1	Record Type Indicator: **01**	recid	Num(2)	1	2
2	Facility ID - CMS assigned National Provider Identifier (effective May 23, 2005) or OHCA assigned SID # or the last four digits of the Medicare Provider Number for the unit from which the patient was discharged for the encounter being recorded.	facid	Char(10)	3	12
3	Fiscal Year – Hospital fiscal year runs from October 1 of a calendar year to September 30 of the following calendar year and is the year of discharge.	fy	Char(4)	13	16
4	Quarter – The quarter of discharge. January 1 – March 31 - 2 April 1 – June 30 - 3 July 1 - September 30 - 4 October 1 – December 31 - 1	quart	Char(1)	17	17
5	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer that 20 characters)**	mrn	Char(20)	18	37
6	Patient Control Number – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical and billing records of the encounter. **Format: string (20, zero filled to left if fewer that 20 characters)**	patcont	Char(20)	38	57
7	Social Security Number – patient's SSN	ssn	Char(9)	58	66
	Format: string (9, hyphens are implied). Blank if unknown				
8	Date of birth – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (8, yyyy-mm-dd)**	dob	Date	67	74
9	Sex – patient's sex, to be numerically coded as follows: 1. Male = 1 2. Female = 2 3. Not determined = 3	sex	Char(1)	75	75

10	Race – patient-identified designation of a category from the following list, and coded as follows: A. White = 1	race	Char(1)	76	76
	B. Black/African American = 2 C. American Indian/Alaska Native = 3 D. Native Hawaiian/Other Pacific Island = 4 (e.g., Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander.) E. Asian (e.g., Asian Indian, Chinese, Filipino, = 5 Japanese, Korean, Vietnamese, other Asian) F. Two or more races = 6 G. Some other race = 7 H. Unknown = 8				
11	Ethnicity – patient-identified ethnic origin from categories listed and coded as follows: A. Hispanic/Latino = 1 (i.e., Mexican, Puerto Rican, Cuban or other Hispanic or Latino) B. Non-Hispanic/Latino = 2	pat_eth	Char(1)	77	77
12	Patient's State – patient indicated state of primary residence.	patstate	Char(2)	78	79
13	Town – patient indicated town of primary residence.	twn_cty	Char(3)	80	82
14	Zip Code - zip code of the patient's primary residence	patzip	Char(5)	83	87
15	Relationship to Insured1 – means the patient's relationship to the identified insured or sponsor. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines: (A) Patient is insured/Self = 01 (B) Spouse = 02 (C) Natural child/Insured financial responsibility = 03 (D) Natural child/Insured does not have financial responsibility = 04 (E) Step child = 05 (F) Foster child = 06 (G) Ward of the court = 07 (H) Employee = 08 (I) Unknown = 09 (J) Handicapped dependent = 10 (K) Organ donor = 11 (L) Cadaver donor = 12 (M) Grandchild = 13 (N) Niece/Nephew = 14 (O) Injured plaintiff = 15 (P) Sponsored dependent = 16 (Q) Minor dependent of a minor dependent = 17 (R) Parent = 18 (S) Grandparent = 19 (T) Life partner = 20	r_insure1	Char(3)	88	90

16	Employment status (e_stat) – means the patient's employment status. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines: (A) Employed full time = 1 (B) Employed part time = 2 (C) Not employed = 3 (D) Self employed = 4 (E) Retired = 5 (F) On active military duty = 6 (G) Unknown = 9	e_stat	Char(1)	91	91
17	Insured1's employer – means the name of the insured's employer. Blank if unknown or not applicable.	employ1	Char(50)	92	141
18	Insured1's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i1_state	Char (2)	142	143
19	Insured2's employer – means the name of the insured's employer. Blank if unknown or not applicable	employ2	Char (50)	144	193
20	Insured2's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i2_state	Char (2)	194	195
21	Insured3's employer – means the name of the insured's employer. Blank if unknown or not applicable.	employ3	Char (50)	196	245
22	Insured3's state of residence – means the insured's state of primary residence. Blank if unknown or not applicable.	i3_state	Char (2)	246	247
23	Payment sources (Primary (ppayer), Secondary (spayer) and Tertiary (tpayer)) - the major payment sources that were expected at the time the dataset was completed, from the categories listed below: Self pay = A Worker's Compensation = B Medicare = C Medicaid = D Commercial Insurance Company = E Medicare Managed Care = F Medicaid Managed Care = G Commercial Insurance Managed Care = H CHAMPUS or TRICARE = I Other Government Payment = J Title V = Q No Charge or Free Care = R Other = M	ppayer	Char(1)	248	248
24	As defined in (19). **Blank if not applicable**.	spayer	Char(1)	249	249
25	As defined in (19). **Blank if not applicable.**	tpayer	Char(1)	250	250

26	Payer Identification (payer1, payer2, payer3) – the insured's payer (or National Plan ID) that identifies the payer organization from which the facility expects, at the time of the encounter, some payment for the bill. Up to three payer organizations shall be reported in the order of their expected contributions to the payment of the facility's bill. **Format: string (9, zero filled to left if fewer than 9 characters)**	payer1	Char(9)	251	259
27	As defined in (22). Blank if not applicable.	payer2	Char(9)	260	268
28	As defined in (22). Blank if not applicable.	payer3	Char(9)	269	277
29	Encounter type – indicates the priority of the encounter. Emergent = 1 Urgent = 2 Elective = 3	etype	Char(1)	278	278
30	Operating Physician – CT Provider ID or NPI identifying the provider who performed the service/treatment/procedure	ophysid	Char(10)	279	288
31	Attending Physician – CT Provider ID or NPI of the physician primarily responsible for the patient for this encounter.	pphysdocid	Char(10)	289	298
32	Charges – Total charges for this encounter. **(Round the actual value on bill to the nearest whole dollar amount, zero filled and right justified)**	chrg_tot	Num(8)	299	306

33	Disposition – the circumstances of the patient's discharge. The categories of which are defined below and will be kept up-to-date to reflect current National Uniform Billing Committee (NUBC) guidelines: Discharged to home or self care, (routine discharge) 01 Discharged or transferred to another short term general hospital for inpatient care 02 Discharged or transferred to a skilled nursing facility (SNF) 03 Discharged or transferred to an intermediate care facility (ICF) 04 Transferred to another type of institution for inpatient care 05 Discharged or transferred to a home under care of an organized home health service organization 06 Left or discontinued care against medical advice 07 Discharged or transferred to home under the care of a home IV Provider 08 Admitted as an inpatient to this hospital 09 Expired 20 Expired at home 40 Expired in a medical facility (e.g. hospital, SNF, ICF or free- standing hospice) 41 Expired – place unknown 42 Hospice – home 50 Hospice – medical facility 51 Discharged or transferred to another rehabilitation facility including rehabilitation distinct part units of a hospital 62 Discharged or transferred to Medicare certified long term care hospital (LTCH) 63 Discharged or transferred to a nursing facility certified under Medicaid but not certified under Medicare 64 Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital 65	pstat	Char(2)	307	308
34	Principal Diagnosis – the ICD-9-CM code for the condition which is established after the study to be chiefly responsible for the encounter being recorded. **Format: String (5, do not include decimal place -- decimal place is implied)**	dx1	Char(5)	309	313
35	Secondary Diagnoses (dx2 through dx10) – the ICD-9-CM codes for the conditions, exclusive to the principal diagnosis, which exist at the time the patient was treated or which developed subsequently to the treatment and which affect the patient's treatment for the encounter being recorded. Diagnoses which are associated with an earlier encounter and which have no bearing on the current encounter shall not be recorded as secondary diagnoses. **Format: String (5, do not include decimal place -- decimal place is implied)**	dx2	Char(5)	314	318
36	As defined in (31).	dx3	Char(5)	319	323

37	As defined in (31).	dx4	Char(5)	324	328
38	As defined in (31).	dx5	Char(5)	329	333
39	As defined in (31).	dx6	Char(5)	334	338
40	As defined in (31).	dx7	Char(5)	339	343
41	As defined in (31).	dx8	Char(5)	344	348
42	As defined in (31).	dx9	Char(5)	349	353
43	As defined in (31).	dx10	Char(5)	354	358
44	E-code (ecode1 to ecode3) – The ICD-9-CM codes for external cause of injury, poisoning or adverse effect. **Format: string (5, do not include decimal place -- decimal place is implied)**	ecode1	Char(5)	359	363
45	As defined in (40).	ecode2	Char(5)	364	368
46	As defined in (40).	ecode3	Char(5)	369	373
47	Principal Procedure – the ICD-9-CM code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient. Blank if not applicable or not coded. **Format: String (4, do not include decimal place -- decimal place is implied)**	px1	Char(4)	374	377
48	Secondary Procedure (px2 through px10) – the ICD-9-CM codes for other procedures. Blank if not applicable or not coded. **Format: String (4, do not include decimal place -- decimal place is implied)**	px2	Char(4)	378	382
49	As defined in (44).	px3	Char(4)	383	386
50	As defined in (44).	px4	Char(4)	387	390
51	As defined in (44).	px5	Char(4)	391	393
52	As defined in (44).	px6	Char(4)	394	397
53	As defined in (44).	px7	Char(4)	398	401
54	As defined in (44).	px8	Char(4)	402	405
55	As defined in (44).	px9	Char(4)	406	409
56	As defined in (44).	px10	Char(4)	410	413
57	Referring Physician - State license number or NPI of the physician that referred the patient to the service/treatment/procedure rendered.	rphysid	Char(10)	414	423

DATA RECORD TYPE 2*

#	Description	Field Name	Data Type	Start	Stop
1	Record Type Indicator: **02**	recid	Num(2)	1	2

2	Facility ID - CMS assigned National Provider Identifier (effective May 23, 2005) or OHCA assigned SID # or the last four digits of the Medicare Provider Number for the unit from which the patient was discharged for the encounter being recorded.	facid	Char(10)	3	12
3	Medical Record Number – unique patient identification number assigned to each patient for whom services are provided by a facility that distinguishes by itself the encounter of an individual patient from the encounter of all other patients for that facility. **Format: string (20, zero filled to left if fewer that 20 characters)**	mrn	Char(20)	13	32
4	Patient Control Number – unique number assigned by the facility to each patient's individual encounter that distinguishes the medical and billing records of the encounter. **Format: string (20, zero filled to left if fewer that 20 characters)**	patcont	Char(20)	33	52
5	Social Security Number – patient's SSN. **Format: string (9, hyphens are implied)**	ssn	Char(9)	53	61
6	Revenue Code - A UB-92 code that identifies a specific accommodation, ancillary service or billing calculation	rev	Char(4)	62	65
7	HCPCS Code – A uniform code used to report procedures, services and supplies for reimbursement. **Blank if not applicable.**	hcpc	Char(5)	66	70
8	First Modifier Code – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. **Blank if not applicable.**	mod1	Char(2)	71	72
9	Second Modifier Code means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. **Blank if not applicable.**	mod2	Char(2)	73	74
10	Third Modifier Code – means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. **Blank if not applicable.**	mod3	Char(2)	75	76
11	Fourth Modifier Code means by which a physician indicates that a service or procedure performed has been altered by some specific circumstance but not changed in definition or code. **Blank if not applicable.**	mod4	Char(2)	77	78
12	Units of Service –number of days for multiple days or units of supply	units	Num (4)	79	82
13	Charges – charge for the listed service. **Round the actual value contained on the discharge's bill to the nearest whole dollar amount, zero filled and right justified)**	chrg	Num (6)	83	88
14	Service Date – The month, day, and year for each procedure, service or supply. **Format: date (8, yyyy-mm-dd)**	servdate	Date	89	96

Please submit Data Record Type 1 and Record type 2 in two separate files.

*You will need multiple rows of Data Record Type 2 to report all HCPCS/CPT and revenue codes recorded for an encounter; however there should be only unique occurrences of combinations of revenue and HCPCS codes and of revenue codes (if no HCPCS code is assigned) for an encounter.

Provide all new categories of a data element indicated by the external code sources specified in the National Electronic Data Interchange Transaction Set Implementation Guide Section C.