STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor

Nancy Wyman
Lt. Governor

Office of Health Care Access

Certificate of Need
Final Decision

Applicants: **Greater Waterbury Health Network, Inc.**
64 Robbins Street
Waterbury, CT 06708

Prospect Medical Holdings, Inc.
10780 Santa Monica Blvd., Suite 400
Los Angeles, CA 90025

Docket Number: **16-32121-CON**

Project Title: **Transfer of Ownership of The Harold Leever Regional Cancer Center to Prospect Medical Holdings, Inc. or its subsidiary**

Project Description: Greater Waterbury Health Network, Inc. ("GWHN") proposes transferring its 50% ownership interest in The Harold Leever Regional Cancer Center ("HLRCC") to Prospect Medical Holdings, Inc. ("PMH"), with no associated capital expenditure.

Procedural History: The Applicants published notice of their intent to file a Certificate of Need ("CON") application in *Republican-American* (Waterbury) on August 11, 12 and 13, 2016. On September 7, 2016, the Office of Health Care Access ("OHCA") received the CON application from the Applicant for the above-referenced project and deemed the application complete on November 16, 2016. OHCA received no responses from the public concerning the proposal and no hearing requests were received from the public per Connecticut General Statutes ("Conn. Gen. Stat.") § 19a-639a(e). Deputy Commissioner Addo considered the entire record in this matter.

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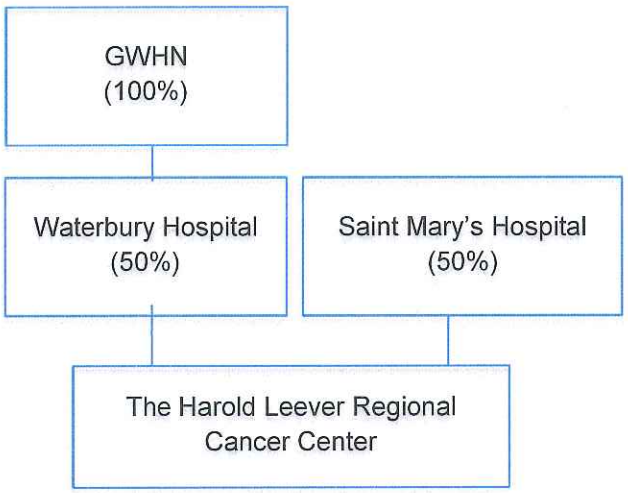
Findings of Fact and Conclusions of Law

1. HLRCC is a not-for-profit joint venture formed in 2002, located at 1075 Chase Parkway in Waterbury, CT, that provides diagnostic and radiation oncology services with two linear accelerators and a PET/CT Scanner. Its current ownership consists of two members: Waterbury Hospital, of which GWHN is the sole member, and Saint Mary's Hospital.

HLRCC'S EXISTING MEMBERSHIP STRUCTURE



Ex. A, pp.10, 76.

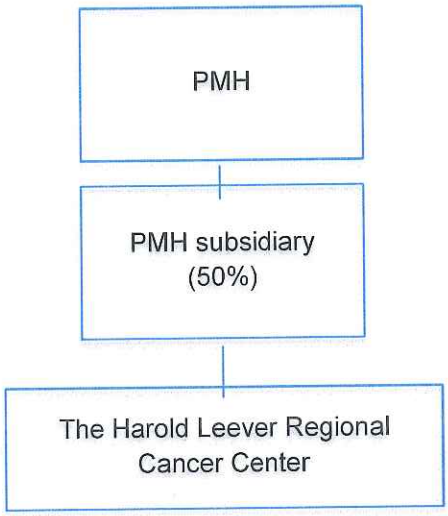
2. In July 2016, GWHN received authorization (OHCA Docket 15-32017-486) to be acquired by and transfer substantially all assets to PMH. As a result of the overarching ownership change, GWHN is requesting authorization to transfer its 50% ownership interest in HLRCC to PMH. Ex. A, p. 9.

3. PMH is a for-profit, privately owned national healthcare services company with its principal place of business in Los Angeles, California. PMH owns 14 acute care and behavioral hospitals in California, New Jersey, Rhode Island and Texas as well as a network of specialty and primary care clinics in each of these regions. OHCA Docket 15-32017-486.

4. The transaction will be structured in a manner to comply with state law requiring the independence of HLRCC's physicians and preventing the corporate practice of medicine. Ex. A, p. 77.

5. The proposed organizational chart for the GWHN-owned portion of HLRCC is presented below:

HLRCC & APPLICANT'S PROPOSED MEMBERSHIP STRUCTURE



Ex. A, p. 76

6. No clinical services offered by HLRCC will be added, modified or terminated as a result of the change in ownership and there will be no change to services or HLRCC's day-to-day operations. Ex. A, pp. 9, 11, 12.

7. HLRCC's service area consists of the following towns: Beacon Falls, Bethlehem, Cheshire, Middlebury, Morris, Naugatuck, Oakville, Oxford, Plantsville, Plymouth, Prospect, Seymour, Southbury, Southington, Terryville, Thomaston, Torrington, Waterbury, Watertown, Wolcott and Woodbury. Ex. A, p. 9.

8. There are no anticipated changes to the patient population to be served by HLRCC. Ex. A, p. 10.

9. Prior to executing the transfer, HLRCC will update its website and post signage in the lobby of its facility for 30 days notifying patients of the change in ownership. Ex. C, p. 84.

10. PMH aligns its hospitals and physicians under its Coordinated-Regional Care model ("CRC"). According to the Applicants, CRC, "provides for clinical integration among hospitals, physicians and other medical, social and community providers working closely with strategic partner health plans and other payers under a value-based, global risk reimbursement payment system to achieve the triple aim of improved patient care and experience, better patient health, and lower costs." Ex. A, p. 13.

11. Historical utilization volumes are shown in the table below:

TABLE 1
HISTORICAL UTILIZATION BY SERVICE

Service	Actual Volume			
	FY 2013	FY 2014	FY 2015	FY 2016*
PET/CT Scan	747	785	704	787
Radiation Oncology	10,595	11,742	11,118	12,587
Total	**11,282**	**12,527**	**11,822**	**13,374**

* Annualized based on 10 months
Ex. A, p. 28; Ex. C, p. 84.

12. Projected utilization volumes are expected to remain constant. As shown in the table below:

TABLE 2
CURRENT AND PROJECTED UTILIZATION BY SERVICE

Service	Projected Volume		
	FY 2017	FY 2018	FY 2019
PET/CT Scan	787	787	787
Radiation Oncology	12,587	12,587	12,587
Total Visits	**13,374**	**13,374**	**13,374**

Ex. A, pp. 21, 25.

13. Currently, 9% of HLRCC's PET/CT patient population is comprised of Medicaid patients. The Applicants do not anticipate any changes in payer mix as a result of this proposal.

TABLE 3
APPLICANT'S HISTORIC & PROJECTED PET/CT PAYER MIX

Payer	FY 2015		Projected					
			FY 2016		FY 2017		FY 2018	
	Patients	%	Patients	%	Patients	%	Patients	%
Medicare*	261	41%	261	41%	261	41%	261	41%
Medicaid*	59	9%	59	9%	59	9%	59	9%
CHAMPUS	0	0%	0	0%	0	0%	0	0%
Total Government	**320**	**50%**	**320**	**50%**	**320**	**50%**	**320**	**50%**
Commercial Insurers	310	50%	310	50%	310	50%	310	50%
Uninsured	0	0%	0	0%	0	0%	0	0%
Workers Compensation	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**310**	**50%**	**310**	**50%**	**310**	**50%**	**310**	**50%**
Total Payer Mix	**630**	**100%**	**630**	**100%**	**630**	**100%**	**630**	**100%**

Ex. A, p. 29; Ex. C, p. 84.

14. Currently, 9% of HLRCC's radiation oncology patient population is comprised of Medicaid patients. The Applicants do not anticipate any changes in payer mix as a result of this proposal.

TABLE 4
APPLICANT'S HISTORIC & PROJECTED RADIATION ONCOLOGY PAYER MIX

Payer	FY 2015		Projected					
			FY 2016		FY 2017		FY 2018	
	Patients	%	Patients	%	Patients	%	Patients	%
Medicare	315	62%	315	62%	315	62%	315	62%
Medicaid	47	9%	47	9%	47	9%	47	9%
CHAMPUS	0	0%	0	0%	0	0%	0	0%
Total Government	**362**	**71%**	**362**	**71%**	**362**	**71%**	**362**	**71%**
Commercial Insurers	144	29%	144	29%	144	29%	144	29%
Uninsured	0	0%	0	0%	0	0%	0	0%
Self Pay	0	0%	0	0%	0	0%	0	0%
Workers Compensation	0	0%	0	0%	0	0%	0	0%
Total Non-Government	**144**	**29%**	**144**	**29%**	**144**	**29%**	**144**	**29%**
Total Payer Mix	**506**	**100%**	**506**	**100%**	**506**	**100%**	**506**	**100%**

* Annualized based on 10 months of data
Ex. A, p. 29; Ex. C, p. 84.

15. There are no incremental revenues or expenses as a result of this proposal and there are no associated capital expenditures. Docket No. 15-32017-486; Ex. A, pp. 19, 28; Ex. C, p. 85.

16. HLRCC projects operational losses of $2,354,000, $541,000 and $617,000 for FY 2016 through FY 2018.

TABLE 5

HAROLD LEVER REGIONAL CANCER CENTER PROJECTED LOSS FROM OPERATIONS

	FY 2016	FY 2017	FY 2018
Revenue from Operations	$8,077,000	$8,151,000	$8,151,000
Total Operating Expenses	$10,431,000	$8,692,000	$8,768,000
Gain/Loss from Operations	$2,354,000	$541,000	$617,000

Ex. A, p. 27

17. Given its 50% ownership interest, PMH would assume half of HLRCC's losses. Ex. A, p. 76

18. In its audited financial statements for FY 2015, PMH reported total revenues of over $1.3 billion from its operations on a consolidated basis. As of fiscal year end 2015, PMH reported free cash flow of over $112 million and close to $75 million in cash from operations. Further, the company received credit upgrades by both Moody's and S&P in 2015. Docket:15-32017-486, FF23

19. The transfer of ownership will not require any changes to the existing price structure and no additional facility fees will be imposed. Ex. A, p. 26; Ex. C, p. 84.

20. HLRCC previously had no formal charity care policy. On February 1, 2017, the Finance Committee approved a charity care policy similar to that implemented at Waterbury Hospital. Ex. G, pp 89-90.

21. OHCA is currently in the process of establishing its policies and standards as regulations. Therefore, OHCA has not made any findings as to this proposal's relationship to any regulations not yet adopted by OHCA. (Conn. Gen. Stat. § 19a-639(a)(1)).

22. The proposal is consistent with the Statewide Health Care Facilities and Service Plan. (Conn. Gen. Stat. § 19a-639(a)(2)).

23. The Applicants have established that there is a clear public need for the proposal. (Conn. Gen. Stat. § 19a-639(a)(3)).

24. The Applicants have demonstrated that the proposal is financially feasible. (Conn. Gen. Stat. § 19a-639(a)(4)).

25. The Applicants have satisfactorily demonstrated that the proposal will maintain quality, accessibility and cost effectiveness of health care delivery in the region. (Conn. Gen. Stat.§ 19a-639(a)(5)).

26. The Applicants have shown that there would be no change in the provision of health care services to the relevant populations and payer mix, including access to services by Medicaid recipients and indigent persons. (Conn. Gen. Stat. § 19a-639(a)(6)).

27. The Applicants have satisfactorily identified the population to be affected by this proposal. (Conn. Gen. Stat. § 19a-639(a)(7)).

28. The Applicants' historical provision of services in the service area supports this proposal. (Conn. Gen. Stat. § 19a-639(a)(8)).

29. The Applicants have satisfactorily demonstrated that this proposal would not result in an unnecessary duplication of existing services in the area. (Conn. Gen. Stat. § 19a-639(a)(9)).

30. The Applicants have demonstrated that there will be no reduction in access to services by Medicaid recipients or indigent persons. (Conn. Gen. Stat. § 19a-639(a)(10)).

31. The Applicants have demonstrated that the proposal will not negatively impact the diversity of health care providers and patient choice in the region. (Conn. Gen. Stat. § 19a-639(a)(11)).

32. The Applicants have satisfactorily demonstrated that the proposal will not result in any consolidation that would affect health care costs or access to care. (Conn. Gen. Stat. § 19a-639(a)(12)).

Discussion

CON applications are decided on a case by case basis and do not lend themselves to general applicability due to the uniqueness of the facts in each case. In rendering its decision, OHCA considers the factors set forth in § 19a-639(a) of the Statutes. The Applicants bear the burden of proof in this matter by a preponderance of the evidence. *Jones v. Connecticut Medical Examining Board, 309 Conn. 727 (2013).*

HLRCC is a not-for-profit joint venture, located at 1075 Chase Parkway in Waterbury, CT, formed in 2002. *FF1.* HLRCC provides diagnostic and radiation oncology services with two linear accelerators and a PET/CT Scanner. Its current ownership consists of two members: The Waterbury Hospital, of which GWHN is the sole member, and Saint Mary's Hospital, a subsidiary of Trinity Health-New England. *FF1.* OHCA authorized the transfer of ownership of GWHN and substantially all of its assets to PMH in July 2016. *FF2.*

As a result of the overarching ownership change, the Applicants have requested authorization to transfer GWHN's 50% ownership interest in HLRCC to PMH or a yet-to-be formed PMH subsidiary. *FF5.* The transaction will be structured in a manner to comply with state law requiring the independence of HLRCC's physicians and avoiding the corporate practice of medicine. *FF4.*

There are no planned changes in the price structure and no additional facility fees imposed as a result of the transfers of ownership. *FF16.* PMH has sufficient revenues, free cash flow and credit worthiness to acquire a 50% ownership interest in HLRCC, despite the projected losses. *FF11,18.* This associated proposal entails no capital expenditures and the Applicants project no incremental impact on revenues or expenses. *FF15.* Therefore, the Applicants have satisfactorily demonstrated that the proposal will not adversely affect health care costs and is financially feasible.

Furthermore, no clinical services offered by HLRCC will be added, modified or terminated as a result of the proposal and there will be no impact on the day-to-day delivery of services at HLRCC. *FF6.* HLRCC expects its payer mix to remain stable. Medicaid patients constituted 9% of HLRCC's patients in fiscal years 2015 and 2016 and the Applicants project they will continue to do so through at least fiscal year 2018 based on observed historic trends. *FF13, 14.* As such, the Applicants have satisfactorily shown that the proposal will have no impact on access to or quality of care to patients, including those with Medicaid coverage.

HLCC previously had no formal charity care policy. However in February 2017, the Applicants in conjunction with St. Mary's Hospital, approved a written charity care policy modeled after that implemented at Waterbury Hospital. *FF20.* Therefore, the proposal will support access to care for indigent, uninsured and underinsured patients.

Overall, the continued operation of HLRCC will support the financial strength of the health care system in Connecticut while ensuring that access to quality care is maintained for the population currently being served, including the Medicaid population. The proposal will also help maintain and support a collaborative joint venture between hospitals from separate health systems. Accordingly, the Applicants have demonstrated that their proposal is consistent with the Statewide Health Care Facilities and Services Plan.

Order

Based upon the foregoing Findings of Fact and Discussion, the Applicants' request to transfer ownership of the Harold Leever Regional Cancer Center from the Greater Waterbury Health Network, Inc. to Prospect Medical Holdings, Inc. or its subsidiary is hereby APPROVED.

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

By Order of the
Department of Public Health
Office of Health Care Access

2/15/2017
Date

Yvonne T. Addo, MBA
Deputy Commissioner