CERTIFIED COPY

STATE OF CONNECTICUT

OFFICE OF HEALTH STRATEGY

Docket No. 20-32392-CON

Encompass Health Rehabilitation Hospital of Danbury, LLC, Public Hearing being held for the Establishment of a 40-Bed Chronic Disease Hospital

Public Hearing held via Teleconference on October 28, 2021, beginning at 10 a.m.

H e l d B e f o r e:

JOANNE V. YANDOW, ESQ., THE HEARING OFFICER

1 **A p p e a r a n c e s:**

2 **For the APPLICANT (ENCOMPASS HEALTH):**

3 **UPDIKE, KELLY & SPELLACY**

4 **100 Pearl Street**

5 **Hartford, Connecticut 06103**

6 **By: JENNIFER GROVES FUSCO, ESQ.**

7 **JFusco@uks.com**

8 **203.786.8316**

9

10 **For the INTERVENOR (DANBURY HOSPITAL)**

11 **ROBINSON + COLE**

12 **By: THEODORE J. TUCCI, ESQ.**

13 **TTucci@rc.com**

14 **860.275.8210**

15 **and: CONNOR DUFFY, ESQ.**

16 **CDuffy@rc.com**

17 **860.275.8342**

18 **and: LISA BOYLE, ESQ.**

19 **LBoyle@rc.com**

20 **860.275.8350**

21

22 **OHA Staff:**

23 **BRIAN CARNEY**

24 **ORMAND CLARKE**

25 **LESLIE GREER**

1 (Begin: 10 a.m.)

2

3 THE HEARING OFFICER: Good morning, everyone.

4 This is the Office of Health Strategy

5 hearing. It's on the certificate of need

6 application filed by the Applicant, Encompass

7 Health Rehabilitation Hospital of Danbury, LLC.

8 This is Docket Number 20-32392-CON. In the

9 application, Applicant seeks to establish a new

10 healthcare facility. The application states that

11 the Applicant is seeking to establish a 40-bed

12 chronic disease hospital providing inpatient

13 physical rehabilitation care in Danbury,

14 Connecticut.

15 The public hearing before the Office of

16 Health Strategy's health system planning unit is

17 being held today on October 28, 2021. Public Act

18 21-2, Section 149, effective July 1, 2021,

19 authorizes an agency to hold a public hearing by

20 means of electronic equipment. In accordance with

21 the public act any person who participates orally

22 in electronic meeting shall make a good-faith

23 effort to state your name and title, and if

24 applicable at the outset of each occasion that

25 each such person participates orally during an

1 uninterrupted dialogue or a series of questions
2 and answers.
3 We ask that all members of the public mute
4 the device that they are using to access the
5 hearing and to silence any additional devices that
6 are around them.
7 This public hearing is held pursuant to
8 Connecticut General Statutes, Section 19(a)-639a
9 and will be conducted under the provisions of
10 Chapter 54 of the Connecticut General Statutes.
11 My name is Joanne V. Yandow. Victoria
12 Veltri, the Executive Director of the Office of
13 Health Strategy has designated me to serve as the
14 Hearing Officer for this matter to rule on all
15 motions and recommend findings of fact and
16 conclusions of law upon completion of the hearing.
17 Office of Health Strategy staff is here to
18 assist me in gathering facts related to this
19 application and will be asking the applicant
20 witness questions. OHS may also ask the
21 intervener witness questions.
22 I'm going to ask each staff person assisting
23 with questions today to identify themselves with
24 their name, spelling of their last name and their
25 OHS title.

1 And if we could start with Mr. Carney,
2 please?
3 MR. CARNEY: Good morning. My name is Brian Carney,
4 C-a-r-n-e-y. I'm the Certificate of Need
5 Supervisor at the Office of Health Strategy.
6 THE HEARING OFFICER: Ormand?
7 DR. CLARKE: My name is Ormand Clarke. First name is
8 spelled O-r-m-a-n-d; last name C-l-a-r-k-e. I'm a
9 healthcare analyst at OHS.
10 THE HEARING OFFICER: Thank you.
11 As I already mentioned, the Applicant here is
12 Encompass Health Rehabilitation Hospital, LLC.
13 The Danbury Hospital has been granted intervener
14 status in this matter.
15 A certificate of need process is a regulatory
16 process, and as such, the highest level of respect
17 will be accorded to the Applicant, the Intervener,
18 members of the public and OHS staff. Our priority
19 is the integrity and transparency of this process.
20 Accordingly, decorum must be maintained by
21 all present during these proceedings. This
22 hearing is being recorded and will be transcribed.
23 All documents related to this hearing that have
24 been or will be submitted to OHS are available for
25 review through our CON portal which is accessible

1 on the Office of Health Strategy's CON webpage.
2 In making my decision I will consider and
3 make written findings in accordance with Section
4 19a-639 of the Connecticut General Statutes. The
5 CON portal contains the table of record in this
6 case. As of this morning exhibits were identified
7 A through DD. And let me just -- yes, DD is the
8 last one on the portal, which was put up at 7:12
9 this morning.
10 In accordance with Connecticut General
11 Statutes Section 4-178, the Applicant is hereby
12 noticed that I may take judicial notice of the
13 following documents.
14 The State facilities plan, OHS acute-care
15 hospital discharge database, hospital reporting
16 system financial data, bed need methodology,
17 hospital reporting system report 400, hospital
18 inpatient bed utilization by department, and all
19 payer claims database also known as APCD for the
20 claims data. These documents are within the
21 agency's specialized knowledge.
22 Mr. Carney, in addition to the Exhibits A
23 through the DD in the portal and the documents I
24 listed as administratively noticed, is there
25 anything else to enter into the record?

1 MR. CARNEY: No, Attorney Yandow. I'm not aware of any
2 additional documents.
3 THE HEARING OFFICER: Okay. Counsel for the Applicant,
4 are there any objections to the exhibits as in the
5 record on the portal or the notice documents?
6 MS. FUSCO: There are no objections to the exhibits in
7 the portal. I would just note that I don't
8 believe there's a revised table of the record that
9 includes those later documents.
10 The table of the record I'm pulling up stops
11 at, I believe, "Z," but all of the documents are
12 in here through DD, and there's no objection -- or
13 to the notice documents.
14 The only issue is that there is an unresolved
15 request in Exhibit O that I know you said you'd
16 deal with today, but otherwise no objection.
17 This is Jennifer Fusco, counsel for Encompass
18 Health.
19 THE HEARING OFFICER: Okay. Then all exhibits are
20 entered and marked as full exhibits.
21
22 (Department Exhibits A through and inclusive
23 of DD, admitted into evidence.)
24
25 THE HEARING OFFICER: I would like to advise the

1 Applicant that we may ask questions related to
2 your application that you feel you have already
3 addressed. We will do this for the purpose of
4 ensuring that the public has knowledge about your
5 proposal and for the purpose of clarification.
6 I want to reassure you that we have reviewed
7 your application complete in its responses and
8 prefiled testimony. As this hearing is being held
9 virtually we ask that all participants to the
10 extent possible should enable the use of video
11 cameras when testifying or commenting during the
12 proceedings. Anyone who is not testifying or
13 commenting shall mute their electronic devices.
14 All participants shall mute their devices and
15 may disable their cameras when we go off the
16 record to take a break. Please be advised that
17 the hearing recording continues during the break.
18 So any audio or video not disabled will be
19 accessible to all participants to the hearing. So
20 I will try to remind everyone when we take a break
21 and when we go to lunch, but that's the standard
22 practice on the OHS hearings. So it's important
23 to remember to do that.
24 Public comment taken during the hearing will
25 likely go in the order established by OHS during

1 the registration process, however I may allow
2 public officials to testify out of order. I or
3 OHS staff will call each individual by name when
4 it is his or her turn to speak.
5 Regarding Exhibit O, which is Applicant's
6 request for technical correction of hearing
7 notice, under 19a-639a(f)(2), OHS may hold a
8 hearing. As noticed OHS is holding this hearing.
9 As such the technical correction is denied,
10 however regarding 19a-639a(e) the record speaks
11 for itself.
12 In Exhibit H the Danbury Hospital made a
13 timely request under 19a-639a(e) for a public
14 hearing regarding this application. In Exhibit I
15 OHS notified the Danbury Hospital that it would be
16 holding a hearing.
17 My ruling is not that 19a-639a(e) does not
18 apply, but that a technical correction is not
19 going to be made as the hearing notice is
20 sufficient. 19a-639a(e) as stated in the statute
21 does require a mandatory hearing as the word
22 "shall" is used.
23 Are there any other housekeeping matters or
24 procedural issues we need to address before
25 starting the technical portion?

1 MS. FUSCO: Just that Cindy Wellman needs -- I believe
2 Leslie Greer is going to give her the ability to
3 cohost so we can screen share during our
4 presentation.
5 THE HEARING OFFICER: Okay. So I'll let Leslie --
6 certainly if that becomes an issue, Leslie can
7 certainly jump in and let us know if we're having
8 any problems with that.
9 I'm just going to turn my camera off for a
10 second and put my shade down. I think there's a
11 glare.
12 MS. FUSCO: No problem.
13 THE HEARING OFFICER: Let me just see if that works
14 out.
15 Now you get to see me, and not the beautiful
16 trees on Capitol Avenue.
17 MS. FUSCO: We can see better. Thank you.
18 THE HEARING OFFICER: Okay. You're welcome.
19 At this time I'd like counsel for the
20 Applicant to identify yourself, please. And I'm
21 sorry -- I know you already did, but if you could
22 do that again also?
23 MS. FUSCO: It's okay. This is Jennifer Fusco from
24 Updike, Kelly & Spellacy, counsel for the
25 Applicant Encompass Health Rehabilitation Hospital

1 of Danbury, LLC.
2 THE HEARING OFFICER: Okay. And as previously stated,
3 there is an intervener in this matter. Could I
4 have counsel for the Intervener identify
5 themselves, please?
6 And I think for the Court Reporter, if you
7 would spell your last names, please?
8 MR. TUCCI: Yes. Thank you. Good morning, Hearing
9 Officer Yandow and staff of the Office of
10 Healthcare Strategy. On behalf of the Intervener
11 Danbury Hospital, this is Theodore Tucci,
12 T-u-c-c-i. And along with Connor Duffy I
13 represent the Intervener, Danbury Hospital.
14 Also with us today is my colleague Lisa
15 Boyle, B-o-y-l-e; Mr. Duffy, D-u-f-f-y.
16 Thank you.
17 THE HEARING OFFICER: Thank you.
18 Attorney Fusco, do you have an opening
19 statement?
20 MS. FUSCO: I just wanted to sort of briefly introduce
21 the project and my clients. So you know, thanks
22 for this opportunity to make some remarks. As I
23 said before, I represent Encompass Health
24 Rehabilitation Hospital of Danbury, which is a
25 subsidiary of Encompass Health Corporation, which

1 is a leading national provider of inpatient
2 rehabilitation services across the country.
3 Encompass Danbury is before you today, as
4 you've mentioned, requesting CON approval to
5 establish a 40-bed inpatient rehabilitation
6 Hospital in Danbury. The state-of-the-art
7 facility will serve a, you know, specific targeted
8 patient population that's in need of this, this
9 intensive level of rehabilitation services which I
10 think we're going to learn a lot about today.
11 But they're services that address significant
12 health conditions such as, you know, stroke,
13 multiple trauma, spinal cord and brain injuries
14 just to name a few.
15 You are going to hear testimony about a needs
16 assessment that was done that identified what we
17 refer to as a significant gap in care for these
18 services in the service area and in Connecticut
19 generally, and that forms the basis of our CON
20 request.
21 You're also going to hear testimony about how
22 the proposal is going to improve the quality,
23 accessibility and cost effectiveness of care as is
24 required by the CON statutes.
25 The proposed hospital is going to be a

1 tremendous benefit to Connecticut residents whose
2 ability to recover from, you know, serious
3 illnesses and injuries and regain functionality
4 relies on there being adequate access to these
5 types of advanced rehab services.
6 So our presentation is going to take a while.
7 So I'll stop talking and introduce to you our
8 witnesses, because you're going to hear today
9 from, first from Patrick Tuer who's the Northeast
10 Region President for Encompass Health. You're
11 going to hear from Dr. Lisa Charbonneau who is the
12 Chief Medical Officer of Encompass Health.
13 And you will hear from Marty Chafin, who is
14 the president of Chafin consulting group. Marty
15 is here with me today. Mr. Tuer and
16 Dr. Charbonneau are remote. And we sound checked
17 them. We should be fine. Mr. Tuer is up now.
18 So thank you again for your time, and I'll
19 turn this presentation over to Pat.
20 THE HEARING OFFICER: Okay. So what I will do, since
21 we're going to take these witnesses, I will swear
22 them in separately. I just want to keep with your
23 flow.
24 Also the Intervener will be allowed an
25 opening statement, but that will be after the

1 Applicant is done with its presentation. So I did
2 want to make the Intervener aware of that. Okay?
3 So Mr. Patrick -- is it Tour [phonetic]?
4 PATRICK TUER: That's correct.
5 THE HEARING OFFICER: Okay. And you filed a prefiled
6 statement. Is that correct?
7 PATRICK TUER: That is correct.
8 P A T R I C K T U E R,
9 called as a witness, being first duly sworn
10 by the HEARING OFFICER, was examined and
11 testified under oaths as follows:
12
13 THE HEARING OFFICER: Thank you. And again, and state
14 your name for the record?
15 THE WITNESS (Tuer): My name is Patrick Tuer. The last
16 name is spelled T-U-E-R, and I'm the Regional
17 President for the Northeast Region of Encompass
18 Health.
19 THE HEARING OFFICER: Okay. Well, you can go ahead and
20 offer whatever evidence it is that you want me to
21 consider today.
22 THE WITNESS (Tuer): Great. Thank you, Attorney Yandow
23 and members of the OHS staff. Again, my name is
24 Pat Tuer and I adopt my prefiled testimony.
25 Thank you for this opportunity to testify in

1 support of our certificate of need application for
2 permission to build a 40-bed inpatient
3 rehabilitation hospital in Danbury.
4 This hospital, if approved, will serve a
5 substantial unmet need for inpatient
6 rehabilitation services in Western Connecticut
7 ensuring that patients have adequate access to
8 high-quality care that is suitable to their
9 health.
10 So in my role as President of the Northeast
11 region of Encompass Health I oversee 19 hospitals,
12 inpatient rehab hospitals located in 6 states
13 including Pennsylvania, Massachusetts, Maine, New
14 Hampshire, New Jersey, and Delaware, with the
15 combined employee count of 3300 FTEs.
16 Before becoming president of the Northeast
17 Region I served as vice president with the company
18 since 2018. And in these roles I've gained
19 knowledge of the market for inpatient rehab
20 services in the Northeastern U.S. where Encompass
21 has a significant presence.
22 Encompass is a national leader in inpatient
23 rehabilitation services with 144 inpatient
24 rehabilitation hospitals located in 35 states and
25 Puerto Rico. We're the nation's largest system of

1 rehabilitation hospitals and the trusted choice of
2 medical professionals in the communities that we
3 serve.
4 At Encompass inpatient rehabilitation is what
5 we do. One of our primary purposes is to own and
6 operate postacute-care facilities like the one
7 being proposed in Danbury. Encompass is committed
8 to delivering connected care and superior outcomes
9 for its patients.
10 We bring the local markets the resources and
11 experience of a national company specializing in
12 inpatient rehabilitation that has proven
13 high-quality cost-effective programs and services
14 along with the financial strength to ensure that
15 our patients and specially trained staff have
16 access to an extensive array of rehab specific
17 equipment and technology.
18 Although I was not involved directly with the
19 planning of this project because it predated my
20 time as the Northeast Regional President, I will
21 be responsible for operationalizing and overseeing
22 the Encompass Danbury Hospital if this CON is
23 approved.
24 We don't take entry into a new market
25 lightly, and would not propose a project like this

1 without confidence that the level of
2 rehabilitation services we provide are needed by
3 the residents of this area. In addition, you will
4 hear from our consultant Marty Chafin who
5 conducted the needs assessment that identified a
6 significant gap in care for inpatient
7 rehabilitation services in Western Connecticut.
8 As you will hear, inpatient rehabilitation
9 utilization in the service area is well below the
10 national average due largely to a lack of
11 inpatient rehabilitation beds, which the proposed
12 Encompass Danbury Hospital will address. You will
13 also hear today from Encompass' Chief Medical
14 Officer Dr. Lisa Charbonneau who will discuss the
15 programs and services we will offer at the
16 proposed hospital and how it will be staffed,
17 designed and operated to achieve superior outcomes
18 for patients.
19 We are excited for this project which will
20 enhance access to high-quality cost-effective
21 inpatient rehabilitation services in an area where
22 they are very much needed. We will bring the
23 strength of a national healthcare company that
24 implements proven high-quality cost-effective
25 programs to the market. At the same time we will

1 establish local relationships with providers and
2 organizations that will ultimately benefit service
3 area residents in need of this enhanced level of
4 rehabilitation and rehabilitative care.
5 For these reasons I urge you to approve our
6 CON application. I am available to answer any
7 questions you have once our presentation is
8 concluded.
9 And I will now turn it over to my colleague,
10 Dr. Charbonneau. Thank you.
11 THE HEARING OFFICER: Thank you. I just want to
12 make -- any kind of cross-examination and
13 questions we will wait for the end of the
14 presentation. So we'll go ahead with
15 Dr. Charbonneau.
16 ELISSA CHARBONNEAU: Thank you so much. Can you hear
17 me okay and see me okay?
18 THE HEARING OFFICER: I can. So please, did you file a
19 prefiled testimony?
20 DR. ELISSA CHARBONNEAU: Yes, I did. And I adopt my
21 prefiled testimony.
22
23
24
25

1 E L I S S A C H A R B O N N E A U,
2 called as a witness, being first duly sworn
3 by the HEARING OFFICER, was examined and
4 testified under oaths as follows:
5
6 THE HEARING OFFICER: And do you adopt your testimony
7 that was prefiled?
8 THE WITNESS (Charbonneau): Yes, I do.
9 THE HEARING OFFICER: Okay. Thank you. Could you just
10 spell your last name for the record?
11 THE WITNESS (Charbonneau): Yes, it's a long one.
12 THE HEARING OFFICER: You might want to spell your
13 first name, too, because I think you might get
14 some different spellings.
15 THE WITNESS (Charbonneau): Yes, my first name is
16 Elissa, E-l-i-s-s-a. And the last name is
17 Charbonneau; C-h-a-r-b-o-n-n-e-a-u.
18 THE HEARING OFFICER: Okay. Thank you. Go ahead.
19 THE WITNESS (Charbonneau): Good morning, Attorney
20 Yandow and members of the OHS staff. My name is
21 Dr. Elissa Charbonneau, and I am the Chief Medical
22 Officer for Encompass Health Corporation. And
23 thank you so much for this opportunity to testify
24 in support of our CON application to build a
25 state-of-the-art inpatient rehabilitation hospital

1 in Danbury, Connecticut.
2 As a resident of Maine I'm especially excited
3 by the prospect of expanding our footprint into
4 another hospital in New England. I really believe
5 that this hospital, if approved, will fill a
6 significant unmet need for inpatient
7 rehabilitation services in the area and will
8 provide high-quality cost-effective care at -- as
9 we do in all of our facilities across the country.
10 It will allow residents of this service area
11 to access much-needed inpatient rehabilitation
12 close to home where their families can help
13 support them as they're recovering from some
14 significant injury or illness. Encompass, as you
15 heard from Patrick Tuer, is a national leader in
16 inpatient rehabilitation services and the trusted
17 choice of medical professionals in their
18 communities all over the country.
19 In an inpatient rehabilitation hospital or an
20 inpatient rehabilitation facility which is
21 referred to as an IRF by CMS; the initials I-R-F
22 is a hospital with a high-intensity rehabilitation
23 service, and this meets the needs of people who
24 have had some type of life-changing injury or
25 illness, and as a result of that injury or illness

1 they've had a significant functional decline.
2 And due to the combination of their medical
3 needs and their rehabilitation needs, they're best
4 served in an inpatient rehabilitation hospital or
5 an inpatient rehabilitation facility. The kind of
6 patients that we take care of in our hospitals are
7 patients who have had significant strokes, spinal
8 cord injuries, brain injuries, brain tumors,
9 amputations and other diagnoses. If this project
10 is approved patients will benefit from our
11 expertise in building staffing and operating an
12 inpatient rehabilitation hospital. This is our
13 specialty and this is what we do.
14 Just to give you a brief background, I've
15 been the Chief Medical Officer of Encompass since
16 2015, and in this role I oversee the clinical
17 quality for our 144 inpatient rehabilitation
18 hospitals as well as our network of home, health
19 and hospice agencies.
20 I also head up a medical services department
21 which is a department that is solely dedicated to
22 physician education to improve our quality, our
23 compliance and our delivery of care in our
24 hospitals by the physicians that practice there.
25 I also oversee our quality reporting program.

1 The focus of my remarks here today are
2 twofold. First, I will provide an overview of an
3 Encompass Hospital to give you a sense of what
4 patients and their families would experience
5 during a stay at the Encompass Danbury facility.
6 We will provide an enhanced level of
7 rehabilitation in that facility with highly
8 specialized staff, and who are trained
9 specifically in rehabilitation and advanced
10 rehabilitation equipment.
11 Our hospitals are all very patient-centric
12 and I think you will get a good opportunity to see
13 what I'm talking about. Second, I will talk to
14 you a little bit about why the postacute care
15 setting where many Connecticut residents appear to
16 be getting their rehabilitation services right now
17 are less than optimal. Skilled nursing facilities
18 and non-IRF chronic disease hospitals are very
19 different than an inpatient rehabilitation
20 hospital, and this includes the ways that they are
21 staffed and their physical appearance as well.
22 As noted in my written testimony, the success
23 of Encompass' hospitals nationwide is really due
24 to our comprehensive team approach to
25 rehabilitation services, and we use the latest

1 technology and treatments using evidence-based
2 medicine to make sure that we're providing the
3 highest quality of rehabilitation care for
4 patients.
5 Let me highlight a few ways in which the
6 staff at the Encompass Health Hospitals work
7 together to benefit our patients. Our hospitals,
8 first of all, have an open-staff model. That
9 means that community-based physicians are
10 available to care for patients' specific needs
11 alongside and in addition to rehabilitation
12 physicians who have specialized training in
13 rehabilitation like myself.
14 This results in enhanced patient access to
15 medical specialists and a seamless transition back
16 to the community so that they can follow up with
17 their care providers in the community after they
18 leave the rehabilitation hospital.
19 We also really pride ourselves on our
20 specialization of our rehabilitation nurses. So
21 our nurses have special training in rehabilitation
22 medicine and are continually being trained and
23 certified through our association with the
24 Association of Rehabilitation Nurses, and many of
25 them have a special certification in

1 rehabilitation nursing.
2 We also have teams of therapists including
3 physical, occupational and speech therapist, along
4 with nutritionists, on-site pharmacists who all
5 work together to make sure that our patients and
6 their families have a good understanding of the
7 care and of how the patients are progressing in
8 their rehabilitation and how they can best
9 transition to home.
10 All of our patients are assigned a case
11 manager. The case managers work very closely with
12 patients and their families to ensure that their
13 needs are met both during and after therapy, and
14 they coordinate the discharge into the community
15 and the follow-up care that the patients will
16 need. So our goal is really to get patients home
17 successfully and to keep them home so that they
18 don't wind up back in the acute-care hospital.
19 Many of our hospitals have what's called
20 disease-specific certification from the joint
21 commission. This requires significant additional
22 training and expertise in specific areas, for
23 example, stroke. And I have every expectation
24 that our hospital in Danbury will also receive
25 disease specific certification in stroke and other

1 diagnoses depending on the needs of the community.
2 In addition to our unparalleled staff, our
3 hospitals also provide a comprehensive array of
4 inpatient rehabilitative services, and this allows
5 us to treat patients who have profound functional
6 deficits from stroke, traumatic brain injuries,
7 spinal cord injury, amputated -- amputations,
8 multiple trauma, orthopedic injury, cardiac
9 episodes, pulmonary issues, to name a few. In all
10 of our patients we strive to make sure that they
11 have superior and successful outcomes from their
12 rehabilitation when working with our team.
13 Our patients also benefit from a
14 patient-centric approach to treatment. So for
15 example, we have a no-pass policy. So we train
16 our staff that if they pass a patient and a bell
17 is on saying that patient needs assistance, that
18 they respond to the patient regardless of what
19 their role is, even if they're a housekeeper and
20 not necessarily a clinician.
21 We have in-room information board that's very
22 useful for our patients and their families. So
23 they can come in and see what the patient's
24 schedule is that day, who their physicians are,
25 how that -- how they transfer, what kind of food

1 are they allowed to eat, and -- and so forth.
2 Some of our hospitals have a victory bell
3 which they ring at discharge, and we have staff
4 lining up in the hallway to applaud patients as
5 they are successfully leaving our hospital.
6 Finally, all of our Encompass Health
7 Hospitals are really designed with the needs of a
8 medically complex patient, and this is a big
9 difference -- and I've worked in skilled nursing
10 facilities. These Encompass Health Hospitals
11 are -- are really a hospital environment where we
12 can treat patients who need IV medication or
13 dialysis, or other complex medical treatment.
14 So I think now what -- what we would like to
15 do is take you on a virtual tour of one of our
16 flagship hospitals.
17 Are you able to see the screen okay?
18 MR. CARNEY: Yes.
19 THE HEARING OFFICER: Yes. Yes, I can see it.
20 THE WITNESS (Charbonneau): Okay. So we will be
21 starting this tour in the parking lot. And as you
22 can see, you will drive up to the front of the
23 building where there's adequate parking and also
24 handicapped parking for visitors and others.
25 And then we would walk into the main entryway

1 of the hospital where we have a reception area.
2 And this is where we're currently doing our COVID
3 screening, by the way. So we screen all of our
4 visitors to make sure that they don't have any
5 symptoms of COVID-19 or any fevers.
6 And then we would progress down the hallway
7 and we will take you into our gym area.
8 We'll come back to this area in a second, but
9 here you can see right in front of you this is a
10 simulated automobile. So this is where we
11 practice with patients getting in and out of a
12 car, and we can raise and lower this device so
13 they can practice depending on whether they need
14 to get into a sedan or an SUV, for example.
15 And as we pass through the gym here, you can
16 see our large gym area with all this different
17 technology available.
18 Here we have some stairs where the patients
19 can practice going up and down the stairs and
20 overhead you can see that there is bodyweight
21 supported harness that -- for patients that are
22 not able to stand unsupported. We -- we have
23 tracks in the gym and they can be put in the
24 harness, and they can practice ambulation and
25 stairclimbing, et cetera.

1 As we look around the gym you can see there's
2 various different types of equipment, and we have
3 the latest and best technology for our therapists
4 to work with the patients to ensure that we're
5 using every -- every tool that we can to help
6 them.
7 For example, over the treadmill on the back
8 right-hand side there is something called a
9 LiteGait. That is a bodyweight supported harness
10 that allows the therapist to work with a patient
11 while they're walking on a treadmill and practice
12 their ambulation while they're being supported
13 with as much as they need to be supported by this
14 device.
15 Then you can see we have our parallel bars.
16 We have some other technology here to the right,
17 which works on different skills such as balance.
18 This is a balance practice device.
19 And if we continue to go over towards the
20 right, in that area that looks like there's a
21 background there. That is actually a one-way
22 window where behind that our therapists are doing
23 their documentation while they're still able to
24 look out with a one-way window and see how
25 patients are doing in the gym.

1 And if we go over to the right you'll see
2 what's called an ADL suite, which is an activities
3 of daily living suite. So this is an area where
4 as patients are getting ready to be discharged
5 they can practice in what looks more like a studio
6 apartment with a regular bed, a kitchenette area.
7 They have laundry facilities so they can practice
8 doing laundry and cooking, and other skills that
9 they'll need when they go home.
10 So I think next we're going to take a tour of
11 the outside area. So this is a courtyard and the
12 great thing about our courtyards is they have
13 various different surfaces for patients to
14 practice walking on; so cement, wood, gravel.
15 We also have outdoor stairs for them to
16 practice on and a ramp if they are wheelchair
17 users. So they can practice going up and down the
18 ramp in their wheelchair. And in the summer we
19 also have gardening skills for the patients to
20 practice gardening if they're interested in other
21 activities that they can do outside.
22 Here we have one of our patient's rooms, and
23 what you see is a whiteboard that all of our
24 patient's rooms have which helps the patient and
25 the family, as I mentioned earlier, understand who

1 their treating clinicians are, who their
2 physicians are, what their schedule is for the
3 day, their goals, how they transfer in and out of
4 bed, and some questions about pain. You can see
5 on the lower left-hand corner where we make sure
6 that we're addressing pain issues as well. And
7 each of our private rooms are wheelchair
8 accessible with a private bathroom as well.
9 I should also mention that we have bariatric
10 rooms. So we don't have to rent equipment for
11 bariatric patients that need special sized
12 equipment. When they come into the rehab hospital
13 we're just ready for them and we put them in a
14 bariatric room.
15 This is our cafeteria for our staff and
16 visitors to use. And you can see there's a lot of
17 natural light in the building. It's a very nice
18 environment for patients to get rehabilitation.
19 Okay. And then this is just our typical
20 nurse's station. So the nurse's stations are
21 located centrally. So they have good access and
22 visibility for the patient rooms.
23 And in that area behind the green you can see
24 where our clinicians can do their documentation on
25 the computers. And all of our hospitals are on an

1 electronic health record, which we have worked on
2 for many years with our partner Cerner to make an
3 electronic health record that is very rehab
4 specific.
5 So I think that you can see that we have --
6 to the right here we have a day room. That's
7 where different team meetings can occur. So all
8 patients in an inpatient rehabilitation facility
9 are required by Medicare to have a weekly team
10 conference where the team gets together and
11 discusses the patient's progress and how they're
12 doing and their progress towards their goals. And
13 in this day room is one area where we can have
14 these conferences.
15 This came in very handy during the pandemic
16 where we had to socially distance. So it's a nice
17 big room where we can have different meetings and
18 activities for patients and their families as
19 well.
20 Okay. I think that concludes our virtual
21 tour. Thank you.
22 I want to just add that all of our patients,
23 as you saw in the gym, really benefit from
24 specialized technology and in order to make sure
25 that we are, you know, there's a lot of technology

1 out there. We want to make sure we're using
2 technology that really is useful for the
3 therapists and the patients.
4 So we have a clinical technology investment
5 committee and they -- and we vet all new
6 technology that we're interested in and we trial
7 it in some of our hospitals before we make a big
8 investment in technology so that we can make sure
9 that we're using technology that the clinicians
10 feel are very valuable to the patients.
11 We also have a teamworks initiative which
12 improves quality of care through standardization
13 and implementation of best practices across all of
14 our -- all of our hospitals. So we have a way of
15 standardizing our admissions procedure, for
16 example, to make it very seamless and easy.
17 We also have a patient safety task force
18 which works to identify and implement
19 improvements, processes and policies to increase
20 patient safety and staff safety. So to reduce,
21 for example, back injuries for nurses that have to
22 transfer heavy patients in and out of bed.
23 And we also have our own internal patient
24 safety organization, a PSO to collaborate and
25 develop safety solutions.

1 We have a very unique postacute innovation
2 center that was established in 2017, and that's in
3 partnership with Cerner Corporation, which is our
4 partner with electronic health record. And our
5 innovation center has worked to develop predictive
6 algorithms based on our own in-house data because
7 we have had our electronic health records for so
8 many years, and we have so much data and so much
9 information on our own patients that we've been
10 able to develop predictive algorithms to improve
11 clinical care for our patients.
12 For example, reducing acute-care transfers
13 back to the acute hospital and reducing
14 readmissions after discharge from the rehab
15 hospital, and we're currently just about to rule
16 out a fall reduction predictive algorithm. So I'm
17 very excited about that as well.
18 We also have a national partnership with the
19 American Heart Association and American Stroke
20 Association. And we were -- we're working on
21 their initiative to end stroke, and we participate
22 in various activities in different communities
23 with outreach and -- and other activities to
24 reduce stroke and increase stroke awareness and
25 education.

1 We also engage in primary research to improve
2 practices and protocols for various diagnoses.
3 We also have many clinical teaching
4 affiliations throughout the country with
5 universities, colleges and technical schools, and
6 we're really working hard to address the -- the
7 nursing shortage across the country in some of our
8 work with our partnerships with different schools.
9 So thanks to the exceptional care that our
10 staff provides our patients. In utilizing this
11 excellent and vast equipment and technology that
12 we have our patients experience superior outcomes.
13 And I'm very proud to say that Encompass has a
14 track record of returning approximately 81 percent
15 of patients directly back to the community, which
16 really outperforms other providers of inpatient
17 rehabilitation nationally.
18 And finally I would be remiss if I didn't end
19 my remarks about the quality of care at Encompass
20 without regard to COVID-19. So throughout the
21 unfortunate pandemic we have found that we have
22 been able to care for individuals recovering from
23 COVID-19, and in doing so we have been able to
24 help relieve some of the overcrowding in the acute
25 hospitals by taking on these patients with very

1 significant medical needs, and also needs for
2 rehabilitation very successfully.
3 And we have treated at this point over 16,000
4 patients recovering from COVID-19 in our
5 hospitals. And I think what this is really
6 highlighted for us is our ability to care for and
7 take care of patients with significant medical
8 needs as well as assisting our acute-care hospital
9 colleagues in helping them to discharge patients
10 so that they can focus on patients who really need
11 to be in the acute-care hospital.
12 So in summary, Encompass leverages its
13 demonstrated best practices, proven staffing
14 models, comprehensive information technology,
15 centralized administrative functions, supply chain
16 efficiencies, economies of scale and its sole
17 focus and commitment to the healthcare industry to
18 ensure that its community focused local hospitals
19 consistently provide the highest clinical
20 outcomes.
21 And just to highlight, I would like to
22 provide OHS with information regarding the
23 different levels of postacute rehabilitative care
24 and why they are really not interchangeable.
25 We know from our needs assessment, which my

1 colleague Ms. Chafin will discuss, that
2 Connecticut residents have a disproportionately
3 low utilization of IRF services and a
4 disproportionately high utilization of skilled
5 nursing services, or SNF services.
6 SNF is not an appropriate substitute for
7 patients in need of intensive inpatient
8 rehabilitation. They don't have the same level of
9 nursing and physician oversight. We are required
10 by Medicare for our patients to see a
11 rehabilitation physician of patients with
12 specialized training and experience with
13 rehabilitation a minimum of three days a week.
14 And in addition to that most of our patients
15 also see our hospitalists or internists and a
16 rehabilitation physician every day, or almost
17 every day in our hospitals. So the three times a
18 week visits by a rehabilitation physician are a
19 minimum requirement that we exceed.
20 The higher-level of care provided in an IRF
21 versus a SNF is one of the reasons why IRFs have a
22 significantly higher rate of discharge to the
23 community, overall 76 percent nationally compared
24 with 40 percent for SNF versus return to an
25 acute-care setting such as a general hospital.

1 I can tell you from my many years of
2 experience as a rehabilitation physician working
3 in the IRF setting that the worst outcome for a
4 patient who's just recovering from something
5 significant like a stroke while they're in rehab
6 is to get sent back to the emergency room, or sent
7 back to the acute-care hospital.
8 So our processes and our quality of care are
9 all geared towards the goal of getting patients
10 home back to the community, and that's why we have
11 so many programs and protocols to help keep
12 patients in the IRF until they're ready to go home
13 and get them home.
14 Physicians in the Danbury community have
15 voiced the need for specialized care provided by
16 IRFs which they cannot get consistently in SNFs in
17 their letters of support for this proposal.
18 Connecticut's non-IRF chronic disease hospitals
19 are also not an appropriate substitute for IRF
20 services. Existing CDHs offer different types of
21 services and treat different patients as evidenced
22 by staffing, facility design and equipment.
23 They're also paid differently than IRFs by
24 Medicare based on this type of level of service
25 that they provide.

1 I hope this information has helped you and
2 OHS understand the ways in which Encompass
3 Hospitals are designed, staffed and operated to
4 ensure access to the highest quality of inpatient
5 rehabilitation services for these patients who
6 need this enhanced level of care.
7 I urge you to approve Encompass Danbury's CON
8 application, and in doing so allow us to fill the
9 unmet need for inpatient rehabilitative services
10 at Western Connecticut with a state-of-the-art
11 beautiful rehabilitation hospital that provides
12 the level of care needed by so many patients who
13 today are not receiving that level of care.
14 I am also available to answer any questions
15 that you may have once our presentation is
16 concluded, and I will now turn it over to
17 Ms. Chafin.
18 THE HEARING OFFICER: Dr. Charbonneau, I'm just going
19 to ask you a few questions. And when the whole
20 presentation is done you will probably get some
21 cross-examination questions from the Intervener,
22 and also some questions from the OHS staff.
23 So I just have a few questions just off the
24 top of my head that I just kind of -- and let us
25 explore it a little bit more later.

1 But when you're talking about Connecticut,
2 the need for Connecticut and where they go, the
3 skilled nursing facilities, where are you getting
4 that information from?
5 THE WITNESS (Charbonneau): I think Ms. Chafin is going
6 to go into that in -- in much more detail.
7 THE HEARING OFFICER: Okay. And as far as when you say
8 the need, the need that's there in Connecticut,
9 can you tell me what you're basing that on when
10 you say, the need?
11 I mean, what you're looking at?
12 THE WITNESS (Charbonneau): So what -- what we know
13 from what is going on in Connecticut is that
14 the -- there are just not -- there's not a
15 sufficient number of inpatient rehabilitation
16 facility IRF beds to serve the population based on
17 demographics and other things that I think
18 Ms. Chafin will explain better than I can.
19 But so it stands to reason that based on what
20 we're seeing in Connecticut, patients are just
21 either going to nursing homes after their acute
22 hospital stay, or they're going home with home
23 care, or they're not getting rehabilitation at
24 all.
25 And I -- I really believe that there are --

1 and we know this just based on, you know, just
2 based on how we receive referrals from patients
3 all over the country, that there are patients who
4 are recovering from significant medical injuries,
5 medical issues and injuries that are just not able
6 to get IRF level services in Connecticut.
7 So I -- they're either not getting them at
8 all, or they're going out of state, or -- or
9 they're just missing out on this specific level of
10 care with this specific level of expertise to
11 treat these, these types of injuries in this
12 particular setting. It's just -- just not
13 available in Western Connecticut.
14 THE HEARING OFFICER: Okay. Thank you. And we'll
15 probably follow up with some more questions a
16 little later, but --
17 THE WITNESS (Charbonneau): Okay.
18 THE HEARING OFFICER: Thank you very much. Okay. I
19 guess, Ms. Chafin. Is Ms. Chafin on?
20 THE WITNESS (Charbonneau): Yes, she's here with me.
21 THE HEARING OFFICER: Hello, Ms. Chafin. You filed
22 prefiled testimony is that correct?
23 MARTY CHAFIN: Yes, I did.
24
25

1 M A R T Y   C H A F I N,

2 called as a witness, being first duly sworn

3 by the HEARING OFFICER, was examined and

4 testified under oath as follows:

5

6 THE HEARING OFFICER: Okay. And do you adopt testimony

7 that was filed?

8 THE WITNESS (Chafin): Yes, I do.

9 THE HEARING OFFICER: Okay. And could you spell your

10 first and last name, please, for the record?

11 THE WITNESS (Chafin): Yes. I'm Marty Chafin;

12 M-a-r-t-y, C-h-a-f-i-n. I'm with Chafin

13 Consulting Group -- you can tell probably --

14 located in the South, based in Georgia.

15 I want to walk through the exhibits that were

16 part of my prefiled testimony. I'll do that in

17 just a minute, but I'd like to, before I do that,

18 do two things if I can. One is to talk about my

19 role in this process, and the second is to give a

20 brief overview of my background.

21 I was contacted by Encompass Health to

22 confirm that Connecticut in general, and Western

23 Connecticut specifically has a need for beds.

24 Based on the research and knowledge at Encompass

25 they felt that was the case. They asked me to

1 confirm that, and if I agreed with that to
2 quantify that.
3 The results of my analysis along with my
4 colleagues at Chafin Consulting is the CON
5 application and the completeness response. So
6 that was my role in the process.
7 In terms of my background, I have been in
8 healthcare since I graduated from Georgia Tech.
9 So I have 34 years of experience only in the
10 healthcare industry only. I always worked in
11 healthcare.
12 In terms of the client scope, I have worked
13 with academic medical centers all the way to small
14 community sole providers. I have worked with
15 ambulatory surgery centers, radiation therapy
16 providers. In terms of postacute-care providers
17 I've worked with all four.
18 You'll see later in the exhibits there are
19 four postacute care, inpatient rehab -- as we're
20 talking about today, home health, skilled nursing
21 facility, and long-term acute care. So I have
22 worked and developed CON applications for all four
23 of those.
24 As an expert witness I have testified in
25 Georgia, Alabama, Mississippi, Tennessee and

1 Oregon. I have also presented to Illinois and
2 Rhode Island state boards. Beyond that I have
3 worked geographically on CONs. And I guess I
4 should say -- this makes me sound old, but I've
5 worked on hundreds, or have been involved in
6 hundreds of CON applications in my 34 years.
7 So beyond the states in which I've testified
8 as an expert witness I have worked on CON
9 applications in Florida, North Carolina, South
10 Carolina, Kentucky, Virginia and Delaware. And
11 then beyond that I've worked on healthcare
12 projects in Massachusetts, New Jersey, Texas,
13 California, Washington and Alaska.
14 And then finally, if you can imagine this
15 accident in the Middle East, I worked in Qatar --
16 Q-u-a-t-a-r [sic.] working with the Supreme
17 Council of Health to develop a regulatory
18 framework so that they can analyze and assess the
19 need for products and services as much as we do in
20 the United States.
21 So we'll bring it closer to home now. Coming
22 back to the exhibits, the -- put those up
23 (unintelligible).
24 The presentation begins with the state
25 analysis. You just asked questions, Attorney

1 Yandow, how do we know that patients are going to
2 skilled nursing? And so I will get to that in a
3 few minutes in terms of the specific data that
4 shows that in Connecticut patients are
5 disproportionately utilizing SNF compared to IRF.
6 That's one way, is we have the data.
7 The second way that we know that is physician
8 letters. In the CON application there are
9 physician letters and providers, for example, from
10 Brian Injury -- Injury Alliance; Dr. Peter
11 McAllister is a neurologist. We have
12 Dr. Winnow who is an anesthesiologist, and
13 Dr. Gray who is an orthopedist.
14 They have all discussed that there is a need
15 for this proposed project, and some of those
16 letters address that when patients are going to
17 SNF, there are suboptimal outcomes and
18 inconsistent care and the patients would benefit
19 from the intensive inpatient rehab services
20 Encompass is proposing.
21 So I wanted to answer your question before I
22 go through the exhibits. The exhibit in front of
23 you -- can everyone see the exhibits, I guess is
24 the question?
25 Okay. The exhibit in front of you is for

1 Connecticut. All of the data that I'm referencing
2 is publicly available. So my -- my approach is
3 there's no black box. There's -- there's no
4 secret. This is full transparency.
5 You may not agree with the conclusions that
6 I'm drawing from the data, but the data is what it
7 is, and it's publicly available.
8 The information that I will present when I
9 talk about Medicare data is Medicare
10 fee-for-service information. I want to be very
11 clear based on the information from the
12 Intervenors that that does not mean Encompass is
13 only serving Medicare fee-for-service patients.
14 What it means is that Medicare fee-for-service
15 data is available, and that when you look
16 nationally Medicare fee-for-service is the primary
17 user of inpatient rehab facility services.
18 So it makes sense that I'm going to use
19 publicly available data and that publicly
20 available data represents what is happening,
21 because it's the primary user of the service. So
22 Medicare, when I reference it, is Medicare
23 fee-for-service unless I say otherwise.
24 Exhibit B is the first time that you will
25 hear me use the phrase "gap in care." What you

1 see, the states are listed along the x-axis. So
2 you have vertical lines that show for Medicare
3 fee-for-service patients that go to the hospital,
4 what percent of those patients are discharged to
5 inpatient rehab facilities. As Dr. Charbonneau
6 said, IRF is how CMS -- and we reference it.
7 The national average is the black horizontal
8 line, 4.22 percent of Medicare patients that go to
9 an acute-care hospital are discharged to an IRF.
10 In Connecticut what you see as red, 1.64 of your
11 patients are discharged to IRF. I call that, from
12 a health planning perspective, a gap in care.
13 You see that nationally Connecticut ranks
14 among the lowest. You are 48 out of 51 -- because
15 this includes D.C. -- 48 out of 51 states in terms
16 of the lowest number or percentage of your
17 discharges to inpatient rehab.
18 North Dakota and Oregon are below
19 Connecticut. What's important I think is to
20 recognize that in Oregon 100 beds have been
21 approved because they recognize that gap in care
22 needs to close.
23 For North Dakota 59 beds are in process.
24 Either they have been built, or will be built. My
25 prefiled testimony I believe says 42. That's

1 because since then I have been aware that 17
2 additional beds are going to be added. So those,
3 those states are recognizing and beginning to
4 close that gap in care.
5 In terms of perspective Connecticut is, you
6 know, I guess I should say at this point the
7 national rate is two and a half times greater in
8 terms of the percentage of Medicare patients
9 discharged to IRF than you see in Connecticut.
10 If you look at the next slide, this is 2020
11 data. This was not available at the time that the
12 application was filed, so I have updated it. The
13 result is the same, or maybe a little bit worse.
14 And what I mean by that is the gap in care has
15 increased.
16 Connecticut as a whole still is 48 out of 51
17 in terms of the lowest percentage of Medicare
18 patients being discharged to IRF. What has
19 happened at the same time that medi --
20 (inaudible).
21 THE REPORTER: This is the Reporter. I can't hear
22 anyone.
23 THE WITNESS (Chafin): I recognize 2020 data --
24 THE HEARING OFFICER: Okay. For a moment there you
25 were frozen, so I don't think anything got

1 recorded. I don't know if you want to go back
2 just a few seconds. I don't know if you started a
3 sentence, or something.
4 I don't know if you were having problems,
5 Attorney Fusco, but the Court Reporter and I -- it
6 seemed to be that your screen and your audio,
7 everything was frozen for a few seconds.
8 MS. FUSCO: We just got a notification that our
9 Internet connection was unstable, but it seems to
10 have cleared. You can hear us now. Right?
11 THE HEARING OFFICER: Yes. Yes.
12 MS. FUSCO: Okay. So maybe you can go back a sentence
13 or two?
14 THE HEARING OFFICER: Just if you want to make sure
15 that the record has whatever you want in it,
16 although I'm sure most of this is in the prefiled.
17 We probably missed about 15 seconds.
18
19 (No response.)
20
21 THE HEARING OFFICER: You're frozen again.
22 I guess -- until she tells us they're back
23 on --
24 MS. FUSCO: We're back now.
25 THE HEARING OFFICER: Okay. When you're frozen, can

1 you hear me?
2 MS. FUSCO: No.
3 THE HEARING OFFICER: You can't?
4 MS. FUSCO: Not at all. Everyone is frozen.
5 THE HEARING OFFICER: All right. Okay. Hopefully
6 that's just temporary. So --
7 MS. FUSCO: We'll get some tech folks in just to make
8 sure, but for now we can.
9 THE HEARING OFFICER: All right. Well, let's continue.
10 If it gets too bad we'll take a break and then you
11 can bring our people in to see if there's a fix on
12 your end.
13 But why don't we go ahead and continue? Like
14 I said, we probably lost about the beginning of
15 the sentence or something, if she needs to back up
16 at all?
17 THE WITNESS (Chafin): I'll just make three points on
18 the slide. The gap in care is increasing, meaning
19 that the U.S. average has increased, whereas
20 Connecticut has remain -- has remained relatively
21 flat. So the U.S. average is 2.8 times
22 Connecticut.
23 Connecticut still ranks 48 out of 51 in terms
24 of the -- (inaudible).
25 THE REPORTER: This is The Reporter. She just cut out

1 again.
2 THE HEARING OFFICER: Let's just see if they come back
3 in a couple of seconds and then --
4 THE WITNESS (Chafin): -- percentage of medicare
5 (unintelligible).
6 THE HEARING OFFICER: Okay. You were frozen again.
7 Attorney Fusco, I don't want to stop the
8 flow, but you are in and out now. Would it be
9 helpful if we took a short break to work on to see
10 if you can get your glitch fixed?
11
12 (No response.)
13
14 THE HEARING OFFICER: I don't know what just happened.
15 Brian, can you hear me?
16 MR. CARNEY: Yes, I can. I think they're frozen.
17 They actually just left.
18 CINDY WELLMAN: Hi. This is Cindy Wellman.
19 THE HEARING OFFICER: I'm not sure -- who is Cindy
20 Wellman?
21 CINDY WELLMAN: Sorry. I'm with the Encompass team
22 chat, Encompass Health. And I just wanted to let
23 you know we're having problems with our screen --
24 our large conference room capabilities. If we
25 could take a break to get some tech people in here

1 we would be very -- (unintelligible).

2 THE HEARING OFFICER: Okay. So it's about 11:08.

3 Would 10 or 15 minutes -- how long do you think?

4 Let's come back at 11:25.

5 CINDY WELLMAN: That would be great. Thank you so

6 much.

7 THE HEARING OFFICER: Okay. Everyone, please remember

8 that there is a recording. When we are on breaks

9 our recording continues. So please shut your

10 audio off.

11 You may want to shut your video off. That

12 one, I'll leave up to you, but we will be back at

13 11:25.

14

15 (Pause: 11:09 a.m. to 11:25 a.m.)

16

17 THE HEARING OFFICER: So Ms. Chafin, if you want to

18 pick up where you left off, that would be great?

19 THE WITNESS (Chafin): Okay. Thank you.

20 Just for the record, I'll make sure that the

21 three points I'd like to make, I can, hopefully

22 with no technical difficulties.

23 One is that the gap in care has increased

24 when we look at 2020 Medicare data compared to

25 2019, the U.S. average percentage of Medicare

1 discharges to IRF as a percentage of total
2 Medicare discharges has increased
3 while Connecticut has remained relatively flat.
4 So that means the U.S. average is 2.8 times,
5 Connecticut. Connecticut remains at 48 out of 51
6 states and D.C. And in 2020 I do put that
7 information forward with a caveat that it is, you
8 know, a full year of COVID.
9 But since I am looking at state-level data I
10 feel that it is an appropriate benchmark because
11 every state -- my assumption and my knowledge in
12 the industry is every state has been impacted
13 pretty much equally in terms of the COVID. It may
14 have been different months, but there was an
15 impact for all hospitals in all states.
16 THE HEARING OFFICER: Let me just ask you -- and I
17 don't mean to interrupt, but just because you
18 brought that up. And I'm looking at this, so
19 these numbers here involve COVID.
20 So do we know, I mean, how many percentages
21 of each of these are COVID patients? Because I
22 don't know if part of your research shows
23 Connecticut versus other states regarding COVID.
24 THE WITNESS (Chafin): I did not have that information.
25 I know that the patients went to IRF, but I do not

1 know the diagnosis with which they entered IRF,
2 and one of those would be whether or not they had
3 COVID. I do not have that information.
4 THE HEARING OFFICER: All right. Thank you.
5 THE WITNESS (Chafin): Next slide.
6 Still looking at Connecticut as a whole,
7 whereas the prior two slides were Medicare
8 fee-for-service beneficiaries that left a general
9 acute-care hospital and went to an IRF. Now we're
10 just looking at Medicare beneficiaries.
11 We're not worried about it if they were in a
12 hospital or not, because I want to compare what
13 happens per 1,000 beneficiaries. In terms of
14 Dr. Charbonneau's point, are some patients going
15 to SNF? Are some patients going to IRF, and how
16 does that compare?
17 And Attorney Yandow, you asked how do we have
18 the data and how do we know about patients going
19 to SNF? This is where we begin to see the data,
20 and what the data shows in front of you is the
21 ranking nationally in terms of highest to lowest
22 IRF discharges per 1,000 Medicare beneficiaries.
23 Connecticut in this ranking is 43rd, however
24 when you look at the SNF discharges, which is 95
25 per thousand beneficiaries, Connecticut ranks

1 **number one in the nation. And that 19.0 is a**
2 **ratio of SNF to IRF to give us an order of**
3 **magnitude to see what does it look like in**
4 **Connecticut, the ratio of SNF to IRF discharges**
5 **from Medicare patients compared to the U.S.**
6 **overall? And that national average is that last**
7 **line that you see, 5.8.**
8 **So this is where Dr. Charbonneau was talking**
9 **about we know the patients are going to SNF, and**
10 **we know they're doing that disproportionately. If**
11 **you look at the next slide --**
12 **THE HEARING OFFICER: And I don't mean to interrupt,**
13 **and I think probably one of our analysts will**
14 **probably ask further questions -- but so these**
15 **charts are important. And I'm looking for your**
16 **sources. And what we do at OHS is that we go back**
17 **to sources just to confirm.**
18 **So all of this, the footnotes where you have**
19 **your information, sources for Medicare and**
20 **Medicaid, from CMS, public use file, can you send**
21 **us links?**
22 **MS. FUSCO: Yes.**
23 **THE HEARING OFFICER: And we can talk about this later.**
24 **There will probably be a list of late-filed**
25 **exhibits by the time of the end of the hearing**

1 that OHS will want -- so on our own to look at to
2 confirm any kind of numbers.
3 So one of the things that, and perhaps on the
4 next break you can talk about it with the
5 attorney. One of the things we'll be looking for
6 is links to this information. I think on the
7 other, slide two you had other sources.
8 And for us we just don't want to -- for us if
9 you want us to have the information, we're going
10 to probably need something more specific than some
11 of the footnotes you've sent.
12 So I think some of these documents are
13 hundreds if not thousands of pages. So if you
14 could kind of send us a link, but talk about that
15 on the break and we'll address this again later.
16 Okay?
17 MS. FUSCO: Yes.
18 THE WITNESS (Chafin): We can definitely do that, and
19 they all -- almost all of the data links
20 specifically to one source that -- that CMS public
21 use files, but we will get you that like.
22 THE HEARING OFFICER: And I think we're going to need
23 specific -- I haven't gone there, but if it's a
24 thousand-page document you're going to want to
25 refer us to what you're specifically referring to.

1 Okay?
2 THE WITNESS (Chafin): Okay. So surprisingly this is
3 one instance where the -- the government has done
4 a good job, and it's an Excel file that's
5 manageable by state.
6 And so that Brian and Ormand are not going to
7 fall out of the chair, it really is user-friendly,
8 surprisingly, but it is user-friendly -- but I'll
9 get that data to you and the link to get to it.
10 If we look at slide four, same data source,
11 CMS data. We're still talking about Medicare
12 fee-for-service beneficiaries. Again, Medicare
13 fee-for-service beneficiaries are the majority
14 users of IRF, about 60 percent nationally. This
15 is 2019 data. Connecticut continues to rank low
16 in terms of the number of IRF discharges per
17 thousand. You're at five, remaining at that
18 level.
19 You see other states around you. Rhode
20 Island, for example, is 41. As I mentioned
21 earlier, they have approved, their review board, a
22 total of 100 beds to try to close that gap in care
23 they're seeing there.
24 Still Connecticut is number one nationally in
25 terms of SNF. So you have the highest discharges

1 of SNF in the nation and among the lowest in IRF.
2 So we see that disproportionate in terms of
3 source -- in terms of discharge status, and we
4 have the physicians saying they see it; boots on
5 the ground. So I'm looking at the data and we've
6 got the physicians who are talking about it.
7 If you look at the next slide, the
8 Intervenors have said that we do not need to use
9 national data when we talk about Connecticut, that
10 essentially Encompass or I just really don't
11 understand what's going on in Connecticut.
12 What you see in front of you now refutes that
13 by looking at the general acute-care discharges,
14 again per Medicare, and using that as a benchmark.
15 So when you see this slide -- to make sure we're
16 all on the same page, what it shows us is that in
17 Connecticut your residents are admitted to general
18 acute-care hospitals similar to the national
19 average. So there's nothing unique about
20 Connecticut that we're seeing here that explains
21 why IRF is solo -- so low, and SNF is so high in
22 terms of utilization.
23 Because for general acute care Connecticut is
24 consistent for the state average. So 296
25 admissions per 1,000 Medicare beneficiaries

1 occurred in 2018 for Connecticut residents. That
2 compares to 266 national average. What you see in
3 the third column is Connecticut is 111 percent of
4 the national average, or pretty commensurate with
5 what's happening on the general acute care.
6 So you have enough beds. The data is showing
7 you have enough beds on the general acute-care
8 side that patients in need of general acute-care
9 services can get that care, and are getting and
10 receiving that care consistent with the national
11 average.
12 Where things go awry, if you will, from a
13 data perspective and are disproportionate is the
14 inpatient rehab facility. You see that instead of
15 similar to the national average IRF is 45
16 percentage of the national average. So
17 Connecticut is very different in terms of what's
18 happening when patients are discharged to IRF
19 compared to when they are seeking general
20 acute-care services.
21 Likewise, skilled nursing is disproportionate
22 to the national average, but the other way,
23 138.4 percent. So the national average is 64 per
24 thousand discharges to SNF. For Connecticut it's
25 95.

1 Cindy, go to the next page, please.

2 (Unintelligible.) Okay. Sorry.

3 The -- and that the same is occurring in
4 2019. The inpatient utilization did not change.
5 Skilled nursing did not change in terms of the
6 percent.

7 So what we're seeing is an outlier, and
8 that's why Dr. Charbonneau mentioned and I'm
9 saying -- and know that there is a gap in care in
10 that what is happening from a data perspective and
11 a physician's perspective is that IRF level that
12 is so low is disproportionate, and patients are
13 not going to IRF as needed or expected. Instead,
14 they're going to a skilled nursing facility
15 disproportionately.

16 The next slide -- I'm shifting gears a little
17 bit. That was Connecticut as a whole. Now I'm
18 going to talk about Western Connecticut. What you
19 see in front of you is the defined service area
20 for the proposed project, and in the prefiled
21 testimony there was -- I described it as Western
22 Connecticut.

23 It was a 52 ZIP Code area that's indicated on
24 the map by that kind of aqua, or blue color. It
25 is in Fairfield, Litchfield, and a small portion

1 of New Haven Counties.
2 In just a minute I'm going to talk about the
3 counties themselves and the utilization. That's
4 because I cannot get Medicare data at the ZIP Code
5 level. So my proxy will be the -- the counties.
6 But to be very clear, when I can get to the
7 bedding methodology, the service area, these 52
8 ZIP Codes, those are the basis and that population
9 is the basis for the bed need. So I'm going to
10 intentionally kind of have to shift, and I'll
11 make -- I'll try to make sure you know what's --
12 what's ZIP Code and what's county. So that's our
13 service area ZIP Code.
14 The next slide uses Fairfield and Litchfield
15 Counties as reasonable proxies for Western
16 Connecticut. Again, I -- I don't have it at the
17 ZIP Code level, and it's because I want to be
18 transparent, and because we're going to share all
19 the data sources with you and they're -- they are
20 a source on the table. That's why I have to rely
21 on the county level.
22 So this is the same type of analysis, whereas
23 Exhibit B was state level. This is county level
24 and what you see is the same phenomenon. In terms
25 of the very first line the two Western Connecticut

1 ZIP Codes are -- residents in those ZIP
2 Codes are -- I'm sorry -- in those counties are
3 utilizing general acute-care services consistent
4 with the levels at the national.
5 So 285 discharges per thousand to general
6 acute-care hospitals from Fairfield County is
7 similar to the 266 national. That's the
8 107.1 percent calculation. Litchfield is 104.
9 Go to the next page for a second. It may be
10 easier to --
11 THE HEARING OFFICER: I have a question. Can we go
12 back to that last chart?
13 So in these charts where would someone like
14 Danbury Hospital or other hospitals that do a
15 rehab, is that considered part of your IRF? Or if
16 it's done in a hospital, if rehab is in a hospital
17 it's not included.
18 Where would that show in this chart?
19 THE WITNESS (Chafin): You know, that's a great
20 question. It would show in the chart for
21 Fairfield and Litchfield County residents that use
22 Danbury Hospital IRF, they're included in that
23 number, the IRF number.
24 So let me say it this way to make sure.
25 We're looking at where patients go, and I'm just

1 looking at IRF. And it does include
2 hospital-raised inpatient rehab facilities.
3 They're called distinct park units, and Danbury
4 Hospital has one. They're, from my understanding,
5 licensed for 14 beds.
6 So when they treat a patient in that IRF unit
7 all of the data you see here, they are included.
8 And that's where the patients are going just like
9 if a patient goes to Stamford or Yale New Haven,
10 or Mount Sinai.
11 If they're leaving their county and going
12 anywhere, even if they went into New York care, we
13 know where the resident lives and that's the basis
14 for this number. So I'm not hospital specific.
15 I'm resident specific.
16 Does that answer your question?
17 THE HEARING OFFICER: Okay. I just wanted to know were
18 those -- who got these, the rehabilitation in a
19 hospital, where they would be counted.
20 So it's under the IRF?
21 THE WITNESS (Chafin): Yes. Yes, that was probably too
22 long an answer -- but yes.
23 And as Dr. Charbonneau mentioned and said I
24 would talk about, the outlier is the IRF. Western
25 Connecticut residents, the benchmark is that

1 they're using general acute care consistent with
2 the national average.
3 There is no reason that you would not expect
4 IRF to be commensurate within that national
5 average. Instead, it's significantly below in
6 terms of a percentage of the rate per thousand
7 beneficiaries. And skilled nursing, consistent
8 with what we saw at the state level, is
9 significantly higher.
10 The next slide shows this graphically. And I
11 know we had a break and we had technical
12 difficulties, but if you remember on Exhibit B I
13 had a line that was the national average. Here
14 we -- I probably should have put a dotted line at
15 the maybe 105 percent across because that is the
16 benchmark that we consider here. That's your
17 general acute-care utilization for Western
18 Connecticut.
19 And if you think of it that way you see that
20 Fairfield County has a significantly lower SNF
21 utilization. That's at 63.6 percent. Litchfield
22 has even lower at 36.4, and if you imagine that
23 about a hundred percent line you see SNF is
24 disproportionately higher for both Fairfield and
25 Litchfield.

1 Slide four is updated data for 2019. I'm not
2 going to walk you through that unless you have
3 questions, but we'll look at the next page and it
4 is a graphic illustration of what we just talked
5 about, but updated for 2019. And you see that
6 Fairfield is the same with the 63.6 percent,
7 meaning that Western Connecticut residents in
8 Fairfield County are using SNF much lower than the
9 national average.
10 While they're using general acute-care
11 services about the same, it has dropped in terms
12 of skilled nursing usage in Litchfield County down
13 to 27.3 percent. So again, this is the data that
14 we are relying on to understand that there's a gap
15 in care, and SNF is disproportionately being used
16 in lieu of IRF.
17 What's in front of you now is a graphic to
18 show that -- I just looked at 2018. I just looked
19 at 2019. This just gives you a longitudinal look
20 from 2007 to 2019 to know that this gap in care
21 has existed for many years. That despite your
22 population aging in place, Fairfield County and
23 Litchfield County are low utilization compared to
24 the national average and compared to what I use as
25 the national benchmark, which is the 75th

1 percentile. So this is just a graphic
2 illustration showing that.
3 And again, all of this is the CMS data.
4 THE HEARING OFFICER: Okay. And what's the reason? Do
5 you have any -- so I look at it, it starts going
6 down 2012, 2013. So Connecticut is down from the
7 national average. Are you saying that's because
8 there aren't enough beds?
9 THE WITNESS (Chafin): Yes. And thank you. I should
10 have drawn that conclusion for you, but that is
11 exactly the -- the point is that there are not
12 beds for -- that are locally available and
13 accessible for this population. And in fact, the
14 intervenors -- oh, I'm sorry.
15 THE HEARING OFFICER: So you're saying there are not
16 enough beds, and that's all based on the Medicare
17 data?
18 THE WITNESS (Chafin): There's -- there are not
19 enough -- yes, there are not enough beds. And so
20 what is happening is patients are substituting
21 inappropriately less intensive care that is
22 skilled nursing instead of going to inpatient
23 rehab. So that's the data that showing there's
24 not enough beds. Patients don't have the options
25 locally.

1 We know that Danbury Hospital is at, I think,
2 85 percent occupancy in FY '20, 94 percent in FY
3 '19. So they're full and they're the only game in
4 town. So patients don't have the number of beds
5 needed to be discharged to IRF.
6 The physicians have written letters as had
7 the Brain Injury Association that described that,
8 and talk about that the patients are unable to get
9 IRF care when needed, and then a problem is
10 resulting because they are using SNF in lieu of
11 that.
12 Does that answer your question? That was a
13 long answer.
14 THE HEARING OFFICER: Yeah. I think there will be some
15 follow-up questions later, but I just wanted to
16 see what these numbers are based on. So -- but go
17 ahead.
18 THE WITNESS (Chafin): Okay. And again, to be clear
19 for the record, they are Medicare based. Medicare
20 is about 60 percent nationally of the population
21 served, but it is represented to -- in terms of
22 what's happening in the market.
23 The gap in care that -- that I've talked
24 about and the fact that there are too few beds.
25 So patients are utilizing skilled nursing

1 facilities instead of inpatient rehab facilities
2 will exacerbate and worsen, I believe, if you do
3 not approve -- if OHS does not approve this
4 project.
5 The reason I say that is the elderly
6 population is the largest user. What is happening
7 in the service area -- this is not County. This
8 is the 52 ZIP Code service area. The population
9 of 65 and over, as you can see, is increasing by
10 15 percent between 2020 and 2025. That means by
11 2025 almost one in four residents will be 65 and
12 over.
13 So that gap in care, that disproportionate
14 use of SNF to IRF will -- will worsen because you
15 have too few beds currently and you have an aging
16 population, and that's the primary user of this
17 service.
18 In front of you now is the bed-need analysis.
19 A couple of comments before I walk through the
20 detail. This is a population-based analysis. I
21 told you early on that I had two -- I guess, a
22 twofold charge from Encompass. One is to confirm
23 that there was beds needed in Western Connecticut,
24 and then to quantify the beds needed.
25 And when you have a service that is currently

1 not being utilized because there are too few beds,
2 it is not appropriate to look at historical
3 utilization as a measure of need, because that
4 historical utilization is going to be understated.
5 So what I have done here is a
6 population-based methodology that relies on
7 publicly available data, and I have proposed, or
8 used a target rate of 13 per thousand discharges.
9 So this is quantification of beds needed for
10 the 52 ZIP Code area. This methodology does
11 differ fundamentally from OHS and the question
12 before OHS is really simple. Do you believe the
13 status quo is acceptable? Or do you not?
14 The status quo, if you believe it's
15 acceptable, then you look at the needs based on
16 historical use and just factor in population.
17 What I am proposing that you do instead is
18 recognize a gap in care and try to quantify how
19 many beds are needed to try to fill that gap in
20 care.
21 This methodology or something very similar
22 has been accepted in Rhode Island, Illinois,
23 Georgia, Florida, Kentucky, and South Carolina.
24 It does differ intentionally from OHS's. So I do
25 want to make people aware about that.

1 Line by line -- is that, I assume you would
2 like me to walk through that, OHS would?
3 Line by line is that the first line you see
4 is the Medicare beneficiaries projected for 2025.
5 So in that we think back to that map and that blue
6 area on the map, that defined service area, 111 to
7 56 beneficiaries are projected.
8 The data that I have available that's
9 publicly available is for Medicare fee for
10 service. So I needed to take the total 65-plus
11 population and just look at Medicare fee for
12 service before I applied that Medicare
13 fee-for-service target discharge rate.
14 So that's why the 56.8 which was your
15 calendar year 2018 Medicare fee-for-service
16 beneficiary number results in how many Medicare
17 fee-for-service beneficiaries are in that 52 ZIP
18 Code area. That's your 63,193.
19 From there it's math. It's 13 per thousand
20 discharges as the target rate. So that you can
21 close that gap in care, have enough available beds
22 so that patients are getting care close to home.
23 If you multiply the 13 times the fee-for-service
24 beneficiaries, you have a protected 822, line 5,
25 Medicare fee-for-service admissions.

1 But we know that Medicare fee-for-service
2 admissions are not all. We know that there are
3 Medicare Advantage. There's Medicaid. There's
4 commercially insured. And so we've got that, get
5 that 822 and -- and look at the rest of the
6 population who are patients that will be served so
7 that all payers are -- are covered, if you will.
8 That is the 1,393 number.
9 From there again, math. What is the
10 Connecticut average length of stay in count -- in
11 fiscal year '19 was the 12.8. That gives you on
12 line nine your total rehab days. You would need
13 49 beds if that's the case, but your state health
14 plan uses an 80 percent rehab occupancy rate. So
15 I applied that to the 49 beds to get a gross bed
16 need of 62 on line 12.
17 I gave effect to the 14 existing beds at
18 Danbury Hospital and the net bed need for that 52
19 ZIP Code area, therefore, is 48 beds.
20 I don't know if you have any questions or
21 you -- you want me to keep going?
22 THE HEARING OFFICER: No. I think there will probably
23 going to be quite a few questions on the
24 methodologies. So we'll just wait until later,
25 but you can go ahead.

1 THE WITNESS (Chafin): Okay. In thinking about the
2 state -- in thinking about the state health plan I
3 would like to make two comments. You know,
4 I've -- I've recognized and appreciated the state
5 health plans and respect the state health plan's
6 methodology.
7 Also when you look at the state health
8 plan -- I think it's the next page. I think it's
9 27, page 27 of the 2012 state health plan -- I'm
10 probably -- probably messing that up -- but it
11 does, the state health plan talks about two
12 things.
13 And it talks about, not just looking at the
14 quantitative approach, but considering the
15 innovation or changes in the delivery of health
16 care that may be needed, which is what you heard
17 Dr. Charbonneau talk about, and the ability to
18 take care of the patients. I will talk about the
19 complementary services Encompass proposes in just
20 a minute.
21 Dr. Charbonneau talked about the resources to
22 treat your patients as well. So that's one
23 consideration I would ask OHS to consider. And
24 then the other in your state health plan is that
25 quality of patient concerns is also another factor

1 that should be considered.
2 With that, I'll turn to Exhibit F.
3 Encompass -- (unintelligible) is the expert
4 on this obviously. Encompass provides a wide
5 range of services and in terms of the data the
6 point I'll make in a minute and why I want to
7 start with this is that I believe, and the data
8 shows that Encompass's service -- services will
9 complement the existing provider.
10 If you look at Danbury Hospital -- let me
11 tell you what's in front of you first. I'm sorry.
12 These are the conditions that are served in
13 inpatient rehab facilities. This is the first
14 instance in which you see specific hospitals in
15 Connecticut mentioned, and that's across the top.
16 You see, for example, Danbury Hospital, Stamford
17 Hospital. What the numbers and the percent
18 represent, that Medicare fee-for-service
19 patients -- again that's our public data, what
20 type of patients have been served in each
21 hospital.
22 The first column percentage is the national
23 average, and then the numbers and percent for each
24 hospital, you know, and as what does their -- what
25 does their patient array look like?

1 In Connecticut your hospitals are primarily
2 focused on stroke. Danbury Hospital is focused
3 primarily on stroke and then secondarily spinal
4 cord disease. Encompass will complement those
5 services by not just caring for stroke or spinal
6 cord, but a wide array of services.
7 In fact, the updated data that Danbury
8 provided I believe shows an even greater focus on
9 stroke, but we'll hear about that from them, I'm
10 sure later.
11 So my point in showing this is that Encompass
12 believes that they will complement the services,
13 not compete with Danbury. And that because of the
14 aging population and the size of the population
15 and so few beds, that there is enough patients for
16 both providers. There's more than enough likely.
17 If you look at the next page, we -- we think
18 about IRF and discharges and we think about where
19 the patients come from. So the purpose of this
20 slide is to look at the vast array of hospitals in
21 the 52-ZIP Code area or adjacent to the 52-ZIP
22 Code area, and think about the number of patients
23 that are not only going to Danbury or Nuvance
24 Hospital, but are going to other hospitals as
25 well, for example, to Waterbury Hospital.

1 So you have residents that are seeking care
2 at multiple hospitals in and around Western
3 Connecticut. Those are the patients that
4 Encompass seeks to serve.
5 To be very clear, Encompass, in my
6 projections are not based on redirecting or
7 shifting Danbury Hospital's patients. Danbury
8 Hospital serves predominantly it's own patients
9 and patients from Nuvance's health system.
10 I view that as a closed system, if you will.
11 Waterbury Hospital, for example, if they have a
12 patient in need, Encompass would accept that
13 patient and not prioritize any systems patient
14 over the other. So I do think that's important to
15 think about in terms of a freestanding inpatient
16 rehab provider that would be located in this
17 Western Connecticut area.
18 THE HEARING OFFICER: So each one of these hospitals,
19 each one of these yellow dots is also an IRF?
20 THE WITNESS (Chafin): No. Thank you for asking that.
21 That tells me I did an awful job of explaining it.
22 The yellow dots are hospitals, general
23 acute-care hospitals. And those, those yellow
24 dots are where patients are being discharged and
25 would need inpatient rehab facilities.

1 THE HEARING OFFICER: Okay. So I know Danbury
2 Hospital, as you just said, is considered an IRF.
3 Correct?
4 THE WITNESS (Chafin): Yes, and it's an IRF within
5 Danbury Hospital. So here I'm just showing what
6 general acute care provider is what Waterbury --
7 THE HEARING OFFICER: Okay. So --
8 THE WITNESS (Chafin): Does that make sense? Waterbury
9 hospital --
10 THE HEARING OFFICER: Well, I'm just wondering. So all
11 these yellow, these hospitals, so how many of
12 these other hospitals, like Danbury Hospital has
13 the IRF services?
14 THE WITNESS (Chafin): That's a good question. Within
15 the service area there are none. Within the
16 service area there are none. I also have the
17 service area, statewide there's a total of six.
18 So if you look at St. Vincent's, Stamford,
19 those, and Yale New Haven on the shoreline, those
20 three general acute-care hospitals also have
21 inpatient rehab facilities.
22 I believe that I have in the CON -- and can
23 find it if it will help you -- a map that shows
24 you where the IRFs are located.
25 THE HEARING OFFICER: Okay. I'm sure I went through it

1 and I'll look again. If you say it's there, I'll
2 find it.
3 THE WITNESS (Chafin): Okay. And I will find that and
4 can get that to you.
5 So the yellow dots are general acute-care
6 hospitals that are in need of an inpatient rehab
7 provider to which they can refer patients.
8 Danbury has talked very specifically about the
9 importance of their continuity of care for their
10 patients.
11 And so again, what Encompass brings to the
12 table is the ability to accept patients from any
13 system without prioritizing one system or the
14 other. I'll have to look. I'll look for that map
15 and we'll -- I'll get back to you.
16 But just big picture, outside of the fifty --
17 go back (unintelligible). Outside of the 52 ZIP
18 Code area you have a few IRFs on the shoreline on
19 that I-95 corridor. You have an IRF. You have
20 two IRFs in Hartford, and then you have one,
21 Lawrence & Memorial is in the -- far eastern
22 Connecticut, if that helps you.
23 MS. FUSCO: Bates page (unintelligible). It's on, just
24 Attorney Yandow again, the map on Bates page 51 of
25 the CON application -- is a map that shows where

1 all of the hospital-based and IRFs are in the
2 state.
3 THE WITNESS (Chafin): In thinking about the -- the
4 number of general acute-care hospitals and the
5 number of patients from each general acute-care
6 hospital which is the purpose of the prior slide.
7 I used that and I'm now turning to this data
8 to show that there is sufficient volume and
9 sufficient discharges from all those area
10 hospitals, general acute-care hospitals. So that
11 when Encompass comes in and educates the market,
12 begins talking to physicians, begins talking to
13 case managers, that for lack of a better phrase,
14 rising tide lifts all boats.
15 This is data that shows four different areas.
16 You see those on the left. Philadelphia is the
17 second one. Their average IRF occupancy before
18 Encompass opened a new facility, and then you see
19 three years post Encompass coming in, in the
20 market with a new facility and what happened. And
21 in each instance the occupancy, or the average
22 occupancy for existing providers remained the same
23 or increased, and that is because -- going back to
24 Dr. Charbonneau, and to the physician letters that
25 we have in the CON.

1 When patients are going to SNF instead of IRF
2 and there is available bed capacity because
3 there's too few beds now, then patients begin
4 going to IRF in proportion to what we expect. And
5 as Encompass is educating the market, it's not
6 just Encompass that will see increased volume as
7 shown here. Other providers do as well.
8 There is a CON requirement about -- you don't
9 call it adverse impact, but you call it
10 unnecessary duplication of services. What this
11 shows with the data and the facts is that
12 Encompass, when it opens this hospital will not be
13 an unnecessary duplication of service, but instead
14 it will bring accessible services that are
15 high-quality to the market.
16 The next page -- I'm shifting gears. This is
17 skilled nursing facilities. So on the one hand
18 what I just showed you was that when Encompass
19 comes in and educates the market, they identify
20 patients in need of rehab that have not previously
21 received it. And a number of those patients, more
22 than in the past are going to inpatient rehab
23 facilities. So they're closing that gap in
24 care and it benefits existing inpatient rehab
25 providers.

1 What also happens when Encompass is going
2 into markets -- and these are in CON states -- is
3 that the skilled nursing facilities have benefited
4 as well. Because Encompass will go in and
5 identify a pool of patients that need rehab
6 services. Not all of those patients are able to
7 withstand three hours of therapy a day, which is
8 one of the distinctions between skilled nursing
9 and inpatient rehab, for example.
10 So what you see here is when Encompass went
11 into the market in Middletown. In Delaware you
12 see the skilled nursing facilities occupancy
13 before and after -- I'm sorry, the first year and
14 the following years, and you see that the
15 occupancy continued either the same or increased
16 almost in every case.
17 And the same thing with the next slide. This
18 is in Georgia. Encompass opened a new 50-bed
19 hospital. The skilled nursing facilities
20 occupancy increased the same or stayed relatively
21 flat. There was not a detrimental impact on
22 skilled nursing facilities.
23 The same thing is true on the next slide,
24 which is Virginia. It's another CON state when
25 Encompass came in and opened a new hospital. You

1 see that the occupancy there remained the same, or
2 in many instances increased.
3 The point of all that is that there are
4 enough patients for the skilled nursing and for
5 inpatient rehab providers, Danbury and Encompass
6 together.
7 The last section is shifting gears a little
8 bit. In Connecticut, as in many states, one of
9 the criteria is also cost-effective care and I
10 want to talk about the cost-effectiveness of care
11 in two buckets. The first one is IRF inpatient
12 rehab facility, and then the other will be
13 comparing IRF to SNF.
14 What you see in front of you is essentially
15 showing that Encompass has lower cost and lower
16 payment per discharge compared to other IRFs. So
17 on -- on apples to apples. This is IRF to IRF.
18 And if we want to -- this is national data. So
19 before I get beat up on that, let me talk about
20 Connecticut data. Now because in Connecticut if
21 we look at the cost effectiveness of care,
22 Encompass' proposed fiscal year '24 charges are
23 $3,700 lower per patient or per discharge than
24 Danbury Hospital current.
25 So that's one reason that Encompass, when I

1 talk about cost-effective care, I have the data to
2 support that, and that information was in the
3 rebuttal response filed last night.
4 So when we look at IRF, which is what we just
5 did, Encompass has cost-effective care. If I now
6 shift and talk about Encompass versus a skilled
7 nursing facility, an easy and incorrect way to
8 compare costs between Encompass IRF and skilled
9 nursing would be to say, well, skilled nursing is
10 cheaper. The cost per day is cheaper. The
11 reimbursement is cheaper. Just like home health,
12 it's cheaper. It costs less. Well, you're right
13 because it's less intensive services provided at
14 skilled nursing, home health, for example,
15 compared to rehab.
16 For what you see here is illustrative of
17 resource intensiveness and what is identified by
18 Medicare and what they're willing to pay. For
19 example, inpatient rehab, 1,689 per day is the
20 Medicare reimbursement. Skilled nursing is the
21 595 -- these are actual costs -- and then home
22 health is 38.
23 So my point here is if we just say, well,
24 it's cheaper to go to skilled nursing than
25 inpatient rehab. You're right, but we can't stop

1 there because there are peer-reviewed journal
2 articles, two of which are referenced in my
3 prefiled testimony that talks about the downstream
4 medical calls and the downstream morbidity.
5 If you turn to the next slide, for example,
6 what you see is that -- this is one example; it
7 was from a Texas health system -- that you have to
8 consider the readmission rate, and therefore the
9 full cost of care for patients who are
10 inappropriately placed in SNF.
11 Without walking through all the detail -- and
12 I can if you'd like me to -- the point of this
13 slide is skilled nursing may be cheaper, and it is
14 cheaper in your patients are staying their longer.
15 It's cheaper because there's less resources. The
16 patients aren't receiving as many intensive
17 services.
18 We have to consider the readmission. So here
19 what happened is for cardiac valve patients did
20 change from going from IRF to SNF. That's your
21 blue bars. So let's -- the facility or the system
22 thought they would save money by shifting from IRF
23 to SNF, and then what you see is the second set of
24 light green is the system did say, oh, their first
25 admission when the patient left their hospital and

1 went to skilled nursing rather than IRF it was
2 cheaper, but their third column is those patients
3 were readmitted because they did not receive the
4 appropriate level of care. And so because of that
5 the cost of care has to be considered for that
6 readmission.
7 So when -- in the fourth set of columns what
8 you see is that the total episode of care is
9 actually greater when you try to get the cheaper
10 cost on the front end for the patients that are
11 more appropriately placed in IRF.
12 And with that, I'm through with my exhibits
13 and I'm sure there will be questions.
14 THE HEARING OFFICER: Thank you. I have a few, and
15 then I think -- then I'm going to let Attorney
16 Fusco see if she has any more direct she wants to
17 follow up with any of her witnesses, and then
18 we're going to take a brief break.
19 And then I'll come back and then we're going
20 to allow cross-examination. I'm going to see what
21 witnesses. I'm going to ask the Intervener, and
22 I'm sure of Ms. Chafin, I'm imagining that there's
23 some questions. And I'm going to want to limit it
24 to 19a-639. And certainly any kind of questions
25 that might bring any of your direct testimony you

1 know that would help me weigh how, whether or not,
2 how relevant and how much weight I should give the
3 data.
4 My concern is, I want to focus on Connecticut
5 and I know a lot of your stuff is based on
6 national statistics and Medicare. And I
7 appreciate that and I'm going to certainly take
8 that, and I'm going to give that into some serious
9 consideration.
10 You know I'm hoping maybe from the OHS and
11 maybe what we're going to hear from the
12 Intervener, or maybe some questions to see that
13 the effect of Connecticut versus the other, the
14 other states.
15 So where would you get your patients from?
16 Are they referrals from hospitals?
17 THE WITNESS (Chafin): That's a really good question.
18 The 90 percent -- so 9 out of 10 patients come
19 from the general acute-care hospitals. They are
20 admitted to Encompass directly from general
21 acute-care hospitals.
22 And if you look at the map, that was the
23 yellow dots. That's why I put all those yellow
24 dots. There are a number of hospitals that have a
25 number of patients in need of inpatient rehab

1 services.

2 In the application when I looked at where the

3 patients would come from, I would see on page 711,

4 seven-one-one. Then that gives you an idea of the

5 number of hospitals that would provide discharges

6 for Encompass and the order of magnitude.

7 For example, Danbury Hospital had over 3,000

8 discharges that I would identify, and Encompass

9 would identify as rehab appropriate. And that's

10 only Medicare fee for service. So when we think

11 about their total patients, Danbury Hospital had

12 over 4500 -- 4,500 patients that we identified as

13 rehab appropriate. And out of that, 200 I believe

14 last year received inpatient rehab facility

15 services.

16 So to answer your question, patients would

17 come from we expect Danbury Hospital as well as

18 the other hospitals in the area. Dr. Winnow will

19 talk this afternoon, and he's from Waterbury. And

20 he will talk about the need for additional

21 inpatient rehab services.

22 So that's just illustrative of the need and

23 where patients are coming from. So general

24 acute-care hospitals are the dominant source of

25 the admissions.

1 THE HEARING OFFICER: Attorney Fusco, do you have other
2 witnesses you're putting on in your direct?
3 MS. FUSCO: No, Attorney Chafin is our last witness.
4 THE HEARING OFFICER: Okay. So 90 percent from -- and
5 who? I know you said there are other witnesses
6 available if OHS wants to talk to them.
7 Who was it that you are making available?
8 MS. FUSCO: We have -- I mean, I guess it just depends
9 factually. We have someone who works with
10 Ms. Chafin who worked on the financials, if there
11 are questions about the financials.
12 We have an individual who can talk about
13 facility design. He's actually been involved in
14 the design and planning of the facility. We have
15 development folks you could speak to. I know
16 Mr. Tuer mentioned that he was not involved in the
17 initial planning stages for this project. The
18 individual who's position he took is retired.
19 So you know, if there were questions
20 historically about the development of the project,
21 there is development staff that could answer.
22 THE HEARING OFFICER: Okay. All right. I have a few
23 more questions of Ms. Chafin. So 90 percent,
24 you're expecting 90 percent of the patients to
25 come with referrals from hospitals. So it would

1 be Danbury.

2 And I believe there's a list in the prefiled

3 about there was a certain percentage of patients

4 you believe will be from Danbury.

5 Is that correct?

6 THE WITNESS (Chafin): Yes, that's correct with the --

7 the caveat that it really is a rough estimate and

8 I think I may have used the phrase, almost a

9 mathematical exercise -- but that is correct.

10 THE HEARING OFFICER: And do you recall, what was the

11 percentage that was in the chart?

12 THE WITNESS (Chafin): In the chart it was

13 20.9 percent. In terms of -- and that's of the

14 90 percent. I'm not trying to be confusing, but

15 because 90 percent of patients will come from

16 hospitals, of the hospital generated patients,

17 Danbury is 20.9 overall (unintelligible).

18 THE HEARING OFFICER: Okay. And out of that 90 percent

19 what other hospitals? And I know there's a chart,

20 but just if you could sort of just repeat that for

21 me. I think Sharon. Was Sharon one of them? Was

22 that the second?

23 THE WITNESS (Chafin): Sharon was one. Sharon was one

24 and there was only eight patients from Sharon out

25 of --

1 THE HEARING OFFICER: What was the percentage?
2 THE WITNESS (Chafin): 1.4 percent.
3 THE HEARING OFFICER: 1.4. What was the second? I
4 think you had Danbury as number one. What was the
5 second highest percentage from a hospital?
6 THE WITNESS (Chafin): Norwalk Hospital.
7 THE HEARING OFFICER: Norwalk?
8 THE WITNESS (Chafin): That was -- yeah, that --
9 they -- I realized they're a Nuvance hospital.
10 They -- they closed their inpatient rehab
11 facility, if I'm not mistaken. Their percent is
12 13.2.
13 So -- yeah, so for order of magnitude, that
14 being 74 referrals out of over 1,625 rehab
15 appropriate patients that are discharged from that
16 hospital. Medicare only. Right? So that that
17 number is going to probably be more like 2,000.
18 So just to answer your question fully, the --
19 the 13.2 percent may sound high, but it's 74
20 patients out of almost 2,000 patients that
21 Encompass believes are candidates for inpatient
22 rehab facility services, if that helps.
23 THE HEARING OFFICER: Okay.
24 So it's a third -- I mean, it's a third of
25 the 90 percent. Correct?

1 THE WITNESS (Chafin): No, it was 13 percent.
2 THE HEARING OFFICER: Plus the 20 of the Nuvance
3 Hospitals. I guess, it's Nuvance?
4 THE WITNESS (Chafin): No. That would combine.
5 They're 33 percent -- that's correct.
6 THE HEARING OFFICER: So that's 33 percent of the
7 90 percent. Is that right?
8 THE WITNESS (Chafin): That's -- that's correct, yes.
9 THE HEARING OFFICER: Okay. I wanted to make sure.
10 Okay.
11 And these hospitals, I know you have a list
12 of other hospitals. Have you had discussions with
13 those hospitals about the referrals?
14 THE WITNESS (Chafin): I have not. I know that
15 Encompass has spoken with Danbury Hospital in the
16 past, and I know that Encompass has spoken with
17 physicians in the community that will talk today
18 or have written letters, but I have not spoken to
19 any of the hospitals.
20 THE HEARING OFFICER: Okay. And do you know who in
21 Encompass would have to talked to the hospitals?
22 THE WITNESS (Chafin): I do. It would have been Bill
23 Heath. He is their business development person.
24 I believe I'm telling you -- right?
25 (Unintelligible.)

1 That's true. And then Marylin Schwartz has
2 also spoken with community positions that are in
3 support of the proposed project. She is a
4 former -- she's a nurse by training and a former
5 hospital CEO, and had some outreach to specific
6 positions that had expressed support for the
7 project.
8 But she did not speak with Danbury Hospital
9 representatives, I do not believe. But the
10 physician who ultimately referred the patients,
11 that's who she talked to. And I guess that's one
12 thing, if I can try to clarify, is that -- and
13 this is a Pat Tuer issue perhaps even better -- is
14 that the patients are being discharged from
15 Danbury Hospital.
16 It's the physicians and case managers that
17 are taking care of those patients who are looking
18 at where they need to go and referring those
19 patients. So the physician is key, which is why
20 Marylin Schwartz talked to community physicians
21 and why there are several community physician
22 letters in the -- in the application.
23 So they are discharged from the hospital, but
24 the physician is going to be key in referring or
25 dictating, or prescribing where they go for

1 postacute-care services, if that helps.
2 THE HEARING OFFICER: Okay. Thank you.
3 Attorney Fusco, do you have anything else
4 with your case in chief?
5 MS. FUSCO: Just one minute.
6 If I could redirect, very briefly just to
7 clarify something?
8 THE HEARING OFFICER: I mean, I read this is all part
9 of your direct, so.
10 MS. FUSCO: Absolutely. Just because I think it will
11 help clarify this chart that we're talking about.
12
13 DIRECT EXAMINATION (of Chafin)
14
15 BY MS. FUSCO:
16 Q. (Fusco) Ms. Chafin, can you explain to me how
17 you arrived at the number of Medicare
18 fee-for-service rehab appropriate discharges
19 for each hospital?
20 A. (Chafin) Yes, that's --
21 Q. (Fusco) (Unintelligible) -- you look at?
22 A. (Chafin) Right. This chart -- and I'm sorry
23 we don't have it to show, although I think we
24 can go to -- which might be helpful
25 (unintelligible).

1 CON page 711 has -- has 2 sides to it.
2 It has -- to your question, Attorney Yandow,
3 is that, what is the estimated percent of
4 patients at the hospital. That's on the left
5 side, those, those numbers.
6 And then on the right side of this chart
7 is, what I wanted to give was perspective.
8 You know, I was quoting the total number of
9 patients. Again, using that publicly
10 available Medicare fee-for service data I
11 know, for example, that Danbury had 3,013
12 rehab appropriate discharges in calendar year
13 '19, and a couple of points with that.
14 One is that that is only a portion of
15 patients that I expect and Encompass expects
16 are rehab appropriate, eligible and would
17 likely benefit from rehab. And the rehab
18 appropriate terminology is that the total
19 discharges from the hospital, when you think
20 about patients that are being discharged,
21 they're not all going to go to rehab.
22 They're not all appropriate for rehab. We
23 can easily limit -- not clinical, but now can
24 easily eliminate OB, typically psychiatric as
25 well. So we -- we will -- and, like, cardiac

1 cath lab.

2 So there are certain patients that

3 Encompass, based on the data that

4 Dr. Charbonneau talked about and years of

5 experience, they know who is likely going to

6 be in need of and benefit from IRF. That is

7 what the far right two columns show, is that

8 if we look at Medicare fee-for-service only

9 which is a portion of patients, and we

10 whittle that down to rehab appropriate, you

11 see a minimum number of patients that we

12 expect are eligible or appropriate for rehab.

13 Does that answer your question?

14 Q. (Fusco) Uh-huh.

15 A. (Chafin) Okay.

16 Q. (Fusco) And then in comparison speaking with

17 Danbury Hospital as an example, what

18 percentage? You know you focused on the fact

19 that they would account for 20.9 percent of

20 all referrals, but what percentage of their

21 rehab appropriate discharges would we expect

22 to come to us?

23 A. (Chafin) This page 711, and what's in front

24 of you shows 3.9 percent of Danbury Hospital

25 patients we expect would go to Encompass

1 Health, but my caviat -- and that's why I
2 mentioned that this is only Medicare
3 fee-for-service.
4 If you look at Danbury Hospital, they
5 treated in their rehab unit, 64 percent of
6 their patients were ages 65 plus, essentially
7 Medicare. So I've got to take that 3,013 and
8 bump it up to represent apples to apples in
9 this chart to show you total rehab
10 appropriate patients, which would be about
11 4700.
12 So that's a long answer to say
13 2.5 percent of Danbury Hospital's over 4700
14 rehab appropriate patients in 2019 would be
15 expected or estimated to go to Encompass
16 Danbury. So it was a very small percentage
17 of the total pie.
18 Q. (Fusco) And so in followup, so you know,
19 let's just focus on the Medicare
20 fee-for-service data that we have here in
21 front of us. If Danbury Hospital were
22 to refer Encompass 117 of those rehab
23 eligible discharges, how many patients
24 approximately -- how many rehab eligible
25 discharges does that leave them, you know,

1 with which to fill their own unit and to
2 refer elsewhere?
3 A. (Chafin) Over 4,000 if you consider all
4 the -- all the payers, which would be
5 appropriate, a significant number. And
6 that's why I previously, in a slide I showed
7 the data, the data and the reality and the
8 history of Encompass going into the market
9 has been that the existing providers do see
10 an increased volume.
11 And if you step back and think about it
12 for just a minute, from a health plannings
13 perspective and a business perspective it
14 would be nonsensical to think that Encompass
15 would come in and try to run Danbury's IRF
16 out of business when they will provide care
17 for patients at Danbury Hospital.
18 I see that they will have a positive
19 relationship, which they do in other markets
20 with Danbury Hospital.
21 Q. (Fusco) And so just to clarify, those 170
22 patients that Danbury -- that we would
23 anticipate Danbury would refer, those are not
24 patients that are already getting care or
25 would be getting care in Danbury's IRF.

1 Correct?

2 Those are just general acute-care
3 discharges from the hospital that are IRF
4 eligible. Meaning, we're not saying we're
5 going to, you know, shift 117 of those IRF
6 patients to our inpatient rehabilitation
7 facility. Correct?

8 A. (Chafin) That's correct. I would expect
9 Danbury to continue caring for their patient
10 population. Patients that are currently not
11 receiving IRF that need it would get it.
12 That's why we talk about the high number that
13 go to skilled nursing instead, or go to home
14 health, or just don't get it at all.

15 There's not a shifting of patients
16 anywhere in my analysis, nor do I expect it
17 in reality. That's why I keep going back to,
18 rising tide lifts all boats. And you have
19 someone come in and educate the market. When
20 you have that gap in care, when you have that
21 disproportionate skilled nursing utilization
22 high and a disproportionately low IRF
23 utilization, there is more than enough.
24 There are more than enough patients to go
25 around. This is not assuming any shifting or

1 any adverse impact on Danbury Hospital.
2 MS. FUSCO: Thank you. I don't have any more
3 questions, and that concludes our presentation and
4 direct evidence. Thank you very much.
5 THE HEARING OFFICER: Okay. Great. So nothing of the
6 other witnesses either then?
7 MS. FUSCO: No.
8 THE HEARING OFFICER: Okay. So what we're going to do
9 is we're going to take a lunch break. We're going
10 to break until -- well, it's about 12:30. We're
11 going to break until 1:10 -- let's make it 1:15.
12 We're going to break until 1:15.
13 When we come back we're going to start with
14 the cross-examination by the Intervener of
15 Ms. Chafin.
16 And who -- which counsel will be doing
17 cross-examination? Okay. Thank you. Thank you.
18 So actually, let's make it 1:10. 1:10 we'll come
19 back and by that time we'll get started. So 1:10
20 we will be back and then start with
21 cross-examination. All right?
22 So we'll go on break. Remember to turn off
23 your audio and your video, too. And we'll be back
24 at 1:10.
25

1 (Pause: 12:28 p.m. to 1:09 p.m.)

2

3 THE HEARING OFFICER: Ms. Chafin, remember you're still

4 under oath.

5 THE WITNESS (Chafin): Yes.

6 THE HEARING OFFICER: Okay. Attorney Tucci? Am I

7 pronouncing that right, Too-chee [phonetic]?

8 MR. TUCCI: That is exactly right, Hearing Officer

9 Yandow. Thank you.

10 THE HEARING OFFICER: Okay. All right.

11 MR. TUCCI: May I proceed?

12 THE HEARING OFFICER: You may proceed. I mean, keep

13 it -- what I'm interested in is the elements under

14 19a-639. And as far as any kind of information

15 during the direct that needs more expansion, or if

16 you believe that there's any type of anything that

17 would help go to how I should weight a piece of

18 evidence that was offered?

19 MR. TUCCI: All right. Thank you very much.

20

21 CROSS EXAMINATION (of Chafin)

22

23 BY MR. TUCCI:

24 Q. (Tucci) Good afternoon, Ms. Chafin. How are

25 you?

1 A. (Chafin) Good how about you.
2 Q. (Tucci) I'm just fine. Can you hear me all
3 right?
4 A. (Chafin) It's not great, but it's okay.
5 MR. TUCCI: All right. I'll proceed. Just for the
6 record this is Ted Tucci, Counsel for the
7 Intervenor Danbury Hospital.
8 BY MR. TUCCI:
9 Q. (Tucci) Ms. Chafin, am I correct in
10 understanding that you took principal
11 responsibility for the creation and
12 submission of the written materials on behalf
13 of Encompass Health, including the CON
14 application and the responses to the
15 completeness questions? Would that be fair?
16 A. (Chafin) That's correct, yes.
17 Q. (Tucci) And we -- as I understand from your
18 direct testimony, the business model that
19 Encompass is presenting in its CON is one
20 where the expectation is that the volume for
21 the new facility that is being proposed in
22 Danbury, approximately 90 percent of the
23 patients who will be expected to admitted
24 into that facility will be as a result of
25 referrals coming out of acute-care general

1 hospitals in the state of Connecticut.
2 Correct?
3 A. (Chafin) That's correct. I say to 90 --
4 approximately 90 percent would be discharged
5 from a general acute-care hospital. Again,
6 the physician is driving that when they are
7 going from a general acute-care hospital into
8 Encompass.
9 MR. TUCCI: All right. And if you could go to your
10 2020 completeness question submission, in
11 particular the response to question number 10,
12 please?
13 THE WITNESS (Chafin): Can you repeat the question?
14 BY MR. TUCCI:
15 Q. (Tucci) Yes, the 2020 completeness question
16 response, and specifically I'm directing your
17 attention to question Number 10?
18 A. (Chafin) Can you give me a page number
19 please, a Bates stamp?
20 THE HEARING OFFICER: Are you looking, Attorney Tucci,
21 at the first completeness response, the one from
22 October 16, 2020?
23 BY MR. TUCCI:
24 Q. (Tucci) That's correct, page 8, question 10?
25 A. (Chafin) Page 8 of the -- let me just make

1 sure I'm on the October 16, 2020 submission.
2 Q. (Tucci) Yes. It's Bates page 000492.
3 A. (Chafin) Okay. 493?
4 Q. (Tucci) Two.
5 A. (Chafin) Okay.
6 Q. (Tucci) So in this completeness question OHS
7 asked Encompass which hospital Encompass was
8 establishing transfer agreements with, and
9 the response that you provided on behalf of
10 Encompass was, quote, Encompass typically
11 executes a transfer agreement with one or
12 more of the closest hospitals. Correct?
13 A. (Chafin) That is what it says, yes.
14 Q. (Tucci) And we know from your earlier
15 testimony that with respect to the acute-care
16 hospitals that are in the 52 ZIP Code service
17 area that you've identified, that there the
18 acute-care hospitals within that service area
19 are Danbury Hospital, New Milford Hospital,
20 Sharon Hospital and Charlotte Hungerford
21 Hospital. Correct?
22 A. (Chafin) If you could point me to my exhibit
23 to make sure we're looking at the same
24 exhibit?
25 Q. (Tucci) Sure. You can feel free to pull up

1 your map on your screen if you'd like the
2 Hearing Officer to see it, the service area
3 that you've identified?
4 A. (Chafin) I just want to make sure you're
5 looking at my Exhibit F, page 2.
6 Q. (Tucci) Sure. Can you put that up on the
7 screen so the Hearing Officer can see it?
8 All right. So I have that information
9 correct, don't I? That we're talking about
10 four hospitals that are in the geographic
11 service area that your proposal has
12 identified?
13 A. (Chafin) In terms of hospitals within the
14 geographic area, yes, there are four general
15 acute-care hospitals. That does not equate
16 to the hospitals that will refer patients to
17 Encompass Danbury, as long as we're clear on
18 that.
19 Q. (Tucci) I'm very clear on that. What I'm
20 asking you, ma'am, is if you agree with me
21 that in the geographic service area you
22 identified, which is the service area where
23 you believe there is a gap in care, am I
24 correct that there are in Connecticut four
25 acute-care hospitals, Sharon, Charlotte

1 Hungerford, Danbury Hospital, New Milford --
2 and Danbury Hospital?
3 A. (Chafin) That's correct.
4 Q. (Tucci) That's a fact. Right?
5 A. (Chafin) That's correct. In Connecticut --
6 Q. (Tucci) Yeah, and --
7 A. (Chafin) (Unintelligible) -- that are
8 contiguous, so I would agree with that.
9 Q. (Tucci) Yes. And it's also a fact that as of
10 the last written materials that Encompass has
11 submitted to OHS you have reported the
12 existence of no transfer agreements with any
13 of the hospitals in that service area.
14 Correct?
15 A. (Chafin) That's -- that's correct. The CON
16 application is not yet approved, so I would
17 not expect Encompass to have established a
18 transfer agreement at this point in the
19 process.
20 Q. (Tucci) And in fact, in your response to the
21 completeness question number 10 that we're
22 looking at on page 492, I believe you
23 reported to OHS that Encompass' typical
24 approach is to, quote, begin discussions
25 regarding transfer agreements while the new

1 hospital is being built. Is that right?
2 A. (Chafin) That's correct, and that is -- that
3 is typically what they do, and they have been
4 successful in establishing those transfer
5 agreements.
6 Q. (Tucci) So the plan that's being proposed
7 here is to get regulatory approval for a
8 40-bed hospital, start building it, and then
9 see if you can fill it up. Correct?
10 A. (Chafin) Say that last part? I'm sorry. I
11 couldn't hear you. I'm having a hard time
12 with the sound.
13 Q. (Tucci) Just to get approval from the Office
14 of Healthcare Strategy for a 40-bed hospital,
15 start constructing it, and then see if you
16 can get agreements in place to obtain
17 90 percent of your referrals from hospitals.
18 Correct?
19 MS. FUSCO: I'm going to object to the form. That's
20 not what a transfer agreement is as OHS requests.
21 This question deals with transfer agreements that
22 have to do with sending patients from the IRF who
23 are in need of acute-care hospital services to the
24 hospital for those services.
25 The transfer agreement is not a referral

1 agreement, so I object to the question.
2 THE HEARING OFFICER: Okay. Hold on.
3 Okay. So Attorney Tucci, can you reframe
4 your question?
5 MR. TUCCI: Very simple, and I won't belabor it,
6 Hearing Officer Yandow.
7 BY MR. TUCCI:
8 Q. (Tucci) Ma'am, you will agree with me, will
9 you not, that with respect to the
10 establishment of any written transfer
11 agreements with acute-care hospitals in
12 Connecticut Encompass has not yet been able
13 to accomplish that. Correct?
14 A. (Chafin) That's correct because the transfer
15 agreement is for inpatient from Encompass
16 Danbury who needs general acute-care services
17 to be transferred to an existing general
18 acute-care hospital.
19 So it would be the patients in the
20 facility that they are transferring to
21 another facility. So it doesn't make sense
22 that they would have a transfer agreement in
23 place now.
24 Q. (Tucci) In addition to the four hospitals
25 that are located in the geographic service

1 area you've identified, the Encompass
2 proposal also relies on the expectation of
3 referrals of patients who are discharged from
4 ten other hospitals in the state of
5 Connecticut.
6 Correct?
7 And if it would help you, I direct you
8 to your response of January 8, 2021, to --
9 I'll get you a page reference in a minute --
10 to page 000524?
11 A. (Chafin) There -- yes. To answer your
12 question, there are hospitals outside but in
13 close proximity to the service area or
14 hospitals that are serving residents from the
15 service area are included.
16 So hospitals listed here are serving
17 patients from the Western Connecticut area.
18 So as these patients are discharged from
19 hospitals we would expect if there are
20 available IRF beds those patients would go
21 closer to home and receive that IRF care.
22 Q. (Tucci) All right. And I believe you've put
23 this chart on the screen earlier. Can you
24 put it up again so we can talk about it in a
25 little more detail?

1 **A. (Chafin) Yes.**
2 **Q. (Tucci) All right. Now looking at the ten**
3 **other hospitals outside the 52 ZIP Code**
4 **service area that you have identified as the**
5 **primary service area for your proposed new**
6 **facility, there the chart shows that**
7 **Encompass expects to get patient referrals**
8 **from the following hospitals.**
9 **In particular I want to focus on the**
10 **following five hospitals -- Bristol Hospital.**
11 **Correct?**
12 **A. (Chafin) Sixteen referrals, that is correct.**
13 **That will be more than 500 rehab appropriate**
14 **discharges. That is correct.**
15 **Q. (Tucci) And according to your chart you**
16 **expect that Bristol Hospital will send**
17 **approximately 2.8 percent of the 90 percent**
18 **hospital referrals will emanate from Bristol**
19 **Hospital discharges. Correct?**
20 **A. (Chafin) Mathematically that's correct.**
21 **Again, that is based on patients that are**
22 **currently going to Bristol Hospital from the**
23 **service area.**
24 **Q. (Tucci) For Bristol Hospital your projection**
25 **is that it will be 11.8 percent of the total**

1 volume you're projecting for your hospital
2 discharges. Correct?
3 A. (Chafin) From Hartford Hospital, that is
4 correct. Again, based on the patient's and
5 the residents from the geographic service
6 area that are currently traveling to Hartford
7 Hospital for services that are rehab
8 appropriate.
9 And when you factor in more than just
10 Medicare fee for service, to give
11 perspective, out of probably more than 5,000
12 rehab appropriate patients 66 would be
13 expected to be from Hartford Hospital based
14 on residents now that leave their area to go
15 to Hartford Hospital for care.
16 Q. (Tucci) Hartford Hospital of Central
17 Connecticut, 1.1 percent. Correct?
18 A. (Chafin) That's correct, which is six
19 patients.
20 Q. (Tucci) John Dempsey Hospital, 3.9 percent;
21 and St. Francis Hospital, 9.0 percent.
22 Correct?
23 A. (Chafin) Correct. Again, 22 patients out of
24 more than 900 for John Dempsey, and then --
25 I'm sorry. The other one, the St. Francis is

1 kind of -- the other one, 51 out of close to
2 4,000 patients that reside --
3 Q. (Tucci) Excuse me. Right now I'd just like
4 you to focus on percentage. I've read to you
5 percentages, and you're very good at math.
6 And correct me if my math is wrong, but
7 of the five hospitals that I read to you and
8 the percentages that are in your chart,
9 that's a little less than 30 percent of the
10 total hospital discharge volume that you
11 project will make up the patient census at
12 this hospital that's being proposed to be
13 built. Correct, 28.6 percent?
14 A. (Chafin) I would have to add it, but
15 that's -- the math, again, mathematically
16 that -- that sounds correct.
17 Q. (Tucci) Okay. And you would agree with me
18 that the five hospitals that we just focused
19 on are clearly outside of the primary 52 ZIP
20 Code service area that you've identified
21 where there's this gap in care. Right?
22 A. (Chafin) The hospitals themselves are located
23 outside of the service area. The residents
24 they serve are within the service area, and
25 that's why I would expect if they are

1 sufficient numbers of inpatient rehab
2 facility beds, and they are with a provider
3 such as Encompass that is freestanding and is
4 not going to prioritize one system over the
5 other, then those patients could in fact
6 receive care close to home through Encompass.
7 Q. (Tucci) Your expectation is that 28.6 percent
8 of the volume is going to come from patients
9 who are discharged out of hospitals in
10 Central Connecticut. Is that correct?
11 A. (Chafin) Well, you're ignoring Waterbury
12 Hospital, I guess, in that.
13 Q. (Tucci) I've strictly asked you to focus on
14 the hospitals that we can agree are located
15 geographically in the Central Connecticut
16 area.
17 A. (Chafin) You are -- if you are ignoring
18 Waterbury, then let me just do the math on
19 the ones that you are selecting and ignoring
20 the others to make sure I am following you.
21 Q. (Tucci) Well, ma'am, I'm not ignoring
22 anything. I'm asking you to focus on the
23 geographic region in the state of Connecticut
24 which is in the central part of the state.
25 You would agree with me that all the

1 hospitals that I've identified are hospitals
2 that are physically located in neither
3 Fairfield County nor Litchfield County?
4 THE HEARING OFFICER: Okay. Attorney Tucci, she may
5 need to look at the map while she's talking. So I
6 just want to give her the time. You're asking her
7 to do math. She probably has to look at the map
8 for Connecticut about where are these hospitals.
9 So just give her time to pull together with
10 the answer.
11 MR. TUCCI: Sure.
12 THE HEARING OFFICER: While she's looking, one of the
13 questions I'm interested in and certainly Attorney
14 Chafin is much more aware of what's in this
15 information that she cites to.
16 But does this information that's cited tell
17 you that the patient's that go to Hartford
18 Hospital or St. Francis go specifically -- will
19 specifically need rehab services, and that they
20 live in the geographical area? So that the
21 sources that are there, do those sources tell you
22 that information?
23 THE WITNESS (Chafin): Yes, and that -- that's why I
24 keep trying to be responsive to his question that
25 when you're talking about the hospital location

1 you have to instead focus on the patient's
2 location, and you're exactly right. This, the
3 estimated referrals are based on the patient's
4 residence, and these are absolutely for patients
5 who are -- unless they're involved in an accident,
6 they end up going to Bristol Hospital in his
7 example.
8 And when they are discharged from Bristol
9 Hospital, because they live in the service area,
10 if Encompass Danbury were there and had available
11 beds we would expect the patient to be discharged
12 to the IRF closer to their home, which would be
13 Encompass Danbury.
14 THE HEARING OFFICER: And you got that information from
15 the Medicare discharge data source?
16 THE WITNESS (Chafin): That's correct, in terms of
17 their residence and in terms of their diagnosis,
18 their DRG that calls them to get into that general
19 acute-care hospital, yes.
20 THE HEARING OFFICER: Okay. I'm sorry, Attorney Tucci.
21 I just wanted to clarify that for me. So go ahead
22 and reask your question.
23 MR. TUCCI: Let's focus on the Bristol Hospital example
24 where you have estimated that 16 patients out of
25 the 90 percent that will come from hospitals will

1 come from people who are discharged after getting
2 care at Bristol Hospital.
3 BY MR. TUCCI:
4 Q. (Tucci) The column that you've identified on
5 the right-hand side of your chart is what you
6 describe as Medicare fee-for-service rehab
7 appropriate discharges in calendar year 2019.
8 Correct?
9 A. (Chafin) That is correct.
10 Q. (Tucci) And you say that in 2019 there were
11 495 patients discharged from Bristol Hospital
12 who you describe as being Medicare
13 fee-for-service rehab appropriate. Correct?
14 A. (Chafin) That's correct, and so it is a
15 subset of their total patients that would be
16 discharged at a rehab appropriate, because it
17 is only Medicare fee for service.
18 So it is more, I guess, appropriate to
19 look at 825 discharges to have apples to
20 apples, because if you assume approximately
21 60 percent of the total rehab appropriate
22 patients are Medicare fee-for-service, then
23 all payers would be 825. So let me say it a
24 different way. The total (unintelligible) --
25 Q. (Tucci) Ma'am? Ma'am? Ma'am, can you

1 please --

2 A. (Chafin) I'm still responding to your

3 question.

4 MR. TUCCI: No, you're --

5 THE HEARING OFFICER: Counsel, let her finish her

6 response. Okay? I appreciate the questions, but

7 I do want her to finish her response. If she goes

8 off -- I want the cross-examination. I want to

9 hear it from Danbury, but I do want to allow her

10 to finish her questions, and I want to gather all

11 the information.

12 MR. TUCCI: Very good.

13 THE HEARING OFFICER: You can finish your answer.

14 THE WITNESS (Chafin): Thank you. So that we're

15 comparing apples to apples, the 495 represents

16 only a subset of the rehab appropriate discharges.

17 So if we assume 60 percent of the total rehab

18 appropriate discharges at Bristol Hospital are

19 Medicare fee-for-service, what that means is it's

20 a bigger pool.

21 It's 825 patients in total that Bristol

22 Hospital saw in calendar year '19 that had that

23 car accident, that need that intensive rehab care

24 after they are discharged. So the 16 would be 16

25 patients out of a total potential pool of patients

1 being discharged of 825.

2 Because what you see in front of you is the

3 left side is all patients, all payers on that

4 chart and the right side with the order of

5 magnitude was just Medicare fee for service. Just

6 a subset. So it was apples and oranges to some

7 extent.

8 THE HEARING OFFICER: Ms. Chafin, your attorney will

9 have a chance for redirect. So I want you to

10 focus on the question, answer the question and

11 your attorney has a chance for redirect. So if

12 she feels that she needs to ask you on any

13 followup, she will. Okay?

14 Go ahead, Attorney Tucci.

15 BY MR. TUCCI:

16 Q. (Tucci) Sure. So looking at your table one

17 chart again, Ms. Chafin. Let's focus on

18 Bristol Hospital since we've been discussing

19 it.

20 And I'll direct your attention to the

21 data that you have listed for calendar year

22 2019 in the category that you describe as

23 Medicare fee-for-service, quote, rehab

24 appropriate discharges -- but that number is

25 495. Correct?

1 A. (Chafin) That is what's in the table, yes.
2 Q. (Tucci) Can you tell OHS staff and Hearing
3 Officer Yandow what the actual number of
4 patients discharged from Bristol Hospital in
5 calendar year 2019 were actually discharged
6 to IRF care?
7 A. (Chafin) I do not have that.
8 Q. (Tucci) Can you tell the Hearing Officer and
9 OHS staff for Danbury Hospital out of the
10 3,013, quote, unquote, rehab appropriate
11 discharges that you list in your column, how
12 many of those 3,000, quote, unquote,
13 appropriate discharges for rehab care -- how
14 many of them were actually discharged into
15 IRF facilities anywhere in the state of
16 Connecticut?
17 A. (Chafin) I know the number of discharges. I
18 know the number of admissions that Danbury
19 Hospital accepted, which was just over 200.
20 And I know that Danbury Hospital
21 predominantly serves patients from its own
22 hospital.
23 So I can estimate around 200 of the
24 3,013 Medicare fee-for-service patients went
25 to Danbury Hospital for IRF services. So a

1 **small percentage of that total, again knowing**
2 **the total 3,013 is only a portion of rehab**
3 **appropriate patients.**
4 **Q. (Tucci) Hartford Hospital, according to your**
5 **2024 projection, 66 patients who are**
6 **discharged from Hartford Hospital are going**
7 **to be filling up beds at Encompass Healthcare**
8 **of Danbury.**
9 **Looking at the calendar year 2019 data**
10 **for Hartford Hospital, can you tell us how**
11 **many patients discharged out of Hartford**
12 **Hospital were discharged from acute care into**
13 **inpatient rehabilitation facilities?**
14 **What is the actual number?**
15 **A. (Chafin) I can look at their Hartford**
16 **Hospital admissions and tell you how many**
17 **patients they served. What that will not**
18 **tell me is how many came from the service**
19 **area.**
20 **Q. (Tucci) All right. Thank you very much.**
21 **Now you have made very clear, I think in**
22 **your direct comments, that from your**
23 **perspective the Encompass Danbury Hospital**
24 **that's proposed will complement rather than**
25 **compete with Danbury Hospital, which you**

1 acknowledge is the sole provider of inpatient
2 rehabilitation facility services in the
3 proposed service area. Correct?
4 A. (Chafin) That is what I've said, yes, because
5 of the array of services, for example, and
6 the fact that --
7 Q. (Tucci) And could you direct your attention
8 to page 74 of the CON application that you
9 prepared?
10 Do you have that in front of you?
11 A. (Chafin) Page 74, yes.
12 Q. (Tucci) In particular I want to direct your
13 attention to applicant table twelve.
14 Do you have that handy?
15 A. (Chafin) I do.
16 Q. (Tucci) So with respect to just identifying
17 applicant table twelve, this shows the
18 utilization rates for existing inpatient
19 rehabilitation facility providers throughout
20 the state of Connecticut. Correct?
21 A. (Chafin) I wouldn't say it that way. It
22 shows the occupancy rate. I would just
23 clarify that it shows the occupancy rate for
24 each provider, yes.
25 I mean, we're interchanging utilization

1 and occupancy. I just wanted to be clear
2 that it's the occupancy rate, yes.
3 Q. (Tucci) Applicant table 12, please tell me if
4 I have not read correctly what your CON
5 application says. It says, utilization of
6 existing inpatient rehab providers, dash,
7 Connecticut. Correct?
8 A. (Chafin) That's correct, and the conclusion
9 is the occupancy rate, yes. (Unintelligible)
10 You're saying the same thing. I've just
11 talked about the use rates previously, so I
12 wanted to be clear that we're focused on
13 occupancy of units now.
14 Q. (Tucci) So taking Danbury Hospital which is
15 at the top of the table twelve chart, this
16 reflects actual data from fiscal year 2018.
17 Correct?
18 A. (Chafin) It actually is 2019 -- and I
19 apologize. That's a typo. You see how to
20 the right I've got FY '19 IRF average length
21 of stay, and then I did not even include the
22 full FY '19 on the far right column. So my
23 apologies, because it's not clear.
24 This is all FY '19 data.
25 Q. (Tucci) And so that's fine. So this reflects

1 actual experience for fiscal year 2019.
2 Correct?
3 A. (Chafin) That's correct.
4 Q. (Tucci) And I believe you said at one point
5 in your direct comments or direct testimony
6 that Danbury Hospital was full up. In fiscal
7 year 2019 Danbury Hospital's actual occupancy
8 rate of its licensed beds was 74 percent.
9 Correct, 74.1 percent?
10 A. (Chafin) That's correct. 94.4 percent of the
11 staff beds, but 74.1 percent of licensed.
12 That is correct.
13 Q. (Tucci) (Unintelligible) percent of licensed
14 beds and not 80 percent as recognized by the
15 state facilities plan as optimal occupancy.
16 Correct?
17 A. (Chafin) For licensed beds, that -- that is
18 correct. It was far beyond 80 percent for
19 staffed beds.
20 Q. (Tucci) Okay. And well, we know that based
21 on the actual data that you've included in
22 your chart for Danbury Hospital the actual
23 number of patients discharged into the
24 inpatient rehabilitation facility to receive
25 care was 272 cases. Correct?

1 A. (Chafin) That's correct.
2 Q. (Tucci) And when you talked to earlier, I
3 believe, in response to a question from the
4 Hearing Officer, that you are projecting that
5 Encompass will be referred from Danbury
6 Hospital a total of 117 patients in your
7 first full year of operation in 2024.
8 Correct?
9 A. (Chafin) That's correct. So those patients
10 would be in addition to what Danbury is
11 serving. That would help close that gap in
12 care, potentially.
13 Q. (Tucci) All right. And what data or chart
14 can you point me to that shows at any time in
15 the past three years Danbury Hospital has
16 referred 117 patients out of its facility
17 because it lacked bed capacity to provide
18 inpatient rehabilitation services.
19 MS. FUSCO: I'm going to object to the form. I don't
20 think that's the basis -- is the lack of available
21 bed capacity at Danbury Hospital --
22 (unintelligible).
23 THE HEARING OFFICER: I'm going to overrule the
24 objection, because that is a question of mine --
25 is how do we determine? You know bed need is key

1 here. So part of the bed need would be that
2 they're coming from Danbury. She earlier talked
3 about a 94 percent capacity rate filled.
4 So I'm going to allow the question.
5 THE WITNESS (Chafin): Would you repeat it, please?
6 BY MR. TUCCI:
7 Q. (Tucci) What I'm asking you is, what data or
8 chart can you provide us with that shows that
9 at any time in the past three calendar years
10 or at any time in the past Danbury Hospital
11 has found it necessary to refer 117 patients
12 to some other facility for inpatient
13 rehabilitation care because it did not have
14 enough capacity in its 14 licensed beds?
15 A. (Chafin) I do not have data that shows that
16 they have denied or not cared for the 117.
17 What I have data showing is that a
18 disproportionate number of patients in the
19 area known as SNF, and I have physician
20 letters referencing the need for patients to
21 receive inpatient rehab that have not.
22 But I cannot point you to the 117
23 because they're simply not getting the care
24 now. They're not being referred anywhere.
25 Q. (Tucci) How many physician letters do you

1 have?

2 A. (Chafin) There are -- I believe there are

3 three letters, and then a brain injury

4 letter. So I would say four providers, but

5 three physician letters.

6 Q. (Tucci) And according to your projections you

7 expect 8 percent of your total patient census

8 to come from physicians. Correct, physician

9 referrals?

10 A. (Chafin) Well, I wouldn't agree with that

11 statement, because you're conflating the

12 physician and hospital referrals. There's

13 not a patient that is seen at an inpatient

14 rehab facility that does not have a physician

15 referral.

16 So even if they come from the hospital,

17 it is through a physician.

18 Q. (Tucci) I apologize for my lack of clarity.

19 Your own projections project that of the 40

20 beds that you proposed will be occupied in

21 this new facility, is my percentage correct

22 that you project 8 percent of that census

23 will come from physician office referrals?

24 MS. FUSCO: Can you point us to the chart, Attorney

25 Tucci, that you're referring to? Well, your

1 asking a specific question and percentages. We
2 would appreciate it -- for my benefit if I could
3 look at the chart while you're asking the
4 question.
5 THE HEARING OFFICER: We can, but she can first see if
6 she can answer the question?
7 THE WITNESS (Chafin): Yes. If you look at CON
8 page 710, the 8 percent represents patients who
9 come from physician offices rather than discharged
10 directly from the hospital.
11 BY MR. TUCCI:
12 Q. (Tucci) All right. So my memory is correct
13 then. Right?
14 A. (Chafin) That's correct, 8 percent come from
15 physician offices.
16 Q. (Tucci) All right. Now can I direct your
17 attention back to the table 12 included in
18 your CON response?
19 A. (Chafin) I'm there.
20 Q. (Tucci) In this chart what you're showing to
21 the Office of Healthcare Strategy are the --
22 it's the existing landscape in Connecticut
23 that shows who the inpatient rehab providers
24 are in the state, and what their experience
25 is for fiscal year 2019. Correct?

1 A. (Chafin) That's correct.
2 Q. (Tucci) All right. And looking at the column
3 titled, total staff type IP rehab beds, you
4 would agree with me that according to the
5 data you're reporting for the total number of
6 inpatient rehabilitation facilities
7 throughout the state of Connecticut, there
8 are 159 staffed IP rehab beds. Correct?
9 A. (Chafin) That is correct. And just for
10 clarification of the record, you said what
11 I'm reporting. I am summarizing in this
12 table what came from the hospitals'
13 reports -- but yes, it's 159 from seven
14 providers combined.
15 Q. (Tucci) Right. And for the seven providers
16 the total number of licensed beds is 167
17 throughout the state of Connecticut. Right?
18 A. (Chafin) That is correct, based on the
19 hospitals reporting, yes.
20 Q. (Tucci) And the experience, actual experience
21 that's recorded in your table twelve chart
22 for the fiscal year of 2019 with respect to
23 the occupancy of those 167 beds throughout
24 the state of Connecticut is 68.8 percent.
25 Correct?

1 A. (Chafin) That is correct, and that's why
2 again I keep talking about the gap in care,
3 historical versus what I think it should
4 be -- but that 68.8 percent is based on FY
5 '19.
6 Q. (Tucci) So we know in 2019 there were 167
7 total available licensed beds in the state of
8 Connecticut. Right?
9 A. (Chafin) That is correct, with 14 of those
10 within the geographic defined service area.
11 Q. (Tucci) And the seven providers existing in
12 the state of Connecticut managed to fill up
13 approximately 68 percent of their beds.
14 Right?
15 A. (Chafin) That is what their utilization was.
16 That is correct.
17 Q. (Tucci) All right. Now we spent some time
18 earlier talking about the geographic area in
19 central Connecticut, and you identify as one
20 of the existing providers Mount Sinai Rehab
21 Hospital, which is located in Hartford.
22 Correct?
23 A. (Chafin) Yes. (Unintelligible.)
24 Q. (Tucci) I'm sorry?
25 A. (Chafin) Yes. That is a freestanding IRF.

1 Q. (Tucci) And Mount Sinai has 60 licensed beds
2 and 60 staffed beds, at least it reported
3 that in fiscal year 2019. Correct?
4 A. (Chafin) Yes, that just for the record, to be
5 responsive to your question, that data, they
6 don't report their long 400 to OHS.
7 I went to a different source which is
8 noted in the table AHD, American Hospital
9 Directory. And that is what was provided
10 there. They would not have a difference in
11 staffed versus licensed in that report as you
12 do in Connecticut.
13 Q. (Tucci) And according to the data you found
14 and reported to OHS in the applicant table
15 twelve that you have presented, Mount Sinai's
16 actual experience in fiscal year 2019 with
17 respect to its ability to fill up the 60 beds
18 in it's freestanding facility has showed an
19 actual experience of a 55.3 percent occupancy
20 rate.
21 Correct?
22 A. (Chafin) Based on their data, yes, that's
23 correct.
24 Q. (Tucci) And you'd agree with me that Mount
25 Sinai is located in Central Connecticut?

1 A. (Chafin) It's in Hartford, a fair distance
2 from the proposed project in Danbury, but it
3 is in Central Connecticut.
4 Q. (Tucci) About 60 miles away. Isn't it?
5 A. (Chafin) You cut out at the beginning.
6 Q. (Tucci) In fact, it's 60 miles away from
7 where you propose to build this new hospital?
8 Right?
9 A. (Chafin) It's over an hour drive, so that --
10 that sounds right.
11 Q. (Tucci) Now I believe it was your testimony,
12 but if not, it was one of the other
13 witnesses -- you've talked about how in terms
14 of the state-of-the-art care at this proposed
15 facility and returning people to
16 functionality, the worst outcome would be a
17 situation where you had a patient in
18 inpatient care for rehabilitation services
19 and then they had to go back to the
20 acute-care hospital if they were discharged.
21 That's a less than optimal result.
22 Would you agree?
23 A. (Chafin) A readmission following discharge
24 from IRF is not desirable.
25 Q. (Tucci) All right. Could you go, please, to

1 page 32 of your CON materials?
2 A. (Chafin) I'm there.
3 Q. (Tucci) All right. And I believe this is a
4 chart that you put up. Do you have it
5 available?
6 A. (Chafin) Yes.
7 Q. (Tucci) I don't believe we have it available
8 unless you want to wait a few minutes. It's
9 CON page 32.
10 A. (Chafin) I have it front of me. I don't know
11 if you want it on screen or not.
12 Q. (Tucci) We don't need to wait. So this is a
13 chart that you prepared to show sort of what
14 encompasses national experiences in terms of,
15 you know, where patients end up. Correct?
16 A. (Chafin) I would not agree with the
17 characterization of it. I did not prepare
18 it. This actually comes from an Encompass
19 annual report.
20 And I -- I know you'll continue asking
21 me questions. I probably am not going to be
22 the best person to address it, but it is
23 addressing quality of care. It is Encompass
24 national data, and I did put it in the CON
25 application.

1 Q. (Tucci) National data that Encompass reports
2 from its own experiences that for Q4 2019 and
3 Q1 2020 with respect to that category of
4 patients that had treated who had to be
5 discharged back to an acute-care hospital;
6 that's just over 10 percent for both years.
7 Correct?
8 A. (Chafin) That's what's shown in the chart,
9 yes.
10 Dr. Charbonneau would be better to
11 address that.
12 Q. (Tucci) I want to ask you about statistics.
13 I want to do some math here. Not my favorite
14 subject, but we'll get through it. So let's
15 now go to page 68 of the CON table 10.
16 A. (Chafin) I'm there.
17 Q. (Tucci) And this is -- this shows the payer
18 mix projections for the total Number of
19 patients that Encompass projects it will
20 treat for fiscal year, for various fiscal
21 years.
22 Correct?
23 A. (Chafin) That is correct.
24 Q. (Tucci) And if we focus on year one, which is
25 your fiscal year 2024 projection, do you see

1 that?

2 A. (Chafin) I do.

3 Q. (Tucci) Your projection is that the Encompass

4 Danbury facility will treat a total of 623

5 patients?

6 A. (Chafin) That is correct.

7 Q. (Tucci) So applying Encompass' national

8 experience to your projection of 623 patients

9 we then reasonably expect that approximately

10 62 patients who were housed at the inpatient

11 rehab facility that is proposed to be built,

12 they have to go back to a acute-care

13 hospital.

14 Correct?

15 A. (Chafin) Mathematically you are correct.

16 Dr. Charbonneau is better positioned to talk

17 about the current discharge to acute care, if

18 it's the same or lower and any reasons why,

19 but I totally agree with your math.

20 Ten percent of 620 -- 623 is seeking

21 connections.

22 Q. (Tucci) Back to an acute-care hospital

23 because they need care that can't be provided

24 in an inpatient rehabilitation facility.

25 Right?

1 A. (Chafin) This is following discharge. So
2 again, Dr. Charbonneau is the best person
3 because that is -- it can have other medical
4 morbidities -- that you're outside my lane on
5 the clinical reasons, that I am not the right
6 person.
7 Q. (Tucci) I'm not outside your lane with
8 respect to the geography. And you would
9 agree with me that the closest acute-care
10 general hospital to the facility that's being
11 proposed here is Danbury Hospital, which is
12 four and half miles away. Correct?
13 A. (Chafin) That's correct. That's the closest
14 hospital.
15 Q. (Tucci) Could you now please turn your
16 attention to the January 8, 2021,
17 completeness question response that was
18 submitted on behalf of Encompass? And I'll
19 give you a page reference in a moment.
20 I direct your attention to page 00522?
21 A. (Chafin) Page 522?
22 Q. (Tucci) Yes.
23 A. (Chafin) Okay. I'm there.
24 Q. (Tucci) And in particular I'm just asking you
25 to focus on the question that Office of

1 Healthcare Strategy asked with respect to an
2 explanation concerning the projection that
3 90 percent of the proposed facilities'
4 rehabilitation volume referrals will come
5 from acute-care hospitals.
6 Do you see that, question number two?
7 A. (Chafin) I see that question, yes.
8 Q. (Tucci) And as part of the response to that
9 question, that goes to the chart that we
10 spent some time looking at where you list the
11 various hospitals and the projected referrals
12 for those hospitals. Correct?
13 A. (Chafin) That's correct, and I believe I have
14 several caveats in that response where I
15 talked about estimated and mathematical
16 exercise -- but yes.
17 Q. (Tucci) Right. And in response to question
18 2C asked by the Office of Healthcare Strategy
19 about the ability of the Applicant to
20 quantify the referral volume from each of the
21 ten hospitals listed in the chart that we
22 just looked at, the response that you
23 prepared reads in part, quote, it is
24 impossible to immediately quantify the
25 referral volume expected from each referring

1 hospital because referral patterns are driven
2 by a number of factors and so on.
3 That's what you reported to OHS in
4 response to that question. Correct?
5 A. (Chafin) Correct, including the individual
6 patient's needs and circumstances, the
7 physicians patient mix, et cetera, as you see
8 there on page 522.
9 THE HEARING OFFICER: Attorney Tucci, do you have an
10 estimate on how long you have with questions?
11 MR. TUCCI: Five minutes, ten minutes.
12 THE HEARING OFFICER: Okay.
13 BY MR. TUCCI:
14 Q. (Tucci) Can we now go to table two in your
15 CON materials? And this is in page 14.
16 A. (Chafin) I'm there.
17 Q. (Tucci) Help me make sure I understand what's
18 being depicted in applicant table two.
19 This is data for 2018. Is that correct?
20 A. (Chafin) That is correct. I presented 2019
21 earlier today, but you have 2018 on page CON
22 14, yes.
23 Q. (Tucci) Right. And this is data that shows
24 actual utilization in the area of Western
25 Connecticut which you have defined as

1 Fairfield County and Litchfield County per
2 1,000 discharges. Is that correct?
3 A. (Chafin) That is correct. It's for residents
4 who live in those two counties per 1,000
5 where they went -- I'm sorry, the utilization
6 and how they went to, to your point, either
7 inpatient rehab or general acute care.
8 Q. (Tucci) Actual data for Western Connecticut
9 shows is that for Fairfield and Litchfield
10 County combined there were a total of seven
11 cases for postacute care services in
12 Fairfield County and four per 1,000?
13 A. (Chafin) That is correct. I want the record
14 to be a little bit clearer if I can be
15 responsive to your question by saying -- by
16 saying that, yes, it's -- for residents in
17 Fairfield County there were 7 discharges to
18 inpatient rehab facilities, 7 discharges per
19 1,000 Medicare fee-for-service beneficiaries.
20 Four IRF discharges per 1,000 Medicare
21 fee-for-service discharges for Litchfield
22 County residents.
23 Q. (Tucci) And you also report there that the
24 actual experience across Connecticut as an
25 average is that the actual performance rate,

1 if you will, is a discharge of five patients
2 per 1,000 Medicare fee-for-service patients.
3 Correct?
4 A. (Chafin) Correct, which is why I mentioned
5 it's among the lowest in the nation.
6 Q. (Tucci) And in order to make your bed-need
7 methodology that you went through in some
8 detail in your direct testimony uses as the
9 multiplier for the expected level of
10 discharges per 1,000 Medicaid fee-for-service
11 patients the 75th percentile of the national
12 rate of 13 per 1,000 discharges. Correct?
13 A. (Chafin) That's correct. That is
14 (unintelligible) --
15 Q. (Tucci) Go ahead.
16 A. (Chafin) That's the fine.
17 Q. (Tucci) Not the national average of eleven.
18 Correct?
19 A. (Chafin) That's correct. And the reason that
20 it is --
21 Q. (Tucci) And not the Connecticut average of
22 five.
23 Correct?
24 A. (Chafin) That's correct. I would not use the
25 national average of five when I know that

1 there is no reason for Connecticut to have
2 such a low, a disproportionately low IRF rate
3 when, for example, you compared it to the
4 benchmark of general acute care.
5 Q. (Tucci) And inside of your prefiled
6 testimony, I believe you state -- and you can
7 refer to it to make sure I'm reading it
8 correctly. Quote, residents in Western
9 Connecticut with too few IRF beds have IRF
10 utilization rates significantly below that of
11 the U.S. national average?
12 A. (Chafin) What page are you on? I'm sorry.
13 Q. (Tucci) Page 5 of your prefiled testimony?
14 A. (Chafin) That is correct. The
15 full utilization rate is reflective of too
16 few beds and the physician letters echo that
17 or expound on that.
18 Q. (Tucci) Can you please put up for us the
19 chart that you showed earlier which is the
20 figurative representation of utilization in
21 Fairfield and Litchfield Counties? I believe
22 it's figure 3 on page 17.
23 The chart, that's it.
24 So this chart shows what you've plotted
25 out as the experience in Fairfield and

1 Litchfield County, and then the Connecticut
2 average. And I want to focus on the years 27
3 through 2011. Do you see those years?
4 A. (Chafin) I do.
5 Q. (Tucci) You're showing a national average of
6 eleven. So that's 11 cases per 1,000
7 Medicare fee-for-service beneficiaries.
8 Right? Eleven per 1,000 get IRF care.
9 Right?
10 A. (Chafin) That is correct.
11 Q. (Tucci) And it shows that for Fairfield
12 County for 2007 through 2011, that for
13 Fairfield County the residents in that county
14 were operating at just a little bit under the
15 national average showing 10 patients per
16 1,000 Medicare fee-for-service beneficiaries
17 receiving IRF care. Correct?
18 A. (Chafin) That is correct.
19 Q. (Tucci) Are you aware of whether there were
20 any more beds in the IRF, licensed beds in
21 Connecticut in 2007 through 2011 than there
22 are today?
23 A. (Chafin) My understanding is that I think
24 Bridgeport consolidated and moved beds. And
25 if understanding is correct, then that really

1 makes my point that when you don't have the
2 local available accessible IRF beds then that
3 utilization drops.
4 And that's why our position is that you
5 have such low utilization. It is
6 illustrative and documents that there are too
7 few beds. If the beds aren't there the
8 patients will not be able to access them or
9 use them.
10 Danbury's own physician talks about
11 proximity in patients choosing SNF over IRF,
12 because of closeness. So my understanding is
13 that there was consolidation and closure of
14 beds in Fairfield County.
15 Q. (Tucci) What data have you presented about
16 closure of beds in Fairfield County in 2007,
17 2008, 2009 or 2010?
18 A. (Chafin) I did not go back and talk about the
19 closure of beds to change the utilization
20 pattern from ten to where it is now at seven.
21 Q. (Tucci) So with respect to the table you've
22 presented, sort of the mathematical bed-need
23 protection that you did, you, in order to
24 satisfy yourself and Encompass that there was
25 a sufficient need to add 40 additional beds

1 to the Western Connecticut service area, you
2 have adopted what you have discussed as a
3 population-based methodology. Correct?
4 A. (Chafin) I would take issue with the -- the
5 characterization of satisfying myself, but I
6 have used a population-based methodology.
7 That's correct. That was conducted in
8 multiple states.
9 Q. (Tucci) And that's the methodology that is
10 reflected in the calculations you performed
11 in table three. Correct?
12 A. (Chafin) Yes, which is CON page 23 for the
13 record.
14 Q. (Tucci) And you indicate in your prefiled
15 testimony that this population-based
16 methodology formula that you're using has
17 been approved in several states, Connecticut
18 not being among the states you've listed.
19 Right?
20 A. (Chafin) That's correct, and I do not believe
21 that there's been an application in
22 Connecticut. So there has not been an
23 approval, nor to my knowledge has there been
24 a denial either. This, this presentation of
25 table three I believe is new.

1 Q. (Tucci) In fact I believe, if I heard you
2 correctly in your direct testimony, you've
3 made quite clear that the methodology that
4 Encompass Health is using it it's CON, quote,
5 differs fundamentally from the OHS
6 methodology.
7 Those are the words you used. Correct?
8 A. (Chafin) Of course, because what I'm looking
9 at is to close a gap in care, and what OHS
10 has for the state health plan mathematically
11 is to look at the historical utilization. So
12 either you accept status quo, which is what
13 OHS's methodology is based on, or you
14 recognize a gap in care, which is what my
15 methodology is based on. So because of that
16 there is a fundamental difference.
17 Q. (Tucci) I'm going to talk now about the
18 commentary that you have made during your
19 remarks today and in your prefiled testimony
20 concerning patients who are receiving
21 suboptimal care because they are being housed
22 in skilled nursing facilities. In
23 particular, I want to direct your attention
24 to your prefiled testimony on page 2.
25 A. (Chafin) Page what? I'm sorry.

1 **MS. FUSCO: Which page? Page 2? Sorry, can't hear**
2 **you.**
3 **MR. TUCCI: It's all right. Page two.**
4 **BY MR. TUCCI:**
5 **Q. (Tucci) Now you see the sentence that you've**
6 **written there beginning, the service area?**
7 **A. (Chafin) I did see that.**
8 **Q. (Tucci) And you say, quote, the service**
9 **area -- and there you're referring to the**
10 **proposed 52 ZIP code Western Connecticut**
11 **service area?**
12 **A. (Chafin) That is correct.**
13 **Q. (Tucci) This area has a substantial deficit**
14 **of inpatient rehabilitation beds, comma,**
15 **which is leading to many patients who qualify**
16 **for this level of care receiving suboptimal**
17 **care at skilled nursing facilities.**
18 **Have I read that correctly?**
19 **A. (Chafin) You have read it correctly, yes.**
20 **Q. (Tucci) And now would you please turn your**
21 **attention to Encompass' response, 2020**
22 **response, completeness question response.**
23 **And I'm referring to the October 16, 2020,**
24 **response.**
25 **And let me direct your attention to page**

1 486.

2 A. (Chafin) Page what?

3 Q. (Tucci) Four-eighty-six.

4 A. (Chafin) Okay.

5 Q. (Tucci) And here on the Office of Healthcare
6 Strategy is asking a question about the
7 ability to quantify the number or percentage
8 of patients in various categories, including
9 the category of those patients who are
10 receiving care in a skilled nursing facility
11 that you identify as being more properly
12 patients who should be getting IRF care.
13 That's the gist of the question that OHS was
14 looking for information on. Correct?

15 A. (Chafin) Let me read it, please.
16 Yes, I would agree with your statement.

17 Q. (Tucci) And in providing a response to this
18 question Encompass has agreed in essence that
19 there is really no reliable way to quantify
20 the number of patients who purportedly are in
21 SNF care who should, in Encompass' view, be
22 receiving IRF care. Correct?

23 A. (Chafin) I would agree with that to the
24 extent that I don't have a database I can
25 point to. The physicians talk about their

1 experience, but we've not quantified that.
2 Q. (Tucci) (Unintelligible) -- you have what?
3 The three doctors that you have letters from?
4 A. (Chafin) I'm sorry. I could not hear you.
5 Q. (Tucci) The three doctors that you have
6 letters from, that's what you're talking
7 about?
8 A. (Chafin) Yes, that represent large groups and
9 multiple physicians.
10 Q. (Tucci) To be specific, the response that
11 Encompass has given to OHS on this topic of
12 what percentage or number of patients who are
13 in the category of getting care at skilled
14 nursing facilities, which you say is being
15 utilized higher than the national average.
16 Your answer is, quote, the extent to
17 which patients will be referred from general
18 acute-care hospitals to Encompass Danbury
19 instead of to each of the aforementioned
20 categories, which includes SNF, quote, is not
21 quantifiable, end quote. Correct?
22 A. (Chafin) That is correct. And to be
23 responsive to your question when you're
24 talking about (unintelligible) reportedly
25 talking about the SNF patients. That's not

1 my data. That's CMS data, and Connecticut
2 and Western Connecticut are significantly
3 above the national average.
4 So I do take issue with it's not my
5 data. It's the fact of the matter, and it's
6 140 percent for Fairfield and Litchfield
7 County, disproportionately high to SNF and
8 disproportionately low to IRF.
9 MR. TUCCI: Appreciate your time.
10 THE HEARING OFFICER: Is that your cross?
11 MR. TUCCI: Yes, it is.
12 THE HEARING OFFICER: Okay. Redirect?
13 MS. FUSCO: Yeah -- (unintelligible).
14 So if you could just give me one second to
15 read (unintelligible).
16 Okay. I'm sorry about that. I just have a
17 few questions, very few questions bringing you
18 back, Ms. Chafin, to those initial questions about
19 transfer agreements.
20
21 REDIRECT EXAMINATION (of Chafin)
22
23 BY MS. FUSCO:
24 Q. (Fusco) Can you explain again for Attorney
25 Yandow and OHS staff just so it's clear what

1 a transfer agreement is and which patients it
2 pertains to?
3 A. (Chafin) Yes, the transfer agreement is
4 distinct from a referral into the inpatient
5 rehab facility. A transfer agreement is for
6 an existing provider who is offering service
7 and has an existing patient, and that patient
8 needs to be transferred to a general
9 acute-care hospital.
10 Q. (Fusco) Okay. So a transfer agreement
11 doesn't have anything to do with referring
12 patients into an IRF or IRF services.
13 Correct?
14 A. (Chafin) That's correct, which is why the
15 transfer agreement is not developed now. It
16 would only be established once the project is
17 under construction.
18 MS. FUSCO: All right. I have no further questions.
19 That's it. Thank you.
20 THE HEARING OFFICER: Okay. Thank you.
21 Attorney Tucci, do you have cross of the
22 other witnesses?
23 MR. TUCCI: No. Thank you very much.
24 THE HEARING OFFICER: No? Okay. So that the
25 witnesses, I would like them to -- they're not

1 excused, because we do have questions from OHS
2 coming later on. We do want to get through the
3 intervener before OHS asks its questions, because
4 we certainly don't want to be repetitive.
5 Okay. So that, we are done then with the
6 Applicant's evidence. I appreciate everyone's
7 time on that. So for the Intervenor, Attorney
8 Tucci, are you the one, still the lead here?
9 MR. TUCCI: It's still me.
10 THE HEARING OFFICER: Okay. I had three appearances,
11 so I just, you know.
12 Okay. We'll start with an opening, an
13 opening argument.
14 MR. TUCCI: Yes. Thank you very much. On behalf of
15 the Intervener, Danbury Hospital, this is Ted
16 Tucci. And first of all, let me just express our
17 appreciation on behalf of Danbury Hospital for the
18 opportunity to participate in these proceedings,
19 and also this year Danbury Hospital's perspective
20 as the sole provider of inpatient rehabilitation
21 services in the Danbury service area with respect
22 to this proposal.
23 Now to be clear, what we're talking about
24 here is an application by Encompass Health to
25 build a brand-new hospital at an estimated cost of

1 just under $39 million in order to bring 40 new
2 beds into the Western Connecticut service area.
3 And if you look at that proposal, it doesn't
4 take too much math fill to determine that that is
5 a cost of about $977,000 per bed.
6 In Danbury's Hospital view, and what you'll
7 hear from the witnesses today, is that this
8 application represents a classic example of a
9 proposed solution in search of a problem that
10 doesn't exist. Stating very simply, Encompass'
11 repeated statements over and over and over again,
12 no matter how much they say them, that there's a
13 gap in care for Western Connecticut and
14 Connecticut residents simply does not exist. It's
15 nothing more than an illusion.
16 The Applicants ask the Office of Healthcare
17 Strategy to believe that they're uniquely suited
18 to meet the anticipated future need for more IRF
19 bed capacity in the service area, but that simply
20 isn't the case.
21 You're going to hear from Sharon Adams, who's
22 the President of Danbury Hospital, that Danbury
23 Hospital which has an existing IRF facility of 14
24 beds, has more than ample financial resources and
25 also the capacity to expand its existing 14-bed

1 unit to accommodate any reasonable anticipated
2 growth in demand as a result of aging population
3 in the service area, or in Connecticut in general.
4 The Applicants ask OHS to believe that
5 existing providers of intensive rehabilitation
6 services in Connecticut like Danbury Hospital
7 focused on a limited number of clinical
8 conditions. That simply is not correct.
9 You're going to hear from Dr. Beth Aaronson,
10 who is the Medical Director of the Inpatient
11 Rehabilitation Unit at Danbury Hospital and who
12 has 27 years of experience caring for patients in
13 her hospital that Danbury Hospital has a full
14 complement of care specialists and a full array of
15 equipment and services to provide comprehensive
16 therapeutic services that address all of the
17 impairment diagnosis that you would expect for
18 rehabilitation services.
19 The Applicant asks OHS to believe that the
20 reason that Connecticut's average utilization
21 rates for inpatient rehabilitation are less than
22 the national average or should be at some target
23 percentage of 13 is because patients who want or
24 need inpatient rehabilitation care simply can't
25 get a bed anywhere in the state of Connecticut.

1 That is simply not correct. We've already seen it
2 from the data that the Applicant has -- itself has
3 provided.
4 But more than that you'll actually hear from
5 somebody who has boots on the ground experience.
6 You'll hear testimony from Dr. Aparna Oltikar
7 who's a board-certified internal medicine doctor
8 and who practices hospital medicine at Danbury
9 Hospital, and she'll testify that Danbury Hospital
10 has adequate bed capacity to meet her patient's
11 needs when she needs to refer them for inpatient
12 rehabilitation care, and that her actual
13 experience in the service area as a doctor who
14 treats patients is much more reliable than
15 national statistics.
16 When all the evidence is in, Danbury Hospital
17 is going to ask OHS to conclude that this is a
18 costly proposal to add capacity for
19 un-demonstrated need, and it fails to satisfy the
20 CON requirements, and frankly represents a bad
21 healthcare public policy choice to the citizens of
22 the State of Connecticut. Thank you.
23 THE HEARING OFFICER: All right. Attorney Tucci, your
24 witnesses today -- I know we have three of the
25 prefiled. If you could state their names for me?

1 MR. TUCCI: Yes, so the first witness who will be
2 offering testimony is Sharon Adams, last name
3 A-d-a-m-s.
4 Hearing Officer Yandow, you will then hear
5 from Dr. Beth Aaronson, capital A-a-r-o-n-s-o-n.
6 And then finally our presentation will
7 conclude with testimony from Dr. Aparna Oltikar,
8 O-l-t-i-k-a-r.
9 THE HEARING OFFICER: Are they there with you? Or are
10 they each separately out on remote?
11 MR. TUCCI: They should be coming on now. You see the
12 Danbury Hospital indicator on the screen.
13 SHARON ADAMS: Hi, I'm Sharon Adams.
14 S H A R O N A D A M S,
15 called as a witness, being first duly sworn by the
16 HEARING OFFICER, was examined and testified under
17 oath as follows:
18
19 THE HEARING OFFICER: Do you adopt the testimony, the
20 prefiled testimony that's dated October 27, 2021?
21 THE WITNESS (Adams): I do.
22 THE HEARING OFFICER: And again, could you state your
23 name for the record?
24 THE WITNESS (Adams): Sharon Adams, A-d-a-m-s.
25 THE HEARING OFFICER: Okay. All right. Attorney

1 Tucci, we do have the prefile. We have gone
2 through. We've read it. So I don't know if your
3 presentation is for her to reread her prefile, or
4 anything brief.
5 MR. TUCCI: No, I think I can clarify. Consistent with
6 my earlier remarks we anticipate that our total
7 presentation time would take about 15 minutes, and
8 the intent of our witnesses is to provide a very
9 high level summary to add color and flavor to
10 their prefiled testimony, rather than simply
11 rereading what's already there.
12 THE HEARING OFFICER: Okay. I would appreciate that,
13 because we do have it and we do read it. We go
14 through everything with a fine-toothed comb. So
15 with this witness, since we have Ms. Adams on, do
16 you have some follow-up questions? Or do you want
17 her to make some sort of statement?
18 MR. TUCCI: Ms. Adams is prepared to provide a very
19 high level summary of the information that she'd
20 like to communicate to you right now.
21 THE HEARING OFFICER: Okay. Thank you. You can go
22 ahead.
23 THE WITNESS (Adams): Thank you. Good afternoon,
24 Hearing Officer Yandow and staff of the Office of
25 Health Strategy. First, let me thank you for

1 allowing me to testify today. As I've said, my
2 name is Sharon Adams.
3 Danbury Hospital currently operates a 14-bed
4 inpatient rehabilitation unit that is physically
5 integrated into Danbury Hospital. And you've
6 heard it's clinically integrated with Nuvance's
7 Health System. It does maintain an approximate
8 average daily census of 11.
9 For over 35 years the inpatient
10 rehabilitation clinical team has been providing
11 comprehensive health care, quality care that meets
12 the needs and preferences of our patients and
13 families within the Danbury community.
14 Throughout these years the physician's
15 clinical teams alongside patients and families
16 have been determining what is the best place for
17 that transition in care that, not only meets the
18 patient's clinical, functional needs and
19 psychosocial needs, but also keeping in mind the
20 patient's and family's preference.
21 We are committed to providing that high
22 quality and cost effective inpatient
23 rehabilitation care as the component of the full
24 continuum that you've heard that we provide
25 throughout Nuvance Health included the extended

1 rehab care, the outpatient rehab and physical
2 medicine, as well as a very complex home care.
3 A proposal to spend nearly $39 million to add
4 40 new inpatient rehab beds to the Danbury service
5 area is not justified from a quality of care or a
6 cost perspective, especially at a time now when we
7 are so focused intently on controlling the cost of
8 delivering high quality care as well as a
9 challenge with the national and statewide
10 healthcare worker shortage.
11 A proposal to build a new freestanding
12 hospital that triples capacity in a service area
13 all at once is not a responsible choice.
14 When the need for expanded capacity to
15 provide inpatient rehabilitation arises, we have
16 those resources and capacity to grow our unit in a
17 responsible and a cost-effective way to meet our
18 patient communities.
19 And why should it not be Danbury Hospital?
20 We've been providing those cares for 35 years.
21 We've been the one meeting the community needs for
22 all those years.
23 Furthermore, it's important to point out that
24 Applicant's projection of volume to fill up the 40
25 beds of the new hospital do not reflect the actual

1 utilization that's been the experience that we've
2 been experiencing throughout the service area, and
3 they do rely heavily on the Nuvance health
4 referrals.
5 In my view as someone with years of clinical
6 and executive experience in health care, relying
7 solely on national averages for inpatient
8 rehabilitation utilization cannot justify that
9 need, let alone account for the characteristics of
10 the circumstances affecting the Danbury service
11 area.
12 Finally, as you've heard the proposal
13 threatens the stability of Danbury Hospital as the
14 existing nonprofit provider for inpatient
15 rehabilitation services in the area. The
16 Applicant believes that adding 40 new inpatient
17 rehab beds approximately four miles away will not
18 take away existing patient volume from our
19 hospital. That is not realistic.
20 As a nonprofit hospital Danbury Hospital has
21 been proud to meet the healthcare needs of the
22 community residents regardless of our ability to
23 pay. The proposal here is geared toward capturing
24 the higher generating cases in our service areas,
25 which will adversely affect Danbury Hospital,

1 therefore impacting our most vulnerable patients
2 and their families who rely on Danbury Hospital's
3 doors to remain open to them.
4 On behalf of Danbury Hospital, I respectfully
5 ask the Office of Health Strategy to reject this
6 application because there is no need for it and it
7 is not in the best interests of our patients in
8 Western Connecticut.
9 Thank you for the opportunity.
10 THE HEARING OFFICER: Thank you. Attorney Tucci, your
11 next witness, please?
12 MR. TUCCI: Hearing Officer Yandow, I now ask
13 Dr. Aaronson to come to the microphone.
14 THE HEARING OFFICER: All right. Dr. Aaronson, Hi I'm
15 Joanne Yandow. I'm the Hearing Officer in this
16 matter.
17 Could you raise your right hand, please? I'm
18 going to swear you in. Do you solemnly swear the
19 testimony you're about to give in this matter,
20 along with the prefiled testimony you filed on
21 October 27, 2021, is the truth the whole truth and
22 nothing but the truth so help you god?
23 BETH AARONSON: Yes.
24
25

1 B E T H A A R O N S O N,
2 called as a witness, being first duly sworn by the
3 HEARING OFFICER, was examined and testified under
4 oath as follows:
5
6 THE HEARING OFFICER: And do you adopt the testimony
7 that was the prefiled testimony that you signed
8 and filed?
9 THE WITNESS (Aaronson): Yes, I do.
10 THE HEARING OFFICER: Okay. Thank you. Attorney
11 Tucci, do you have questions, or is there a
12 presentation?
13 MR. TUCCI: So again, thank you Hearing Officer Yandow.
14 Dr. Aaronson is prepared to deliver a summary
15 of her remarks and testimony.
16 THE HEARING OFFICER: You can go ahead, Dr. Aaronson.
17 THE WITNESS (Aaronson): Thank you, Hearing Officer
18 Yandow and staff of the Office of Health Strategy
19 for allowing me to testify today. My name is Beth
20 Aaronson and I am the Medical Director of the
21 Inpatient Rehabilitation Unit at Danbury Hospital.
22 I adopt my prefiled testimony for the record.
23 Let me start by saying that the Danbury
24 Hospital rehabilitation units already provides
25 high quality intensive level rehabilitation. We

1 have a 14-bed unit. We have an extremely
2 dedicated staff with very low turnover. That's
3 one of the major reasons I've been at Danbury
4 Hospital for 27 years.
5 On the rehab unit we provide individualized
6 and patient-centered as well as family-centered
7 care. We spend time training and educating family
8 regarding patients' care needs.
9 We have the full complement of rehab
10 services. We have certified rehab nurses,
11 physical therapists, occupational therapists,
12 speech therapists, cognitive therapy, recreational
13 therapy, social workers and discharge planners.
14 Our census can be variable and is directly
15 related to hospital census. We rarely have a
16 waiting list or need to turn patients away.
17 Patients rarely have to leave the area for
18 specialty rehab care.
19 We're capable of handling a multitude of
20 diagnoses from strokes, spinal cord injuries,
21 amputations, multi-trauma, brain injury,
22 cardiovascular disease, cancer rehabilitation --
23 one of my areas of expertise, pulmonary conditions
24 and fractures.
25 In fact, we and all other intensive rehab

1 facilities have to make sure we are compliant with
2 Medicare's 60 percent rule, where 60 percent of
3 patients need to have 1 of 13 qualifying
4 conditions.
5 About 10 percent of our patients come from
6 outside hospitals where they're used to returning
7 to their home community after a specialized
8 surgery, or major medical or surgical event when
9 they're out of town.
10 We've had patients as far from Europe as well
11 as Florida and Cape Cod. We have a nice referral
12 stream from Columbia Presbyterian as well as Yale
13 for patients who go there. For specialized
14 surgical procedures they know they can trust us as
15 their rehabilitation unit of choice.
16 We do get referrals from around the state.
17 Usually these referrals are patients with
18 specialized issues such as having an unsafe
19 discharge plan, major drug addition -- addiction
20 issues, or they were not accepted by any local
21 rehab unit due to lack of insurance or not
22 appropriate for intensive level rehab care.
23 Our patient satisfaction remains consistently
24 high. We recently received a very generous gift
25 from a patient who sustained a hip fracture and

1 had complications related to bleeding. He was
2 very grateful for the excellent nursing and
3 therapy care as well as the responsiveness of all
4 the staff members.
5 One of our roles in the hospital is to
6 function as a consultant to many patients in need
7 of rehabilitation services in the hospital
8 setting. We see patients very early on the
9 hospitalization station side, usually by day two
10 or three, and we get to know the patients and
11 their families and make recommendations to the
12 medical team regarding care and prevention of
13 complications. We help to educate the house staff
14 regarding the patient's needs.
15 We are not screeners just scouting for to
16 fill beds. Seeing patients early allows us to
17 detect subtle changes once in rehab rather than be
18 a complete unknown entity once they're transferred
19 to an outside rehab facility.
20 For an inpatient rehabilitation stay we have
21 to assess these patients carefully. First and
22 foremost, we consider their functional needs as
23 well as their medical needs. We determine, do
24 they need daily monitoring by a physician? Can
25 they tolerate the intensity of three hours of

1 therapy a day? We also determined, do they need
2 round-the-clock nursing, which is a requirement
3 also for intensive rehab, as opposed to skilled
4 nursing facility level of care.
5 We assess medical stability, tolerance for
6 three hours and an ability to fully participate
7 and make reasonable functional gains. If
8 someone's not going to be able to make the gains
9 and be able potentially to go home, then they may
10 not be appropriate for our level of rehabilitation
11 care.
12 We also review the patient's psychosocial
13 issues and resources as well. We help the patient
14 and the family decide the best level of rehab care
15 depending on the stage of their illness, their
16 tolerance for rehabilitation, as well as
17 recommendations from the referring or treating
18 care team players.
19 Geography is important. Patients and
20 families don't want to travel too far. Visitation
21 is extremely important and participating in the
22 patient's care, and to get training is also
23 extremely important. Sometimes patients will
24 actually forgo an intensive rehab unit opportunity
25 to get closer to home and stay at an extended care

1 facility as a result.
2 We are cautious regarding taking patients
3 that are functionally too good or medically
4 uncomplicated, or can be appropriately managed at
5 another level of care. These patients can
6 potentially be retrospectively denied by Medicare.
7 We work closely with hospitalists and
8 specialists. They are very conscientious in their
9 followup of our patients and in the comanagement
10 of these patients once on the rehab unit.
11 Our three greatest obstacles into regarding
12 filling beds are geography, insurance denials,
13 particularly managed Medicare, and regulatory
14 intervention with less and less patients being
15 approved for intensive rehab level care.
16 CMS has strict admission criteria. IRF
17 volume has dropped significantly over the past few
18 years due to regulatory interventions.
19 In the community it is rare for a physician
20 to leave their busy office to take care of
21 patients in outside facilities. I know this
22 firsthand, having done consultations at many of
23 the extended care facilities.
24 Because we work hand in hand with our
25 hospital doctors who already know our patients

1 well, our patients get the attention they need on
2 a timely basis. In conclusion, the rehab unit at
3 Danbury Hospital already provides optimal quality
4 rehabilitation care to patients in Danbury and the
5 surrounding communities.
6 You already meet the needs of the community
7 at large, both in the inpatient and outpatient
8 arenas. In my 27 years of experience, patients
9 rarely want to leave their community for rehab
10 care. As a rehab unit we help reduce length of
11 stay for the hospital; we reduce complications; we
12 provide ready access to hospital-related services
13 including radiology, internal medicine, surgery
14 and specialist care.
15 We're also mindful of the trend to decrease
16 healthcare costs and over utilization of
17 inappropriate levels of care. We help reduce
18 readmissions to the hospital and prevent
19 unnecessary ER visits by being hospital based. We
20 optimize the continuum of care by ready access to
21 the systemwide electronic health record and by
22 following patients from acute hospitalization to
23 rehab, to home.
24 We continue to stand poised and ready to
25 expand the unit as needed during the process of

1 hiring screeners in our affiliated hospitals with
2 their limited rehabilitation consultation services
3 which will help optimize census and continue to
4 provide care to those in need. Thank you.
5 THE HEARING OFFICER: Thank you.
6 Attorney Tucci, anything else of this
7 witness?
8 MR. TUCCI: No, Hearing Officer. That concludes
9 the (unintelligible) --
10 THE HEARING OFFICER: Okay. I do want the witnesses to
11 be ready. So Dr. Aaronson, and I hope Ms. Adams
12 is still around because there may be cross
13 examination. So I just wanted to make sure they
14 don't go too far. Okay.
15 And also there will be questioning from the
16 OHS team. So they need to be available.
17 Okay. Call your next witness, please?
18 MR. TUCCI: This is Dr. Aparna Oltikar. She's now on
19 screen, and let me introduce her to you, Hearing
20 Officer Yandow. And she will again provide you
21 with some high level commentary based on her
22 prefiled testimony.
23 THE HEARING OFFICER: Okay. Hello, Dr. Oltikar.
24 APARNA OLTIKAR: Hello, Hearing Officer Yandow. I'm
25 sorry. We just are logging back into this

1 computer. I apologize for the delay.
2 THE HEARING OFFICER: Oh, that's okay. I think we can
3 see you. We can hear you.
4 APARNA OLTIKAR: Okay.
5 THE HEARING OFFICER: I'm going to swear you in. Are
6 you ready?
7 APARNA OLTIKAR: I am. I am ready. Thank you.
8 THE HEARING OFFICER: Okay. Could you raise your right
9 hand, please?
10 Do you solemnly swear that the testimony
11 you're about to give in this matter along with the
12 prefiled testimony that you filed on October 27,
13 2021, is the truth, the whole truth and nothing
14 but the truth, so help you god?
15 APARNA OLTIKAR: I do.
16
17
18
19
20
21
22
23
24
25

1 **A P A R N A   O L T I K A R,**
2 **called as a witness, being first duly sworn by the**
3 **HEARING OFFICER, was examined and testified under**
4 **oath as follows:**
5
6 **THE HEARING OFFICER: And do you adapt the prefiled**
7 **testimony that was filed and in the record?**
8 **THE WITNESS (Oltikar): Yes, I do.**
9 **THE HEARING OFFICER: Okay great. So I understand you**
10 **have a small presentation; we've read the filed**
11 **testimony. And then when you're done, there may**
12 **be cross-examination. I just don't want you to go**
13 **too far.**
14 **THE WITNESS (Oltikar): So good afternoon, Hearing**
15 **Officer Yandow and staff of the Office of Health**
16 **Strategy, and thank you again for allowing me to**
17 **testify today.**
18 **So as I've stated, my name is Aparna Oltikar**
19 **and I am the Vice President of Medical Affairs and**
20 **the Chair of the Department of Medicine at Danbury**
21 **Hospital.**
22 **I have been practicing hospital medicine in**
23 **the state of Connecticut for 23 years, the past 13**
24 **of which have been at Danbury Hospital. I have**
25 **been the Chair of Medicine at Danbury Hospital for**

1 the past six years, and VPMA for almost two.
2 The purpose of my testimony today is twofold,
3 to share my experience as a practicing hospitalist
4 who has frequent interaction with the inpatient
5 rehab unit at Danbury Hospital, and to share my
6 experience as a senior clinical leader at Danbury
7 Hospital.
8 In my role as a hospitalist I am responsible
9 for discharging patients from the acute-care
10 setting to the next appropriate level of care
11 which based on the patient's medical condition and
12 needs can include inpatient rehab, subacute rehab
13 or home care services.
14 In my roles as Chair of Medicine and VPMA, I
15 am one of the key individuals at Danbury Hospital
16 responsible for managing our length of stay. To
17 do this effectively I must understand all barriers
18 to discharge being experienced, not only by my
19 personal patients, but by all patients admitted to
20 Danbury Hospital.
21 To gain this understanding I meet several
22 times a week with my chiefs of hospital medicine,
23 critical care medicine, et cetera. I regularly
24 attend multidisciplinary rounds on our inpatient
25 units, and I chair the hospital's utilization

1 review committee.

2 In my experience both as an extremely

3 experienced hospitalist in the state of

4 Connecticut and as a senior clinical leader at

5 Danbury Hospital bed availability is not the

6 primary barrier to patients who require discharge

7 to inpatient rehab in the Danbury Hospital service

8 area.

9 In my experience the most common reason for

10 patients at Danbury Hospital not having access to

11 inpatient rehab services after their discharge is

12 denial of coverage by the patient's insurance

13 company, or in other words, lack of prior

14 authorization.

15 In my experience, again both as a hospitalist

16 as -- and as a senior clinical leader, another

17 significant barrier to patients being discharged

18 to inpatient rehab is that they are not eligible

19 for these services based on their medical

20 condition. As you likely know, the average age in

21 Connecticut is much hot -- is higher,

22 significantly higher than the national average,

23 and with advancing age come multiple

24 comorbidities.

25 As a result, many of our patients at Danbury

1 Hospital are simply too sick and/or too frail at
2 the time of their discharge to tolerate the
3 intensity and duration of the multi model
4 rehabilitation services that they would need to
5 participate in on any inpatient rehab unit.
6 As a result, contrary to the Applicant's
7 projections, I do not feel it is realistic to
8 assume that in 2024 Danbury Hospital will generate
9 a referral volume of 117 eligible patients who
10 cannot get IR in our own unit.
11 I also have concerns about care disruption
12 and cost effectiveness if 40 new IR beds are added
13 to the Danbury Hospital Service area. Patients
14 who require inpatient rehab services after
15 discharge are generally medically complex, and in
16 my experience very frequently they require medical
17 and subspecialty consultation while they are
18 receiving inpatient rehab services to manage their
19 ongoing medical needs.
20 So you know, as a hospitalist, I'm often
21 called to consult on patients on the inpatient
22 rehab unit at Danbury Hospital to treat their
23 medical conditions. Given the real world demands
24 of medical practice, it is not realistic to assume
25 that treating physicians will be able to provide

1 on-site consultation services at a new facility
2 not connected to Danbury Hospital.
3 In other words, while the Applicant may have
4 an open model -- open medical staff model, it
5 seems unlikely that the majority of my hospitalist
6 and subspecialty colleagues will be able -- will
7 avail themselves of that model due to the
8 extraordinary pressures facing all clinicians
9 these days. This will be particularly true for
10 patients being referred from geographically more
11 distant hospitals in the proposed service area
12 such as Hartford and Bristol on which the
13 Applicant's volume projections are predicated.
14 As a result, it seems very probable or
15 possible that the Applicant's patients may not
16 have the level of on-site medical and subspecialty
17 followup that the complexity of their medical
18 condition demands.
19 The most likely end result of this will be
20 that the Danbury Hospital ED, which is the closest
21 ED to the proposed site, will become the safety
22 net for such patients in the event of clinical
23 decompensation. This will place a greater burden
24 on our ED which is already struggling with high
25 volumes, rising acuity and staffing shortages.

1 In conclusion, I would like to say that
2 Danbury Hospital serves its community by providing
3 all patients including the most vulnerable with
4 care across the clinical continuum. It is also
5 part of Nuvance Health, which is an evolving
6 integrated care network utilizing a common
7 electronic medical record, a network service line
8 approach and other initiatives to coordinate care
9 and adopt population health strategies.
10 Carving out IR services or inpatient rehab
11 services from this care continuum will potentially
12 compromise the quality and safety of patient care
13 and threaten the financial viability of Danbury
14 Hospital, which has been faithfully serving its
15 community as a safety net provider for over 100
16 years.
17 On behalf of Danbury Hospital I therefore
18 respectfully ask OHS to reject this application
19 which I do not believe will bring better or more
20 cost effective health care to Western Connecticut
21 residents. Thank you.
22 THE HEARING OFFICER: Attorney Tucci, anything else?
23 MR. TUCCI: Thank you. That concludes the presentation
24 on behalf of Danbury Hospital. Thank you very
25 much.

1 **THE HEARING OFFICER: Okay. You're welcome.**

2 **Okay. Attorney Fusco, I'll let you call them**
3 **in the order you want on cross-examination. I'll**
4 **allow a little -- some redirect after your cross**
5 **on each witness. Okay?**

6 **MS. FUSCO: Okay. And I don't, you know, in the**
7 **interests of time I know it's getting late in the**
8 **day. I'm going to keep my cross fairly short, but**
9 **I will start with Ms. Adams, if I can. Let's go**
10 **in order.**

11 **THE WITNESS (Adams): Are you able to hear me.**

12 **MS. FUSCO: I am able to hear you well. Thank you.**

13

14 **CROSS EXAMINATION (of Adams)**

15

16 **BY MS. FUSCO:**

17 **Q. (Fusco) So Ms. Adams, I just want to ask you**
18 **a few questions about Danbury Hospital's**
19 **proposed expansion of its IR unit. If you**
20 **can turn to page 6 of your prefiled**
21 **testimony?**

22 **On page 6 at the bottom, you mentioned**
23 **that as part of its fiscal year 2022 budget**
24 **Danbury has allocated up to $3 million to**
25 **renovate and expand the IR unit as needed to**

1 meet the needs of our community.

2 Is that correct?

3 A. (Adams) Sure. One second. I'm sorry. I'm

4 just getting the right page.

5 Yes, that's correct.

6 Q. (Fusco) And I don't know if you have this in

7 front of you but your colleague, Dr. Aaronson

8 sort of took that concept a step further on

9 page 21 of her testimony and said, Nuvance

10 Health has prioritized an expansion of the

11 inpatient rehabilitation unit in fiscal year

12 2022.

13 Are you aware that that's what she

14 testified?

15 A. (Adams) One second. I'm just confirming it.

16 Q. (Fusco) Oh, that's fine.

17 A. (Adams) Yes, I see it on page 5.

18 Q. (Fusco) Okay. So my first question for you

19 is when did Danbury Hospital actually

20 allocate these funds for its 2022 budget?

21 Like, when was the budget approved?

22 A. (Adams) The budget was approved a couple of

23 months ago for -- before -- for preparing for

24 October fiscal year.

25 Q. (Fusco) Okay. So it was approved in 2021?

1 **A. (Adams) Uh-huh.**
2 **Q. (Fusco) Okay. So it was approved after**
3 **Encompass filed its CON application in August**
4 **of 2024 for a 40-bed inpatient rehabilitation**
5 **facility. Is that correct?**
6 **A. (Adams) That's because that's how our fiscal**
7 **year trans -- transforms for our --**
8 **Q. (Fusco) Understood, but we filed our CON**
9 **application, it sounds like, almost a full**
10 **year before you budgeted the money to expand**
11 **your unit. Is that correct? We filed it on**
12 **August 14, 2020.**
13 **A. (Adams) But we had other -- I would have to**
14 **look, but I think we had other things in**
15 **process prior to that for the rehab unit.**
16 **Q. (Fusco) Okay. This $3 million budged**
17 **expansion came within the last several months**
18 **of 2021?**
19 **A. (Adams) It was presented to the fiscal**
20 **budget.**
21 **Q. (Fusco) Okay. And would you agree that that**
22 **then came after a letter that was sent to the**
23 **Office of Health Strategy in November of 2020**
24 **regarding Encompass' proposal? It was sent**
25 **by Sally Herlihy saying that Encompass'**

1 proposal was unnecessary and that Danbury
2 Hospital had additional capacity to meet the
3 IR needs in the service area?
4 A. (Adams) Can you explain to me what I'm asking
5 to agree to? I'm sorry. I'm just --
6 Q. (Fusco) I'm asking you whether after your
7 hospital submitted a letter to OHS in
8 November of 2020 saying that our hospital
9 wasn't needed because you had sufficient
10 rehab capacity to meet the needs of the
11 market; you then decided that there was a
12 need to expand your rehab capacity after
13 representing to the agency that you had ample
14 capacity to meet the need?
15 A. (Adams) I can't -- I can only verify to you
16 when we actually presented approval for the
17 $3 million fiscal year renovation. I can't
18 per se go back chronologically and say when
19 we actually started the other approvals and
20 when they linked to that timeframe of the
21 letter that you're saying.
22 Q. (Fusco) Okay. But --
23 A. (Adams) Because what I'm saying is there may
24 have been other steps ahead of time in our
25 process.

1 The $3 million renovation that we did
2 for this capital year, there are other steps
3 that we do in our capital years ahead of
4 time, and what you're asking me to do is
5 refer to the letter and the timing and I
6 can't validate that there weren't other steps
7 ahead of time in capital years prior that had
8 to do with an expansion -- that may have
9 been.
10 So I can only --
11 Q. (Fusco) (Unintelligible) -- oh, go ahead and
12 finish.
13 A. (Adams) I can only validate that this fiscal
14 year for '22 we approved the $3 million
15 expansion.
16 Q. (Fusco) I'll ask it another way.
17 Would it be fair to say then that when
18 that letter was sent to OHS in November of
19 2022 when you said in a postal letter -- just
20 so I don't misstate it -- oh, I'm sorry. Not
21 2022, 2020.
22 So on November 25, 2020, you said
23 Danbury Hospital's longstanding inpatient
24 rehabilitation service has additional
25 capacity to meet the inpatient need in the

1 service area. Okay?

2 So at that time -- did she not hear me?

3 Are we frozen?

4 A. (Adams) No, that's all right. I couldn't --

5 sorry. Go ahead. Please repeat yourself.

6 Q. (Fusco) So at the time you wrote the letter

7 or that Sally Herlihy from your office wrote

8 the letter in November of 2020 saying that

9 Danbury has additional capacity to meet the

10 need for IR services -- and we're referring

11 to your current capacity. You did not

12 mention anywhere in this letter that a

13 planned expansion is in the works. Did you?

14 A. (Adams) I did not mention. I did not mention

15 in the letter that there was a planned

16 expansion. That does not mean I have --

17 have -- there wasn't anything in the process.

18 There wasn't anything in the letter.

19 You're correct. And we were in the process

20 at that time. If I remember correctly, we

21 were right in the middle of COVID, if I

22 remember correctly, if the timing was

23 correct.

24 Q. (Fusco) Correct. But I mean, you took the

25 time to write a letter about the project and

1 the project does -- just it's a yes-no
2 question. You took the time to write the
3 letter and the letter doesn't mention the
4 proposed extension?
5 A. (Adams) You're right, the letter does not
6 mention that.
7 Q. (Fusco) And as we sit here today and we look
8 at your testimony, again if you look at -- I
9 believe it's on page 6 you say that Danbury
10 Hospital provides integrated inpatient and
11 outpatient rehab services in a coordinated
12 care setting and already meets the need for
13 inpatient rehab services in Western
14 Connecticut. So you're saying there's no
15 unmet need right now. You're meeting that
16 need. Correct?
17 A. (Adams) Would you like to tell me what page
18 you're referring to? I apologize. Did you
19 say what --
20 Q. (Fusco) Page 6, the bottom.
21 Right below the Roman numeral two. It's
22 the first sentence.
23 A. (Adams) You're referring to my --
24 Q. (Fusco) (Unintelligible.)
25 A. (Adams) You're referring to my prefiled

1 testimony?

2 Q. (Fusco) Uh-huh. Page 6 at the bottom. It's

3 the paragraph that starts, as you will learn.

4 A. (Adams) And you've just said that -- in that

5 sentence you said that we -- Danbury has been

6 meeting. Where did you -- you just read the

7 sentence of it?

8 Q. (Fusco) Yeah, the third line down. It says,

9 Danbury Hospital, from the first line,

10 already meets the need for inpatient

11 rehabilitation services in Western

12 Connecticut.

13 A. (Adams) Yes, I read it. I see it, yes. I'm

14 sorry. I apologize.

15 Q. (Fusco) I mean, did you participate in

16 drafting your prefiled testimony and review

17 your prefiled testimony before it was

18 submitted?

19 A. (Adams) Yes.

20 Q. (Fusco) Okay. So that sentence, based upon

21 that sentence you're saying you already meet

22 the need, that there is no unmet need for

23 inpatient rehabilitation services at the

24 current moment in Western Connecticut. Is

25 that correct?

1 A. (Adams) Yes.
2 Q. (Fusco) Okay. And consistent with your
3 position that there's no unmet need your
4 only, at least according to the forms 500 I
5 looked at -- you're only staffing 9 of your
6 14 rehab beds?
7 A. (Adams) We're staffing eleven.
8 Q. (Fusco) Okay. So you're now staffing eleven,
9 but you're not staffing all of your rehab
10 beds. Correct?
11 A. (Adams) We're staffing for an average daily
12 census of eleven. We can go up to 14.
13 Q. (Fusco) So you staff eleven beds for an
14 (unintelligible) --
15 A. (Adams) We have the flexibility to go up,
16 because we have an average daily census. So
17 we have the flexibility, as I think most
18 people do, we have the ability to flex up and
19 down.
20 Q. (Fusco) Do you have the ability to flex up
21 and down on a daily basis if need be?
22 A. (Adams) Yeah.
23 Q. (Fusco) Okay. But you are only currently
24 staffing eleven of them. And is that down --
25 if I looked at the forms correctly, is that

1 down from staffing twelve rehab beds in 2017
2 and 2018?
3 A. (Adams) No. I think what it is, is that
4 based on an average daily census, we staff up
5 and down. We have the flexibility. That's
6 how we staff to -- get per diem staff and
7 have the flexibility to step up and down.
8 Q. (Fusco) How do you then report to OHS at the
9 end of the year for that form 400 how many
10 beds you staff if you flex up and down on
11 (unintelligible) --
12 A. (Adams) I'm sorry. I'm sorry. You paused
13 for a moment. Can you repeat yourself? I'm
14 sorry.
15 Q. (Fusco) If you flex up and down on a daily
16 basis, how do you report to OHS at year end
17 on the number of beds that you staff?
18 A. (Adams) Because what it is, is your average
19 daily census. If you staff for eleven for
20 your average daily census, we flex our
21 staffing based every day on what our needs
22 are for those patients for an average daily
23 census.
24 If I have an average daily census of
25 eleven, then I'm going to staff for that

1 eleven, but if I come in and have a patient
2 need of twelve, then I'm going to have staff
3 for that twelve.
4 Q. (Fusco) Okay. So right now you're staffing
5 for an average daily census of eleven.
6 Correct?
7 A. (Adams) Yes.
8 Q. (Fusco) Okay. And you know, so we're
9 talking, you know, back to we're talking
10 about, you know, your statement that there's
11 no unmet need in the area. Consistent with
12 that and since we're talking about Nuvance
13 Health priorities here, is it consistent with
14 that statement that there's no unmet need
15 that Norwalk Hospital closed its twelve-bed
16 IRF in 2015?
17 A. (Adams) Norwalk closed their beds for --
18 because my understanding was because they
19 actually had -- were having a difficult time
20 having specialty physician, specialty
21 recruitment. It was not necessarily just
22 related to physician -- I mean, patient need.
23 Q. (Fusco) Okay. But it's still your position
24 that there's no unmet needs even with those
25 twelve beds closed. Correct?

1 A. (Adams) Correct.
2 Q. (Fusco) So there's no unmet need in the
3 service area, but you --
4 A. (Adams) What --
5 Q. (Fusco) Go ahead.
6 A. (Adams) Go ahead, no. Go ahead. Finish your
7 statement.
8 Q. (Fusco) So there's no unmet need in the
9 service area. Okay? And yet you are
10 budgeting $3 million to expand a unit that
11 your colleague said is happening In 2022.
12 There's no unmet need.
13 Are you building a 20-bed inpatient
14 rehabilitation unit in 2022?
15 A. (Adams) What we have said is we have the
16 ability to meet the need of any census that
17 arises. We have absolutely capital
18 allocated. We have the ability and have the
19 resources to expand. And yes, we have the
20 ability to expand physically as well as
21 financially the ability to meet the needs
22 when it arises.
23 Q. (Fusco) When it arises. Okay. So when
24 you're calling costs --
25 A. (Adams) And it has been allocated.

1 Q. (Fusco) Okay. The money has been allocated,
2 but the statement Nuvance Health has
3 prioritized an expansion of the inpatient
4 rehab in fiscal year 2022 would suggest to me
5 that you are expanding that unit --
6 A. (Adams) Uh-huh.
7 Q. (Fusco) -- next year. Is that not accurate?
8 Is it accurate?
9 A. (Adams) That is accurate?
10 Q. (Fusco) Okay. So you're expanding your
11 inpatient rehabilitation unit even though
12 there's no unmet need in the area?
13 A. (Adams) That we will be able to phase it in?
14 Absolutely.
15 Q. (Fusco) Okay. So well, is it that you'll be
16 able, or that you'll actually be doing it?
17 Because you're saying there is no unmet need,
18 that you can meet all the capacity.
19 And then a competitor has filed a CON
20 application and now you've allocated funds
21 and you're saying you're building out a unit
22 to meet need that you're also saying doesn't
23 exist.
24 So are you building the units and is
25 there need?

1 **A. (Adams) I'm saying that we have started the**
2 **process and have dollars allocated to be able**
3 **to start an expansion of the rehab unit.**
4 **Q. (Fusco) Is that all you've done? Have you**
5 **done anything else? Do you have schematics?**
6 **Have you hired an architect?**
7 **A. (Adams) Yes, we have an architect. We have**
8 **an architect. We've been looking at**
9 **architects, absolutely.**
10 **Q. (Fusco) Okay. You've been looking at**
11 **architects, or do you have schematic**
12 **drawings? I'm trying to figure out --**
13 **A. (Adams) We have tentative schematic drawings**
14 **and then we are looking at architects.**
15 **Q. (Fusco) Okay. So you're actively moving**
16 **forward with a project to expand an inpatient**
17 **rehabilitation unit in your hospital when you**
18 **say there is no need for additional**
19 **rehabilitation services in the area.**
20 **Is that correct?**
21 **A. (Adams) We said that we would be looking at**
22 **expanding the rehabilitation unit, yes.**
23 **Yeah.**
24 **Q. (Fusco) Just a few more questions for you.**
25 **Do you know -- and OHS has noticed all**

1 the forms 500, you know, when they get
2 printed out, but do you know how many
3 licensed beds there are combined at the
4 Connecticut Nuvance Hospitals. I'm sure you
5 know how many licensed beds Danbury has.
6 Correct?
7 A. (Adams) I'm -- for Nuvance, are you asking?
8 Q. (Fusco) Yeah for the Nuvance Connecticut
9 Hospital. So Danbury, Sharon and Norwalk I'm
10 looking for their combined license bed
11 capacity?
12 A. (Adams) I -- I don't have that off the top of
13 my head.
14 Q. (Fusco) So if I pointed to you -- and I'm
15 trying not to testify. So you know, please
16 give me some latitude, but I'm going to try
17 to help -- but you know, forms 500 that are
18 in the record in this matter that you may not
19 have in front of, one for Danbury Hospital
20 shows that you have 456 licensed beds.
21 Is that correct?
22 A. (Adams) Let me check.
23 That's correct.
24 Q. (Fusco) Okay. And one, the one for Norwalk
25 Hospital shows that Norwalk has 366 licensed

1 beds.

2 Is that correct?

3 A. (Adams) Let me -- let me validate that.

4 THE HEARING OFFICER: While she is looking, I just want

5 to say for the public who have signed to talk, the

6 agenda had public comment for 3 p.m. We're still

7 going on with our technical part of the hearing.

8 I will reorder it so that closing arguments

9 will happen after public comment, but we will

10 finish up with this technical piece which is

11 finishing cross-examination of Intervener's

12 evidence, and then Office of Health Strategy's

13 questions with a short break before the Office of

14 Health Strategy's questions.

15 So I do want the public aware that we are

16 reordering the agenda. We will take the public

17 comment after, after the evidentiary piece.

18 I'm sorry. Attorney Fusco, you can go ahead.

19 MS. FUSCO: I'm sorry. I was just waiting.

20 BY MS. FUSCO:

21 Q. (Fusco) Ms. Adams -- I'm not sure if she has

22 the forms?

23 A. (Adams) Norwalk, 366. Sorry.

24 Q. (Fusco) Okay. That's correct. And then

25 is Sharon 94? Is that correct, on the

1 (unintelligible) form?

2 A. (Adams) I think we have Sharon as 78.

3 MS. FUSCO: Seventy-eight licensed? Because the form

4 400 I have shows 96 licensed.

5 MR. CARNEY: 70 used adult -- adult.

6 MS. FUSCO: Okay.

7 MR. CARNEY: (Unintelligible) 16 (Unintelligible).

8 MS. FUSCO: Okay.

9 MR. CARNEY: For a total of 94.

10 MS. FUSCO: Ninety-four, okay.

11 BY MS. FUSCO:

12 Q. (Fusco) So just using those, those larger

13 numbers -- and my math is not very good

14 either, but when I add those three up I hit

15 916 total licensed beds for the Nuvance

16 System hospitals in Connecticut.

17 Am I correct -- if you can answer

18 this -- that the only inpatient rehab beds at

19 Nuvance Hospitals in Connecticut are in

20 Danbury. Correct? They're the 14 beds that

21 are in your hospital. So that's -- you're

22 muted I think?

23 A. (Adams) I'm sorry. In Connecticut.

24 Q. (Fusco) That's okay. Yes, okay. And so

25 that's 14 out of 916 beds, which if I do the

1 math correctly, means that only 1.5 percent
2 of Nuvance Connecticut's license beds are
3 inpatient rehab. Correct?
4 And based on that would you agree that
5 inpatient rehab is not a core service for the
6 Nuvance System in Connecticut?
7 A. (Adams) No, I don't agree with that. When
8 you're looking at it as Nuvance? Yes, but I
9 am not looking at it for Nuvance. We're
10 looking at it for Danbury.
11 You're looking at it for 916 beds, when
12 we're sitting here talking about it for
13 Danbury.
14 Q. (Fusco) And they're beds, and I was going to
15 ask questions (unintelligible) beds, you
16 know, for which a majority of your referrals
17 come from Nuvance Connecticut Hospitals,
18 which is why I'm looking at it as a system,
19 but we can move on.
20 I just have one last question for you,
21 which is you mentioned in your remarks before
22 that you're concerned -- and forgive me if I
23 quote you wrong. I was just jotting it down,
24 but your concern that the Encompass Danbury
25 Hospital might jeopardize Danbury's ability

1 to keep its doors open.
2 Have you submitted any evidence to
3 support the fact that this hospital would
4 cause Danbury Hospital to need to close?
5 A. (Adams) What I said, I think and I -- I think
6 you did misquote a little bit, but that's --
7 I understand -- was -- and I think I'll just
8 make sure I look at my own -- was that I was
9 concerned that we would end up, you know,
10 taking -- it would impact our IRF doors.
11 Q. (Fusco) Okay?
12 A. (Adams) And it would be changing -- it would
13 be impacting our population for that, the
14 community there.
15 Q. (Fusco) Okay, but that wasn't what I heard --
16 but assuming we're talking about your IRF
17 services, the same question.
18 Like, have you submitted any evidence to
19 show that this hospital will cause Danbury
20 Hospital to close it's IR service?
21 A. (Adams) No, and that's -- no, I have not.
22 And what I was saying was because -- I think
23 if you recall what I was saying prior to it
24 was because of the type of payer mix that we
25 will be taking versus what you may be taking.

1 MS. FUSCO: Okay. I have no further questions of
2 Ms. Adams. Thank you.
3 THE HEARING OFFICER: Thank you. Redirect?
4 MR. TUCCI: Ms. Adams, can you hear me?
5 THE WITNESS (Adams): This is Ted Tucci for the record.
6
7 REDIRECT EXAMINATION (of Adams)
8
9 BY MR. TUCCI:
10 Q. (Tucci) Ms. Adams, can you tell me whether
11 Danbury Hospital is committed to responsible
12 investment in the IRF as it is shown in the
13 future?
14 A. (Adams) Yes, we are.
15 Q. (Tucci) Thank you.
16 A. (Adams) We -- thank you.
17 THE HEARING OFFICER: Is that it? Anything else?
18 MR. TUCCI: That's it.
19 THE HEARING OFFICER: That's it. And?
20 MS. FUSCO: I think you're asking -- I have no further
21 cross. That's it. Thank you.
22 THE HEARING OFFICER: How about another witness?
23 MS. FUSCO: Oh, do I have another witness?
24 THE HEARING OFFICER: No, the Interveners --
25 MS. FUSCO: Oh, no. I'm sorry. I have no crosses of

1 the other witnesses.

2 I'm sorry. It's been a long day.

3 THE HEARING OFFICER: Okay. So we're going to take a

4 brief break and come back with the Office of

5 Healthcare Strategy's questions, and then move

6 onto public comment. Closing argument will be

7 after public comment.

8 I believe at this time there are -- I think

9 four people signed up for public comment. So

10 anyhow, we're going to take -- it's 3:12. I want

11 to come back at 3:20. Okay?

12 And don't forget for anyone who has not

13 signed up -- we continue to record during the

14 break. Please turn off your audio, and you can

15 turn off your video also.

16

17 (Pause: 3:12 p.m. to 3:20 p.m.)

18

19 THE HEARING OFFICER: Attorney Fusco, all your

20 witnesses are available?

21 MS. FUSCO: I believe so. Is Dr. Charbonneau on?

22 THE WITNESS (Charbonneau): Yes, I'm here. I'm here.

23 THE HEARING OFFICER: Okay. How about Attorney Tucci,

24 are you there?

25 MR. DUFFY: Good afternoon. Sorry, Hearing Officer

1 Yandow. We have Attorney Tucci returning in just
2 a second.
3 THE HEARING OFFICER: Okay. We'll wait.
4 And for the public that have just tuned in, I
5 mentioned earlier we did have to reorder the
6 agenda because we're still taking on the
7 evidentiary part, which is we have questions now
8 from the Office of Health Strategy, from the OHS
9 staff of the witnesses.
10 We will reorder closing arguments until after
11 public comment.
12 Attorney Tucci, are your witnesses all
13 available?
14 MR. TUCCI: Yes, I can confirm all our witnesses are
15 available.
16 THE HEARING OFFICER: Okay. You know how they used to
17 say, can you hear me now? Can you hear me now on
18 the phone? The other thing is going to be you're
19 on mute. You're on mute. Right? If it's not
20 already, anyway. You know?
21 So Mr. Carney and Mr. Clark will do the
22 questioning. They will either identify the
23 witness that they want the answer from or they may
24 just ask for the best witness available to answer
25 their question. So we're going to start with

1 Mr. Carney.
2 MR. CARNEY: The first set of questions revolve around
3 clear public need. I'm thinking probably that
4 Ms. Chafin would be probably the best person to
5 respond to, but I'll let you make the decision.
6 The first question revolves around prefiled
7 testimony asserting quantified gap in care and
8 sort of your bed-need analysis that we spoke to
9 earlier.
10
11 CROSS-EXAMINATION (of Chafin)
12
13 BY MR. CARNEY:
14 Q. (Carney) First question is, most of the focus
15 of it was on national rates. How can we be
16 assured that these national rates correspond
17 with the need for inpatient rehab in
18 Connecticut in the proposed service area?
19 And further, how do we know that
20 discharged patients from the hospitals here
21 in Connecticut are not, for example, older or
22 sicker, or unable to tolerate three hours of
23 therapy per day and may be a more appropriate
24 referral for SNF than IRF?
25 A. (Chafin) This is Marty Chafin. That is

1 appropriately me, I believe.
2 I would refer you to Exhibit C of my
3 prefiled testimony to go from national data
4 to Western Connecticut data. And in those
5 exhibits that is where Fairfield and
6 Litchfield county data was utilized.
7 Now to your point, it was in comparison
8 to the national average, but when you look at
9 those county data points, that is part of the
10 assessment of need in terms of -- if this
11 makes sense, the general acute-care
12 utilization is consistent with the national
13 average and SNF and IRF are so
14 disproportionate.
15 So again, I am still using that national
16 benchmark, but it's at least at the county
17 level. That's -- that's one comment to
18 answer your question.
19 The other in terms of the age and the
20 medical complexity of the patients, because
21 the SNF and IRF are so disproportionate to
22 what we expect based on the data of the
23 experience of Encompass, I don't believe that
24 Connecticut is so different that you have a
25 much older population or much sicker

1 population. I'm not seeing that data to say
2 that that's why they're not getting care.
3 So -- so two points. One is on a
4 national basis -- and again, I am going
5 national -- Encompass' average age of their
6 Medicare fee-for-service patient is 73.
7 So they are experienced in taking care
8 of older patients. Dr. Charbonneau can
9 address that better. That's one comment, and
10 I know I keep getting beaten up for only
11 having three physician letters, but the
12 physicians that represent themselves and
13 their groups talk about patients that they
14 have seen that need SNF.
15 I don't know if that addresses your
16 question or not -- well enough or not.
17 Q. (Carney) Yeah. I mean, did you look at the
18 data relating to, sort of -- you said you
19 looked at age, you know, age differences.
20 Did you look at whether patients are
21 sicker or not? The term is escaping me right
22 now, but hospitals have a term for sicker
23 patients compared to less sicker patients, an
24 advisive term?
25 A. (Chafin) That I think case mix index. Does

1 that ring a bell.
2 Q. (Carney) That's it. That's it.
3 A. (Chafin) I got it. That I -- that I was
4 unable to get that data, because unless I'm
5 mistaken as a new provider, rather than
6 existing we did not have access to your alt
7 payer database, the APD database. And that,
8 as you know, is a wealth of knowledge.
9 So I do not have the CMI for existing
10 providers.
11 Q. (Carney) Okay. Besides you predominantly
12 looked at these Medicaid conversion rates for
13 rehab, did you look at any other types of
14 measures like historical utilization trends
15 in the state for rehab or such in addition
16 to, you know, your main focus?
17 A. (Chafin) That's a good point, and I've looked
18 at the most recent two years only. So if we
19 look at fiscal year '19 versus fiscal year
20 '20, there has been an overall increase in
21 patient days.
22 In fact, I have that data.
23 Yeah, the -- the patient days increased
24 slightly from the 42,000 -- or 41,943 on CON
25 page 74, to 43,289. And that recognizes, of

1 course, we do have COVID in 2020. So the
2 patient days went up despite that -- but I
3 did not go further back to answer your
4 question.
5 Q. (Carney) Okay. And this is -- the last thing
6 is not really a question. It's more of a
7 followup to Hearing Officer Yandow's request
8 that you provide us with, sort of, the links
9 related to the numbers that you've used for
10 Medicare fee-for-service beneficiary rates,
11 the 56.8 percent? The national rehab admits
12 of 59 percent?
13 A. (Chafin) Yes, I -- I will get you the links
14 for -- to make sure I understood, I will get
15 you the links for the database that gives the
16 county level data and the state data for the
17 utilization rates.
18 And then tell me your second part again?
19 I want to make sure I give you
20 everything that you ask --
21 MR. CARNEY: All the sort of pertinent figures that you
22 use. So I gave two examples, the Medicare FF
23 fee-for-service beneficiary rate, the 56.8
24 percent; the national rehab admits percentage of
25 59 percent.

1 So the relevant numbers that you're using in
2 your methodology so that we can go and verify that
3 on our own without having to spend tons of hours.
4 So we'll call this, like, Late-file 1.
5
6 (Late-Filed Exhibit Number A-1, marked for
7 identification and noted in index.)
8
9 THE WITNESS (Chafin): Okay. Yes, I'll give you the
10 links. Or I might even send a file on one of
11 those. It would -- may be easier if I just send
12 you the (unintelligible) file.
13 BY MR. CARNEY:
14 Q. (Carney) Okay. All right. So the second
15 question, the prefiled testimony states that
16 although the population-based methodology
17 results in an estimated inpatient rehab
18 facility of 48 beds, Encompass Danbury
19 believes that a 40-bed facility is the right
20 sized facility for today.
21 Please explain the rationale for this
22 statement and describe the criteria, like
23 facility space, volume costs, et cetera, used
24 to determine this figure as the right size of
25 40 bed.

1 A. (Chafin) I can address it, but I'm probably
2 not the best person. I would think that Pat
3 Tuer is probably better positioned for that.
4
5 CROSS EXAMINATION (of Tuer)
6
7 THE WITNESS (Tuer): Sorry. Can you repeat the
8 question?
9 BY MR. CARNEY:
10 Q. (Carney) Sure. So the inpatient -- the
11 bed-need methodology came up with 48 beds.
12 However, in testimony it was stated that the
13 40-bed facility is the right number.
14 So I was just wondering, you know, how
15 did you come up with that rationale for the
16 statement? Was it based on facility space,
17 volume, costs? Or what? How did you get
18 (unintelligible)?
19 A. (Tuer) Sure. So thanks for the question.
20 That's more based on us, you know, we think
21 that's the right size facility for now to
22 allow us to grow into a potentially logger --
23 larger building down the line; so positions
24 for growth while being conservative with what
25 we build out for now.

1 Q. (Carney) Do you know what your bed occupancy
2 rates at your other IR facilities are, how
3 they run?
4 A. (Tuer) Yeah. Yeah, so in -- and I was going
5 to -- I'm glad you asked. So just across the
6 state border in Massachusetts we operate with
7 an ABC of 328 across 4 hospitals at 7
8 locations, because there's three satellite
9 locations. And that's an average per
10 facility of about 82.
11 So that, I don't have the exact
12 occupancy percentage. We can get that for
13 you. But you know, that it's -- it's a
14 matter of us capturing the right patients at
15 the right time from the acute-care hospitals
16 that would otherwise go in -- be going to
17 skilled nursing facilities, much like what's
18 happening -- happening in Connecticut with
19 the over utilization of SNF.
20 MR. CARNEY: Yes. So I think I would appreciate if you
21 could give me, like, occupancy rates for maybe
22 like your three closest facilities or something?
23 We'll call that Late-File 2.
24
25

1 (Late-Filed Exhibit Number A-2, marked for
2 identification and noted in index.)
3
4 THE WITNESS (Tuer): So I can give you our -- the
5 closest facility to you is in Ludlow,
6 Massachusetts. And over the last four years
7 that's a 53-bed hospital that has a 4-year ABC of
8 48.4, so 91 percent occupancy.
9 But we can give you the -- the additional
10 facilities that you're -- you're looking for as
11 well.
12 BY MR. CARNEY:
13 Q. (Carney) Yeah, that would be good. How
14 about, you know, the three? The three
15 closest? I think that would be appropriate.
16 A. (Tuer) We'll do that. We'll do that. Thank
17 you.
18
19 (Late-Filed Exhibit Number A-3, marked for
20 identification and noted in index.)
21
22 BY MR. CARNEY:
23 Q. (Carney) All right. All right. The next
24 question relates to sort of volumes and your
25 projected volumes.

1 So your projected volumes indicate for
2 the first four years. The first year I
3 understand is partial. Discharge volumes are
4 to be 92, 623, 793 and 963 respectively.
5 So I was kind of wondering how those
6 volumes were derived? I really didn't sort
7 of see. I mean, I saw the bed-need
8 methodology; kind of understood where, how
9 you got to the beds, 48 beds.
10 But how did you come up with 92, 623,
11 793, and 963.
12 A. (Tuer) So I'm happy to take this question, or
13 Jennifer, I can -- or Attorney Fusco, I can
14 turn this to -- to Marty or Bill Heath if
15 they would prefer. But I'm -- I'm happy to
16 give that a shot as well.
17 MS. FUSCO: Yeah, you can answer, Pat. You can answer.
18 THE WITNESS (Tuer): Yeah. So we have a lot of
19 experience opening new hospitals. You know,
20 between this year and 2023 we're opening 32 new
21 hospitals across the -- the company and we've had,
22 you know, we have 144 hospitals now.
23 And we, when we go to model out what a
24 potential growth rate will look like in -- in a
25 hospital year over year we look at comparable

1 markets from a 65-plus perspective, from an age
2 demographic. We'll look at claims data from --
3 from the different service areas, and what the
4 ramp-ups were in our historical -- the experience
5 has been. And that's -- that's what we use for
6 that modeling.
7 MR. CARNEY: Okay. So like, what now for like the
8 specific number? Like 623, like, was there some
9 math used in determining why 623 and not 625 or 7,
10 you know?
11 I get you're basing it on sort of -- I think
12 it would be better for the record to be more
13 complete if we had some kind of calculation as to
14 how you arrived or derived those numbers other
15 than your experience in other (unintelligible) --
16 MS. FUSCO: I'm sorry to interrupt, Brian, but we can
17 get that from the Encompass finance folks who did
18 the projections. I mean, I don't think I have
19 them here, but I can get it. I can get sort of an
20 assumption if you want that in the late file, more
21 detailed assumptions?
22 THE WITNESS (Chafin): And let me add -- let me add if
23 I can to follow up on what Pat said is, the actual
24 discharges and days are a function to some extent
25 of the expected occupancy.

1 And so if we have the target -- this is my
2 fault. I probably should not have rounded to
3 84.8. I probably should have used 85. So if you
4 step back and think of it in terms of the 55
5 percent, 70 percent and 85 percent, to follow up
6 on a Pat, that is kind of the target. And then
7 based on the length of stay we had our -- our
8 discharges.
9 The partial year number is based on the first
10 quarter ramp up. So I think we owe you some
11 written explanation to give you a little bit
12 better explanation in this broad picture I'm
13 giving you now.
14 MR. CARNEY: That would be great. I would appreciate
15 that. Yeah. The first year and, I guess, three
16 months or something like so I can get the lowness
17 of the number, so.
18 THE HEARING OFFICER: That would be a Late-File 3?
19
20 (Late-Filed Exhibit Number A-4, marked for
21 identification and noted in index.)
22
23 BY MR. CARNEY:
24 Q. (Carney) Yeah. Okay. The next thing relates
25 to sort of referral sources. So you're

1 saying, stating basically that your projected
2 volumes are going to be based on 90 percent
3 from referrals from hospitals, 8 percent from
4 physician offices and 2 percent from skilled
5 nursing facilities.
6 Again, how did you determine this, this
7 breakdown of referral sources? From your
8 other facilities is that typically what you
9 see?
10 A. (Chafin) This is Marty. I'll go big picture
11 and then Pat can add to it if he needs to.
12 That's exactly right. This is based on
13 Encompass' experience that they typically get
14 those percentages.
15 Q. (Carney) Okay. And again I'm just, you know,
16 following up. I think we touched on this
17 before but it's important for us to be able
18 to validate, you know, claims that you make
19 regarding your volumes and where they're
20 coming from. So I'll ask kind of again.
21 It's like, do you have any established
22 commitments from any of these referral
23 sources, whether it be hospitals or area
24 physicians where you actually have some kind
25 of in-place agreement that says, all right.

1 Well, you know, my practice can provide you
2 with approximately ten referrals a year?
3 Or anything concrete that we can add it
4 as evidentiary, an evidentiary finding to the
5 record?
6 A. (Chafin) Okay.
7 A. (Tuer) Marty, did you want to take that or
8 are you just going to provide that?
9 A. (Chafin) I mean, my thought is if you can
10 discuss it, that's better. We'll provide --
11 A. (Tuer) So the only thing that I think I can
12 add is I think it's premature to -- to seek a
13 commitment in the absence of an approved CON.
14 And even when we have a CON, what we
15 would try to do is we would begin creating
16 relationships in the market educating. A lot
17 of times what we see is that opportunities
18 for patient identification, but each market
19 is a little bit different. And you know,
20 across my 19 hospitals I have hospitals that
21 had -- their largest referral source provides
22 17 percent of their -- their admission source
23 and I have markets where they provide 80
24 percent.
25 So each market is -- it's very

1 different. And I think at this point it
2 would be premature to put that in stone.
3 Q. (Carney) Kind of a chicken or the egg kind of
4 situation where -- on your side, it's kind of
5 premature. On our side, it's like we sort of
6 want concrete evidence that can show you can
7 support the volumes.
8 A. (Tuer) Yeah. And I -- I certainly respect --
9 and what I would say is, you know, we've
10 opened 145 hospitals -- 144 hospitals and we
11 have an had -- we have not had an issue where
12 we have closed a hospital where we -- and in
13 fact we are doing bed additions all the time
14 because we underbuild hospitals in -- in many
15 markets.
16 So it's -- it's, you know, we've -- this
17 is all we do and -- and we've gotten pretty
18 good at that, determining bed need and
19 committing capital to -- to help the patients
20 in those communities get the care that they
21 would otherwise not get.
22 Q. (Carney) Okay. And just pushing this a
23 little further I will say I do have some
24 concerns. So given Danbury Hospital
25 participating as an intervener, part of the

1 Nuvance System three hospitals in Danbury,
2 Norwalk, Sharon, accounting for about
3 35.5 percent of the 90 percent of your
4 referral volumes.
5 And they're stating that, you know, in
6 opposition to the proposal. So I'm not sure
7 how likely that volume is going to come from
8 them, and it's a large, large proportion of
9 your projected volume.
10 So I guess how would you speak to that?
11 A. (Tuer) So again in many markets -- and I can
12 give you specifics. Western Pennsylvania our
13 largest referral source at our Harmarville
14 location which operates within an ABC of 45
15 is a hospital, a UPMC Hospital that has its
16 own IRF unit.
17 We, you know, I think the comment was
18 made earlier that a rising tide lifts all
19 boats, and when we enter a market we see, not
20 only the fulfillment of occupancy that --
21 that we have projected, but we see an
22 increase in the other providers in the market
23 just in the way that we market and the way
24 that we create and leverage our information
25 systems and market data to -- to target

1 **patient populations that are absolutely**
2 **appropriate for inpatient rehab.**
3 **Q. (Carney) Thank you. The next question is**
4 **related to sort of access of services within**
5 **the region. And this has probably been**
6 **answered, you know, to some degree, but again**
7 **since it's a public hearing just give me a**
8 **general overall sense of how this proposal**
9 **will improve access to inpatient rehab**
10 **services in the area?**
11 **Like, specifically will certain types of**
12 **conditions be treated as part of your program**
13 **that are not readily available in the service**
14 **area beyond sort of just the IRF designation?**
15 **A. (Tuer) So I can start with that and Marty,**
16 **Jennifer, if anyone else wants to chime in**
17 **you certainly can, but you know, I think**
18 **Attorney Chafin did a really good job of**
19 **showing the underutilization of SNF, you**
20 **know, skilled nursing facilities in the state**
21 **of Connecticut. And it is a completely**
22 **different level of care that there's really**
23 **not a lot of access to in Western Connecticut**
24 **in the Danbury area.**
25 **If you were to look at claims data and**

1 you were to look at how long -- and one of
2 the physicians from Danbury Hospital
3 commented on this as well, you know, about
4 reducing length of stay. We help hospitals
5 like Danbury take patients faster than
6 skilled nursing facilities can.
7 Not only that, we -- those patients that
8 come to us readmit significantly less than a
9 skilled nursing facility that they're
10 currently going to. Outside of that, because
11 of that delay in care Danbury Hospital or
12 other acute-care hospitals are saddled with
13 costs of care when their reimbursement has
14 stopped, and we help reduce those expenses by
15 approving their throughput, reducing ER
16 holds.
17 And then the other piece is direct care
18 to the patient. Aside from readmissions, if
19 you look at the state of Connecticut it's
20 generally required that a skilled nursing
21 facility would have 1.9 direct care hours per
22 patient day. Our hospitals have almost five
23 times that per patient day.
24 We average around six hours of direct
25 care hours per patient day from a nursing

1 perspective, and three hours per patient day
2 from a therapy perspective.
3 We also typically have a full complement
4 of -- of medical staff and in our experience
5 we -- we have always been able to
6 successfully procure that and build programs
7 around the community's needs to deliver
8 better outcomes for -- for the patients.
9 And I think we would help complement
10 Danbury's service in -- for the Danbury
11 community that is currently underserved.
12 Q. (Carney) Okay. Just --
13 A. (Chafin) May I add? May I add two things to
14 that without (unintelligible).
15 Q. (Carney) Okay.
16 A. (Chafin) One is that in terms of specifically
17 improving access, because my sense is you
18 want more than just going back to the
19 charts we've already talked about ad nauseam
20 this morning.
21 I would point you to CON page 245 where
22 the Brain Injury Alliance Executive Director
23 who will speak this afternoon actually says,
24 and I quote, countless times over the years
25 Connecticut residents have been forced to get

1 their care in Massachusetts or New York
2 simply because there wasn't an appropriate
3 place for them in Connecticut, end quote.
4 So that, that's one comment. I
5 recognize it's anecdotal and I don't have the
6 volume, but we have boots on the ground, I
7 believe was the phrase earlier, of providers
8 saying, patients are going out of the state
9 to get the care because it's not available.
10 The other --
11 THE HEARING OFFICER: Brian, is this helpful?
12 MR. CARNEY: Yes, sure.
13 THE HEARING OFFICER: Okay. Because the letter is in
14 there, and he's thinking. So we don't need to
15 reiterate, but I just want to let you know if this
16 is going on and it's not helping we can move on.
17 BY MR. CARNEY:
18 Q. (Carney) That's okay. She can finish.
19 A. (Chafin) Thank you. The only other point I
20 would make that is not in the CON application
21 is there are Medicaid residents who are
22 leaving Connecticut. So Connecticut Medicaid
23 residents are traveling to Encompass
24 Massachusetts facilities today because of the
25 lack of access of care. So I would use those

1 two data points to address your question.
2 Q. (Carney) Okay. Can you provide some form of
3 evidence to support that assertion?
4 A. (Chafin) Yes, we will get you that.
5 Q. (Carney) You knew that was coming. Right?
6 A. (Chafin) I did.
7 MR. CARNEY: All right. Late-file 4, Medicaid
8 beneficiaries receiving care, Medicaid
9 beneficiaries receiving IRF in Mass.
10
11 (Late-Filed Exhibit Number A-5, marked for
12 identification and noted in index.)
13
14 MR. CARNEY: This is kind of like a tangential question
15 just for my knowledge -- or lack of knowledge,
16 actually.
17 BY MR. CARNEY:
18 Q. (Carney) How do you generally receive
19 patients at Encompass' IRFs? I know the
20 referrals are coming from hospitals. Are
21 they mostly, like direct transport, like you
22 know, medical transport from the hospital to
23 your facility? Or how do they get there.
24 A. (Chafin) That's either Pat -- can you answer
25 that, Pat?

1 A. (Tuer) Typically medical transport ambulance.
2 Q. (Carney) All right. I think we've touched on
3 this question quite a bit, but I'm asking
4 about the new hospital, you know, it will
5 affect existing providers in the service
6 area. Danbury's perspective of it's going to
7 be sort of harmful to them.
8 You're saying it's more a complement,
9 you know, complementary service and it's not
10 going to take patients away from Danbury
11 Hospital's IRF.
12 Can you comment on that?
13 A. (Tuer) Yeah, I can touch on that in a couple
14 different ways. So first, you know, we've
15 talked a lot about that the rising tide lifts
16 all boats theme and the -- I think that the
17 lack of rehab beds and the overutilization of
18 skilled nursing patients, but -- so I don't
19 want to repeat what I've already stated.
20 But you know, another thing that we do
21 is we typically try to engage the dominant
22 market provider in some agreements, such as
23 labs serve -- we -- we purchase lab services.
24 We would purchase radiology services.
25 If we had to have a patient that needed

1 a scheduled procedure we would look to
2 collaborate with Danbury Hospital on that.
3 So there's -- there's revenue upside in
4 addition to the cost control that exists when
5 we move into a market.
6 So from a physician component, you know,
7 if -- if there is capacity we would leverage,
8 you know, medical and program directorships
9 from the local community physicians. If --
10 if there -- if that was purely tapped out we
11 would look to recruit physicians into the
12 market. So there's a number of ways that we
13 would work in complementary fashion.
14 And again, as I've said before we're
15 used to -- we're kind of like Switzerland.
16 We're an independent body. We would be an
17 independent body here where we can service
18 patients from all different kinds of referral
19 sources. But you know, if -- if they had a
20 need Danbury Hospital is the closest hospital
21 and they would see benefit from that in the
22 form of purchased services.
23 Q. (Carney) Just a question about payer mix. So
24 80 percent of your payer mix is basically
25 Medicare patients. So approximately

1 12 percent will be commercial insurance,
2 people covered by commercial insurance
3 providers. Will these commercial patients be
4 in network? Is it in network they
5 participate with, or out of network?
6 A. (Tuer) So that, that varies. Most of the
7 time it's an in-network benefit. In the
8 event it's not covered by insurance we
9 typically pursue a single case agreement that
10 will cover the cost of care for -- for that
11 patient's stay.
12 You cut out, or cut out for me when you
13 stated the percent of Medicare. That -- but
14 Medicare is the largest payer source for --
15 Q. (Carney) Eighty percent, 80 percent.
16 A. (Tuer) Yeah. One thing I think -- that I
17 think is important to note, and if you follow
18 Becker's or Modern Healthcare, or any of the
19 major healthcare publications, is that
20 there's -- has been a shift to Medicare
21 Advantage programs and -- and I think that
22 was alluded to in prior testimony today.
23 And you know, we -- we have seen that
24 and we work really well with managed-care
25 companies and Medicare Advantage companies.

1 In fact, we have grown our Medicare Advantage
2 population in our hospitals by over
3 20 percent year-over-year, and we have really
4 strong outcomes with that patient population.
5 Q. (Carney) Okay. Thank you. This is something
6 near and dear to our Executive Director's
7 heart. Describe how you would be planning to
8 promote health equity at this proposed
9 facility in Danbury?
10 MS. FUSCO: I think, Dr. Charbonneau, if you're on, you
11 can talk about that.
12 THE WITNESS (Charbonneau): Yes. Hi. Can you guys
13 hear me?
14
15 CROSS EXAMINATION (of Charbonneau)
16
17 BY MR. CARNEY:
18 Q. (Carney) Yes.
19 A. (Charbonneau) So in terms of health equity,
20 one thing that I think is important to point
21 out is that the way that it works is that we
22 get referrals from the care teams, the
23 physicians, the discharge planners from these
24 various acute hospitals, and when a patient
25 needs rehabilitation.

1 And we have systems in place. Medicare
2 requires a rehabilitation physician to sign
3 off on those referrals and attest to the fact
4 that those patients are appropriate for our
5 level of care for inpatient rehabilitation
6 from them. The physicians who sign off on
7 those referrals are agnostic to the type of
8 insurance, you know, race, religion, et
9 cetera, sexual orientation.
10 So that's just one thing. I just -- I
11 know that there has been some literature
12 published about access to inpatient
13 rehabilitation with certain minority
14 populations and I can assure you, and as a
15 practicing physiatrist in our hospital for
16 several decades that we are agnostic to that
17 information when we accept the patient.
18 In addition to that, the company has
19 invested quite a bit in improving awareness
20 in terms of diversity, inclusion and
21 education of different minorities, sexual
22 orientation, et cetera. So we have that
23 training for all of our employees and our
24 physicians as well, and that's something that
25 we are also are very -- and our board of

1 directors is also very committed to as well.
2 Q. (Carney) Thank you, Dr. Charbonneau. The
3 next set of questions relate to quality. So
4 you might be the right person as to -- stay
5 right seated.
6 A. (Charbonneau) Okay.
7 Q. (Carney) So describe the clinical quality
8 measures utilized in other existing Encompass
9 inpatient rehab. Basically what types of
10 quality measures are used to evaluate IRFs?
11 A. (Charbonneau) Okay. How much time do we
12 have? You know --
13 Q. (Carney) A high level.
14 A. (Charbonneau) A very high level view. So we
15 have initiated metrics for all of our
16 hospitals with various goals on quality
17 metrics. So we follow things like acute-care
18 transfer rates, discharge to SNF, patient
19 satisfaction.
20 We have a program to ensure patients are
21 getting the correct type of prophylactics
22 against blood clots. We look at our
23 medication reconciliation process. We have a
24 huge project to reduce opioid prescribing.
25 In fact, just this week we presented at a

1 national rehab conference a poster on our
2 interdisciplinary approach to pain management
3 in the inpatient rehabilitation setting.
4 And since we initiated this program in
5 2018 we've had a dramatic reduction in opioid
6 prescribing in our hospitals, and I'd be
7 happy to share that poster with you if you're
8 interested.
9 So these are all metrics that we follow
10 very closely in addition to our usual quality
11 reporting metrics that I'm sure that the unit
12 at Danbury also is familiar with that are
13 required reporting metrics for Medicare.
14 Q. (Carney) Okay. Thank you. And I was going
15 to sort of follow up with, you know, how does
16 Encompass rate on those quality metrics, you
17 know, relative to --
18 A. (Charbonneau) Yeah.
19 Q. (Carney) -- standards, you know, benchmarks
20 and what have you?
21 A. (Charbonneau) We surpass all national
22 expected goals. So we have both internal and
23 external benchmarks that we follow, and I
24 think our outcome metrics speak for
25 themselves.

1 We have last year an 80.3 percent
2 discharge to the community rate. Our -- we
3 use net promoter score for patient
4 satisfaction. I think our last quarter
5 metric was about 67 or 66, which is very high
6 if you're familiar with those kinds of data
7 points.
8 Also as I mentioned previously in my
9 statement, just briefly, we work very closely
10 with the joint commission. All of our
11 hospitals are joint commission certified and
12 we meet with the joint commission on a
13 regular basis and are always lauded for --
14 for our quality outcomes.
15 We have a very robust infection control
16 process, and we have disease specific
17 certification in many of our hospitals in
18 different areas depending on what the needs
19 may be in that community.
20 So most of our hospitals have disease
21 specific certification and stroke, but
22 there's also orthopedic, pulmonary, amputee,
23 spinal cord, traumatic brain injury. So
24 when -- when the hospital is established
25 depending on the needs of the community, and

1 I think brain injury was mentioned
2 previously, maybe in that area getting a team
3 that's really focused on brain injury and
4 disease specific certification would be
5 helpful.
6 And that would mean that you would have
7 clinicians who have a specific interest and
8 extra training in brain injury just to work
9 on the brain injury unit with brain injury
10 patients. So that's something that we can,
11 again due to economies of scale, we -- we
12 don't have to reinvent the wheel.
13 We have many, many of our hospitals with
14 these different certifications and can help a
15 new hospital get off the ground depending on
16 what their interest is and what the need is
17 in the -- in the area for that.
18 A. (Tuer) If I could just -- one thing to bring
19 that a little closer to Danbury is our
20 closest hospital is in Ludlow, Massachusetts;
21 it's less than two hours away from you. And
22 for the last three years 82.9 percent of the
23 patients that we have taken there have
24 returned to the community.
25 And what I think is really impressive

1 about that is that UDS, Uniform Data Systems
2 gives you an expected, gives you an
3 expected -- gives you an expected number for
4 what -- your patient population that you're
5 surfing, what they would expect you to return
6 to the community. And the UDS expected for
7 that three-year period for the closest
8 hospital to you is 74 percent, and we were
9 82.92 percent. Under 9 percent for both
10 discharge to skilled nursing facility and
11 under 9 percent for acute-care transfers back
12 to an acute-care hospital.
13 And then that patient satisfaction
14 number, that's actually a 200-point scale.
15 So I, you know, I think that's important to
16 note. You can be negative 100 on that. So
17 this facility is at 76.9, which is in the top
18 ten nationally for our hospitals.
19 Q. (Carney) Okay. Thank you. So the next
20 follow-up kind of related again to data would
21 be to provide us with Encompass, you know,
22 quality measure ratings for either -- I don't
23 know if you do it on a, you know, location
24 basis, like, or a system basis. You could do
25 it for the three closest facilities. So

1 like, quality measures, you know, comparing
2 what the facility did to, say, the benchmark
3 for the last three years as a late file.
4 A. (Charbonneau) Certainly.
5 MS. FUSCO: Sure, we can do that.
6 MR. CARNEY: I think that's Late-File Number -- what is
7 it? We're up to five here.
8 MS. FUSCO: And excuse me Brian, but will we be able to
9 go at the end of the hearing? Can we just go over
10 these as a housekeeping matter to make sure I have
11 exactly what you need?
12 MR. CARNEY: Absolutely.
13 THE HEARING OFFICER: Yeah, we'll do it at the end.
14
15 (Late-Filed Exhibit Number A-6, marked for
16 identification and noted in index.)
17
18 MS. FUSCO: Yeah, after everyone is done. Perfect.
19 BY MR. CARNEY:
20 Q. (Carney) Okay. Moving on.
21 Prefiled testimony speaks to the fact
22 that Encompass utilizes an array of
23 information tech to leverage best practices
24 across the nation and to clinical outcomes.
25 Several things were noted like ACETIP, your

1 clinical information system, Beacon
2 Management Reporting System, ReACT and
3 (unintelligible) and HealtheIntent, a
4 population health platform.
5 I'm hoping to get just a bit more
6 information on how the technology works and
7 how it improves clinical outcomes.
8 A. (Charbonneau) Okay. So you mentioned quite a
9 few programs, but I'll give you an overview.
10 So in terms of our work with our -- our
11 partner for our electronic health record
12 which we internally call ACETIP, Clinical
13 Excellence Through Information Technology is
14 the acronym.
15 And we have worked with them and their
16 data scientist to design predictive
17 algorithms that help our clinicians with
18 certain things. So one program is called
19 ReACT and that program is geared towards
20 reducing acute-care transfers, ReACT.
21 So acute-care transfers are patients who
22 are in the rehabilitation hospital that need
23 to go back to the acute-care side for
24 whatever reason. And our -- what we did is
25 we looked at our own data from multiple

1 years, 80,000 patient encounters and worked
2 with a data scientist and all of our patients
3 are -- now receive a rating in terms of the
4 risk of them being acutely transferred back
5 to the hospital based on certain factors,
6 what apps, medication, changes in their
7 appetite, their participation in therapy, et
8 cetera.
9 And we have incorporated this
10 information into our electronic health
11 records so that it is up front for the
12 clinicians to use on, you know, on an ongoing
13 basis. And so for example if a patient
14 status changes from high risk to very high
15 risk of being acutely transferred, the
16 clinical team can reassess that patient and
17 intervene accordingly depending on what the
18 metrics are that are changing, for example.
19 So similarly we have a predictive
20 algorithm for evaluating patients at high
21 risk of readmission to the hospital after
22 discharge from our rehabilitation hospital.
23 And that, that program allows the clinicians
24 to make certain arrangements for those
25 patients to reduce that, that risk of winding

1 up back in the emergency room or back in the
2 hospital after discharge. And those would be
3 things like access to medications,
4 communication with their primary care
5 physician, making sure that the home health
6 nurse gets there to see the patient the day
7 of discharge, and follow-up calls.
8 We call the patient the next day after
9 they get home and a few days later to make
10 sure things are going okay. So we have
11 leveraged our own internal database, data
12 warehouse which is a huge amount of data
13 right now to be able to work with Cerner to
14 design these algorithms to help with patient
15 care.
16 Currently we're working on a fall risk
17 algorithm which will be a real game changer
18 for inpatient rehabilitation in general,
19 because the scale that's currently used to
20 evaluate patients for fall risk was designed
21 for patients in the acute-care hospital, not
22 in an inpatient rehabilitation setting where
23 our patients are different and they're moving
24 around and they're going to the gym, et
25 cetera, and they're all at a high fall risk

1 to some extent.
2 So we're excited about that. This is
3 something that we're just in the process of
4 rolling out and, you know, our new hospitals
5 coming on board get training and get all of
6 these resources when they open their doors.
7 And we train our clinicians in terms of how
8 to use these resources to improve clinical
9 outcomes.
10 Q. (Carney) Thank you. On Exhibit O, Bates page
11 581, Encompass states that you discharge a
12 higher percentage of patients, 79 percent to
13 the community compared to nursing homes,
14 which a few of you list 40 percent.
15 Was the 79 percent for any specific type
16 of treatment, like hip fracture, you know,
17 patients? Or was it for services across the
18 board?
19 A. (Chafin) This is Marty. The data is for all
20 Encompass patients. So all patient types.
21 It's not specific to any one diagnosis. It's
22 across the board.
23 MR. CARNEY: Okay. And I didn't see any data to
24 support that assertion. So can you provide me
25 with specific, like, discharge status for patients

1 to validate that 79 percent of the community.
2
3 (Late-Filed Exhibit Number A-7, marked for
4 identification and noted in index.)
5
6 THE WITNESS (Chafin): Yes, you're pointing out that I
7 missed my footnote on that. So I owe you a
8 footnote on that. And I apologize. We'll get
9 that to you.
10 BY MR. CARNEY:
11 Q. (Carney) Just one further question about sort
12 of discharges in general. You know, what's
13 sort of your protocol for discharging
14 patients after they complete their rehab?
15 A. (Charbonneau) Basically the way it works is
16 that we work with the patient and the family
17 when they first get in, in terms of what
18 their goals are for discharge.
19 And then as the patient progresses
20 towards those discharge goals we have
21 conversations with the patient and the family
22 about appropriate discharge arrangements
23 depending on -- on what their needs are,
24 where they're going and so forth.
25 So the discharge date is something that

1 gets discussed and communicated with the
2 team, the patient and the family and gets set
3 accordingly. And we have programs in place
4 to ensure a good transition of care. So we
5 know that patients are at high -- highest
6 risk of readmission to a hospital what they
7 go through a transition of care, and the
8 highest risk is when patients go from a
9 hospital to the home environment.
10 So that brings into play all of our
11 programs that we have on discharge medication
12 reconciliation, making sure patients and
13 their family understand their medication,
14 have access to their medication and -- and
15 that we have arranged appropriate followup
16 with their primary care physician, or
17 whatever other physicians they need to see
18 and so forth. And so that's how the
19 discharges are planned well in advance.
20 Q. (Carney) Okay. Thank you. So the last
21 question on quality. Your testimony in
22 Exhibit O, Bates page 687 states that studies
23 that show patients receiving SNF rather than
24 IRF care had higher mortality, more
25 admissions and ER visits and ultimately --

1 ultimately more days in the hospital.
2 Can you explain, you know, IRF care is
3 different and helps to lower those things?
4 And if there's any evidence for supporting
5 studies that can confirm, you know, lower
6 mortality, fewer readmissions and ER visits
7 between the two?
8 A. (Charbonneau) Yeah. So I think that the
9 major differences is the -- the medical
10 oversight and attention that patients get in
11 the IRF setting. And in fact in 2016, the
12 American Heart Association, American Stroke
13 Association published clinical practice
14 guidelines specifically that stating patients
15 who have had a stroke who need rehabilitation
16 are best served in an inpatient
17 rehabilitation environment because the
18 studies do show reduced mortality and
19 morbidity and better functional outcomes for
20 those patients.
21 And there are many studies that -- that
22 look at that sort of thing and we'd be happy
23 to provide you with some references.
24 MR. CARNEY: Okay, great. That will be great. So I'll
25 put that down as Late-File 7, studies confirming

1 reduced mortality, lower readmissions and ER
2 visits in IRFs compared to SNFs.
3
4 (Late-Filed Exhibit Number A-8, marked for
5 identification and noted in index.)
6
7 THE WITNESS (Charbonneau): If I may just add one point
8 to that? And everybody I'm sure is aware of how
9 patients who were in the nursing home environment
10 did when COVID reached our shores. And -- and we
11 all are familiar with the tragedies that ensued in
12 the nursing home environment for many of these
13 elderly vulnerable patients.
14 So I think that just has highlighted the
15 differences in terms of infection control and
16 training of staff and of medical oversight, et
17 cetera, across the country. I'm not picking on
18 Connecticut by any means, but across the country
19 it was just kind of a startling contrast.
20 MR. CARNEY: Yes, very sad. Thank you, those are my
21 questions. I'm going to pass it along to Ormand.
22 THE HEARING OFFICER: Yeah, I know. Ormand is next.
23 Leslie, I hope you don't mind me asking you this,
24 but how many do we have to sign up? And if
25 they're here we can take them.

1 I just know that some of the public might
2 just be calling in to do their comment, and I know
3 we can take it out of order. But I know Ormand
4 has some important questions and we have legal
5 argument still.
6 Anyhow Leslie, can you send me the list?
7 MS. GREER: We have four, and if you want to start
8 Mayor Cavo is here from the City of Danbury.
9 THE HEARING OFFICER: Mayor Cavo, are you present?
10 MAYOR JOSEPH M. CAVO: I am.
11 THE HEARING OFFICER: Okay. I'm going to start with
12 you, but I'm going to just put a little intro. So
13 I am taking this -- I am doing a little break in
14 the office of Health Strategy questioning to take
15 the public comment. For anybody who took a longer
16 break I'll just check again before we close to see
17 if there's any.
18 Leslie, just remind me just if there's
19 someone that maybe tuned out and is planning on
20 coming back, we will take their testimony, but I
21 don't want to make the public wait any longer. So
22 I just want to give you a little instruction
23 before we start with the Mayor.
24 So we will call the names of those who have
25 signed up to speak in the order in which they are

1 registered. If we miss anyone, please utilize the
2 "raise your hand." Speaking time is limited to
3 three minutes.
4 Please do not be dismayed if we stop you at
5 the conclusion of your time. We want to make sure
6 we give everyone the opportunity to speak, and we
7 want to be fair. Additionally we strongly
8 encourage you to submit any further written
9 comments to OHS by e-mail or mail no later than
10 one week from today. Our contact information is
11 on our website and on the public information sheet
12 which you were provided at the beginning of this
13 hearing.
14 Thank you for taking the time to be here
15 today and for your cooperation. All your
16 statements are very important to us. We do
17 consider them and sometimes even do follow-up
18 questions based on what we hear from the public.
19 You are limited to three minutes.
20 And Mayor, go ahead -- and I'm going to have
21 you identify yourself. We have a Court Reporter.
22 This is all being transcribed. So if you would
23 also just spell your name for the record, please.
24 MAYOR JOSEPH M. CAVO: Sure. Thank you, Ms. Yandow.
25 And thank you, everybody, for having me here

1 today. My name is Mayor Joe Cavo, C-a-v-o and I
2 am currently the Mayor of the City of Danbury, and
3 a graduate of a speed reading class so you should
4 be in great shape here (unintelligible). Thank
5 you very much.
6 As Mayor of the City of Danbury and a 35-year
7 resident I am proud and honored to provide this
8 letter in support for the proposed new
9 freestanding comprehensive inpatient
10 rehabilitation hospital to be built within our
11 city.
12 Having previously been a member of the
13 Danbury City Council for 17 years, 15 of those as
14 the President, I have been very involved and
15 committed to the ongoing growth and development in
16 the greater Danbury community. The provision of
17 high quality comprehensive healthcare services is
18 of paramount importance to meet the needs and the
19 expectations of our citizens, particularly those
20 who will greatly benefit from advanced and intense
21 physical inpatient rehabilitation.
22 Encompass Healthcare is a nationally known
23 and respected inpatient rehabilitation hospital
24 providing 137 rehabilitation hospitals across the
25 U.S. and Puerto Rico, and brings tremendous

1 experience and expertise to our community. In
2 addition to the benefit for patients suffering
3 from strokes, traumatic and non-traumatic brain
4 injuries, orthopedic trauma, hip fractures, spinal
5 cord injuries, and many other conditions,
6 Encompass Rehabilitation Hospital of Danbury, LLC,
7 brings significant economic benefits to our
8 region.
9 This $39 million investment in land building
10 and equipment along with the provision of
11 long-term tax revenues, over a hundred
12 construction jobs and 80 to 130 new employment
13 opportunities to staff the new hospital brings
14 great economic growth to our city. I echo former
15 Mayor Boughton's previously submitted letter of
16 support regarding Danbury and the neighboring
17 cities and the planning region of Western
18 Connecticut's tremendous advancement in growth in
19 all of the commercial and healthcare sectors.
20 We have become a very desirable location to
21 live and work, as evidenced by the year-over-year
22 population growth in this area. We work
23 diligently on local and state level to anticipate
24 and project the infrastructure needs and the
25 support for all of our residents now and into the

1 future.

2 Convenient cost-effective and quality access

3 to comprehensive healthcare services is critically

4 important to serve all of our citizens. Currently

5 there is a gap in the care for many of those

6 patients who would benefit from comprehensive

7 inpatient rehabilitation as evidenced by the

8 variable inpatient rehabilitation utilization rate

9 in our region and our state as compared to other

10 parts of the country.

11 We are fortunate to have Danbury Hospital's

12 rehabilitation unit as one resource for such

13 services, and I believe Encompass Health

14 Rehabilitation Hospital of Danbury, LLC, will only

15 compliment their program rather than compete.

16 This will for allow for more rehab

17 appropriate patients to access the needed care and

18 therapy within our community rather than travel

19 long distances, or even out of state to obtain

20 their needed comprehensive inpatient

21 rehabilitative therapy and medical care.

22 We look forward to this proposed addition in

23 the new freestanding Encompass Rehabilitation

24 Hospital of Danbury, LLC, in our community. I

25 highly support and encourage your approval in the

1 certificate of need request on behalf of the
2 citizens in Danbury and the surrounding area.
3 Thank you very much for your time today.
4 THE HEARING OFFICER: Thank you, Mayor. And again I
5 apologize for the wait, your wait and the wait for
6 anyone else in the public. OHS takes everything
7 under consideration. We listen to public comment
8 and it's very important that we take all the
9 evidence.
10 So I do apologize for that wait, but I want
11 you to know it's because this matter is very
12 important to us. We want to make sure we take in
13 all the evidence in a very orderly way.
14 MAYOR CAVO: Not a problem, and I understand. I thank
15 you for the time -- and not a problem here.
16 THE HEARING OFFICER: Okay. Thank you. Next on our
17 list is Dr. Bueno. Is Dr. Bueno available?
18 DR. EARL BUENO: Yes, I am. It's Earl, E-a-r-l; Bueno,
19 B-u-e-n-o. Good afternoon. I'm an
20 anesthesiologist at Waterbury Hospital. I've been
21 involved as a patient and provider advocate over
22 the past decade as Chief of Anesthesia, a member
23 of the hospital staff executive committee and the
24 immediate past President of the Connecticut State
25 Society of Anesthesiologists.

1 Also as chair of utilization and peer review
2 of a regional independent physician's association
3 also known as an IPA, I'm experienced in issues
4 regarding prolonged hospitalizations and
5 readmissions from extended care facilities.
6 The impact on patient care and healthcare
7 costs are quite significant when optimal care is
8 not available. There's a multitude of reasons for
9 prolongation of care ranging from surgical site
10 infections to blood clots, known as the deep vein
11 thrombosis or DVT that may even lead to
12 life-threatening pulmonary embolism, or PE.
13 This affects, not just postsurgical patients,
14 but also being discharged after strokes, heart
15 attacks, problems and infections. There's a great
16 variability in the quality of care among different
17 rehabilitation facilities throughout our region,
18 and that is one contributory factor in so many
19 different outcomes. Oftentimes physicians have
20 minimal input regarding which facility to which
21 their patients will be discharged.
22 Rehabilitation services including physical
23 and occupational speech therapy promote faster
24 recovery allowing patients to return to their home
25 environment as soon as possible. Patients benefit

1 from a high care multidisciplinary inpatient rehab
2 facility such as Encompass Rehabilitation, one
3 that can reduce the risk of complications and
4 decrease the length of stay.
5 In doing so better outcomes can be expected
6 and the cost of care will be significantly
7 reduced. I support the establishment of
8 facilities such as Encompass Rehabilitation which
9 focused their skill set on this patient
10 population. Currently the patients and their
11 families have to travel significant distances to
12 receive this degree of inpatient rehabilitation
13 since there's a limited availability of these beds
14 in Western Connecticut. It serves our community a
15 greater good to have access to this level of care
16 locally.
17 Thank you for your time.
18 THE HEARING OFFICER: Thank you. Julie Peters.
19 JULIE PETERS: Good afternoon. Hi.
20 THE HEARING OFFICER: If you could just state and spell
21 your last name for the record, please -- and three
22 minutes.
23 JULIE PETERS: Sure. My name is Julie Peters, that's
24 P-e-t-e-r-s, and I'm the Executive Director of the
25 Brain Injury Alliance of Connecticut, which has

1 advocated on behalf of individuals with brain
2 injury and their caregivers for 40 years. I'm
3 here to express my support for Encompass Health's
4 certificate of need application to build an
5 acute inpatient rehabilitation hospital in
6 Danbury.
7 At BIAC as part of our mission we advocate
8 for accessibility and availability of inpatient
9 rehabilitation for residents of Connecticut with
10 brain injuries. We work with individuals who've
11 sustained brain injuries to support navigation
12 through the complex medical rehabilitation, social
13 financial, vocational and educational outcomes
14 after acquired brain injury.
15 So that past 19 years when -- as I've worked
16 in Connecticut as the Executive Director, I have
17 seen the challenges we face as a result of having
18 so few acute inpatient rehab hospitals in our
19 state, particularly in Western Connecticut. And
20 I'm speaking here particularly for people with
21 brain injuries. There is virtually no competition
22 for individuals with brain injuries in our state.
23 Countless times over the years Connecticut
24 residents with brain injury have been forced to
25 get their care in Massachusetts or New York simply

1 because there wasn't an appropriate place for them
2 in Connecticut. I've seen families who either
3 have to move to another state temporarily or not
4 have daily connection with their loved ones.
5 Individuals forced to go out of Connecticut
6 to receive care also lose the access to their
7 local network of both medical and social support.
8 There's a dire need in this state for more rehab
9 facilities in order to allow individuals with
10 brain injury to get care as close to their home
11 environment as possible. Comprehensive inpatient
12 rehabilitation hospitals such as Encompass provide
13 a much higher level and intensity of rehab and
14 medical care not found at other settings such as
15 SNF.
16 And I can't tell you how thrilled I was to
17 hear Dr. Charbonneau talk about the importance of
18 specific brain injury education and training when
19 dealing with individuals with brain injury. SNFs
20 just don't have that in Connecticut, and they
21 don't have that level of care. So this gives
22 individuals with brain injury the best possible
23 opportunity to achieve better outcomes.
24 Individuals with brain injury who have access
25 to intensive physical occupational and speech

1 therapies will result in lower lengths of stay,
2 improved functionality, returning faster to
3 activities of daily living, inclusion of family
4 participation in the rehabilitation, and a wide
5 range of rehabilitative and social benefits.
6 Brain injuries like ours throughout the
7 country have developed and depend on positive
8 relationships with comprehensive inpatient
9 rehabilitation hospitals, and Encompass Health is
10 well known for their expertise. And I would say
11 we would be another one of those who generate
12 referrals for Encompass health through our
13 helpline.
14 We look forward to welcoming Encompass Health
15 to Danbury and Western Connecticut. For these
16 reasons I hope you will seriously consider the
17 granting of a certificate of need for an acute
18 inpatient rehab hospital in this region. It would
19 provide a much needed service to individuals like
20 those we serve every day as well as to the larger
21 community. Thank you.
22 THE HEARING OFFICER: Thank you very much. Dr. Janet
23 Gangaway.
24 DR. JANET GANGAWAY: Good afternoon. My name is
25 Dr. Janet Gangaway. Last name is spelled

1 G-a-n-g-a-w-a-y. Thank you for allowing me to
2 speak today.
3 I have a doctorate in physical therapy and
4 board certification in orthopedic physical
5 therapy. After six years of practice, I have
6 spent the last 20 years in academia, 15 years in a
7 doctor of physical therapy program, and the past
8 five years in the Connecticut state colleges and
9 university system as program director for the
10 physical therapist assistant program at Naugatuck
11 Valley Community College.
12 We educate physical therapist assistants and
13 prepare them for entry-level practice in the field
14 of physical therapy across multiple settings.
15 This includes both content and clinical education
16 experience across the breadth and depth of
17 physical therapy practice. Acute rehabilitation
18 is one of these areas.
19 An acute comprehensive inpatient
20 rehabilitation hospital provides intensive therapy
21 using state-of-the-art technologies. This unique
22 setting provides our students with the exposure
23 and experiences with patients who are acutely ill
24 or experienced significant trauma.
25 The demand for these services is on the rise,

1 especially due to the long term effects of the
2 COVID-19 infection. To have workers prepared to
3 enter the workforce, including physical
4 therapist's assistants, respiratory therapists and
5 nurses, facilities must be available to provide
6 the necessary clinical education experiences to
7 our students.
8 The availability of acute inpatient
9 rehabilitation for our students is very limited
10 despite there being a number of rehabilitation
11 hospitals more to the east of Connecticut since we
12 are located in Waterbury.
13 As we've all heard several times, there is a
14 wide variety of patients who need inpatient
15 rehabilitation, stroke, neurological disorders,
16 multi-trauma traumatic brain injury, amputation,
17 neuromuscular conditions, just to name a few.
18 Rehabilitation services, including physical,
19 occupational and speech therapy enable faster
20 recovery after brain injury and other conditions
21 to allow patients to return to their home
22 environment as soon as possible. Patients receive
23 three hours of therapy per day and achieve far
24 better outcomes than those received in a lower
25 level of care setting.

1 Acute comprehensive rehab hospital and
2 services are very limited in Western Connecticut,
3 resulting in patients and families having to drive
4 long distances to receive their level of care that
5 they need. It also limits the family's ability to
6 visit and participate in their care. This
7 proposed hospital will greatly benefit patients
8 from throughout Western Connecticut. It's vital
9 for us to be able to train our students to be as
10 prepared as possible for the workforce that they
11 are about to enter, and this hospital will help
12 meet that need.
13 I greatly support this project and encourage
14 your approval for Encompass Rehab Hospital of
15 Danbury. Thank you for your time.
16 THE HEARING OFFICER: Thank you for your time, and
17 thank you. Thank you for your words.
18 DR. JANET GANGAWAY: You're welcome.
19 THE HEARING OFFICER: That is the last. Is there any
20 other participants that's on line with us here
21 that believes that they signed up to make public
22 comment?
23
24 (No response.)
25

1 THE HEARING OFFICER: So that's the end of the list I
2 have.
3 Leslie, do e-mail me or send me a message if
4 someone else signs up. We have taken this out of
5 order. So I just want to make sure we don't miss
6 anyone that wanted to speak.
7 So I apologize, Ormond, for disrupting the
8 question flow, but you can go right ahead.
9 DR. CLARKE: Definitely. My name is Ormand Clarke,
10 spelled O-r-m-a-n-d, C-l-a-r-k-e. I'm healthcare
11 analyst at OHS. My initial round of questions are
12 in relation to cost to consumers.
13
14 CROSS EXAMINATION (of Chafin)
15
16 BY DR. CLARKE:
17 Q. (Clarke) Throughout the application you state
18 that Encompass has comparatively low cost,
19 and provides cost effective care. Kind of
20 discuss how Encompass can provide lower cost
21 of care?
22 A. (Chafin) This is Marty Chafin. I would refer
23 you, I guess, to Exhibit G in my prefiled
24 testimony. And I would talk first about the
25 lower cost of care at Encompass compared to

1 other IRFs.

2 And when you look at this chart you see

3 that -- and again, this is national data, but

4 based on Encompass' experience they have

5 lower cost and lower payment per discharge.

6 What that translates into is less cost to the

7 healthcare payers and to the patients and

8 their families, and that's relative to other

9 IRFs. Does that answer your questions?

10 Because some of that lower cost is the

11 efficiencies that Pat could speak to, some of

12 the efficiencies that they have as a national

13 company.

14 A. (Tuer) So I can expand on this a little bit.

15 And you know, if you look at it from a silent

16 point of view just, from a per case level

17 inpatient rehab is more expensive than a

18 skilled nursing facility stay. That that is

19 a fact, but we readmit patients significantly

20 less and that has monetary considerations to

21 it. So we reduce future downstream episodes

22 of care.

23 The fact that we're able to get, you

24 know, 82 percent of our patients and, you

25 know, at the closest facility to you, home,

1 and -- and not to a still nursing facility
2 less than 10 percent of the time, that
3 reduces cost to -- from an episodic cost of
4 care perspective.
5 And then I talked a little bit about the
6 costs when -- when reimbursement has stopped
7 and a patient is beyond their geometric mean
8 length of stay, which Medicare defines as a
9 completely average amount of time a patient
10 would stay in the hospital for a particular
11 diagnosis.
12 In most hospitals that amounts to
13 several million dollars a year. Okay? And
14 you can arrive at that by looking at their
15 direct costs per day and multiplying that by
16 the days over the geometric mean length of
17 stay.
18 So you know, from an episodic standpoint
19 when you factor all of those things in, we
20 are a cost effective site of care.
21 Q. (Clarke) And Mr. Tuer, as a point of place,
22 then can they explain how is the cost of care
23 at Encompass, since this proposed facility
24 would be lower than existing facilities in
25 the state of Connecticut?

1 A. (Tuer) So if you're talking about existing
2 IRF beds the -- the exhibit that Marty had
3 mentioned -- so hospital based distinct part
4 units on average are paid more from payers,
5 whether that's Medicare or commercial payers,
6 than -- than we are.
7 And as a result of that, you know, from
8 a direct cost perspective in our level of
9 care, you know, we -- because we're able to
10 centralize things with the use of our systems
11 and salaries, and wages are typically one of
12 the most expensive parts of health care. And
13 because we're able to have those efficiencies
14 we're able to save costs on from that
15 standpoint.
16 Marty, I don't know if there's anything
17 you'd like to add to that?
18 A. (Chafin) Yes, the one thing I would add --
19 very specific in terms of Connecticut is in
20 the rebuttal testimony, my rebuttal prefiled
21 testimony that was sent last night. I don't
22 know, Ormand, if you had a chance to see
23 that.
24 But in that there's a table that gives
25 you specifically a comparison of Danbury

1 Hospital versus Encompass Hospital's proposed
2 charges. And -- and to get in the weeds for
3 just a second Encompass Danbury's proposed
4 charge per patient discharge is over $3,700
5 less than what the cost is to Danbury
6 Hospital.
7 So when you ask specifically about
8 Connecticut cost comparison, hopefully that
9 addresses your question.
10 DR. CLARKE: Thank you. If we need additional
11 information we will get back to you.
12 MR. CARNEY: This is Brian. Can I just follow up one
13 question on that chart you were talking about,
14 Exhibit DD, page 5?
15 MS. FUSCO: (Unintelligible.)
16 BY MR. CARNEY:
17 Q. (Carney) You have charges per patient day.
18 You have charges for discharge. Okay. I get
19 that. Then you have charges again, I'm
20 thinking that's total charges -- or I'm not
21 sure what that represents. One says -- is
22 that just total volume?
23 A. (Chafin) It is. You're pointing out all the
24 things that I thought were clear that are
25 not, and I do apologize.

1 Yes, this was the total charge amount so
2 that then you could check our math and see
3 our source document of total charges divided
4 by the patient day. It gives you the charges
5 per patient day. Just like the total charges
6 divided by the discharges gives you the
7 charge per discharge.
8 And if it helps you, we can send you
9 that AHD report. I don't know if you have
10 access to that or not. It's a subscription
11 base.
12 Q. (Carney) Yeah, we wouldn't have access to
13 them.
14 A. (Chafin) Would it help to see it?
15 Q. (Carney) Absolutely it would.
16 A. (Chafin) Okay.
17 MR. CARNEY: Sorry, Ormand.
18 THE HEARING OFFICER: What late file are we up to now?
19 A VOICE: Eight or nine.
20 DR. CLARKE: Eight. I have eight.
21
22 (Late-Filed Exhibit Number A-9, marked for
23 identification and noted in index.)
24
25 THE HEARING OFFICER: Okay, Ormand. Thank you.

1 BY DR. CLARKE:
2 Q. (Clarke) Describe the different care settings
3 and how the costs differ between those and
4 the proposed IP rehab facility?
5 A. (Chafin) I would -- Yes. In doing so I would
6 refer you to Exhibit G, page 3. Because
7 that's a good point when you're asking about
8 each setting and how it differs.
9 If we look just at the cost per day, for
10 example, inpatient rehab will be higher than
11 a skilled nursing facility cost because CMS
12 bases their payment and the cost also is
13 based on resource utilization.
14 So inpatient rehab, for example, per day
15 is 1,689. So it's higher per day relative to
16 the skilled nursing facility cost per day.
17 But two things I would ask you to
18 consider. One is that the length of stay in
19 those two settings varies greatly. So while
20 a per day basis in a skilled nursing facility
21 is lower. On average, the resident's stay in
22 a skilled nursing facility is more than twice
23 as long.
24 And while -- so that means conversely
25 while IRF, the charges and the costs are

1 higher, the patients are in and out quicker.
2 It's a twelve-day length to say versus almost
3 a month length of stay.
4 Q. (Clarke) Thank you.
5 A. (Chafin) Does that help?
6 Q. (Clarke) Thanks. Okay. Thank you. My next
7 round of questions are in relation to a
8 demonstration of the financial feasibility.
9 And these I will direct to Mr Tuer. Your
10 testimony states/indicates that the proposal
11 would cost approximately $39 million. Please
12 discuss Encompass' plan and ability to fund
13 this project?
14 A. (Tuer) Thanks for the question. And we also
15 have a member of our development team.
16 Mr. Bill Heath who may be able to provide
17 some -- some information on -- on this as
18 well.
19 Mr. Heath, I don't know if you want to
20 take that first, or if you want me to take
21 it?
22 THE HEARING OFFICER: If there's going to be another
23 witness I'll need to swear him in.
24 B I L L H E A T H,
25 called as a witness, being first duly sworn by the

1 HEARING OFFICER, was examined and testified under
2 oath as follows:
3
4 THE HEARING OFFICER: Please state your name for the
5 record, and spell your first and last name,
6 please?
7 THE WITNESS (Heath): Sure. It's Bill Heath,
8 H-e-a-t-h.
9 THE HEARING OFFICER: Okay. And Bill, B-i-l-l? Okay.
10 THE WITNESS (Heath): Yes, sorry.
11 THE HEARING OFFICER: Just your name doesn't come up.
12 So that the Court Reporter doesn't know how -- I'm
13 just assuming.
14 So Ormand, whoever you want to ask the
15 question of, I guess you can. Mr. Heath I think
16 is being identified as their financial person.
17 THE WITNESS (Heath): Sure. So I'll say very quickly a
18 couple of ways we can do that. I know in other
19 CON stays we have provided a letter by someone in
20 our finance department testifying that we have the
21 cash available to pay for it.
22 Certainly we could get that if that's --
23 MS. FUSCO: (Unintelligible) -- help.
24 THE WITNESS (Heath): I think we included a copy of our
25 10-K as well. That I can't speak off the top of

1 my head exactly what the cash flow from operations
2 is, but I can tell you we -- we're very busy on
3 the development front. We have opened eight new
4 hospitals this year. We anticipate opening at
5 least that many next year, in the following year.
6 We -- we have sufficient cash flow to fund
7 all of it.
8 THE HEARING OFFICER: Okay. Whatever you can submit to
9 prove. I think his question was specific to this,
10 to this facility, this proposed facility. So we
11 would have a late file then, to support -- what is
12 it exactly, or that we should be getting? We want
13 some sort of financial statement or financial
14 records regarding that they have the funds?
15 DR. CLARKE: Yes, the availability of funds to, you
16 know, create this facility.
17 MS. FUSCO: And what we can do is -- I mean, two
18 things. We can get a funding letter from the
19 Encompass CFO which will confirm what we put. We
20 put in our hearing issues response, there was a
21 question about financial feasibility and the last
22 portion of that -- I don't have it in front of
23 me -- was sort of the substance of what would go
24 into a funding letter to be signed by the chief
25 financial officer of the company.

1 So we can get you that, and then the 10-K is
2 already in the record. And we can look at that a
3 little more carefully and point you to where in
4 that 10-K it would show cash flows and sufficient
5 cash to fund the project.
6 So those are two ways I can think up to do
7 it.
8
9 (Late-Filed Exhibit Number A-10, marked for
10 identification and noted in index.)
11
12 THE WITNESS (Chafin): And we have -- if it helps,
13 because I know it's such a voluminous CON
14 application, we actually have a funding letter
15 from the Senior Vice President Treasurer
16 confirming the ability to fund the project.
17 MS. FUSCO: And that's on page 82 of the original CON
18 submission. I didn't realize that was in there,
19 so I was offering up -- yes.
20 MR. CARNEY: And then just to follow up about that. Is
21 that still relevant? Like, does it have, you
22 know, a timeframe? Or I know a lot of time has
23 passed, so could you just --
24 MS. FUSCO: It doesn't, because it's internal, but I'm
25 happy to get you a fresh one, a newer one. That's

1 fine?
2 MR. CARNEY: I think that would be good idea. Just a
3 long time has passed.
4 MS. FUSCO: Yeah, it's from April 2020. So I'll get
5 you a new one.
6 THE WITNESS (Tuer): And then -- and then Mr. Clarke --
7 Mr. Carney, are you done? I didn't want to --
8 MR. CARNEY: Yes, I am. Thank you.
9 THE WITNESS (Tuer): No problem. And then Mr. Clarke,
10 so once the project is funded, which we can
11 provide that information to you, operationally how
12 that is funded going forward is -- and there was
13 an exhibit. I don't have the reference for it,
14 but that same exhibit that I was talking about
15 that shows our average cost and our average
16 reimbursement, you can see that there is a
17 profitable margin there.
18 And that is through our cost effective care
19 and appropriate management of patients, very
20 similar to what Danbury Hospital is likely doing
21 in their inpatient rehab hospital -- or unit.
22 DR. CLARKE: Thank you.
23 BY DR. CLARKE:
24 Q. (Clarke) Mr. Tuer, if volumes are below
25 projections, how will this affect Encompass'

1 ability to operate the program?
2 A. (Tuer) So the -- and if anyone from the
3 Encompass side wishes to jump in, feel free.
4 But the, you know, we have the ability to, if
5 this hospital -- you say we -- we're under --
6 under-projected on volume, we have the -- the
7 financial capacity to -- to cover the cost of
8 this hospital operationally, and -- and that
9 funding letter will help provide that
10 information.
11 But we -- as I said, we, in our 144
12 hospitals that we've built or acquired, we
13 have none that are not profitable. And
14 even -- but we do have hospitals that are not
15 at their -- their volume projections that we
16 had established on an annual basis from a
17 budgetary perspective.
18 And you know, we work with the
19 hospitals. So myself, I'm -- I'm the
20 Regional President but I have subject matter
21 experts in, you know, nursing and therapy and
22 care coordination, in business development
23 and patient education and identification that
24 if we're not where our volumes were expected
25 to be, that we work to identify the issue.

1 Is it -- is it an outcome issue, which
2 is typically not the case? But is there a
3 frustration from a local referral source over
4 perception of outcomes? And we would work
5 to -- to -- with that referral source to
6 remediate any concerns.
7 And -- and typically from that, if there
8 is a bed need such as there is in the Danbury
9 market, then typically the volume issues
10 subside.
11 You know, if -- if you have a bed need
12 and you provide a great service with great
13 patient satisfaction, great discharge
14 outcomes and you're a good partner for the
15 acute-care hospitals in your market like
16 Danbury Hospital, the -- the volume comes.
17 And across 144 hospitals we have not had that
18 not be the case.
19 A. (Chafin) Let me add briefly -- I know it's
20 late in the day, but let me add briefly, we
21 have a lot of information that has been
22 filed. So Mr. Clarke, one thing that we
23 did -- it's on CON page 715.
24 To cut to the chase, if the volume is
25 not met that we projected for year three,

1 which was 900 and some odd -- 963 admissions,
2 the breakeven number is 524. So
3 significantly lower than our projections, and
4 this facility is breakeven. There's no loss
5 of money there.
6 So The facility could actually operate
7 in a 46 percent occupancy and not lose money.
8 I don't know if that helps address your
9 concern or question.
10 Q. (Clarke) Yeah, my succeeding question was
11 intended to be directed to you as well. What
12 was the volume of patients needed for
13 breakeven?
14 A. (Chafin) We're on the same page?
15 A. (Tuer) Marty, thanks for being much more
16 succinct with your response than I was. I
17 appreciate that.
18
19 CROSS-EXAMINATION (of Aaronson)
20
21 BY DR. CLARKE:
22 Q. (Clarke) Thank you. I have a few questions
23 for Dr. Aaronson. Dr. Aaronson?
24 A. (Aaronson) Yes.
25 Q. (Clarke) What impact will this proposal have

1 on Danbury Hospital?
2 A. (Aaronson) I think it can have a significant
3 impact.
4 THE HEARING OFFICER: Is there a camera available?
5 THE WITNESS (Aaronson): One second. Can you hear me?
6 BY DR. CLARKE:
7 Q. (Clarke) Yes.
8 A. (Aaronson) Okay. I think it can have a
9 significant impact. There are major Medicare
10 rules that we have to abide by. One of the
11 rules I mentioned before in my testimony
12 regard -- is regarding the 60 percent rule
13 where we have to have 60 percent of our
14 patients with 1 of 13 medical conditions or
15 neurologic conditions.
16 And if another rehab hospital is taking
17 patients away from us, it could potentially
18 reduce those number of conditions that we're
19 treating and potentially put -- put us at
20 risk at not being compliant with Medicare
21 guidelines. So that's one way.
22 The other way is, you know, having a
23 brand-new facility is always going to
24 potentially be a lure for patients,
25 regardless of quality. We've seen that with

1 extended care facilities in the past, things
2 that open up that are brand spunking new are
3 going to be certainly a form of attraction,
4 but quality is what counts.
5 And the quality of care at Danbury is --
6 is, you know, beyond none.
7 Q. (Clarke) And what types of rehab services are
8 offered at Danbury Hospital? For instance,
9 are they comparative to what Encompass is
10 proposing?
11 A. (Aaronson) They are comparable. We are
12 intensive level rehabilitation. So we are
13 not a freestanding rehab hospital. So we are
14 within the hospital setting. We offer the
15 same degree of intensive rehabilitation. We
16 deal with the same types of patients.
17 We're just smaller, but we also take
18 very medically complex patients that the
19 surgeons and the physicians still need to
20 follow very closely. That's one of the
21 reasons they don't oftentimes get approved to
22 leave at the hospital. So as a result, they
23 come to our rehab unit, where these doctors
24 can still follow the patients very closely.
25 Q. (Clarke) And we have learned since morning

1 and previously before that there are 14
2 inpatient rehab beds to Danbury, but of these
3 available bands, how many are currently being
4 staffed?
5 A. (Aaronson) At the present time it depends on
6 our census. Right now it's staffed fully
7 because we have a higher census today, but it
8 depends on how full the census is.
9 So the nursing manager is very good at
10 adjusting how many actual PCTs and nurses are
11 available depending on our staffing of the
12 day. So we do what would be considered a
13 huddle and let them know how many admissions
14 we're doing. Based on that they determine
15 what type of staffing ratio they need.
16 Q. (Clarke) And can you give us an idea of how
17 many patients can be treated in a given year?
18 A. (Aaronson) I believe we discharged, like, 370
19 patients, something along those lines. I
20 don't know the exact number. We can get that
21 for you.
22 The other competitive issue is that
23 there is a staffing shortage, particularly
24 for nursing and medical assistants. And we
25 face it every day both in our office and in

1 the hospital setting. So a rehab hospital
2 coming to this environment would potentially
3 pull staff from us, which would be really
4 detrimental.
5 Q. (Clarke) And do you have knowledge of
6 patients being denied services or discharged
7 prematurely due to capacity limits at Danbury
8 Hospital?
9 A. (Aaronson) No, if it happens it's extremely
10 rare.
11 Q. (Clarke) And can you provide a circumstance
12 that that might happen?
13 A. (Aaronson) Again, it's rare. On rare
14 occasion they might go to Gaylord because of
15 specialty care there, but it would be
16 unusual.
17 BY MR. CARNEY:
18 Q. (Carney) So this is Brian. Just a quick
19 followup, Doctor. So today you said your
20 census is full at 14 beds. If someone
21 else -- there was a need for an additional
22 person coming, coming over today, they
23 wouldn't be able to get admitted. Correct?
24 A. (Aaronson) No, that's not correct. We have a
25 very, kind of, revolving door. So if --

1 tomorrow we have two discharges. Saturday we
2 have one discharge. So it's very dynamic in
3 terms of the process.
4 Q. (Carney) Okay. But just say you got a call
5 today and someone was looking for an
6 inpatient rehab bed. So you have to wait
7 until you discharged one to admit them.
8 Correct?
9 A. (Aaronson) If we're at capacity when we're
10 full that, you know, doesn't happen all the
11 time.
12 Q. (Carney) Okay. Thank you.
13 A. (Aaronson) And that's another -- that's
14 another reason why we would consider in the
15 future expanding if indeed that were to
16 happen on a very consistent basis.
17 THE HEARING OFFICER: So how often are you at capacity?
18 I mean, has it happened?
19 THE WITNESS (Aaronson): It's happened. It's not that
20 often. We have --
21 THE HEARING OFFICER: So what does that mean? I just
22 don't know what that -- like, does it happen once
23 a month? Once a year? What does that mean?
24 THE WITNESS (Aaronson): I would say once every few
25 months.

1 THE HEARING OFFICER: Okay. Thank you.
2 MR. CARNEY: One more followup, Doctor.
3 BY MR. CARNEY:
4 Q. (Carney) Are you guys taking patients from
5 Sharon and Norwalk Hospitals as well, the new
6 program?
7 A. (Aaronson) We are -- we are always available
8 to take patients from most hospitals that
9 refer, or all hospitals that refer.
10 Norwalk Hospital, we screen these
11 patients because their case managers are very
12 assertive in sending us referrals. What
13 happens is the patients, we approve them and
14 then they actually decline the offer because
15 geographically we are far from them, and it's
16 about a 45-minute ride. So they oftentimes
17 will select Stamford Hospital instead of us
18 despite us being in the Nuvance --
19 Q. (Carney) Affiliation (unintelligible).
20 A. (Aaronson) Exactly. And also we have
21 neurosurgeons who actually cared for the
22 patients and encourage them to come, and some
23 that indeed do, and it's great because then
24 they have the continuity of care from the
25 neurosurgeon who treated them.

1 But nonetheless, there -- it's their
2 decision. We obviously respect that, but is
3 it in their best interests? Not necessarily,
4 because the surgeons are -- would be here.
5 MR. CARNEY: Thank you.
6 THE HEARING OFFICER: Can I just follow up, because you
7 opened up a nice, you know, I think Brian and I
8 both have some questions, and this is a good line
9 of questioning.
10 So I mean, is there a time where somebody
11 said, oh, you have the option to get your therapy
12 at home, versus, going in an inpatient? I mean,
13 how often does that happen? And what, just from
14 your experience of Danbury, what do patients
15 prefer?
16 I mean, I don't know. So if you could, you
17 know, if someone is an inpatient does it mean they
18 shouldn't be at home?
19 Is that why they're inpatient?
20 THE WITNESS (Aaronson): There are instances where
21 patients are better served being at home. Perhaps
22 someone with dementia might be -- might do better
23 in the home environment, but that's extremely
24 taxing on the family unit. They would have to
25 probably hire additional care or have hands-on

1 care that they would have to deliver themselves.
2 So it really depends on the scenario. We
3 don't oftentimes recommend it, but we can help
4 gear the families up for that type of discharge if
5 it indeed is appropriate.
6 A case, for example, might be if someone has
7 an end-stage condition and nearly can't do the
8 intensive rehabilitation, or the quality of life
9 needs to be optimized. You might want to set them
10 up for home care -- or they're too high level.
11 Let's say they're a cardiac patient who
12 doesn't need oxygen anymore who walks 75 feet, but
13 just may need someone to maybe put a hands on them
14 just to make sure they don't lose their balance.
15 That's someone who might be able to -- might be
16 able to train a family member, get some home care
17 services in.
18 They don't need the intensity anymore,
19 because they're medically stable and functionally
20 do it -- they're doing quite well. Just a little
21 support at home with very appropriate and a good
22 use of our Medicare dollars.
23 THE HEARING OFFICER: So talking about the Medicare
24 dollars versus that the stay in the hospital,
25 versus a stay in a facility like Encompass. So we

1 heard from Encompass, their argument that
2 Encompass will save money.
3 I mean, do you have a position regarding
4 that?
5 THE WITNESS (Aaronson): Hard to say. I think that,
6 you know, we can look at the statistics they have
7 from around the nation from what I see from
8 patients having to be readmitted back, whether it
9 be from other hospitals, which indeed does happen
10 even from large university settings, that those
11 are costly patients. They're sicker patients.
12 The tendency for those patients to be readmitted
13 is high. So that drives up costs.
14 So it's hard to say.
15 THE HEARING OFFICER: Okay. Thank you.
16 DR. CLARKE: Thank you.
17 BY DR. CLARKE:
18 Q. (Clarke) What will be the typical discharge
19 plan be like for patients leaving Danbury
20 Hospital Rehab?
21 A. (Aaronson) very often we will, depending on
22 their functional level at the time of
23 discharge, we aim for as high as functional
24 level as possible, which means independent or
25 modified independent -- meaning they're sent

1 home safe but with an assistive device.
2 Very often we really like to use the
3 continuum of care. We want to make sure that
4 they are really comfortable and safe in their
5 home environment. So we will, most of the
6 time, recommend home health care.
7 That means a visiting nurse coming in, a
8 nurse to check medications and medical
9 stability and pass off care to the primary
10 care doctor. So there's that continuity.
11 Then the nurse reports back to the primary
12 care doctor any changes. Also then a PT and
13 OT, or speech, or all three complemented
14 therapies would be then in place depending on
15 the patient's needs.
16 If a patient is really high level and
17 you feel the best place for them to get more
18 aggressive outpatient care, then we send them
19 to an outpatient rehabilitation facility.
20 That's where they can still get, you know,
21 more access to different types of equipment,
22 a little bit more focused type therapy rather
23 than the home environment.
24 You have specialist equipment. You have
25 a little bit more dedicated neurologic

1 therapists working with these patients, and
2 that would be another way of discharging a
3 patient depending on their needs.
4 BY MR. CARNEY:
5 Q. (Carney) Can I just ask some further
6 questions? Doctor, what can you tell us
7 about your plans for expansion of services at
8 the hospital?
9 A. (Aaronson) So that's something we've been
10 looking at intermittently, but when we became
11 a Nuvance Health System, we thought there
12 might be opportunity in the future.
13 We did look at, was there room to make
14 some beds on our current rehab unit? And we
15 explored that. We didn't put the dollars in
16 per se at that time, but we said, yes. We
17 have the capability. Yes, we would
18 potentially budget for it.
19 Certainly, there's money allocated for
20 it as well. We just needed to get a sense
21 what would happen as a system. Again, when
22 Norwalk Hospital closed their rehab unit and
23 we became more aligned with them, we thought
24 there would be a potential for more referrals
25 coming from them. We get about one patient a

1 month from Norwalk Hospital as it stands now.
2 That potentially will grow once we have a
3 screener in place who will be working closely
4 with the doctors, the case managers and that
5 potentially will grow. So we don't know what
6 that will yield.
7 So again, that's a potential growth
8 phase that we are trying to accommodate for,
9 both from a physical layout standpoint, a
10 budgetary standpoint as well.
11 MR. CARNEY: Thank you.
12 DR. CLARKE: Thank you.
13 BY DR. CLARKE:
14 Q. (Clarke) What are your current volumes for
15 inpatient rehab at Danbury Hospital?
16 Would you know?
17 A. (Aaronson) Per year?
18 Q. (Clarke) Yes.
19 A. (Aaronson) I don't have the number off the
20 top of my head. I think --
21 Q. (Clarke) Would be able to provide that for
22 us?
23 A. (Aaronson) Sure.
24
25

1 (Lated-Filed Exhibit Number I-1, marked for
2 identification and noted in index.)
3
4 BY DR. CLARKE:
5 Q. (Clarke) Thank you. And what is the other
6 daily rate of inpatient rehabilitation?
7 A. (Aaronson) No rate -- you're talking about
8 cost?
9 Q. (Clarke) Yes.
10 A. (Aaronson) We'll provide that. I don't want
11 to misquote that. I have a general sense,
12 but I think we should provide that in great
13 detail.
14 Q. (Clarke) Well, and when you do kind of
15 provide for commercially insured as well as
16 self-pay patient, please.
17 A. (Aaronson) Absolutely. Absolutely.
18
19 (Lated-Filed Exhibit Number I-2, marked for
20 identification and noted in index.)
21
22 DR. CLARKE: Thank you. And that concludes my
23 questions. Thank you so much.
24 THE WITNESS (Aaronson): Thank you.
25 THE HEARING OFFICER: Brian, did you have any more

1 follow-up questions?
2 MR. CARNEY: I'm good, Attorney Yandow.
3 THE HEARING OFFICER: Okay. Attorney Fusco, do you
4 have cross on any of this?
5 MS. FUSCO: No, we don't have any questions.
6 THE HEARING OFFICER: You don't have any questions.
7 Okay. And Attorney Tucci, I don't really need any
8 more cross examination from you unless you can
9 identify something that you think would be -- we
10 know how to go pick through the evidence. Is
11 there anything you want to bring to my attention
12 regarding what you would --
13 MR. TUCCI: The answer is, no. We have no follow-up
14 questions. Thank you for the opportunity.
15 THE HEARING OFFICER: Okay. Good. You're welcome.
16 All right. We're going to have closing arguments
17 now, but before we do that -- Ormand, do you have
18 the list of the late files we'll go over?
19 Hopefully they were getting a little -- I don't
20 even know what number we ended on.
21 DR. CLARKE: I'll just finalize that in a moment.
22 THE HEARING OFFICER: Okay. So we'll go over those at
23 the end of the hearing then. So I want to then
24 move on to closing arguments.
25 Attorney Fusco, so I'm going to start with

1 you. If you can try to keep it to five minutes,
2 if you have more than that I'll let you go, but
3 I'll also let you have the last word.
4 I'm going to then go to Attorney Tucci, and
5 then I'll come back to you for another. You can
6 have the last word. This is your application
7 for -- if you want it for another minute or
8 something.
9 But if you want to go ahead, do you have a
10 closing argument?
11 MS. FUSCO: I do, and I think I could definitely keep
12 the five minutes. I just wanted to start by
13 thanking you, Attorney Yandow and most of the OHS
14 staff.
15 You know I know how challenging these remote
16 hearings are. Now I've down four or five of them
17 over the last year, and I can say I have been
18 impressed with how well you guys have worked
19 through these and kept them orderly and, you know,
20 got a lot of information in, in a short period of
21 time while still accommodating the public and
22 witnesses and attorneys all over the place. So
23 thank you very much again.
24 It's been a long day of testimony and
25 questions and comments, and so I'd just like to

1 take maybe a few minutes to level set and to
2 remind OHS what the proposal is about and why, you
3 know, this critically important project should be
4 approved. And I'm just going to try to hit
5 briefly on some of the key CON decision criteria.
6 So you know, as you know much of the
7 testimony and questions today is focused on
8 whether there's a clear public need for the 40-bed
9 IRF proposed by Encompass. Those who oppose the
10 CON say there isn't. Right? They point to the
11 state health care facilities and services plan and
12 say that it shows, you know, a minimal need for
13 additional rehab beds in the state.
14 However, as you heard from Ms. Chafin, the
15 state health aid need methodology relies only on
16 historic utilization and population growth going
17 forward. And it doesn't account for those
18 patients in need of rehabilitative care and
19 services who are currently receiving them in, you
20 know, less than optimal care settings like SNFs.
21 I know we've talked about this a lot today -- or
22 who are foregoing needed rehab services
23 altogether.
24 You know, on the other hand if you look at
25 the data-driven population based, needs-based

1 methodology used by Encompass Danbury which is --
2 Ms. Chafin has told you uses publicly verifiable
3 Medicare data that we're going to provide to you,
4 it does show that there's a significant unmet need
5 for inpatient rehab services in the area that --
6 the gap in care that Marty is talking about.
7 And so this proposal, if approved, is going
8 to increase access to needed healthcare services
9 for the target patient population, which are these
10 patients who need IRF services and are not getting
11 IRF services due to a lack of beds in the area.
12 I think the Applicant is also showing, and
13 we're going to submit some additional information
14 to show that, you know, based upon our volume
15 projections, our breakeven analysis and such, this
16 project is financially feasible. We can build it,
17 we can run it and that, you know, one of the
18 benefits of being a national provider is that
19 you've got the backing of a company that can help
20 subsidize projects of this magnitude.
21 So in my mind, you know, the question for OHS
22 is a simple one, and Ms. Chafin teed it up before,
23 which, like, is the status quo acceptable? Like,
24 should we allow patients who we know need IRF
25 services and that we know aren't always getting

1 those services to continue to receive them in
2 suboptimal care settings?
3 Or should OHS consider this gap in care that
4 Encompass has identified and approve a hospital
5 that will fill the unmet need?
6 Danbury Hospital suggested in the letter that
7 they wrote to OHS back last November that
8 Encompass Danbury doesn't understand the realities
9 of the market. And I would tell you that they
10 absolutely understand the realities of the market.
11 They just believe that those realities don't need
12 to remain the realities. Right?
13 They're here to -- and it's a phrase people
14 use a lot, like, it's time to disrupt the status
15 quo. You know, they're asking OHS to look at this
16 and say, it's not okay to just go along business
17 as usual, knowing that there are patients who
18 aren't getting this level of care. And you know,
19 or that are getting it in a suboptimal setting.
20 That it's time for OHS to look at the data
21 and to provide residents with sufficient access to
22 the rehabilitative care that they need.
23 I think we've talked at length -- and I thank
24 Dr. Charbonneau about, sort of, enhancements to
25 the quality of care that the Encompass Hospital

1 would bring. I mean, it starts first and foremost
2 with getting patients into the right level of
3 rehabilitative care, getting them into an optimal
4 care setting for the illnesses and injuries that
5 they're recovering from.
6 She told you these patients are going to see
7 a medical doctor who specializes in rehab on a
8 regular basis and in hours of focused therapy
9 every single day, which they're not going to get
10 in an non-IRF care setting. And this is going to
11 give these patients the best possible chance of
12 sort of meeting their rehab goals and objectives
13 and returning to their communities and to live
14 functional lives.
15 Dr. Charbonneau also walked you through sort
16 of all the programmatic staffing, technology,
17 equipment, facility design features, the things
18 that Encompass can offer in an inpatient rehab
19 facility that will improve the quality of care in
20 the area.
21 And you know, it's everything from the open
22 staffing model to the, you know, the specialized
23 therapeutic space. You got to see the tour today,
24 which I thought was very impressive. The, you
25 know, especially trained clinical staff and also

1 just being a facility that's being part of a
2 national network where mostly what you do is
3 inpatient rehab. Right?
4 This is their core business. They know what
5 they're doing. They do it all across the country
6 every day with outstanding results. We'll also
7 talked just moving on about the cost effectiveness
8 of the proposal, you know, the freestanding IRFs
9 like the hospital proposed by Encompass costs less
10 in many instances than our hospital based IRF
11 units. We've put some evidence in our rebuttal to
12 show that.
13 And we've talked kind of length about the
14 fact that all the SNF services on a daily basis
15 may be different. You've got to consider, one,
16 that's just a totally different level of care.
17 You've got to consider the length of care and then
18 you've got to look at, like, sort of the total
19 episodic cost of care and the fact that patients
20 going to SNFs often end up being -- getting
21 readmitted, and it ends up costing a lot more.
22 So you know, cost effectiveness is not as
23 simple as just looking at who charges what and
24 seeing which one is more. There's a bigger
25 picture there.

1 The Applicant does want to assure OHS that
2 although we are a for-profit provider, and that's
3 been brought up many times, that we are committed
4 to being accessible to all patients including
5 Medicare, Medicaid, uninsured.
6 Like Dr. Charbonneau said, they are payer
7 agnostic. They don't even inquire about insurance
8 when these physicians are certifying referrals.
9 So no patients are going to be denied care. No
10 patients are going to be, you know, turned away
11 during care as a result of insurance coverage or
12 payment issues. And that's, you know, that's a
13 policy that's in effect at their hospitals across
14 the country.
15 Also and I think really importantly the
16 proposal does promote patient choice and diversity
17 of providers. And I heard a lot of the Danbury
18 witnesses talking about patient choice and how
19 important it is. And we agree. Right?
20 Patients should be able to be treated in an
21 IRF if that's what a doctor says they need, and if
22 there are beds they sometimes don't have that
23 choice. And Encompass will also be a freestanding
24 facility that's not affiliated with the system,
25 that's going to accept all patients from all

1 **sources rather than, you know, focusing on**
2 **referrals from a particular hospital or system.**
3 **And I know that, you know, Danbury isn't a**
4 **closed IRF per se, but a vast majority of their**
5 **referrals come internally. And I think that's**
6 **true of most of the hospital based perks. It's**
7 **just logically what they do. But you know,**
8 **Danbury will be there to take from, you know, to**
9 **take from all comers.**
10 **And then last, I just want to -- and I know**
11 **this has been a huge focus of the hearing -- to**
12 **talk about the fact that, you know, this is**
13 **intended to complement and not compete with**
14 **Danbury Hospital.**
15 **We're going to have to agree to disagree on**
16 **this. I mean, all of our witnesses testified**
17 **that, you know, we've assessed the need and we**
18 **can -- we can meet that need without impacting**
19 **their service and the need methodology that's**
20 **(unintelligible) subtracted out their beds.**
21 **We believe that there is, you know,**
22 **sufficient volume in the area for us to fill our**
23 **beds without impacting your IRF. And I mean, you**
24 **just heard Dr. Aaronson testify a few minutes ago**
25 **that once every couple of months they hit capacity**

1 and can't take a patient.
2 So you know, there is a need there and
3 Encompass Danbury is here now, ready, willing and
4 able to move forward with this project to meet
5 that need. It's not, you know, it's not a
6 theoretical expansion, so.
7 And we're also committed. I mean, we're
8 committed to working with Danbury Hospital and
9 other providers to educate them on the services,
10 how to refer patients, what we can do for them.
11 And I think it's just going to benefit everyone
12 and we're certain that if this CON is approved and
13 if the physicians at Danbury have rehab
14 appropriate patients that they can't care for
15 themselves in their facility, that they will refer
16 to us, because they are good physicians who put
17 the interests of their patients first.
18 And if a patient is in need of these services
19 and those services are available and at Encompass
20 Hospital, that's where they'll send them.
21 So that is all I have, and I again very much
22 appreciate your time, the time of Attorney Tucci,
23 and the Danbury witnesses, the OHS staff.
24 Thanks again.
25 THE HEARING OFFICER: Thank you.

1 Attorney Tucci?

2 MR. TUCCI: Thank you, Hearing Officer Yandow. And
3 also thank you to OHS staff for all of your hard
4 work on this application. I appreciate the
5 opportunity to make some closing remarks on behalf
6 of Danbury Hospital.

7 In particular I was struck by the information
8 that we learned during questioning by OHS staff.
9 And I thought it was really instructive in terms
10 of shedding additional light on really from a
11 general perspective what this application is all
12 about and how you should be thinking about it.

13 One of the Applicant's witnesses commented on
14 how each market is a little bit different.
15 Danbury Hospital agrees with that 100 percent.
16 Each market is a little bit different. This CON
17 application has nothing whatever to do with the
18 market in Western Connecticut. Instead, the
19 Applicant wants you to look at experience around
20 the country and data around the country and don't
21 look at the actual utilization in Connecticut.

22 Let's talk about averages around the country
23 and that's how we can justify building a new $40
24 million hospital with 40 beds.

25 How are they going to do this? This is truly

1 an if-we-build-it-they-will-come proposal that's
2 before you. You heard what their plan is.
3 They're going to market. They're going to
4 leverage. They're going to target, and that's how
5 we're going to fill up this hospital.
6 OHS staff asked about healthcare equity.
7 Let's talk about healthcare equity. Danbury
8 Hospital is a not-for-profit institution that's
9 been in this state for a hundred -- more than a
10 hundred years. They serve all patients regardless
11 of the ability to pay.
12 This is an applicant that's in the business
13 of making a profit. There's nothing wrong with
14 that, absolutely. God bless them if they can make
15 a profit. They figured out what their payer mix
16 is for them to make a profit and their payer mix
17 for them to make a profit is to have 3 percent
18 Medicare. You know how many -- do you know what
19 the Medicare -- Medicaid census -- medicaid,
20 excuse me -- 3 percent Medicaid. Do you know what
21 the Medicaid census is in Danbury Hospital?
22 We treat 10 percent of our total patient
23 census are Medicaid patients, three times what
24 they propose to, what they propose to treat. Why?
25 Because they need to focus on the higher level

1 reimbursement patients that come from Medicare fee
2 for service in order to make their facility
3 profitable.
4 We've heard over and over and over again
5 there's a gap in care in Western Connecticut.
6 Respectfully, I would suggest to you that the gap
7 in care in Western Connecticut is the figment of a
8 consultant's imagination. If you look at the
9 logic of what has been presented to you today,
10 this applicant is telling you not that there's a
11 gap in care in Western Connecticut, but that
12 statewide on average Connecticut discharges 5
13 patients per 1,000 Medicaid fee-for-service
14 residents across the state, not in Western
15 Connecticut, but everywhere in the state. So one
16 wonders why Encompass shouldn't put this facility
17 maybe in a town like New Britain or New London, or
18 some other poor community.
19 Perhaps OHS might inquire about why it
20 doesn't make sense to locate this facility in the
21 center of the state so more of these patients who
22 supposedly can't get access to IRF beds can go
23 there and get that access. One wonders why they
24 chose the counties of Fairfield and Litchfield
25 which have perhaps the highest per capita income

1 in the state for their proposal.
2 Let's talk about level setting here, because
3 we want to talk about this market and what
4 Connecticut requires, and what the Connecticut
5 approach to determining responsible need is. The
6 first thing that you look at, as I understand it
7 from the way OHS examines these applications is,
8 what is the existing capacity in the marketplace?
9 Well, we know what the existing capacity in
10 the Danbury service area is. There's an existing
11 provider at Danbury Hospital that operates an
12 inpatient rehabilitation unit that is the same
13 thing as what's being proposed by the Applicant,
14 except that it happens to be within the four walls
15 of an acute-care general hospital. It has 14
16 beds. It operates last count at about 74 percent
17 occupancy. Once in a while it gets up to full
18 occupancy.
19 So the first thing you look at is, is there
20 any data that you've been presented with that
21 shows that there are hundreds and hundreds and
22 hundreds of patients who live in Western
23 Connecticut whose doctors have said, I need to get
24 this patient into an IRF bed, and Danbury said,
25 sorry, we can't take them -- got to refer them

1 somewhere else? There's no data that shows that.
2 The next thing you look at is, okay. People
3 are getting older. The community is going to age.
4 There might be more need for these services five
5 years down the road. Seems to me from a public
6 policy standpoint, from an economic standpoint
7 from an OHS standpoint, you would then say let's
8 look at the people in the market who currently
9 provide the service.
10 Do they have the capacity to expand when and
11 if there is a need? The answer you've heard today
12 is, yes, Danbury Hospital has the capacity to
13 expand. It has the financial resources to expand.
14 The way this works in a responsible way is
15 Danbury can commit 2 to 3 million dollars to
16 renovating rooms that it already has licensed. It
17 can use those as acute-care rooms until they're
18 needed to be IRF rooms. It seems to me that's the
19 responsible way for the State of Connecticut to
20 meet the needs of its citizens for IR, IR care
21 going forward and it can do it a heck of a lot
22 cheaper than a million dollars a bed.
23 Let's talk about the math we've heard. My
24 goodness, we've heard a lot of mathematical
25 calculations today. Really what we're talking

1 about here is a mathematical exercise. It's based
2 on how, and the answer to that math problem comes
3 out depending on what variables you include in, in
4 the equation, in the table that you've been
5 presented.
6 So the Applicant has done this bed-need
7 analysis that Connecticut doesn't recognize, but
8 it says that it should. And it says, let's put in
9 the variable that's really going to make the
10 number come out the way we want it to. Let's put
11 in 13 per 1,000 Medicaid fee-for-service
12 discharges. Even though Connecticut has an
13 average rate of 5, and even though the national
14 average is 11, let's put in 13 because that will
15 get us to the number we need to get to justify
16 building a 40-bed hospital.
17 That has nothing whatever to do with any of
18 the actual utilization of these services in
19 Connecticut. It's a national average that they
20 plugged into a math formula in order to come out
21 with the number that they needed in order to
22 attempt to justify this application.
23 There's nothing wrong with looking at
24 national experience and relying on general data,
25 but you ought to test that against what the real

1 world experience is in this market. The theory
2 that you've been presented with here is because
3 IRF beds get used more in other parts of the
4 country, that must mean that there is a need here
5 in Connecticut.
6 Well, respectfully I would ask you, why is
7 that so? Since when under the CON standards is
8 the standard, if it gets used a lot there must be
9 need? Utilization does not equal need. Need is
10 supposed to be demonstrated based on history and
11 statistics and data and utilization that is
12 reasonably projected forward. That's the OHS
13 formula. That's the formula that they're asking
14 you to reject, the one that has been tried and
15 true and used in this state for years.
16 I want to talk about two of the other -- in
17 closing two of the other sort of fundamental
18 pillars or assumptions that underlie this
19 application. And we talked about it at some
20 length with the consultant that the Applicant has
21 retained.
22 The first pillar is, let's look at in
23 figuring out how to get to the number we need to
24 get to. Let's look at, in order to help us get
25 there, the number of what we call Medicaid

1 eligible rehab discharges. What is that?
2 You know what that means? As far as I can
3 understand it, they basically look at some
4 diagnosis codes and they say, Danbury Hospital
5 discharged 3,000 patients who maybe were 65 and
6 had a certain diagnosis or condition in the bill
7 that was sent. And we're going to say that those
8 3,000 patients, all of them potentially need IRF
9 care, but there's no data to back up in any way
10 how you can arrive at a reliable projection or
11 percentage of that 3,000 patients who just
12 happened to be supposedly rehab eligible as to
13 whether they're really going to even need the
14 service, and the Applicant has admitted they have
15 no way to tell you that in any data-reliable way.
16 The other thing that is an enormous guess
17 here, at least as I understand it from what the
18 Applicant has presented to you, is we spend a lot
19 of time -- I think it's table ten. They
20 identified ten hospitals all across the state of
21 Connecticut.
22 They've already told you that 90 percent of
23 their census is going to come from acute-care
24 general hospitals, discharges of patients from
25 those hospitals. The ten of them that they put on

1 that list, OHS asked specifically give us some
2 mathematical formula. Give us some way that we
3 can rationally conclude that you're going to be
4 able to generate hundreds and hundreds of actual
5 patients who are discharged with a recommendation
6 or a diagnosis that they need to go to IRF care.
7 And they told you, we can't do it. All we
8 can do is guess. They sent in their own CON.
9 So all I'm asking you to do is apply the
10 standards that you always apply. Think about what
11 makes sense rationally to the citizens of the
12 State of Connecticut. Think about if in fact
13 expansion is needed, how do we best do that in the
14 most cost effective way for the people of
15 Connecticut?
16 And I would respectfully submit to you the
17 way to do that is to look at how to expand
18 capacity in the existing service platform that we
19 built rather than building a brand-new ground-up
20 hospital and hoping it gets filled up.
21 Thank you.
22 THE HEARING OFFICER: Thank you.
23 Attorney Fusco, do you have any last words?
24 MS. FUSCO: Yeah, just briefly in rebuttal. I mean, I
25 would just ask -- and I know you will, that the

1 OHS staff looked very carefully at our CON
2 application and our findings, and escheatments
3 reports and our testimony, and all of the
4 testimony here today because I think many things
5 that Attorney Tucci just said in his closing
6 statements are mischaracterizations of the
7 evidence that's in the record.
8 He's raising questions that have already been
9 answered but haven't been answered, you know, to
10 his satisfaction. And he's speculating about
11 things that he could have asked about today but
12 didn't. So you know, we rest on our evidence.
13 It's in the record and, you know, we'll be
14 submitting late files. And to the extent that OHS
15 needs any additional information or clarification,
16 we're here to provide that information.
17 Thank you.
18 THE HEARING OFFICER: Thanks.
19 Ormand, do you have a list ready to read on
20 late files? And while he is reading this, I'm
21 going to be asking -- because I think there are
22 some documents from also the Intervener.
23 I'm going to be asking you, when he's done
24 reading the list, how long do you think you need
25 to produce these documents? And then I'm going to

1 issue an order on the late files.

2 The record, though, of course remains open --

3 for the late files remains open for public comment

4 for another week, and is remained open until you

5 get notification from OHS that the record is

6 closed. Okay, Ormand. Go ahead.

7 MR. CARNEY: Hearing Officer Yandow, is it okay? I'm

8 just going to help out if I need to, because most

9 of them were mine, kind of my thoughts. So I'll

10 let him go. I'll just chime in.

11 Thank you.

12 DR. CLARKE: Thanks. Late-file Number 1 is links to

13 important rates used in your analysis.

14 MR. CARNEY: So that's like the Medicare FF --

15 fee-for-service beneficiary rate, the national

16 rehab admits rate, everything pretty much used in

17 the methodology that we don't have a link for.

18 Some of the reports, if it's an important point,

19 just to give you more information.

20 DR. CLARKE: And number two is in reference to

21 appropriate occupancy rates at the Danbury

22 Hospital.

23 MR. CARNEY: No, Ludlow, Mass, facility for Encompass.

24 DR. CLARKE: That's Late-File 2. Thank you.

25 MR. CARNEY: On question two.

1 MS. FUSCO: I think that's the occupancy rates at the
2 Ludlow, Mass Encompass hospital?
3 MR. CARNEY: Yes, please.
4 MS. FUSCO: Did you want the closest three hospitals?
5 MR. CARNEY: Yeah, closest three hospitals would be
6 fine. That would be good. Yes.
7 MS. FUSCO: Okay.
8 DR. CLARKE: And Late-File 3, assumptions for volumes.
9 MR. CARNEY: So that's the mathematical calculation for
10 the volume assumptions of 92, 623, 793 and 963
11 discharges.
12 DR. CLARKE: Four, IRF volumes of the three closest
13 facilities for the last three years.
14 MR. DUFFY: Sorry. This is Connor Duffy, Robinson &
15 Cole. I believe it's Medicaid beneficiaries
16 crossing state lines to receive IRF care in
17 Massachusetts.
18 MR. CARNEY: Yeah, I think -- thank you, attorney
19 Duffy. I think this is one I may not have
20 mentioned, Attorney Fusco, but this is definitely
21 something that will be asked of us.
22 I don't think we have it in the record.
23 MS. FUSCO: I'm sorry is it the volume for the same
24 three Massachusetts hospitals for Encompass?
25 MR. CARNEY: Yes. Yes, because we don't have that.

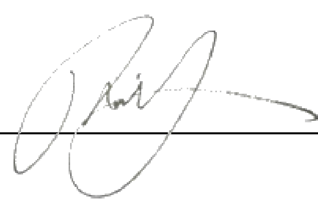
1 And that will be used and looked at in comparing
2 what your volume estimates for the new facility
3 are as an example of what you've done or what
4 you're doing at other locations.
5 I don't think I mentioned it, and I
6 apologize.
7 MS. FUSCO: That's okay.
8 DR. CLARKE: Number 5, Medicaid beneficiaries receiving
9 IRF services in Massachusetts.
10 Number six, quantity of measures for the last
11 three years at the three closest hospitals.
12 MR. CARNEY: So on that one if you can give it for the
13 for the facility itself, and then a compared,
14 comparative number for, like, a benchmark or
15 something.
16 MS. FUSCO: Yeah.
17 MR. CARNEY: Thank you.
18 DR. CLARKE: And data to validate 79 percent discharge
19 to community status.
20 Eight, studies confirming reduced mortality,
21 lower readmission occurrence and ER visits in IRF
22 and compared to SNF.
23 MS. FUSCO: Can you repeat it again? I'm sorry.
24 Reduced mortality, and what were the other two?
25 DR. CLARKE: Studies confirming reduced mortality,

1 lower readmission occurrence, and ER visits in
2 IRFs Compared to SNF.
3 MS. FUSCO: Thank you.
4 DR. CLARKE: Number 9, information for exhibit DD, page
5 5 utilizing the AHD.com report regarding costs.
6 Number 10, the funding letter.
7 MR. CARNEY: And that's it from the Applicants, and
8 then we have two from the Intervenors that we're
9 requesting.
10 DR. CLARKE: Inpatient volumes for the last three
11 historical years, but for IE patients and the
12 number of times in the past three years that the
13 census was at 14.
14 MS. FUSCO: Ormand, could you just repeat that second
15 one? I'm sorry. I couldn't hear.
16 DR. CLARKE: Late-file 1 we have volumes for last --
17 this is for the Intervener.
18 MS. FUSCO: Inpatient rehab volumes for the last three
19 historical years for inpatient -- hi-pay patients,
20 and the number of times in the past three years
21 that the census was 14.
22 And current daily cost of care for
23 commercially insured and for self pay. That's
24 all. Thank you.
25 THE HEARING OFFICER: And now for both Attorney Fusco

1 and Attorney Tucci, how long do you think you
2 need?
3 MS. FUSCO: What's today? The 28th. Could we take two
4 weeks? I know several of us on this call will be
5 having another hearing in just a few days. So
6 I --
7 THE HEARING OFFICER: That's fine. Let's say two weeks
8 from today.
9 MS. FUSCO: Yeah, maybe like the 11th or the 12th,
10 maybe, of November?
11 THE HEARING OFFICER: The 12th? Okay. Attorney Tucci,
12 Can you get yours by the 12th?
13 MR. TUCCI: Yes. Thank you, hearing Officer. That's
14 fine.
15 THE HEARING OFFICER: Okay so I'm going to issue an
16 order on the record now that by November 12 the
17 late files as listed here are due.
18 And perhaps Ormand and Brian maybe since --
19 Ormand, do you have it in on your computer? I
20 think you have it typed up. Maybe we could just
21 issue a letter just as ordered by Hearing Officer
22 Yandow at the hearing, the following documents due
23 on November 12, 2021.
24 And just list them just so there's no
25 confusion, and that could go out next week. It

1 doesn't matter, but I think at least if we have a
2 nice, neat way to have it, and I know it will be
3 in the transcript. Then at least we can also then
4 put it up on the portal. Does that work?
5 A VOICE: Yes, certainly.
6 THE HEARING OFFICER: Okay. I think that that would be
7 great. Okay. Well, I want to just -- Brian,
8 Ormand, is there anything else that you think we
9 need?
10 MR. CARNEY: (Unintelligible.)
11 THE HEARING OFFICER: Okay. I appreciate everybody's
12 time. I thought everyone was very cooperative.
13 And like I mentioned before the record will stay
14 open and the hearing for today is adjourned.
15 Have a good evening.
16
17 (End: 5:28 p.m.)
18
19
20
21
22
23
24
25

1 STATE OF CONNECTICUT

2 I, ROBERT G. DIXON, a Certified Verbatim Reporter within and for the State of Connecticut, do
3 hereby certify that I took the above 301 pages of proceedings in Re: STATE OF CONNECTICUT, OFFICE OF
4 HEALTH STRATEGY, In Re: CERTIFICATION OF NEED, ENCOMPASS HEALTH REHABILITATION HOSPITAL OF DANBURY
5 CONNECTICUT, LLC, DOCKET 20-32392-CON; held before: JOANNE V. YANDOW, ESQ., THE HEARING OFFICER, on October
6 28, 2021, (via teleconference).
I further certify that the within testimony
7 was taken by me stenographically and reduced to typewritten form under my direction by means of
8 computer assisted transcription; and I further certify that said deposition is a true record of the testimony
9 given in these proceedings.
I further certify that I am neither counsel
10 for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and
11 further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor
12 financially or otherwise interested in the outcome of the action.
13
WITNESS my hand and seal the 22nd day of
14 November, 2021.
15
16
17
18
19 
20
Robert G. Dixon, N.P., CVR-M No. 857
21
My Commission Expires 6/30/2025
22
23
24
25

INDEX

WITNESS	PAGE
PATRICK TUER	14
(Cross) Examination by Mr. Carney	200
(Cross) Examination by Mr. Clarke	243
ELISSA CHARBONNEAU	19
(Cross) Examination by Mr. Carney	218
MARTY CHAFIN	41
Direct Examination by Ms. Fusco	91
Cross-Examination by Mr. Tucci	98
Redirect Examination by Ms. Fusco	145
Cross-Examination by Mr. Carney	194, 250
Cross-Examination by Mr. Clarke	243, 248
SHARON ADAMS	151
(Cross) Examination by Ms. Fusco	172
(Redirect) Examination by Mr. Tucci	191
BETH AARONSON	157
(Cross) Examination by Mr. Clarke	262
(Cross) Examination by Mr. Carney	261
APARNA OLTIKAR	166
BILL HEATH	255

LATE-FILED EXHIBITS

NUMBER		PAGE
A-1	County/state utilization links	199
A-2	Occupancy 3 closest facilities	202
A-3	Volumes 1st year plus 3 months data	202
A-4	IRF 3 closest facilities	205
A-5	Medicaid beneficiaries IRF in Mass	214
A-6	3 closest facilities quality measures	225
A-7	Discharge status for 79%	229
A-8	IRFs/SNFs: Mortality, readmin, ER	232
A-9	AHD report	253
A-10	Funding letter	258
I-1	Inpatient rehab volumes, three years	275
I-2	Daily rate inpatient rehab	275

DEPARTMENT EXHIBITS

NUMBER/LETTER		PAGE
1	Investigative Report, MOD packet	28