Office of Health Care Access
Certificate of Need Application

Final Decision

Applicant: **Saint Francis GI Endoscopy, LLC**

Docket Number: **07-30957-CON**

Project Title: **Establish and Operate a Freestanding Endoscopy Center**

Statutory Reference: **Section 19a-638, Connecticut General Statutes**

Filing Date: **August 30, 2007**

Hearing Date: **October 31, 2007**

Hearing Officer: **Cristine A. Vogel, Commissioner**

Decision Date: **November 21, 2007**

Default Date: **November 28, 2007**

Staff: **Laurie K. Greci**

Project Description: Saint Francis GI Endoscopy, LLC ("Applicant") proposes to establish and operate a freestanding endoscopy center at 360 Bloomfield Avenue, Windsor, Connecticut, at a total capital cost of $2,709,034.

Nature of Proceeding: On August 30, 2007, the Office of Health Care Access ("OHCA") received the Applicant's Certificate of Need ("CON") application seeking authorization to establish and operate a freestanding endoscopy center to be located at 360 Bloomfield Avenue, Windsor, Connecticut, at a total capital cost of $2,709,034. The Applicant is a health care facility or institution as defined by Section 19a-630, of the Connecticut General Statutes ("C.G.S.").

Pursuant to Section 19a-638, C.G.S., a notice to the public concerning OHCA's receipt of the Applicant's Letter of Intent was published in *The Hartford Courant* on April 24, 2007. OHCA received no responses from the public concerning the Applicant's proposal.

Pursuant to Section 19a-638, C.G.S., a public hearing regarding the CON application was held on October 31, 2007. On October 2, 2007, the Applicant was notified of the date, time, and place of the hearing. On October 4, 2007, a notice to the public announcing the hearing was published in *The Hartford Courant*. 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 Section 19a-638, C.G.S.

OHCA's authority to review and approve, modify or deny this application is established by Section 19a-638, 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 Applicant's Current Utilization Statistics

1. Saint Francis GI Endoscopy, LLC ("Applicant" or "SFGI"), a newly formed limited liability company, proposes to establish and operate a for-profit freestanding endoscopy center ("Center") at 360 Bloomfield Avenue, Windsor, Connecticut. *(July 10, 2007, Initial CON Submission, page 4)*

2. The members of the SFGI include Saint Francis Hospital and Medical Center ("Hospital") and Central Connecticut GI Endoscopy, LLC ("CCGI"). The members of CCGI include 14 physicians and surgeons ("Physicians") who specialize in diseases of the gastrointestinal tract. *(July 10, 2007, Initial CON Submission, page 1084)*

3. The Operating Agreement of the SFGI has two classes of membership units. The CCGI holds 510 Class A Units and the Hospital holds 490 Class B Units. *(July 10, 2007, Initial CON Submission, page 1118).*

4. The Operating Agreement of the SFGI requires that:
   a. The SFGI operate at all times in a manner that furthers the tax-exempt and charitable purposes of the Hospital;
   b. The business, operations, and activities of the SFGI will be conducted in accordance with the Ethical and Religious Directives for Catholic Health Care Services; and
   c. The Class A Member, CCGI, shall be at all times wholly owned by qualified surgeons[1]; and
   d. The Board of Managers has the power and authority to cause or authorize the SFGI to take actions as necessary so that the activities of the SFGI are in furtherance of the Hospital's tax-exempt, charitable purposes, and the Community Benefit Standard.[2]

   (July 10, 2007, Initial CON Submission, pages 1084, 1086, and 1110).

5. The Applicant proposes to build and operate a single-specialty ambulatory surgery center ("Center") which will provide screening and diagnostic endoscopies, including colonoscopies and colon rectal procedures. The Center will provide services for the existing patient base of the Hospital and the physicians in CCGI. The Physicians currently perform all their outpatient endoscopies at the Hospital's Endoscopic Day Hospital ("Day Hospital"). *(July 10, 2007, Initial CON Submission, page 2086)*

6. Colon cancer is the second most common cancer causing patient death. Routine colonoscopies are the most effect screening and prevention procedure. Ninety-eight (98%) of colon cancers develop from benign polyps. Removal of colon polyps has the potential to prevent almost all colon cancer from developing. *(July 10, 2007, Initial CON Submission, page 11)*

7. The Applicant based the need for the Center on easing the capacity issues at the Day Hospital by moving the volume of procedures performed by the Physicians to the proposed Center. *(July 10, 2007, Initial CON Submission, page 2086)*

8. The Day Hospital[3] is located on the second floor of the Hospital's Patient Care Tower and has 9 procedure rooms, and 19 post-recovery bays. *(August 8, 2007, First Completeness Response, page 5)*

9. Bronchoscopies are limited to two procedures a day due to the volume of other tests that are scheduled in the Day Hospital. *(August 8, 2007, First Completeness Response, page 6)*

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[1] A "qualified surgeon" means, in part, that a person who meets the following requirements: maintains an unrestricted license to practice medicine in the State of Connecticut; maintains malpractice insurance on tems reasonably satisfactory to CCGI and SFGI; maintains medical staff and clinical privileges at the Hospital; and derives a substantial portion (approximately 1/3 or more) of his practice income from performing ambulatory surgical services.

[2] The Community Benefit Standard refers to the requirements of hospitals under Section 501(c) (3) of the Internal Revenue Code.

[3] The Day Hospital for Endoscopy Procedures is on a separate floor from the other outpatient surgical facilities which is located on the 3rd floor of the same building.

10. The following table reports the total number of gastroenterology-related outpatient visits and the percent of grand total for each hospital located in the greater Hartford region:

Table 2: Gastroenterology Volumes and Market Share by Hospital

Hospital	Visits by Fiscal Year			Market Share by Fiscal Year		
	2005	2006	2007	2005	2006	2007
Saint Francis	15,126	15,845	15,535	26%	27%	27%
ECHN*	13,462	14,676	15,455	23%	25%	27%
Hartford	10,018	10,009	10,835	17%	17%	19%
Central CT	10,363	8,811	7,167	18%	15%	12%
Bristol	4,335	3,519	2,919	7.4%	6.0%	5.1%
John Dempsey	2,220	2,494	2,700	3.8%	4.3%	4.7%
CT Children's Medical Center	1,690	1,862	1,971	2.9%	3.2%	3.4%
Johnson Memorial	1,145	1,052	992	2.0%	1.8%	1.7%
Total	58,359	58,268	57,572	100%	100%	100%

* Includes Manchester Memorial Hospital and Rockville General Hospital.

(August 8, 2007, First Completeness Response, page 4)

11. The following table reports the total endoscopy procedure volume and the utilization rate of the Day Hospital by fiscal year:

Table 3: Procedure Room Utilization at the Day Hospital

Fiscal Year:	2004	2005	2006	2007*
Number of Procedures	17,497	17,857	18,370	17,688
Percent Change from Previous Year	-	2%	2.9%	-3.7%
Number of Procedure Rooms	9	9	9	9
Number of Procedures performed per Room	1,944	1,984	2,041	1,965
Maximum Number of Procedures per Room, annually	2,162	2,162	2,162	2,162
Utilization Rate per Room	**89.9%**	**91.8%**	**94.4%**	**90.8%**

* Annualized volume based on first 8 months.

** Maximum procedure volume per room based on 250 days per year and 8 to 9 procedures performed per day.

(July 10, 2007, Initial CON Submission, page 7 and August 30, 2007, 2nd Completeness Response, page 3)

12. In FY 2006, 2,083 pain management procedures were performed outside of the Day Hospital using Day Hospital staff. The following table reports the total number of pain management procedures performed by Day Hospital staff at various locations within the Hospital.

Table 4: Pain Management Procedures by Fiscal Year

	Number of Procedures in Fiscal Year			
Procedure Category	**2004**	**2005**	**2006**	**2007***
Pain Management	3,150	3,384	3,487	3,068**

* Annualized volume based on first eight months of FY 2007.

** During 2007, the Hospital lost one pain management physician; the open position has since been filled and volume should return to the pre-2007 level.

(August 8, 2007, First Completeness Response, page 10)

13. The following table reports by fiscal year the number of inpatient and outpatient endoscopic procedures performed by the Physicians on patients that reside in towns near the location of the proposed Center:

Table 5: Inpatient and Outpatient Endoscopic Procedures Performed by Physician and by Fiscal Year

Fiscal Year:	**FY04**		**FY05**		**FY06**		**FY07***	
Patient Type:	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**	**IP**	**OP**
Physician Name								
Kofi Atta-Mensah	15	543	21	618	18	496	22	489
Saumitra Banerjee	57	326	65	344	50	334	74	326
Michael Butensky	21	340	30	431	13	392	9	410
Henry Danis	0	0	1	30	6	193	3	201
Golam Gazi	20	606	21	550	17	519	9	475
Steven Goldenberg	20	406	37	423	28	402	22	413
Martin Hoffman	9	532	7	428	10	433	9	552
Ronald Josephson	4	339	5	347	8	292	7	243
James Martino	72	255	54	284	58	329	63	333
Carol Petruff	5	361	12	367	4	345	2	360
John Polio	22	702	24	808	24	777	19	645
Richard Stone	27	395	32	452	35	421	24	420
Brian Van Linda	14	337	12	340	8	316	5	343
Anthony Zaldonis	31	278	14	357	10	320	14	327
Total	**317**	**5,420**	**335**	**5,779**	**289**	**5,569**	**281**	**5,535**

* Annualized volume based on first 7 months of FY 2007.

(July 10, 2007, Initial CON Submission, Exhibit 3.4)

14. The Applicant estimated that 84% of patients residing in towns near the proposed Center may receive their procedures at the Center. The remaining percentage of patients would not be eligible for treatment in the Center due to patient choice, patient fragility, or other risk factors; these patients would continue to receive outpatient endoscopy procedures at the Day Hospital. *(August 8, 2007, First Completeness Response, page 8)*

15. The following table summarizes the number of procedures to be performed at the Center and the projected utilization rate:

Table 6: Proposed Utilization of the Center

Fiscal Year:	2008	2009*	2010*
Number of Procedures	4,655	5,121	5,633
Number of Procedure Rooms	3	3	3
Number of Procedures performed per Room	1,552	1,707	1,878
Maximum Number of Procedures per Room, annually	2,162	2,162	2,162
Average Procedure Room Utilization Rate	71.8%	79.0%	86.9%

* Each year has been incremented by 10%, based on the recent historical growth rate of the Physicians' practices. *August 30, 2007, Second Completeness Response, page 6)*

16. The Day Hospital proposes to backfill the capacity that will be created by the shift of endoscopy procedures to the Center with additional endoscopies and pain management procedures, as well as other outpatient procedures. *(July 10, 2007, Initial CON Submission, page 2086)*

17. The following table summarizes the projected volume at the Day Hospital with the proposal:

Table 8: Projected Volumes at the Day Hospital with the Proposal

Total Procedure Volume	Fiscal Year			
	2007*	2008	2009	2010
Day Hospital without the Center	17,688	19,457	21,402	23,543
Volume shifted to the Center	-	3,119	3,431	3,774
Day Hospital after Shift of GI to the Center	-	16,338	17,971	19,769
Day Hospital Pain Management with the Center	3,068	3,129	3,192	3,256
Day Hospital after Shift and Adding Pain Management	-	19,467	21,163	23,025

***** Annualized volumes based on first 7 months of FY 2007.
(July 10, 2007, Initial CON Submission, page 8)

18. The SFGI proposes to be accredited by the Accreditation Association for Ambulatory Health Care and will follow the Standard Practice Guidelines of the American Gastroenterology Association. *(July 10, 2007, Initial CON Submission, page 15)*

19. The hours of operation for the proposed Center will be Monday through Friday from 7:00 a.m. to 5:00 p.m. *(July 10, 2007, Initial CON Submission, page 4)*

20. Healthcare Development Associates International, Inc. ("HDAI"), under a Management Agreement with SGFI, will provide management services to the Center. HDAI will provide to the Center an administrator and a Director of Nursing. All other personnel needed for the proper operation and maintenance of the Center shall be employees of the Center. *(July 10, 2007, Initial CON Submission, pages 1128 and 1129)*

21. Christopher Hartley, Senior Vice President of Planning and Facilities Development at the Hospital, stated that the benefits of the center to the Hospital include:
    a. Increased operational efficiency at the Hospital by the freeing of treatments at the Day Hospital that can then be used to absorb other outpatient procedures presently scattered elsewhere in the Hospital;
    b. Preservation of revenue from endoscopy procedures by providing additional space for future volume growth;
    c. Strengthening of the existing partnership between the Hospital and its medical staff through the creation of a joint venture that benefits both the Physicians and the Hospital; and
    d. Provision of assistance to the Hospital's medical staff in their efforts to recruit new gastroenterologists.

    (October 25, 2007, Prefiled Testimony, page 6)

22. Mr. Hartley testified at the hearing that;
    a. Most gastroenterology physicians expect to be able to practice at an outpatient facility along with their practices at the Hospital. The successful recruitment of new gastroenterologists supports the utilization of the Hospital's services beyond endoscopy and helps the staff's medical education program with the training of residents.
    b. Successful recruitment of new physicians also helps the staff's medical education program, including the training of residents, particularly in gastroenterology.
    c. The Hospital is easier to access for lower income patients due to barriers presented by travel. The volume and the income generated by the joint venture with the Physicians will help the Hospital provide care to the percentage of Medicaid patients that receive screening colonoscopies.

    (October 31, 2007, Hearing Testimony of Mr. Hartley)

23. Cecilia Kronawitter, President of HDAI testified that:
    a. The benefit to the payers in the outpatient setting is due to the lower cost;
    b. The Hospital is reimbursed under Part A of Medicare and the Center will be reimbursed under Part B[4];
    c. Under Medicare, patients pay a 20% co-pay for a screening colonoscopy;
    d. Medicare patients save through lower relative co-pays due to the lower overall cost of having the procedure at the Center.

    (October 31, 2007, Hearing Testimony of Ms. Kronawitter)

24. Anthony Zaldonis, MD, testified that:
    a. The growth in utilization of GI endoscopy has grown in the recognition that screening colonoscopy with polypectomy can be associated with as high as a 90% reduction in the subsequent development of colon cancer in screened populations;
    b. Less than 50% of the population at risk are receiving screening colonoscopies for the prevention of colon cancer; and

[4] In providing services to lower risk patients, Medicare offers a lower reimbursement to the Center as the Center does not need to provide the same level of available equipment and advanced care that the Hospital is required to provide. Hence, the Center will not receive a hospital-based rate benefiting patients with the lower outpatient procedure cost.

c. The need for screening colonoscopy as well as other endoscopic services will continue to grow.

(October 31, 2007, Hearing Testimony of Dr. Zaldonis)

25. Section 19a-613 of the Connecticut General Statutes authorizes OHCA to collect patient-level outpatient data from health care facilities or institutions, as defined in Section 19a-630.

Financial Feasibility of the Proposal and its Impact on the Applicant's 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

26. The total capital cost for the proposal is $2,709,033 and includes the following components:

Table 8: Capital Cost Components

Item	Cost
Renovation of existing space	$1,303,606
Medical Equipment (Purchase)	325,000
Non-Medical Equipment (Purchase)	228,000
Other	523,027
Total Capital Expenditure	**$2,379,633**
Leased Medical Equipment, fair market value	329,400
Total Capital Cost	**$2,709,033**

(July 10, 2007, Initial CON Submission, page 23)

27. The renovation expenditure includes the following:

Table 9: Construction Expenditure Breakdown

Item	Expenditure
Building Work	$1,112,180
Off-site Work	96,341
Contingency	56,159
Inflation Adjustment	38,926
Total	**$1,303,606**

(July 10 2007, Initial CON Submission, page 24)

28. The Center will be located in an existing building that will be renovated to include one operating room, two procedure rooms, four pre-operative beds, and six post-operative beds. *(July 10, 2007, Initial CON Submission, page 24)*

29. The capital expenditures will be funded by the equity contributions of the members of Saint Francis GI Endoscopy, LLC. *(July 10, 2007, page 260)*

30. The Applicant is projecting the following incremental revenues and expenses for the first three years of their proposal:

Table 10: Projected Incremental Revenues and Expenses

Description	**FY 2008**	**FY 2009**	**FY 2010**
Revenue from Operations	$2,952,617	$3,247,879	$3,572,667
Expenses:			
Salaries and Fringe Benefits	480,960	538675	603,316
Professional Services	217,630	240144	265,021
Supplies and Drugs	279,300	307230	337,953
Building Lease	96,937	9360	101,844
Equipment Lease	124,382	136833	150,514
Depreciation	195,534	195534	195,534
Utilities, Property Taxes	33,000	34350	35,759
Other	83,585	180,644	98,343
Total Operating Expenses	1,511,328	1,642,770	1,788,284
Gain from Operations	**$1,441,289**	**$1,605,109**	**$1,784,383**

Assumptions: Reimbursement for procedures is assumed to remain the same every year.
Bad debt allowance is 4% of net revenues.
Salaries will increase 3% each year and employee benefits are estimated to be 28% of salaries.
(July 10, 2007, Initial CON Submission, pages 1080 and 1081)

31. The Hospital is projecting the following incremental revenues, and expenses, and operating loss for the first three years of the proposal:

Table 11: Projected Incremental Operating Revenues and Expenses of the Hospital

	Incremental		
Description	**FY 2008**	**FY 2009**	**FY 2010**
Total Net Patient Revenue	$(2,068,833)	$(4,829,783)	$(5,597,134)
Operating Revenue from SFGI	706,232	786,503	874,348
Revenue from Operations	$(1,362,601)	$(4,043,280)	$(4,722,786)
Operating Expenses	(1,261,381)	(2,889,230)	(3,387,714)
Loss from Operations	**$ (101,220)**	**$(1,154,050)**	**$(1,335,072)**

(July 10, 2007, Initial CON Submission, page 1071)

32. The projected payer mix for the Center, based on the Physicians' practices and calculated using projected gross revenue, is presented in the following table:

Table 12: SFGI Projected Payer Mix

Payer	Payer Percent (%)		
	FY 2008	**FY 2009**	**FY 2010**
Medicare	25	25	25
Medicaid	3	3	3
TriCare (CHAMPUS)	0	0	0
Total Government	**28**	**28**	**28**
Commercial Insurers	69	69	69
Uninsured	3	3	3
Workers Compensation	0	0	0
Total Non-Government	**72**	**72**	**72**
Total Payer Mix	**100**	**100**	**100**

(July 10, 2007, Initial CON Submission, page 27)

33. The SFGI has an uncompensated care and financial aid plan that will offer assistance to patients, in financial need, who have incurred or are in need of medical care. Sliding fee scales or special payment plans established by SFGI will be described and will be made available for patients to review upon request. *(July 10, 2007, Initial CON Submission, page 2062)*

34. In the event of an emergency, the SFGI has established a patient transfer agreement with the Hospital. *(July 10, 2007, Initial CON Submission, page 2078)*

35. There is no State Health Plan in existence at this time. *(July 10, 2007, Initial CON Submission, page 3)*

36. The Applicant has adduced evidence that this proposal is consistent with the long-range plan of SFGI to establish the Center. *(July 10, 2007, Initial CON Submission, page 3)*

37. The Applicant stated that it has not undertaken any activities to improve productivity and contain costs in the past year. *(July 10, 2007, CON Submission, page 19)*

38. The Applicant does not have any teaching or research responsibilities. *(July 10, 2007, Initial CON Submission, page 20)*

39. There are no distinguishing characteristics of the Applicant's patient/physician mix. *(July 10, 2007, Initial CON Submission, page 20)*

40. The Applicant has provided evidence that it has technical, financial, and managerial competence. *(July 10, 2007, Initial CON Submission, Exhibit 16)*

41. The Applicant's rates are sufficient to cover the proposed capital and operating costs associated with the proposal. *(August 30, 2007, Initial CON Submission, Exhibit 34)*

Rationale

The Office of Health Care Access ("OHCA") approaches community and regional need for Certificate of Need ("CON") proposals on a case by case basis. 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 an existing service, the specific type of service proposed to be offered, the current utilization of the service and the financial feasibility of the proposal.

Saint Francis GI Endoscopy, LLC ("Applicant" or "SFGI"), a newly formed limited liability company, proposes to establish and operate a for-profit freestanding endoscopy center ("Center") at 360 Bloomfield Avenue, Windsor, Connecticut. The members of the SFGI include Saint Francis Hospital and Medical Center ("Hospital") and Central Connecticut GI Endoscopy, LLC ("CCGI"). The members of CCGI include 14 physicians and surgeons ("Physicians") who specialize in diseases of the gastrointestinal tract. The Hospital will own 49% of the Center, and the remaining 51% will be owned by CCGI. The SFGI will operate at all times in a manner that furthers the tax-exempt and charitable purposes of the Hospital. In addition, the business, operations, and activities of the SFGI will be conducted in accordance with the Ethical and Religious Directives for Catholic Health Care Services.

Screening colonoscopies is the primary procedure used to detect and prevent colon cancer. The Physicians will utilize the new Center to provide screening and diagnostic endoscopies, including colonoscopies and colon rectal procedures, to their existing patient base. The Applicant estimated that 84% of its patients residing in towns near the proposed Center may receive their procedures at the Center. The remaining percentage of patients would not be eligible for treatment in the Center due to patient choice, patient fragility, or other risk factors; these patients would continue to receive outpatient endoscopy procedures at the Hospital's Endoscopic Day Hospital ("Day Hospital").

The establishment of the Center will provide the needed capacity at the Day Hospital by moving the volume of procedures performed by the Physicians to the proposed Center. To increase its operational efficiency the Hospital will utilize the freed up space and surgical time at the Day Hospital through the absorption of the other outpatient procedures presently scattered elsewhere in the Hospital. The Day Hospital proposes to perform additional endoscopies, pain management procedures, and other outpatient procedures.

The demand for screening colonoscopies is expected to increase. With the Applicant's proposal the Hospital will be able to accommodate future volume growth and preserve the Hospital's revenue from endoscopy procedures. In addition, the Hospital will benefit from the strengthening of the existing partnership between the Hospital and its physicians, as well as aiding in the efforts of the Hospital's medical staff to recruit new gastroenterologists and ensuring patient access to those physicians. The successful recruitment of new gastroenterologists supports the utilization of the Hospital's services beyond endoscopy and helps the staff's medial education program with the training of residents.

The Hospital is easier to access for lower income patients due to barriers presented by travel. The volume and the income generated by the joint venture with the Physicians will help the Hospital provide care to the percentage of Medicaid patients that receive screening colonoscopies. The benefit to the payers in the outpatient setting is that care may be provided at a lower cost. When patients are required to provide a co-payment as a percentage of the procedure cost, the co-payment to the Center will be lower and therefore this proposal is cost-effective for patients and payers.

The Center will be located in an existing building that will be renovated to include one operating room, two procedure rooms, four pre-operative beds, and six post-operative beds. The capital expenditures will be funded by the equity contributions of the members of Saint Francis GI Endoscopy, LLC. Healthcare Development Associates International, Inc. ("HDAI"), under a Management Agreement with SGFI, will provide management services to the Center. HDAI will provide to the Center an administrator and a Director of Nursing. All other personnel needed for the proper operation and maintenance of the Center shall be employees of the Center.

The proposal is financially feasible. The Applicant is projecting the incremental gains from operations of $1,441,289, $1,605,109, and $1,784,383 for the first three years of the proposal. The Applicant expects that 25% of its services will be reimbursement by either Medicare or Medicaid. The SFGI has an uncompensated care and financial aid plan that will offer assistance to patients, in financial need, who have incurred or are in need of medical care. Sliding fee scales or special payment plans established by SFGI. Through its owner-membership in the Center, the Hospital will receive 49% of these gains, helping to offset the loss of volume in the initial years of the Center's operations. Although the Hospital will incur a loss of revenue operations due to the shift of procedures to the Center, it will benefit from the additional capacity in its Day Hospital and the ability to attract new gastroenterologists. Although OHCA cannot draw any conclusions, the Applicant's volume and financial projections upon which they are based appear to be reasonable and achievable.

The Applicant's proposal to establish and operate the new freestanding endoscopy Center will improve the accessibility of outpatient endoscopy procedures, particularly screening colonoscopies, to their current patients. The proposal will also allow the Hospital to continue providing care to the underserved. Although there will be an impact to the Hospital due to the decreases in volume and revenue, the proposal will ensure long term access to gastroenterological services through the recruitment of new physicians. Through the joint venture, the Hospital will share in the revenue of the Center and will be able to absorb the increasing demand for screening colonoscopies, thus securing care for the underserved at the Hospital. OHCA finds that the proposal will increase access and improve the quality of service provided to the Hospital's patients.

Order

Based upon the foregoing Findings and Rationale, the Certificate of Need application of Saint Francis GI Endoscopy, LLC ("Applicant") is hereby authorized to establish and operate a single-specialty, outpatient endoscopy center to be located at 360 Bloomfield Avenue, Windsor, Connecticut, at a total capital cost of $2,709,034. The authorization is subject to the following conditions:

1. This authorization expires on November 21, 2009. Should the Applicant's project not be completed by that date, the Applicant must seek further approval from OHCA to complete the project beyond that date.

2. The Applicant shall report to OHCA, in writing, the date of the commencement of operations at Saint Francis GI Endoscopy Center to OHCA within 30 days of the commencement date.

3. The Applicant shall not exceed the approved capital cost of $2,709,034. In the event that the Applicant learns of potential cost increases or expects that the final project costs will exceed those approved, the Applicant shall file with OHCA a request for approval of the revised project budget.

4. Should the Applicant intend or plan any change in the scope of services provided, expand the existing services beyond the single operating room and two procedure rooms or change the location of the outpatient endoscopy center at 360 Bloomfield Avenue, Windsor, Connecticut, the Applicant shall file with OHCA a Certificate of Need, Determination Request, or Letter of Intent regarding the intended or planned service change or location.

5. The ownership interest of Saint Francis Hospital and Medical Center shall not fall below 49%. If Saint Francis Hospital and Medical Center proposes to change its ownership percentage prior OHCA approval will be required.

6. Saint Francis GI Endoscopy, LLC shall provide OHCA with utilization reports on a quarterly basis. The data elements and the format and submission requirements are described in Attachment 1. The Applicant shall include in the quarterly report 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 the greater Windsor area have appropriate access to the site.

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 November 21, 2007

_____ _____

Date Cristine A. Vogel
Commissioner

CAV:lkg

Attachment 1

Evergreen Endoscopy Center, LLC shall submit patient-specific data as listed and defined below for those patients that receive service, care, diagnosis or treatment at the Central Connecticut Endoscopy Center. This information may be extracted from either the medical abstract or billing records or both and submitted to the Office of Health Care Access ("OHCA") in accordance with this Attachment.

I. The data are to be submitted in ASCII or Excel format on a computer disk.

II. Column headers to be used are listed below in field name after the name of each data element.

III. Data formats to be followed are listed for each data element.

IV. The disk or file should be clearly marked with the applicant's/facility's name, file name, docket number and its contents.

V. Accompanying the data submission, the applicant/facility must submit a full written description of the data submitted and its record layout.

VI. Initial data shall be submitted at the end of the first quarter in which the facility begins to provide the service for which it is licensed. Subsequent data for a calendar quarter shall be filed before the end of the calendar quarter following the calendar quarter in which the encounter was recorded. This data set shall contain the data records for each individual encounter from that facility during the preceding calendar quarter. For example, the data set to be filed before June 30, 2004, shall contain the data records for each individual encounter at that facility from January 1, 2004 until March 31, 2004.

VII. All data collected by OHCA will be subject to the laws and regulations of the State of Connecticut and the Office of Health Care Access regarding its collection, use, and confidentiality.

Outpatient Facility Encounter Data Layout
(For Professionals)

#	Description	Field Name	Data Type	Start	Stop
1	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)	1	10
2	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)	11	12
3	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)	13	13
4	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)	14	33
5	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)	34	53
6	Social Security Number – patient's SSN **Format: string (9, exclude hyphens)**	ssn	Char(9)	54	62
7	Date of birth – the month, day, and year of birth of the patient whose encounter is being recorded. **Format: date (8, mmddyyyy)**	dob	Date	63	70
8	Sex – patient's sex, to be numerically coded as follows: 1. Male = 1 2. Female = 2 3. Not determined = 3	sex	Char(1)	71	71

9	Race – patient-identified designation of a category from the following list, and coded as follows: A. White = 1 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 = 5 (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, other Asian) F. Two or more races = 6 G. Some other race = 7 H. Unknown = 8	race	Char(1)	72	72
10	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)	73	73
11	Patient's State – patient indicated state of primary residence.	patstate	Char(2)	74	75
12	Town – patient indicated town of primary residence.	twn_cty	Char(3)	76	78
13	Zip Code – zip code of the patient's primary residence	patzip	Char(5)	79	83
14	Relationship to Insured1 – means the categories of patient's relationship to the identified insured or sponsor as listed below: 1. Self = 1 2. Spouse = 2 3. Child = 3 4. Other = 4	r_insure1	Char(3)	84	86
15	Employment status (e_stat) – means the categories of patient's employment status as listed below: 1. Employed = 1 2. Full-time student = 2 3. Part-time student = 3 4. Retired = 4 5. Other = 5	e-stat	Char(1)	87	87
16	Insured1's employer – means the name of the insured's employer.	employ1	Char(50)	88	137
17	Insured1's state of residence – means the insured's state of primary residence.	i1_state	Char (2)	138	139

18	Insured2's employer – means the name of the insured's employer.	employ2	Char (50)	140	189
19	Insured2's state of residence – means the insured's state of primary residence.	i2_state	Char (2)	190	191
20	Insured3's employer – means the name of the insured's employer.	employ3	Char (50)	192	241
21	Insured3's state of residence – means the insured's state of primary residence.	i3_state	Char (2)	242	243
22	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)	244	248
23	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)	249	253
24	As defined in (23)	dx3	Char(5)	254	258
25	As defined in (23)	dx4	Char(5)	259	263
26	As defined in (23)	dx5	Char(5)	264	268
27	As defined in (23)	dx6	Char(5)	269	273
28	As defined in (23)	dx7	Char(5)	274	278
29	As defined in (23)	dx8	Char(5)	279	283
30	As defined in (23)	dx9	Char(5)	284	288
31	As defined in (23)	dx10	Char(5)	289	293
32	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)	294	298
33	As defined in (32)	ecode2	Char(5)	299	303
34	As defined in (32)	ecode3	Char(5)	304	308
35	Date of service– the month, day, and year for each procedure, service or supply. "To (dost) & From (dosf)" are for a series of identical services provider recorded.	dosf	Date	309	316

	Format: date (8, mmddyyyy)				
36	As defined in (35)	dost	Date	317	324
37	Principal Procedure - the HCPCS/CPT code for the procedure most closely related to the principal diagnosis that is performed for the definitive treatment of the patient.	px1	Char(5)	325	329
38	Modifier (mod1 & mod2) – 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.	mod1	Char(2)	330	331
39	As defined in (38)	mod2	Char(2)	332	333
40	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum1	Char(2)	334	335
41	Units of services – number of days for multiple days or units of supply.	Units1	Num (4)	336	339
42	Charge – charge for the listed service	Charge1	Num (6)	340	345
43	Secondary Procedure (px2 through px10) – the HCPCS/CPT codes for other significant procedures.	Px2	Char(5)	346	350
44	Modifier (mod3 & mod4) – 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.	mod3	Char(2)	351	352
45	As defined in (38)	mod4	Char(2)	353	354
46	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum2	Char(2)	355	356
47	Units of services – number of days for multiple days or units of supply.	Units2	Num (4)	357	360
48	Charge – charge for the listed service.	Charge2	Num (6)	361	366
49	As defined in (43)	px3	Char(5)	367	371
50	Modifier (mod5 & mod6) – 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.	mod5	Char(2)	372	373
51	As defined in (38).	mod6	Char(2)	374	375
52	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum3	Char(2)	376	377
53	Units of services – number of days for multiple days or units of supply.	Units3	Num (4)	378	381
54	Charge – charge for the listed service	Charge3	Num (6)	382	387
55	As defined in (43).	px4	Char(5)	388	392

56	Modifier (mod7 & mod8) – 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.	mod7	Char(2)	393	394
57	As defined in (38).	mod8	Char(2)	395	396
58	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum4	Char(2)	397	398
59	Units of services – number of days for multiple days or units of supply.	Units4	Num (4)	399	402
60	Charge – charge for the listed service.	Charge4	Num (6)	403	408
61	As defined in (43).	px5	Char(5)	409	413
62	Modifier (mod9 & mod10) – 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	mod9	Char(2)	414	415
63	As defined in (38)	mod10	Char(2)	416	417
64	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum5	Char(2)	418	419
65	Units of services – number of days for multiple days or units of supply.	Units5	Num (4)	420	423
66	Charge – charge for the listed service.	Charge5	Num (6)	424	429
67	As defined in (43).	px6	Char(5)	430	434
68	Modifier (mod11 & mod12) – 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.	mod11	Char(2)	435	436
69	As defined in (38).	mod12	Char(2)	437	438
70	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum6	Char(2)	439	440
71	Units of services – number of days for multiple days or units of supply.	Units6	Num (4)	441	444
72	Charge – charge for the listed service.	Charge6	Num (6)	445	450
73	As defined in (43).	px7	Char(5)	451	455
74	Modifier (mod13 & mod14) – 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.	mod13	Char(2)	456	457
75	As defined in (38).	mod14	Char(2)	458	459
76	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum7	Char(2)	460	461

77	Units of services – number of days for multiple days or units of supply.	Units7	Num (4)	462	465
78	Charge – charge for the listed service.	Charge7	Num (6)	466	471
79	As defined in (43).	px8	Char(5)	472	476
80	Modifier (mod15 & mod16) – 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.	mod15	Char(2)	477	478
81	As defined in (38).	mod16	Char(2)	479	480
82	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum8	Char(2)	481	482
83	Units of services – number of days for multiple days or units of supply.	Units8	Num (4)	483	486
84	Charge – charge for the listed service.	Charge8	Num (6)	487	492
85	As defined in (43).	px9	Char(5)	493	497
86	Modifier (mod17 & mod18) – 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.	mod17	Char(2)	498	499
87	As defined in (38).	mod18	Char(2)	500	501
88	Dx Reference Number – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum9	Char(2)	502	503
89	Units of services – number of days for multiple days or units of supply.	Units9	Num (4)	504	507
90	Charge – charge for the listed service.	Charge9	Num (6)	508	513
91	As defined in (43).	px10	Char(5)	514	518
92	Modifier (mod19 & mod20) – 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.	mod19	Char(2)	519	520
93	As defined in (38).	mod20	Char(2)	521	522
94	Dx Reference Number (dxnum) – diagnosis code number relating the date of service and procedures performed to the primary diagnosis.	Dxnum10	Char(2)	523	524
95	Units of services – number of days for multiple days or units of supply.	Units10	Num (4)	525	528
96	Charge – charge for the listed service.	Charge10	Num (6)	529	534
97	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	ppayer	Char(1)	535	535

	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				
98	As defined in (97).	spayer	Char(1)	536	536
99	As defined in (97).	tpayer	Char(1)	537	537
100	Payer Identification (payer1, payer2, payer3) – the insured's group number (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(5)	538	542
101	As defined in (100).	payer2	Char(5)	543	547
102	As defined in (100).	payer3	Char(5)	548	552
103	Encounter type – indicates the priority of the encounter. Emergent = 1 Urgent = 2 Elective = 3	etype	Char(1)	553	553
104	Referring Physician - State license number or NPI of the physician primarily responsible for the patient for this encounter.	rphysid	Char(10)	554	559
105	Attending Physician – State license number or NPI identifying the provider who performed the service/treatment/procedure.	pphysdocid	Char(10)	560	565
106	Operating Physician – State license number or NPI identifying the provider who performed the service/treatment/procedure.	ophysid	Char(10)	566	575
107	Charges – Sum of all charges for this encounter.	chrg_tot	Num(8)	576	583
108	Disposition – the circumstances of the patient's discharge, categories of which are defined below: Discharged to home or self care, (routine discharge) 01	pstat	Char(2)	584	585

	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				

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