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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH STRATEGY

PUBLIC HEARING

In Re:
Docket No. 22-32594-CON

Yale New Haven Health Services Corporation
and Prospect CT, Inc.

Transfer of Prospect CT, Inc., Hospital Systems (Prospect Manchester Hospital, Inc. d/b/a Manchester Memorial Hospital; Prospect Rockville Hospital, Inc., d/b/a Rockville General Hospital; and Prospect Waterbury, Inc., d/b/a Waterbury Hospital) and imaging equipment owned by said hospital systems to Yale New Haven Health Services Corporation.

HELD BEFORE: DANIEL CSUKA, ESQ.,
THE HEARING OFFICER

DATE: April 26, 2023

TIME: 9:31 A.M.

PLACE: Department of Public Health
410 Capitol Avenue,
Hearing Room 1
Hartford, Connecticut
(and VIA TELECONFERENCE)

Reporter: Robert G. Dixon, N.P., CVR-M #857

APPEARANCES

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BOZENA PIASCIK
FAYE FENTIS
LESLIE GRIER

(Begin: 9:31 a.m.)

THE HEARING OFFICER: Good morning, everyone. Thank you for being here. This is quite the turnout.

Yale New Haven Health Services Corporation and Prospect CT, Inc, the Applicants in this matter, seek a certificate of need for the transfer of a healthcare facility pursuant to Connecticut General Statutes Section 19a-638a-2.

Specifically they seek to transfer Prospect's Connecticut-based hospital systems, that is Manchester Memorial Hospital, Rockville General Hospital, and Waterbury Hospitals, their imaging equipment and certain equity interests in certain joint ventures all to Yale.

There is a separate certificate of need application for the transfer of Prospect's Medical Foundation to Yale's Medical Foundation, Which although related is not the subject of today's hearing.

Today is April 26, 2023. My name is Daniel Csuka. Dr. Deidre Gifford, the Executive Director of the Office of Health Strategy designated me to serve as the Hearing Officer for this matter to rule on all motions and to recommend findings of

fact and conclusions of law upon completion of the hearing.

This is a hybrid hearing. This is the first in-person hearing that OHS has done in quite some time since before COVID. So it's been over three years at this point. So by hybrid, I mean it is being held both in person and electronically via Zoom.

Public Act Number 21-2, as amended by Public Act 22-3 authorizes an agency to hold a public hearing by means of electronic equipment. In accordance with this legislation, any person who participates orally in an electronic meeting shall make a good-faith effort to state his or her name and title at the outset of each occasion that such person participates orally during an uninterrupted dialogue or a series of questions and answers.

For anyone attending remotely, unless you are actively participating in the hearing, either as one of the Applicant's witnesses or as a member of the public providing comment at the designated time, I ask that you mute your device and silence any additional devices that are around you.

I will get more into this later on, but public comment for right now is scheduled to begin

at three o'clock. That assumes that we get through all of the technical portion by then.

If we don't get through the technical portion by then I may sort of push that back, but I do understand that we have some elected and appointed officials Who do want to make some comments. So I'll take them at around three o'clock.

And if there are any other physicians or executives for either of the hospital systems who are tight on time we can take them at the same time.

This public hearing is held pursuant to Connecticut General Statutes Section 19a-639a, Sub f, Sub 1. As such, this matter constitutes a contested case under the Uniform Administrative Procedure Act, and it will be conducted in accordance therewith.

I do have some Office of Health Strategy staff here with me to assist in gathering facts related to the application, and they will be asking the Applicant's witnesses questions. I will also be asking questions.

At this time I'm going to ask that each of the staff persons assisting me identify themselves with their name, spelling of their last name and

OHS title. I think all of our names are on placards -- but we can start with you, Roy?

MR. WANG: Sure. Good morning. My name is Ruonan Wang. I go by Roy, and I'm an associate research analyst at the Office of Health Strategy.

THE HEARING OFFICER: Thank you.

MS. PIASCIK: Good morning. My name is Bozena Piascik and I'm an associate healthcare analyst.

MR. LAZARUS: Hi, my name is Steven Lazarus, l-a-z-a-r-u-s, and I'm the Certificate of Need Program Supervisor.

THE HEARING OFFICER: Thank you.

Up until yesterday afternoon we had expected to have another staff member with us as well, but he can't be present today unexpectedly.

We're going to do our best to sort of fill in the blanks and address any issues that present as they arise. I don't think it will present any issues, but I just wanted to bring that up in the event there are any hiccups.

Also present in the other room are Faye Fentis and I believe Leslie Grier as well who are also OHS staff members, and they're going to assist with gathering names for public comment both virtually and in person.

The certificate of need process is a regulatory process, and as such the highest level of respect will be accorded to the Applicants, members of the public and our staff. Our priority is the integrity and transparency of this process. Accordingly, decorum must be made by all present during these proceedings.

This hearing is being transcribed and recorded, and the video will also be made available on the OHS website and its YouTube account. All documents related to this hearing that have been or will be submitted to OHS are available through our certificate of need portal, which is accessible on the OHS CON webpage.

In making my decision I will consider and make written findings in accordance with Section 19a-639 of the General Statutes. And lastly, for anyone attending remotely, as Zoom hopefully notified you in the course of entering this hearing, I do want to point out that by appearing on camera in this virtual hearing you are consenting to being filmed.

If you wish to revoke your consent, please do so at this time either by exiting the Zoom meeting or by exiting this, this hearing room. As you can

see, the camera over there is picking up pretty much everybody in this room.

So let's see. Now on to the substance. I'm going to start by going over the exhibits and items of which I am taking administrative notice, and then I will ask if there are any objections.

The CON portal contains the pre-hearing table of record in this case. At the time of its filing this past Thursday exhibits were identified in the table from A to R.

On Monday of this week I issued and had uploaded to the record a notice regarding parking and in-person access. I'm going to identify that right now as Exhibit S. That's S as in Sam.

(Record Exhibit Letter S, marked for identification and noted in index.)

THE HEARING OFFICER: I also note that the Applicants uploaded some additional support letters yesterday. That will be Exhibit T.

(Record Exhibit Letter T, marked for identification and noted in index.)

THE HEARING OFFICER: And although the agenda was posted to the OHS hearings and meetings webpage and the Secretary of State's site this past Friday, it was not uploaded to the CON portal until last night. So that would be Exhibit U.

(Record Exhibit Letter U, marked for identification and noted in index.)

THE HEARING OFFICER: I think that covers it.

So Steve, Roy, do we have any other exhibits that we need to enter for the agency at this time?

MR. LAZARUS: I don't believe so.

THE HEARING OFFICER: Okay.

MR. WANG: I see a presentation and an attendee list that were uploaded on the 26th.

THE HEARING OFFICER: Okay. And those are two separate filings?

MR. WANG: Two separate filings.

THE HEARING OFFICER: Okay. And I believe that references the PowerPoint presentation by Mr. O'Connor. Is that correct?

CHRISTOPHER O'CONNOR: Yes, that's correct.

THE HEARING OFFICER: And what was the other one?

MR. WANG: It's a Prospect/Yale New Haven attendee

list.

THE HEARING OFFICER: Okay.

MR. WANG: I believe it's the one that was sent with the names that we referenced earlier.

THE HEARING OFFICER: Okay. Yeah. So the attendee list will be V.

(Exhibit Letter V, marked for identification and noted in index.)

THE HEARING OFFICER: And then the PowerPoint presentation -- W.

(Exhibit Letter W, marked for identification and noted in index.)

THE HEARING OFFICER: Sorry, I have to go through the alphabet in my mind. You guys are asking a lot of me today.

The Applicant is hereby noticed that I am taking administrative notice of the following documents; the statewide healthcare facilities and services plan and its supplements, the facilities and services inventory, the OHS acute-care hospital discharge database, all payer claims

database claims data, and the hospital reporting system that's the HRS financial and utilization data.

There are also some dockets that I'm going to be taking specific administrative notice of at this time. One is Docket 20-32405. That's the docket for the application filed by Prospect ECHN, Prospect Manchester Hospital, and Prospect Rockville Hospital related to the consolidation of hospital licenses.

I'm also taking administrative notice of 18-32270. That's Yale's acquisition of Milford Hospital via Bridgeport Hospital.

15-32016-486, that's the docket pursuant to which Prospect acquired ownership of the three hospitals at issue in this docket. Docket 12-31768, which is Yale's acquisition of Lawrence & Memorial Hospital.

And then the final two I couldn't find docket numbers for yesterday. One is Yale's acquisition of Greenwich Hospital from 1998, and Yale's acquisition of Bridgeport Hospital from 1996.

I'm not expecting to have to rely on any of those for any specific purpose, but I did want to mention that since those do to some extent relate

to today's proceeding, I may be referring to those at some point.

MS. RINEHART: Hearing Officer Csuka, we don't have an objection to noticing those prior transactions. In fact, we were going to request it -- but our numbering is slightly different on the numbers for the CONs.

THE HEARING OFFICER: Okay.

MS. RINEHART: And I don't know if you mentioned St. Raphael's, the acquisition of St. Raphael's? We'd like to add that as well.

THE HEARING OFFICER: I did not.

MS. RINEHART: We're happy to check at the break and go over the numbers to make sure we have the correct numbers referenced.

THE HEARING OFFICER: Sure, that would be great. Thank you.

MS. RINEHART: And I guess we have no objection to noticing the consolidation proceeding and the events that have occurred. We would object to the extent that there's a proposed decision that's not final to the extent that that is not, you know, the final decision at this point.

THE HEARING OFFICER: Understood. So just so that I'm clear going forward, I know that there are two

attorneys here. So if you're objecting, you're objecting on behalf of Yale.

Should I also impart that objection on Ms. Volpe? Or should I just assume --

MS. VOLPE: Yeah, that's fine.

THE HEARING OFFICER: Okay.

MS. VOLPE: Kim is going to speak on the Applicant's behalf today.

THE HEARING OFFICER: Okay. Thank you very much.

MS. VOLPE: I'll speak when spoken to.

THE HEARING OFFICER: Okay.

MS. VOLPE: I know it's unusual for me.

THE HEARING OFFICER: Thank you for clarifying that.

So counsel for the Applicant, Yale New Haven Health Services Corporation, can you please identify yourself for the record?

MS. RINEHART: My name is Kim Rinehart -- the last name is spelled R-i-n-e-h-a-r-t -- from the law firm of Wiggin and Dana. And I'm representing Yale New Haven Health System.

I know that there was a request to identify abbreviations that are likely to be used. And so for the benefit of these folks not having to do that, you may hear Yale New Haven Health Services referred to as YNHHS, or sometimes by folks that

work there as the System.

I think there's also references going to be made to ECHN, which is, you know, the health system that operates Rockville and Manchester. And so that's -- hopefully we'll be clear on the record.

And I just wanted to take a moment to thank the Hearing Officer Csuka as well as OHS staff for having us today, and especially for taking on the challenge of doing the hybrid hearing, allowing for both in-person presence and the maximum amount of public engagement.

We think this is a really important project and we really appreciate the opportunity to have as much of that public, you know, input as possible in the process.

Shall I go ahead and turn it over to Chris?

Or do you have other procedural matters?

THE HEARING OFFICER: I hadn't -- let's see. So subject to your one objection, I hadn't entered any of the exhibits as full exhibits. So I am going to enter those right now as full exhibits.

Let's see.

There are a few other things I did want to try to get through before we moved on to that.

MS. RINEHART: Absolutely.

THE HEARING OFFICER: So there, there was an agenda that was uploaded. So we're going to proceed to the greatest extent possible in the order in which it's listed in the agenda.

I would like to advise the Applicants and their witnesses that we may ask questions related to your application that you feel you have already addressed. We will do this for the purpose of ensuring if the public has knowledge about your proposal and for the purpose of clarification.

I also want to reassure you that we have reviewed your application completeness responses and prefile, and I will do so many, many times before issuing a decision.

As this hearing is being held in hybrid fashion, again we ask that all participants attending via Zoom, to the extent possible, enable the use of video cameras when testifying or commenting remotely.

And I also wanted to mention that since it's partially remote, when we go on breaks anybody who's attending should mute their devices, turn the camera off, that sort of thing, because in the event it continues to record, anything you say or

do will remain on camera. The same thing goes for the people in this room. Keep in mind that the video recording may continue, and even if it doesn't you will still be viewable to everybody attending it via Zoom.

So as I mentioned earlier, public comment during this hearing will likely go in the order established by OHS during the registration process. However, I may allow public officials to testify out of order. I or OHS staff will call each individual by name when it is his or her turn to speak.

Registration for public comment has already begun, and is scheduled to start at 3 p.m. If the technical portion of the hearing has not been completed by 3 p.m., public comment may be postponed. And the Applicant's witnesses must be available after public comment, as OHS may have additional follow-up questions based on any of the public comment.

So are there any other housekeeping matters, Attorney Rinehart, that you wanted to address at this time?

MS. RINEHART: I think this is clear, but the public officials that we've already let you know about

are already considered to be registered. Correct? They don't have to do anything separate?

THE HEARING OFFICER: Correct. Yeah, we've taken notice of those and their names have been added to the list.

So with that, we're going to move on to the technical portion. Is there an opening statement, Attorney Rinehart or Attorney Volpe, that you wanted to make at this time?

MS. RINEHART: I would just say, Hearing Officer Csuka, we've put together a large number of materials and we believe those materials, combined with the prefiled testimony, you know, clearly show that the statutory factors are met.

As I mentioned, I feel this is a very important transaction, and you know we're obviously here and waiting to answer any questions that you and the staff have. I know before we turn it over to Chris, we do need to get everyone sworn in.

So thank you very much.

THE HEARING OFFICER: So that's the next step. If you can identify all the individuals by name and title who are planning to provide any remarks today, that would be great. And then I will swear them

all in at the same time.

MS. RINEHART: And in terms of remarks, do you want only the list of people who'll be making affirmative remarks? Or also those that we anticipate may need to be available for answering questions?

THE HEARING OFFICER: Let's just do them all at once. That way I don't have to swear people in individually.

MS. RINEHART: That's perfect. Maybe it would just make sense then to go along the table starting again, and let each person introduce themselves, and also through the back so they can provide their titles as well.

THE HEARING OFFICER: Okay. Perfect.

VON CROCKETT: Great. Von Crockett, Prospect Medical Holdings, Senior Vice President.

DEBORAH WEYMOUTH: Deborah Weymouth, President and CEO of Eastern Connecticut Health Network.

JUSTIN LUMBY: Justin Lumby, President, CEO of Waterbury Health.

MS. VOLPE: Michelle Volpe, counsel for Manchester Memorial, Rockville Hospital, Waterbury Hospital; and Prospect CT is the parent of those three hospitals. I'm their CON counsel.

THOMAS BALCEZAK: Hi. Tom Balcezak. I'm the Chief Clinical Officer for Yale Haven Health.

CHRISTOPHER O'CONNOR: Good morning. Chris O'Connor. I'm the Chief Executive Officer for Yale New Haven Health.

MS. RINEHART: Kim Rinehart, counsel for Yale New Haven Health.

WILLIAM ASELTYNE: Good morning. Bill Aseltyne, Executive Vice President Yale New Haven Health, Chief Legal and Administrative Officer.

ANNE DIAMOND: Good morning. Anne Diamond, President of Bridgeport Hospital.

GAIL KOSYLA: Good morning. Gail Kosyla, Chief Financial Officer of Yale New Haven Health.

LISA STUMP: Lisa Stump, Chief Information Officer for Yale New Haven Health and Yale Medicine.

MELISSA TURNER: Melissa Turner, Chief Human Resource Officer, Yale New Haven Health.

THE HEARING OFFICER: So I'm going to ask anybody who -- well, other than the attorneys, anybody who just introduced themselves to raise their right hand at this time.

C H R I S T O P H E R O' C O N N O R,

V O N C R O C K E T T,

D E B O R A H W E Y M O U T H,

D R. J U S T I N L U M B Y,

D R. T H O M A S B A L C E Z A K,

W I L L I A M A S E L T Y N E,

A N N E D I A M O N D,

G A I L K O S Y L A,

L I S A S T U M P,

M E L I S S A T U R N E R,

called as witnesses, being first duly sworn by the HEARING OFFICER, were examined and testified under oath as follows:

THE HEARING OFFICER: Thank you. So when giving your testimony make sure that you state your full name, and adopt any written testimony you may have submitted on the record prior to testifying today.

And with that, the Applicants can now proceed with their testimony. And Attorney Rinehart, you can start whenever you're ready.

BY MS. RINEHART:

Q. (Rinehart) Yes. Chris O'Connor is going to be leading off for Yale New Haven Health.

And he has a PowerPoint, which hopefully

is going to be displayed for everyone.

A. (O'Connor) Flawlessly.

Good morning. And like Kim, I want to express my gratitude to all of you, and particularly Hearing Officer Csuka for your oversight of this important day today.

My name is Chris O'Connor. As I mentioned, I'm the Chief Executive Officer of Yale New Haven Health. I've been a part of Yale New Haven Health System for over a decade, and I entered through the acquisition of the hospital of St. Raphael where I was the chief executive officer at that time.

Through that acquisition I saw firsthand how transformative it can be when a community hospital is acquired by an academic health system like Yale New Haven Health.

St. Raphael's has been completely revitalized as a result. I am excited here today to talk about our proposal to acquire Prospect Connecticut Hospitals.

It is a momentous challenge given the current financial environment for hospitals, but also a momentous opportunity, an opportunity to bring these hospitals back

under local leadership and ownership so that resources are invested back into the community, to convert the hospitals back to not-for-profit status, putting patients first and to bring Yale New Haven's unique world-class signature of care to Waterbury and the ECHN regions.

Next slide.

I said flawlessly too early.

But we take on this challenge, not because it's easy, but because it's consistent with our mission, vision and values. We are focused on people, not profits. Our goal is to enhance the lives of people we are serving by providing access to high-value patient-centered care, and we believe we can bring a substantial value to the Waterbury and ECHN communities.

By way of overview, this proposal focuses on the Yale New Haven Health's acquisition of Waterbury Hospital and the ECHN Hospitals, Rockville and Manchester. And if this proposal is approved we plan to operate Waterbury Hospital as a standalone licensed hospital, and Rockville and

Manchester that are as two campuses under a single licensed hospital.

This is because Rockville and Manchester are less than 10 miles apart, and have already been operationally integrated. Additionally, both hospitals are currently underutilized. In combining them, that will allow us to build on the strengths of each campus, as my colleague Tom Balcezak will discuss further in a moment.

We have used this approach successfully in prior transactions involving small community hospitals Including the Hospital of St. Raphael, which became the St. Raphael campus of the Yale New Haven Hospital, and Milford Hospital which became part of the Bridgeport Hospital license.

This proposal also includes the acquisition of hospitals' imaging equipment. These items are already owned by the hospitals and they will continue to be owned and used by the hospitals post-transaction, as well as certain joint venture interests that are held by the hospitals or affiliate entities.

Additionally, overall the transaction involves the acquisition -- acquisition of Prospect's medical foundation By the Yale New Haven Health's Medical Foundation Northeast Medical Group. That aspect of the transaction, as you mentioned, is being reviewed under a separate CON, and we will also purchase Prospect's home health business in Connecticut.

Prospect made the choice to sell these hospitals putting out a request for proposal. So this is not a situation of whether the hospitals will be sold, but to whom? Yale New Haven Health is the clear pro-competitive choice to acquire the Prospect Hospitals. It is my understanding that aside from Yale New Haven, Prospect received two other proposals to acquire hospitals and both came from large Connecticut health systems with existing acute care hospitals in the same geographies.

On this map, we've identified the Prospect Hospitals in red circles and the existing Yale New Haven Hospitals in blue circles. The other symbols reflect other hospitals.

As you can see from the map, while there are other hospitals in the proximity to the Prospect Hospitals, Yale New Haven Health has no existing acute-care hospitals in the Waterbury or ECHN service areas. Thus, Yale New Haven's is the only choice that maintains patient choice and provider diversity in the region. We also believe that as a high-quality system with strong ties to our academic subspecialty care we can bring a more active competition to the region.

This proposal will also bring significant benefits to patients. We will bring Yale New Haven's world-class care signature to Waterbury and the ECHN communities.

By bringing expert resources from Yale Medicine and the Yale New Haven health system into the hospitals we will be able to enable more patients to receive care closer to home even for more serious conditions. When truly complex conditions emerge transfer to a higher level of care will be seamless, enhancing the continuity of care.

We will also implement EPIC, the gold

standard in electronic health records. This will allow patients to have a seamless access to all of their health records in one convenient place, all major benefit for -- all of it a major benefit another -- I'm sorry.

Another major benefit -- if I can read -- for patients is the implementation of our more generous financial assistance policy.

The transaction will also benefit employees. Yale New Haven has agreed to assume all collective bargaining agreements, hire substantially all employees, and provide benefits that are comparable or better to their existing benefits.

Over time we believe that Yale New Haven will be able to attract additional providers and employees to the hospitals. Prospect has actually told us they're already seeing more interest since the announcement of this potential affiliation. We pride ourselves in being an employer of choice, and we've gotten many recognitions for being a great place to work.

We also expect that the transaction will not increase costs of healthcare services in the state. Medicare and Medicaid rates are set by the government and will continue to be set by the government going forward. We've agreed to assume Prospect's commercial rates subject to payer consent. So there too we don't expect the transaction to impact cost.

And as I noted for self-paid patients or insured patients with balances, they will have access to Yale New Haven's far more generous financial assistance policy. For example, individuals who make up to 250 percent of the federal poverty -- poverty level are eligible for free care under Yale New Haven's policy, while currently patients must make less than 125 percent of the federal poverty level to receive free care at Manchester or Rockville, and less than 200 percent of federal poverty level to receive free care at Waterbury.

As explained in our application and in my prefiled testimony, the Prospect Hospitals have been facing significant financial headwinds for a number of years. These

challenges are rapidly growing more acute.

For example, Prospect's draft financial 2022 financials showed an increase in the net loss from financial -- from fiscal year '21 of a negative 15 million, to negative 45 -- 49.5 million in fiscal year 2022. Thus, there is a clear need to allow these hospitals to be acquired so they can be financially stabilized and revitalized.

Ultimately, you should not trust what we say, but what we have done. Our track record speaks for itself. We have successfully integrated multiple community hospitals since 2012. In each instance they were facing major financial struggles at the time, and each time we managed to increase utilization, expand services, enhance quality of care, achieve forecasted cost savings, invest in facilities to address the community needs and preserve jobs.

I'd like to speak a bit more about the specific experience involving the acquisition of the Hospital of St. Raphael. As I mentioned, that transaction is very personal for me as I was the CEO of St. Raphael's at

the time. My mother also worked at the hospital for a nurse for over 40 years.

It was a difficult decision to be acquired, as a hospital had been a proud independent institution for a very long time, and there was a fear that it could lose its character, particularly because it would no longer be independent, but instead would become a campus of the Yale New Haven Hospital.

However, I also recognized that the hospital was in a very difficult position and it was clear that it could not continue to survive and thrive in the changing healthcare environment. The transaction proved to be extremely successful for both St. Raphael and the Yale New Haven Hospital. We were able to maintain many aspects of the distinct character of the hospital, and the acquisition allowed us to invest in the campus and address the pension liabilities.

For Yale New Haven Health the transaction provided a cost-effective solution to address over utilization at the York Street campus. Through the acquisition

almost 3500 employees were seamlessly integrated with no gaps in pay and benefits. And over time significant investments have been made in the St. Raphael campus, including the most recently -- development of a neuroscience tower.

While we're dealing with a much more difficult time financially for hospitals, I believe we have similar opportunities to revitalize the Prospect Hospitals.

We are committed to not only Maintaining Prospect's current community engagement programs, but to growing them. Yale New Haven has consistently been recognized for its community benefits contributions. The Office of Healthcare Strategy's most recent community benefit report found that Yale New Haven provided more community benefit than its peers, regardless of what the weighting factors were used.

Moreover, bringing these hospitals back to under local ownership will ensure that resources are back invested into Connecticut. Reversion of not-for-profit status will also ensure that the focus is where it should be,

on patients, not profits.

As I've said, this transaction -- this is a readable chart -- offers the opportunity to financially stabilize the Prospect Hospitals, but it won't be easy. This is a very difficult, difficult time for all of Connecticut hospitals in the wake of the COVID-19 Pandemic, and Yale New Haven Health is dealing with its own challenges.

This slide is our revised worksheet A. And as you can see -- certainly not by reading the PowerPoint -- we are beginning from a very difficult starting point with significant losses as a system in fiscal year 2022. Adding the Prospect Hospitals will bring incremental losses for the next several years.

Ultimately, we believe we have the ability to achieve a positive total margin for the system overall by fiscal year 2024, and a positive operating margin by 2025. However, this model assumes that we can meet our own deficit mitigation targets and have the flexibility to operate the Prospect Hospitals in an effective manner. It also

assumes reasonable market returns over the next several years.

Thus, there are real risks.

This, undoubtedly an enormous -- this is an undoubtedly enormous undertaking, but as John F. Kennedy once said, we choose to take on these challenges not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one that we are not willing to postpone.

I strongly urge you to move rapidly to approve the application without conditions so that Yale New Haven can get to work revitalizing these hospitals and serving the surrounding communities.

Let me turn it to Dr. Tom Balcezak.

A. (Balcezak) Thank You, Chris.

Good morning, everyone. Thank you for the opportunity to provide this testimony. My name is Tom Balcezak, and I would like to adopt my prefiled testimony.

I'm the Chief Clinical Officer of Yale

New Haven Health System, and in that role I will oversee the clinical integration of the Prospect Hospitals as well as the clinical planning for each campus.

I bring to this table and to this testimony more than 30 years experience of working at Yale New Haven Hospital and Yale New Haven Health. I first came there as a medical resident trainee, then as a student and graduate of the School of Public Health at Yale, then as a junior faculty member. And for 17 years I was a community practitioner in primary care. I was an internist primary care physician in Branford, Connecticut.

Chris mentioned to you that more than ten years ago we acquired and integrated the Hospital of St. Raphael's into the Yale New Haven Health System, specifically as a campus of Yale New Haven Hospital. At that time I was the chief quality officer for Yale New Haven Hospital and the associate chief medical officer, and experienced firsthand much of what Chris just described.

Based on that experience and the

subsequent experiences of acquiring and integrating Milford campus of Bridgeport Hospital into the Yale New Haven Health system and the Lawrence & Memorial Health system, meaning Bridgeport -- sorry, Lawrence & Memorial Hospital and Westerly Hospital, I believe there are enormous benefits of bringing community hospitals into the Yale New Haven Health system because of our foundational academic medical center.

New Haven, with its 1500-bed academic medical center, is a world-class facility that provides exquisite care with the Yale School of Medicine faculty to thousands of patients across multiple states every day.

The concept of an academic medical center founding an academically based health system is relatively new and the concept is, is that we can bring the right care to the patients in their in-home institutions where possible and we can expand those services, and we've proven that at each one of our previous acquisitions.

There are many ways that we can demonstrate how that's done, and I'm going to

go through a couple of them. One is -- is through, as Chris mentioned, EPIC, which is our electronic medical record.

Back in the year 2000 when to Err is Human, the Seminole Institute of Medicine publication was published about safety in American hospitals, one of the main things they pointed to improve quality of care was the institution of what was called then CPOE, or computerized physician order entry. That was really the first step in an integrated electronic medical record, and it was really a very small step.

We have taken that far beyond computerized physician order entry, and we now have a single instance of EPIC, which is extremely important across all the places where Yale New Haven Health operates. This is in contrast to the Prospect Hospitals that have different instances of different electronic medical records at their different locations.

What functionally does that mean? Well, it seems bizarre that in this day and age that electronic medical records do not

communicate with one another, but unfortunately that's the situation that we are in -- except when you have a single instance of that electronic medical record.

With that single instance of EPIC we were able to show that care is much more efficient. We can drive consistency of care, something we call Care Signature, and we can demonstrate efficiency and care enhancements. It makes transfer from outlying facilities or outlying physician offices seamless. It ensures that their care is both efficient and effective.

So the combination of that electronic medical record, which is really an avenue to stitch together high-quality care across the different domains of care and across different providers -- is really emblematic of what we -- one of the things that we can do to provide.

When we acquired Lawrence & Memorial, for example, we both were able to populate their medical staff with specialists from Yale's School of Medicine and bring The technologies like EPIC to bear at Lawrence &

Memorial.

And what we were able to do at Lawrence & Memorial was we allow them to retain a much greater percentage of patients at that hospital than had previously been retained. This is an example of what Chris was talking about, how our goal is to deliver right care in the right place.

There are still some instances -- for example, Lawrence & Memorial does not provide cardiac surgery, does not provide transplant surgery. So those patients naturally would be transferred to the academic medical center. It's both ineffective, unsafe, and inefficient to reproduce all kinds of care at every institution, but there are certain circumstances where you can provide very safe high-quality tertiary care in a community setting. That's our goal, and that's what we've been shown to do at the previous -- at the previous -- our previous acquisitions.

There are numerous publications showing that care at academic medical centers is both more efficient in the long run, and certainly more effective with better outcomes in terms

of quality outcomes, in terms of things like mortality. And we believe that we've demonstrated that. And in fact, we've published that a number of times on certain -- in certain circumstances within our health system.

One of the most recent examples of the strength of the Yale New Haven Health System, the strength that the school faculty integrated across our health system with backbones such as a common medical record, EPIC, a common pharmacy standard, et cetera, is our EPIC pandemic.

You may have seen that in the national press Yale New Haven Hospital has been lauded as one of the institutions in the United States with the lowest mortality throughout the COVID pandemic for the treatment of COVID patients.

And our own internal data, which is soon to be published, demonstrates that there's not a statistically significant difference between the mortality of the patients cared at Yale New Haven and our affiliate hospitals that are part of the health system.

That means that if you're in the community hospital in Westerly, New London, Bridgeport or Greenwich, and you've sought care at that institution with COVID and you stayed in that institution for the treatment of COVID, you experienced the same high-quality care and the same good outcomes as if you were in the academic flagship. For us, that's success.

Our goal is not to bring every patient to New Haven. In fact, we cannot. New Haven runs at a 95 percent current occupancy. Our goal is to keep patients where possible in the communities where they are cared.

The way we did this was to use our EPIC medical record backbone source, the ever-evolving clinical pathways from our Yale school of medicine and other experts. And we reiterated that clinical care pathway for the treatment of COVID patients more than 200 times since March of 2020, because the knowledge has continued to evolve in how to care for COVID patients.

You may remember, if we were sitting in this room three years ago no one would have

understood how to care for COVID. Today we know how to do that. In large part the way we've been able to learn how to care for COVID patients as an evolving disease has been driven by the researchers in the Yale School of Medicine, and we immediately transmit that knowledge into our care pathways, which then every clinician across our health system can immediately follow that same day.

That's really unique, and we believe that that is real evidence, an empiric demonstration of the value of an academic medical center. That's the kind of care we want to bring to Manchester, Rockville and Waterbury Hospital.

So how have we gone about the clinical planning? I can't say that our clinical planning has been complete. There are issues with an antitrust and other that prevent us from getting our hands on certain documents, contracts and such that allow us to do a complete comprehensive study of each hospital to identify each of its strengths, weaknesses, gaps, community needs, et cetera.

We would like to do that immediately upon completion of the transaction, and we believe we can do that within six months and really hit the ground running.

The good news is, is that the quality of care and the services are generally strong across both ECHN and Waterbury Hospital. Let me address the two of them.

At Waterbury Hospital our initial focus is really going to be around stabilizing the systems of care. The transition as we have experienced at both L&M, Milford and with the St. Raphael's transaction is there's a real concern around the transition between one entity to another in making sure that high-quality care and continuity is established during the time of that transaction.

We have experience in doing that. We can do it, and we've demonstrated that patient care will continue seamlessly, that we were able to pay our bills. We were able to keep our staff paid and that we were able to create a smooth transition from one ownership entity to another.

We would then begin strengthening the services. We think there's initial opportunity to strengthen already stong offerings in oncology, heart and vascular disease and maternal fetal medicine. The same with Manchester and Rockville.

Manchester and Rockville as well as Waterbury Hospital, the ECHN and Waterbury Hospital are interesting institutions as we've looked at them. They both serve about the same size population. They have roughly the same number of beds. They both have about a little more than a thousand deliveries. There they're quite similar in many ways, even though Manchester and Rockville are -- are two institutions.

Chris mentioned that our intent would be to bring Rockville and Manchester and operate them under a single license. We believe that that is the best way to provide high-quality and safe care.

Now we have a number of experiences where we've done similar things. We have a freestanding emergency department in Guilford, which is open 24 hours a day, seven

days a week. We see surgical cases there that are transferred from Guilford to New Haven or New London. We see heart attacks there. We see all manner of emergency care at our Guilford freestanding emergency department.

That Guilford freestanding emergency department is twelve miles from New Haven. We have an outstanding safety record and a high-quality record for getting those patients safe high-quality care as they're transferred from that ED to New Haven for their care.

Our intent would be to continue to operate the emergency department in Rockville, augment it and add outpatient services, I think study what we would like to do there on the in-patient side, but we would like to operate the two as a single institution.

The same is to be said, I think, and Anne Diamond is going to talk about our experience with Milford and Bridgeport that we operate under a single license.

When we acquired Milford -- and Anne

will go into this detail -- its inpatient census was lagging. Their quality of care was in question. We were able to stabilize that, and today, as Anne will tell you, Milford is very busy with high-quality care overseen and integrated completely with Bridgeport Hospital, which is almost exactly nine miles away, I believe, as are Manchester and Rockville.

While both -- both hospitals, as you can see from the data, are underutilized currently as compared to their number of staff beds, or operating beds as compared to their number of licensed beds. And we believe, like we've demonstrated in Lawrence & Memorial, Westerly and in Milford, that we have an opportunity to increase that census as we bring high-quality programs to those, and staffing in -- into those markets.

We believe that there are lots of patients leaving those geographies, driving past those institutions, going to other institutions that would be better served by being cared for closer to home.

I mentioned Rockville. Rockville

currently right now has an inpatient census, I believe, of three patients on average, three med-surge patients on average per day. And they operate their inpatient surgical cases about a half day a week. This is unsustainable and un-stave -- unsafe.

Low volumes have been repeatedly shown to be associated with poor clinical outcomes in virtually every clinical setting that they've ever been studied. Not seeing enough patients to maintain or hone your skills, whether you're a physician or a respiratory therapist, a nurse, a surgical tech, an anesthesiologist -- just is not sustainable.

But we do intend to build on services in Rockville that are strong and consolidate those services that are not utilized in Manchester, and we will, as I mentioned, enhance this, the offerings at the Rockville's emergency department services.

I mentioned how Rockville's distance from Manchester of nine miles is not dissimilar to Guilford's distance from New Haven, and we have significant experience with this, this model already.

When there is a need for patients, as I mentioned, that need emergency surgery we have a great record over many years, more than -- I think 15, almost 20 years now of transferring patients to New Haven from the Guilford ED.

We also -- we also planned significant clinical expansions at Manchester and Rockville over time. Again, it's hard for us to know exactly every move we will make, and you can look at our track record. Please do on what we've done at Westerly, L&M, and Milford, about how we've assessed what the community need is and then built those clinical programs according to that community need and what we are seeing on an ongoing basis.

Rockville's operating rooms are -- are ideal for using them for procedures like endoscopies or scheduled ophthalmologic or ENT surgery, and we plan to evaluate that fully. And there's a need for more ambulatory services in the area as well as adding -- as a primary care doc, I'll potentially be very interested in adding more

primary care doctor access, cardiology, diabetes care, neurology, pain management, et cetera.

Manchester Hospital, as I mentioned, does about the same number of deliveries as Waterbury. That's a very important service that we are very dedicated to, and we would like to enhance that service with obstetrical care, breast, gynecologic -- gynecological oncology, which we are experts in with our Smilow Cancer Hospital, pelvic floor disorders, and children's health issues. These are additions to the already strong services at Manchester that we think would really serve the community well, and are excited to do so.

Also, there is a growing need in Connecticut as an aging state as our population rapidly ages for more men's -- targeted men's health in neurology and prostate cancer, and conditions such as that.

So in conclusion, I'd like to say -- and I think you probably have seen that I'm very excited about this opportunity to bring academic medical care, academic medical

center level care to the communities of Waterbury -- Waterbury, Rockville and Manchester. Thank you.

So I think I'll turn it over to my colleague, Anne Diamond -- I'm sorry.

Q. (Rinehart) And before we do that, I am not a hundred percent certain if you adopted your prefiled testimony, because you jumped into the PowerPoint. So I just --

A. (O'Connor) No, I did.

Q. (Rinehart) You did?

A. (O'Connor) I did.

THE HEARING OFFICER: Well, let's do it again just to make sure.

THE WITNESS (O'Connor): I adopt my prefiled testimony, officially.

THE HEARING OFFICER: Okay. Thank you.

BY MS. RINEHART:

Q. (Rinehart) We both weren't sure.

A. (Diamond) Thank you, Dr. Balcezak.

Good morning, hearing -- Hearing Officer Csuka, and the staff of the Office of Health Strategy. I'm Anne Diamond. I'm President of Bridgeport hospital and I would like to adopt my prefiled testimony.

Thank you so much for the opportunity to speak with you today in support of the Yale New Haven Health System proposed acquisition of Waterbury Hospital and the Eastern Connecticut Health Network.

I joined bridge -- Bridgeport Hospital in November of 2019, only a few months after the acquisition of Milford Hospital, which then became the Milford campus of Bridgeport Hospital. And as a result I've had the opportunity to personally witness and participate in the comprehensive and thoughtful way that the Yale New Haven Health System integrates new facilities into its system, including new campuses of the existing hospitals.

I believe that the experience in Milford is a strong indication of the system's capabilities and helps us illustrate the value that Yale New Haven Health System will bring to the Prospect Hospitals.

Now in my prefiled testimony I provided background information on financial stabilization, the significant capital investments, and the journey to bring Milford

Hospital to clinical standardization that elevated the standard of care within the community. Today I'm going to provide some additional depth to my written testimony and frame that transformation that happened over the 39 months.

The quality of care, the pride that was displayed by the employees for their new organization and that shift that really revitalized the trust felt by the Greater Milford community to once again seek care within their hospital and the outpatient services that were now available within their community is the direct result of the effective integration plan.

You are going to hear a little later in the public testimony from some long-term Milford Hospital -- now Bridgeport Hospital employees, but I think Dominick sums it up the best -- and this is a direct quote.

At the time of integration I had been with Milford Hospital for 26 years. Like a lot of my coworkers, I was a little skeptical and didn't quite know what to expect. What I've learned it's that it's been a good fit

and it just meant so much to all of us that they've delivered on the promises, and that Milford is thriving again.

Another example of the benefit to the community includes the clinical expansion of subspecialty services including behavioral health, ear, nose and throat, critical-care pulmonologists that are now in the intensive care unit, allergists and geriatricians, just to mention a few.

In May 2019 Milford Hospital had a very low inpatient volume, around 20 patients. Today the Milford campus of Bridgeport Hospital cares for 75 hospital and rehabilitative patients each day. On the outpatient side volume increased from 36,000 in 2019, to over 60,000 patients served in the Greater Milford community.

The Yale New Haven Health System added 100 new technologies in 100 days of the transition, including electronic medical health systems, communication systems, drug dispensing technologies, new materials trackers, revenue cycle management, digital diagnostics to take blood pressures,

temperatures and other vital signs are among the number.

These investments by the Yale New Haven Health System have enabled a renewed confidence in the clinical care provided to the regional communities. That very deep connection between hospital and the patients that they serve is stronger than ever.

I have every confidence that the Yale New Haven Health System will have the same positive outcomes in Waterbury and the Eastern Connecticut Health Network.

I than you.

And now, next I believe is president Deborah Weymouth from ECHN.

A. (Weymouth) Great. Thank you, Anne. Good morning, everyone. My name is Deborah Weymouth, and I too adopt my prefiled testimony. And I also would like to thank Hearing Officer Csuka for investing your time and attention with your team into this valuable and important process.

As noted, I currently serve as President and CEO of ECHN which includes Manchester Memorial, Rockville General, visiting nurse

services and numerous medical offices and outpatient services.

ECHN sees significant value in the partnership with Yale New Haven Health System because the people of Eastern Connecticut will benefit enormously from this proposal. Just some examples of these benefits include improved coordination of care delivery, quality of care being enhanced, improvements in recruiting and retention of physicians and staff, local investment in resources as well as the capacity to address health equity concerns we believe that will be expanded.

Care coordination will be enriched due to the availability of clinical information and data, as was mentioned earlier, which will be accessible through a unified electronic medical record, EPIC.

The system upgrade will benefit patients and physicians alike with simplified access to medical history, lab and test results and medications. A connected EMR will reduce the need for duplicative tests, ensure adherence to established best practices and automate administrator tasks which can increase

productivity and efficiency for healthcare providers.

ECHN currently operates a family medicine residency program to train, recruit and place full-spectrum family physicians in our community. EC -- ECHN, excuse me, Working with Yale New Haven Health will expand the current physician mentoring programs, enhance disease-specific education and other related opportunities resulting in physicians that would be more likely to remain local and build strong relationships with their patients.

Joining a larger hospital system like Yale New Haven can strengthen employee recruitment and retention overall. There are greater opportunities for career advancement through promotions, or access to training and development programs which can increase employee and physician satisfaction and loyalty.

We want to continue to retain our highly skilled nurses and physicians, and all health professionals who call Connecticut home while caring for others and strengthening people's

lives throughout Eastern Connecticut.

Also, ECHN's return to nonprofit status will be positive Connecticut-focused results. ECHN's operational performance will result in capital investments in our community-based facilities, technology, and infrastructure, as well as programs and services that our local communities need.

ECHN will be able to engage in community members and volunteer opportunities that result in increased interest in healthcare career opportunities and will result in deeper relationships with people across our region. The expansion of philanthropic programs will also enhance ECHN's ability to sustain and provide exceptional patient care.

This transaction will further address health equity issues across the State. Yale New Haven Health System has earned the health equity index award designation for its focus on diversity, equity and inclusion. ECHN believes that our communities can further benefit from this important work by being aligned with Yale New Haven Health Systems.

With a special focus on the unmet needs

of the financially disadvantaged and underserved population coupled with the results of our next community health needs assessment, we can develop and implement service expansion strategies that are responsive to community needs. This demonstrates our shared interest in treating the whole person and the social and economic and environmental factors that shape the health of individuals and communities.

ECHN is a patient-centered community-focused organization with 100 years -- has been in the making for 100 years. ECHN's two hospitals and our visiting nurse and health services of Connecticut organizations have certainly stood the test of time. We are stewards of this asset to our community.

Remaining a community healthcare provider while benefiting from a larger local system is the best path forward. This proposed transaction will further strengthen our ability to help people in our community with a broad spectrum of quaternary care services including clinical trials while

remaining close to home and connected to those who have provided care for them for years.

I urge you to consider the hundreds of thousands of people who reside in Eastern Connecticut, and provide them the opportunity to benefit from having ECHN's hospitals and affiliated services join Yale's healthcare organization.

Thank you for your attention, and I'll now turn it over to Dr. Justin Lumby, president and CEO of Waterbury Health.

A. (Lumby) Good morning. My name is Dr. Justin Lumby, and I too adopt my prefiled testimony.

I'm a board-certified cardiologist practicing today, and the President and Chief Executive Officer of Waterbury Health, a role that I've held since November of 2021. I've previously served as the chief medical officer for Waterbury health for five years.

Going back, I did my training at the University of Connecticut and residency in internal medicine, and a cardiology fellowship, and since then have been actively involved in academics as well as the

continued care of our patients. I am here to provide testimony and support of the propose -- of the proposal to transfer Prospect's Connecticut assets to Yale New Haven Health Services Corporation.

Waterbury Health operates a 357-bed acute-care hospital serving Waterbury and eleven neighboring communities in Western Connecticut. We provide comprehensive services to those communities through our hospital, our outpatient clinics, primary care practices and rehabilitation services.

Our service line includes emergency medicine, cancer care, cardiovascular care, orthopedics, neurology, pediatrics, women's health, behavioral health, and many, many more. We focus on patient-centered care, community outreach and education while employing a team of highly trained professionals and investing in the latest medical technologies and treatments.

We are committed to recruiting and retaining high-quality staff evidenced by our nurse residency program, staffing committee and educational opportunities. Our goal is

to improve the health and well-being of our patients.

The active acquisition proposal will help us reach this goal by allowing us to offer a broad -- excuse me, a broader array of services available through the support of a regional healthcare system. The proposed transaction is expected to have significant benefit for the patients of Waterbury Health. By collaborating with a larger academic system we will be able to enhance our financial strength and become more of a fully integrated and streamlined regional healthcare system.

In addition, this transaction will allow us to transition to a single electronic medical record system which has been addressed several times previous to me, improving care coordination, ensuring all provide -- providers have access to critical information in a timely manner, lowering costs by streamlining clinical encounters and enhancing quality and safety through improved information management.

Furthermore, existing joint programs

such as our cancer care at the Harold Leever Cancer Center, neonatal intensive care unit, maternal fetal medicine and internal medicine residency program will continue to provide comprehensive care to the community while serving as a foundation for further collaboration in other programs.

The acquisition will also provide Waterbury Health patients enhanced access to Yale -- Yale New Haven Health's subspecialty providers and care closer to home. As such, the acquisition will further enhance access through specialty care closer to home ensuring that patients receive the best possible care.

In summary, the proposed transition is expected to have significant benefit to the Waterbury community, including continued access to critical healthcare services for the uninsured and the underinsured. The transaction will also help maintain a strong commitment to recruitment and retention efforts for highly -- high-quality staff.

Lastly, the transaction will further Waterbury Health's mission and its public's

best interests.

Thank you for the opportunity to testify to support the Waterbury Health's application to transfer its assets to Yale New Haven Health Systems.

THE HEARING OFFICER: Thank you. Do you have anyone else that you wanted to make an opening statement at this time?

MS. RINEHART: We don't, Hearing Officer Csuka.

THE HEARING OFFICER: Okay. At this time I think we're going to take a 15-minute break. Attorney Rinehart, you and I have to go over those dockets during the break, so we'll do that.

Let's come back at, let's say, 10:52. So we'll start off at 10:52.

And just a reminder that, although the recording will stop the video will probably still keep going. So just be careful what you say.

(Pause: 10:37 a.m. to 10:53 a.m.)

THE HEARING OFFICER: For those just joining us or for those coming back, this is a hearing regarding Docket 22-32594. It's a Yale New Haven Health Services Corporation and Prospect CT, Inc, the

transfer of ownership of a healthcare facility.

Before we get back into things I did want to mention that for those of us who are present in person, we're being asked to be extremely quiet in the hallway or have your conversations in the breakout room, which I believe is Conference Room 3C. Or you could speak in here as well, but there are people who are working for DPH and they need to be able to concentrate. So I would appreciate everybody's consideration in that regard.

So earlier we did the preliminary presentations by the Applicants and their witnesses. On break we clarified some of the dockets for which I took administrative notice.

The numbers for -- let's start with Lawrence & Memorial data acquisition; that is 15-32033. The Milford acquisition, that is 18-32270. The St. Raphael's acquisition is 12-31747.

And also the Prospect acquisition, I gave one of the docket numbers earlier. There's a separate one related specifically to Waterbury Hospital, which I did not provide. That is 15-32017-486. The other one that I did provide was for ECHN, and it's two hospitals.

There was also one other clerical sort of

matter that we wanted to address, and I will leave it to Attorney Rinehart to speak on that.

MS. RINEHART: Yes. Thank you. The correct version of our revised worksheet A is Exhibit 25 in the record, and I think a draft version was inadvertently included in the slide deck.

That was shared, so if anyone needs to access the correct version, it is Exhibit 25 in the record. And we'll file an amended PowerPoint that -- just showing the correct worksheet so that it's clear in the record.

THE HEARING OFFICER: Okay. Thank you.

So with that we are going to jump right into questions by OHS staff and I believe we're going to start with Roy?

MR. WANG: Yeah.

THE HEARING OFFICER: Correct?

MR. WANG: Correct. All right. Good morning, Attorneys Rinehart and Volpe. And good morning, leadership team of Yale New Haven Health Systems and Prospect CT. Thank you for being here in person to provide additional testimony and for answering OHS's additional questions.

So my name is Ruonan Wang, W-a-n-g. I'm an associate research analyst with the Office of

Health Strategy. And to begin I would just like to ask some questions regarding the financial feasibility and strength of the healthcare organizations involved in the proposed transfer of ownership.

So my first question would be, would you please provide an overview of the current financial status of each of the Prospect CT's hospitals with focus on income losses for operations versus nonoperating revenue?

MS. RINEHART: If it's okay I think we would like to have Ms. Kosyla come --

THE WITNESS (O'Connor): That's prospect.

MS. RINEHART: It was directed to both of the applicants. Right?

MR. WANG: To begin I just asked for Prospect Connecticut, yes.

MS. VOLPE: Okay. Roy, if it's okay? We'd like to have James Phillips sworn in, and Sheryl DeCilio. If they could both come forward, Jim and Sheryl?

And maybe what we could do is -- I mean, can we just pull up two chairs right there?

Would that be okay?

Thanks, Jim.

MR. WANG: And there will be additional questions for

the Yale New Haven side of this. So if you want to get everybody in on the financial side --

MS. VOLPE: I think they were sworn.

If we could have them sworn in?

MR. WANG: Okay. Sure. And we kept all their financials hopefully in one section of the questions.

MS. VOLPE: Sure.

MR. WANG: So that way we can rearrange once we move on to the next section.

MS. VOLPE: Dan, you want to swear them in?

THE HEARING OFFICER: Yeah, I will.

To the greatest extent possible we're going to try to take this topic by topic, but there is going to be some jumping around, a little bit.

So I'll first have you just state your name and your position.

We'll start with this gentleman?

JAMES PHILLIPS: James Phillips, Chief Financial Officer for Waterbury Hospital.

SHERYL DeCILIO: Sheryl DeCilio, Chief Financial Officer and Senior Vice President of Revenues at both of our ECHN --

THE REPORTER: Could you spell your last name please?

SHERYL DeCILIO: Sure. It's D-e-C-i-l-i-o.

THE REPORTER: Thank you.

SHERYL DeCILIO: It's Sheryl with an 'S.'

J A M E S P H I L L I P S,

S H E R Y L D e C I L I O,

called as witnesses, being first duly sworn by the HEARING OFFICER, were examined and testified under oath as follows:

THE HEARING OFFICER: And please just -- I know we're awfully close, but please just speak up so that the camera can hear you, and so that the Court Reporter can hear you.

MR. WANG: Sure. Thank you. So I will repeat the question for the new witnesses that were just sworn in.

BY MR. WANG:

Q. (Wang) Would you please provide an overview of the current financial status of each Prospect Connecticut Hospital with a focus on the income and losses from operations versus the nonoperating revenue?

A. (Phillips) Are you looking for specific numbers, or just in general?

Q. (Wang) I think general trends, or any major changes or shifts in the recent financials?

A. (Phillips) So for Waterbury Health recently in fiscal year '22 we had a loss both from operations as well as the bottom line loss.

And we are still continuing to experience losses currently in fiscal year '23 which is now six months into the year.

Q. (DeCilio) ECHN, similar results. For losses in '22, '23, we've seen a little bit of uptick, but we didn't have a full turnaround.

MR. WANG: Sure.

THE REPORTER: Would you speak up a little bit?

THE HEARING OFFICER: Both of you can speak up.

THE WITNESS (DeCilio): Sure.

THE HEARING OFFICER: I'm sorry.

BY MR. WANG:

Q. (Wang) So for the ECHN hospitals would you discuss a little bit more about the non-operating revenue operating loss and what that entails?

A. (DeCilio) So for non-operating revenue we have a lot of our joint ventures fall within our non-operating revenues. So those losses from operations obviously were affected by COVID.

So a lot of those non-operating losses

come from those joint ventures.

Q. (Wang) Okay. And then broadly speaking we can do it for the system, and then also for each hospital. What would you identify as the root causes of the financial struggles as you kind of mentioned earlier?

A. (DeCilio) A lot on the expense side. I mean, you know, COVID brought a whole different level of expenses. So all organizations, all hospitals across Connecticut, those increased inflation is mostly on the -- on the wage side. That's really -- we're experiencing, as well as the rebound in volume. I think patients still struggle to return to the hospital as we turn to some of our outpatient facilities.

Those were, I would pinpoint, as the major focus.

Q. (Wang) And the same for Waterbury Hospital?

A. (Phillips) The Same for Waterbury.

Q. (Wang) Okay.

A. (Phillips) The cost of labor is the primary driver on the expense side of having to use contracted labor, because we're having difficulty filling positions. That's been an

issue in the past.

Q. (Wang) Sure. And just to break apart, kind of, the time periods about the financial issues, would you mind clarifying if these issues have been the same from since the acquisition of the hospitals by Prospect CT? During COVID? At the peak of COVID? And then versus, you know, present-day?

Have there been any shifts to these root causes of financial issues?

A. (Phillips) I would say that the issues came up during COVID, not necessarily from the onset of Prospect acquiring Waterbury, but definitely from COVID onset forward.

And then coming out of COVID more so with the inflation, and wage growth was more post COVID.

Q. (Wang) Sure. So moving onto the financial status of Yale New Haven Hospital Health Systems, would you please also highlight the current financial status?

A. (Phillips) Sure.

Q. (Wang) And please provide a focus on, again the operational incomes and losses versus nonoperating, if those are different?

And please focus on any of the prior or recently acquired hospitals such as Bridgeport Hospital's acquisition of Milford Hospital, L&M or St. Rafael's.

A. (Kosyla) Sure. So in 2022 the -- the health system reported a loss from operations of about $300 million, and also a loss from non-operating -- operating -- from non-operating of about the same for a total loss of $600 million.

And within the operations we don't include things like investment markups for the market value of those investments, or markdowns, if you will, as was the case in 2022. It was a tough year from the market perspective.

In 2023 we're experiencing a similar loss of about $250 million. It's budgeted for 2023 from an operations perspective. The markets have rebounded somewhat. So that mark-to-market impact in 2023 is -- was better than it was in 2022.

I would cite some of the same reasons for the -- the operating loss. We have expenses outpacing revenue growth at this

point in time mainly due to the shortage of significantly important positions.

We have use of labor that is outside of the organization, contract labor we're using, and the revenue growth has not -- has not kept pace with that. Also inflationary factors are affecting the supply chain and things like -- of that nature, of malpractice insurance, et cetera.

We have a strong mitigation program that we put into effect. If you recall in 2021 we were getting a lot of dollars from COVID relief that helped offset some of those losses, and now we're -- we're at about the same, or a little bit better without the relief funds.

Q. (Wang) Thank you. So with the overviews of the two systems sort of answered, how does Yale New Haven Hospital's System propose to address Prospect CT's financial issues as outlined?

And please also highlight any solutions that worked for prior acquisitions as examples?

A. (Kosyla) Sure. You know, as we look out and

project into the future, what are our planned initiatives? Which as I understand were what took place prior to my arrival with the acquisition of the other -- of the other organizations, was really looking at efficiencies in the way that we operate. So those are really factoring into the greatest amount of what we call synergies.

So we're doing the best we can to estimate how we would potentially operate under -- under the scenario where the -- the hospitals were part of the Yale New Haven Health System. And so looking at synergies, supply chain costs mainly -- or would help us to achieve a near breakeven by 2025.

MR. WANG: Okay. Thank you.

The next questions are actually derived from Mr. O'Connor's prefiled testimony on Bates page 1485 and 1486 where he describes some of the benefits to St. Raphael and Lawrence & Memorial Hospital after joining Yale New Haven Health Systems.

So my first question -- and it can be to you, Mr. O'Connor, or the finance team here. How are the total cost savings of $638 million at

St. Raphael and $46 million at L&M from the merger calculated?

MS. VOLPE: Let me know if you want to refer --

MS. RINEHART: Can I just see it?

MS. VOLPE: 1485 and 1486, Bates stamp?

BY MR. WANG:

Q. (Wang) Correct, yeah. I believe the first paragraph is regarding the benefits of St. Raphael, and the second page has the info similar for L&M?

A. (Kosyla) So those costs would be related to functionality that we were able to bring -- gain greater efficiencies. I mean, perhaps some examples might help.

I think that in looking at the way that certain back-office functionality works, we can consolidate those operations so that it would create greater efficiencies. We also -- by being on the same platforms we can help reduce costs associated with running different systems.

We also have vendors that are common across our health system that we can help get better pricing because of the implementation costs of those.

Q. (Wang) Okay. And was the similar methodology that you just kind of described for calculating those savings applied to the financial projections in the event that --

A. (Kosyla) That's correct.

Q. (Wang) -- these are what was required?

A. (Kosyla) Absolutely.

Q. (Wang) And then, of those components which would you say contributed most to each hospital's savings and/or their positive financial performance?

For example, I believe that in Mr. O'Connor's testimony he mentioned that L&M's positive margins in 2021 -- or L&M experienced positive margins in 2021, despite the financial challenges posed by the COVID-19 pandemic?

A. (Kosyla) I would have to look back at the detail to see where the -- where the specific things were.

Q. (Wang) Okay.

A. (Kosyla) You know, in terms of the projections for this, again as I -- as I mentioned those process improvements really are where -- where we're looking for the

opportunity.

Q. (Wang) Sure.

A. (Kosyla) So I -- I'd have to go back and look at those.

MR. WANG: Sure. Hearing Officer Csuka, may I request that as a late file just to have a breakdown of the savings?

THE HEARING OFFICER: Sure.

MR. WANG: Okay.

BY MR. WANG:

Q. (Wang) And then the last question related to that is, do separate financials exist showing the contribution of the acquired hospitals versus affiliations to the overall financial stability and savings?

Are they separated, or is it all --

A. (Kosyla) The contribution margins for the -- for the --

Q. (Wang) Yeah, the contribution of the hospitals versus the affiliations and joint ventures to the overall savings that were experienced by St. Raphael and L&M?

A. (Kosyla) I -- I would have to look at that --

A. (O'Connor) So for the hospitals that were integrated, so St. Raphael's and Milford,

they're fully integrated into Yale New Haven Hospital and Bridgeport Hospital.

For L&M it still stands as a stand-alone. So those are separated financials.

Q. (Wang) Okay. So then I guess in the late file of breaking down the savings, if there are financials that exist for teasing apart any of the joint ventures versus the hospital itself, that would be greatly appreciated for that breakdown just to visualize?

A. (Kosyla) I think it's in our audited financial statements. The breakout of the individual entities is in the audited financial statements, but we'd have to look at that.

Q. (Wang) Okay. Thank you. My next question is, as both Mr. O'Connor and Ms. Diamond shared in their prefiled testimony, the integration of Milford Hospital into the campus of Bridgeport Hospital in 2019 represents another example of successful integration of a hospital in, quote, dire straits. This is prefiled testimony of Ms. Diamond on Bates page 1495.

The question is, please explain the reported loss for operations of 16.3 million experienced by Bridgeport Hospital in 2020, and then the net positive income in revenue in 2021, and then the net negative 31.7 million deficit in 2022?

A. (Kosyla) Are you looking at -- is it total? Total income? Or is it the -- just from operations?

Q. (Wang) This would be net deficit?

A. (Kosyla) Total?

Q. (Wang) Yeah, total.

A. (Kosyla) Yeah, so I would say similar to the explanations that we gave there. So in 2020 we were receiving COVID relief funds. There were -- there were gains from the investments in 2021 -- that was '21.

'Twenty-two we were also seeing losses from investments, the same would fall true for -- for Bridgeport.

Q. (Wang) Sure.

A. (Kosyla) In 2020 during the height of the pandemic volumes were significantly lower as we grappled with outpatient services, elective services and not seeing the volume

of patients that we've seen in the past.

Q. (Wang) Okay.

A. (Kosyla) And then -- and then struggling with the same expense categories, nursing, contract employees, supply chains, et cetera.

Q. (Wang) Okay. Thank you.

A. (O'Connor) We didn't furlough any of our employees. So they maintained their current employment through the shutdown as well in 2020.

MR. WANG: I will pass it along to my colleague Bozena who's going to continue along with some financial questions.

MS. PIASCIK: Good morning. My name is Bozena Piascik. The spelling of the first name is B-o-z-e-n-a. The last name is P-i-a-s-c-i-k. I'm an associate healthcare analyst. And as Roy said, I'll continue the financial disability and strength questions.

This has to do with regarding for prior transactions involving the affiliation of Milford Hospital with Bridgeport Hospital and the transfer of ownership of Lawrence & Memorial Hospital.

BY MS. PIASCIK:

Q. (Piascik) My question is, what was the

process for implementing Yale New Haven Health System's financial and accounting practices with the newly acquired hospitals, and how long did the process take?

A. (O'Connor) So for each hospitals we implemented -- well, let me take you first from St. Raphael.

So we actually used a third party during the St. Raphael's integration, and then we transitioned to our internal resources for both Lawrence & Memorial and Milford. So in that process, we go through a full integration planning, assessment.

I think, Tom, as you mentioned in your testimony today, that, you know, we -- we don't have full clarity until the close, because there are a number of pieces of information that are just not available until you actually close on the transaction.

Once that occurs, our team goes into full deployment. They begin to do an assessment phase. We create gaps between what we are currently doing within the health system, and how we -- and what's going on at the newly acquired entity, and begin to

prioritize what are those. And they're different depending upon the state of the individual organization.

So for instance, we did not convert our supply chain systems in Lawrence & Memorial immediately, because we were going through a full systemwide upgrade of our enterprise management system.

So those are things that are determined based upon a case-by-case basis and evaluated by the internal team.

Q. (Piascik) So would you be able to give me an idea of how long did this process take? At least, I understand it takes progress from one to another, but roughly, do you have a timeline that that usually takes?

A. (O'Connor) We try and get the majority of it done within a year.

Q. (Piascik) Okay.

A. (O'Connor) I think if you -- if you look at the year horizon, that depends. EPIC, as was mentioned earlier, is the backbone of the clinical systems, and then we evaluate the other systems based upon the needs.

But you know, we try to move through

that within a year, 18 months, to convert those systems over to the systems we're using across the system.

MS. PIASCIK: Great. Thank you.

BY MS. PIASCIK:

Q. (Piascik) My next question is, the Applicants described Yale New Haven Health System official in-migration plan in response to question -- it's 10A of OHS's first completeness letter. It's in Bates pages 1048 to 1050.

If you'd like to just look it up for a minute before I --

A. (Kosyla) 1048?

MS. PIASCIK: It's in the first completeness letter. It's Bates pages 1048 to 1050.

MS. RINEHART: I'm extremely impressed with the fact that you are all paperless right now.

MR. WANG: We have binders.

MS. RINEHART: I was going to say, we have -- yeah.

THE WITNESS (Kosyla): So you're referring to the five-year plan?

MS. RINEHART: There's going to be a question regarding that.

THE WITNESS (Kosyla): Okay. So the question is?

MS. RINEHART: It's not matching. 1048?

Could you repeat the number that you --

MS. PIASCIK: Sure.

MS. RINEHART: And the number of the question?

MS. PIASCIK: The question is 10A. So you just -- correct, when you're referring to the question that starts with five-year plan.

MS. RINEHART: Okay.

MS. PIASCIK: But this is regarding the response that it was within that response of that question, 10A.

And that's where my question is going to come in from. So you are in the right section.

MS. VOLPE: Is that 10A?

MS. PIASCIK: Yes.

THE HEARING OFFICER: If it's helpful, that's Exhibit F in the table. I just want to make sure you're looking at the right document.

MS. PIASCIK: Yeah, I have that document.

BY MS. PIASCIK:

Q. (Piascik) I'll be happy to ask the question.

A. (Kosyla) Is the question about the five-year plan, or the mitigation?

Q. (Piascik) The mitigation.

A. (Kosyla) Okay.

Q. (Piascik) So my question is, has this plan

had any impact on current financial results or any of the projected results indicated in revised worksheet A, Exhibit 23, for Yale New Haven Health Systems, or any of the affiliate hospitals?

A. (Piascik) So if you are referring to the -- and I'm just trying to find a reference to the --

MR. WANG: I can. It's the last paragraph of the response on page 1049 that begins with, Yale New Haven Health System however has a long track record. And then it goes through, kind of, examples of the mitigation plans.

MS. PIASCIK: Yes.

BY MR. WANG:

Q. (Wang) That paragraph?

A. (Kosyla) Yeah. So to the extent that items have been implemented and are reasonably expected to be implemented, they were included in the five-year projection for Yale New Haven Health System.

BY MS. PIASCIK:

Q. (Piascik) Okay. And my second part of this question is, can you provide a statement of operations for Yale New Haven Health Systems

and any affiliate hospitals showing six months year to date as a late file, please?

A. (Kosyla) Can you repeat the late file?

Q. (Piascik) Of statement of operations for Yale New Haven Health Systems?

A. (Kosyla) Yes.

Q. (Piascik) Great. Thank you so much.

A. (Kosyla) Sure.

Q. (Piascik) And I can go on to my next question?

A. (Kosyla) Yes.

Q. (Piascik) And this question is, regarding the Applicant's response to question 26 of OHS's first completeness letter, Bates page 1058 -- so we're still in the same section, just if this helps -- which stated, it is expected that the current negative operating results of Yale New Haven Health Systems will continue due to the factors above, and the significant investment needed in facilities in IT.

And the restoration of services and other measures will be required to migrate the losses.

My question is, what is the significant

investment needed in the facilities in IT?

That's my first part.

A. (Kosyla) So I -- with respect to the IT, it would be the integration of the EPIC system.

Q. (Piascik) Okay.

A. (Kosyla) Okay. Any other systems, that once we determine aren't compatible with the -- with the integration into the health system, that would be included.

There's also the facilities review to ensure that they're meeting the safety needs of the -- of the patients and that we can continue to operate in those facilities. So there were placeholders for facilities.

And I don't know if any of my other colleagues have any information on other investments, but the -- but those would be --

A. (O'Connor) I think the biggest is -- is EPIC coming out.

A. (Kosyla) Do they have it?

A. (O'Connor) Yeah. So Lisa may want to --

MS. RINEHART: If you would like additional details specific to EPIC, we have someone who can directly answer IT and EPIC-related questions.

MS. PIASCIK: Sure.

THE WITNESS (Stump): Hi.
MS. PIASCIK: Hi. So she specifically it says --
MS. RINEHART: She has not been sworn in. We should probably move her closer.
THE WITNESS (Stump): I was sworn in this morning.
MS. RINEHART: Oh, yes. You were.
THE WITNESS (Stump): This is Lisa Stump.

So the other investments in IT extend beyond EPIC as well. We will invest in cybersecurity and underlying network infrastructure, the -- the connectivity of wireless infrastructure to support the -- the healthcare environment that we envision, EPIC being one piece of that.

But as my colleagues have mentioned, we will implement other core platforms that operate our business, our human resources systems, our general accounting systems, our procurement systems.

And then again, that -- that underlying infrastructure, the network capabilities and cybersecurity are some of the major components beyond EPIC.

BY MS. PIASCIK:

Q. (Piascik) Great. My next part of this question -- so the next part is, can you please clarify and provide examples of

additional services and other measures involved in mitigating future losses?

A. (Kosyla) I didn't catch the first part of what you said? I apologize.

Q. (Piascik) If you can please clarify and provide examples of the rationalization of services and other measures involved in mitigating future losses?

A. (Kosyla) So with respect to services, I guess, Dr. Balcezak, if you could respond to that?

A. (Balcezak) Sure. So again, I mean, our clinical services plan, as we mentioned, is not yet complete. There it needs a lot of work for us to be able to complete that plan. We expect to do that within six months.

I can give you numerous examples of how we've rationalized services at both the Milford campus at Bridgeport Hospital or Lawrence & Memorial, Westerly, and -- and St. Raphael's Campus.

In each one of those circumstances we did not have a plan prior to the close of the transaction, but we undertook that plan rapidly after the close, and we instituted it

within six months.

This is a continuous evolution of process, and we have continued to evaluate those. We always do that on an annual or frequent basis, what services we should provide where. It depends on changing demographic, patient need, community need, et cetera.

We did say already one of the rationalizations we are asking for at the close is a single license to operate the Rockville and Manchester Memorial Campus under a single license, and we will anticipate closing the inpatient med-surg service at Rockville and moving those inpatients to Manchester.

It's neither safe, effective, nor fiscally responsible to operate an average daily census of three med-surgical patients, and that's a small example. There's not substantial savings there, but I think it's one of the very first and one of the ones that we see already that we think is appropriate in terms of the rationalization of service.

A. (Kosyla) And -- and some of the other factors to help mitigate the loss for what I described earlier when we talked about process improvement, economies of scale, and trying to -- with the implementation of our IT platforms, to enable some of those, that functionality to be offered across a greater breadth of facilities, mainly not patient-facing type of activities.

MS. PIASCIK: Thank you. I'll go to my next question. In the original worksheet A, Bates page 743, it was -- I'll just wait until -- yeah.

So it's the original worksheet A.

I can continue? Okay. It was projected that Yale New Haven Health System would have a loss from operations of 72.6 million and 112.3 million for fiscal year '24 and fiscal year '25, respectively.

My question is, in worksheet A it was projected -- I'm sorry, in worksheet A, Bates 743, it was projected that Yale New Haven would be a loss from operations, 73.6 million and 112 million for fiscal year '24 and '25, respectively.

And in the revised worksheet, Exhibit 25 -- if you'd like to pull that up?

MS. VOLPE: What's the Bates stamp on that?

MS. PIASCIK: Exhibit 25.

MR. WANG: It was sent in as a separate Excel sheet --

MS. PIASCIK: An Excel document.

MR. WANG: As part of the response to the first agreements letter.

MS. RINEHART: I think it was also done as Bates number 1295. We did both, because Excel is easier for you to see.

MS. PIASCIK: Oh, okay. Thank you.

So in the revised worksheet A, Exhibit 25, the projection changed to 36.7 million and 9.5 million for the fiscal '24 and fiscal year '25, respectively.

BY MS. PIASCIK:

Q. My question is, can you explain the significant changes in the projected incremental amounts between the two worksheets?

A. (Kosyla) Sure. A couple things. So first was that we did identify a modeling error in the first document. That, that has a significant -- like the double million dollar impact.

Q. (Piascik) Correct.

A. (Kosyla) We were calculating the increase on -- on the increase versus the total. So it -- it sort of multiplied and then became exponentially larger in the out years. So that was the number one item.

We also had, you know, there there was the State's Medicaid rate settlement, and we inadvertently forgot the rate increase that was part of that in the first model and added it to the second model.

We also, we looked at the asset purchases identified and the depreciation associated with the assets purchased, and we were using an average life that was consistent with -- with typical IT acquisitions, but certain items like the EPIC install have a life that is much longer than the recommended depreciable life. So we reduced the depreciable life on that, and that expanded the -- the number of years over which we depreciate the asset, lowering the expense.

We also incorporated -- we had updated financial statements from -- from Prospect that we updated and included in -- in that.

We also modified some of our synergy assumptions. As we got more information we were able to estimate those to a little bit greater degree. Those, the -- the largest by far was the model.

We also moved the cost of capital. We had previously put that in the interest expense. Since we would be financing this potentially with cash, we recog -- we recognized that in the non-operating piece instead of in the operating. So we moved that below the line.

MS. PIASCIK: Okay. Understand.

BY MR. WANG:

Q. Can I ask a quick clarifying question regarding the Medicaid rate increase that you mentioned?

Are those increases part of the Prospect projections now as well?

A. (Kosyla) They're in the column that's in the incremental.

Q. (Wang) Okay.

A. (Kosyla) It was in that that the changes were made.

MR. WANG: Okay. All right.

MS. PIASCIK: Thank you.

BY MS. PIASCIK:

Q. My next question is, can you please submit as a late file the final version of the fiscal year 2022 audit financial statements for all three Prospect Connecticut hospitals and non-hospital entities that have an ASFS, audit financial statements?

It is understood that there's an extension that was granted to the Prospect until May 1st.

A. (Kosyla) I'll leave that to my Prospect colleagues.

MS. VOLPE: Correct. Yeah, there are letters on file. Jim can speak to that in terms of the extension.

MS. PIASCIK: It's just that there was an extension that was granted until May 1st. So we're just asking for a late file, if we can have the financials for 2022 for Prospect?

MS. VOLPE: Yes.

THE HEARING OFFICER: So you don't expect to seek another extension? Is that correct?

MS. VOLPE: I'd have to confirm with my client.

THE HEARING OFFICER: Okay. We can work out timing on late files.

MS. VOLPE: Yeah. I mean, we've been diligent in seeking extensions early on and timely. It's in the file.

THE HEARING OFFICER: I wasn't asking you to commit to a timeframe. If you need to do another extension I'll leave that --

MS. VOLPE: Okay.

THE HEARING OFFICER: -- HRS to deal with.

MS. VOLPE: All right. Thank you.

THE HEARING OFFICER: I was just looking at it from the perspective of how would we work that with the late-file timeline?

MS. VOLPE: Understood, and we'll try to get a good estimate on the audited financials for the three hospitals for 2022.

THE HEARING OFFICER: Okay.

MS. PIASCIK: Thank you. I've asked my questions. I'll move to Steve -- and?

MR. LAZARUS: Sure. I'm going to switch. My name is Steve Lazarus --

THE HEARING OFFICER: I should just -- sorry, not to interrupt.

MR. LAZARUS: No, go ahead.

THE HEARING OFFICER: I did just want to say we are going to be skipping around some more. So just

because we've gone off before and caught up before, there are more questions.

So don't think you're out of the woods.

MR. LAZARUS: All right. So again, my name is Steve Lazarus, and the following couple of questions have to do with more with the accessibility part of it.

So the prefiled testimony of Anne Diamond described the increases in the inpatient discharges and increases of the outpatient volume at Milford Hospital following its affiliation with Bridgeport Hospital.

BY MR. LAZARUS:

Q. (Lazarus) My question is, were these increases to the existing inpatient and outpatient services? Or were they changes to the types of inpatient and outpatient services provided at Milford Hospital in the years following the acquisition?

A. (Diamond) Good morning.

Anne Diamond. Anne with an "E"; D-i-a-m-o-n-d, President of Bridgeport Hospital.

So the increase in the inpatient and outpatient volumes occurred because we were

able to add different specialty services to both the inpatient and outpatient service offerings.

For example, there is a 10-bed intensive-care unit at Milford Hospital. It did not have neurological specialty services. It did not have psychiatry. We added teleneurology. We hired pulmonary intensive care physicians to be physically on site.

This enabled us to admit patients that would present at the emergency department of a higher acuity than would have been able to be cared for safely under the Milford Hospital paradigm.

Q. (Lazarus) And what was the timing of that one after the post transaction? Was it within one year to 18 months? Or was it something that was, like, gradually over a three-to five-year period?

Can you talk a little bit about that?

A. (Diamond) Yeah, sure. So in the integration period, there's really four phases that Yale New Haven Health System uses. The first 100 days is what we were -- call a stabilization. It enables us to go in, look at the clinical,

the support and ancillary services, ensuring that there is safe care happening.

And so examples of that would be transitioned the employees from Milford Hospital over to Bridgeport Hospital and Yale New Haven Health System. The standardization then took place at that six-month timeframe, and that's where you heard from Ms. Stump that we brought in the EPIC system.

And by doing that, that enables clinical pathways, or what the lawyers think of as a standard of care, to be able to be implemented -- and Dr. Balcezak spoke to that. That also has cost-effective outcomes in a positive way. There's not duplications of tests, et cetera. So that happens during the standardization phase.

Then between the seven- and 24-month phase, we look to optimize. That's the opportunity to really understand from the community what the needs are from a clinical perspective and increasing our local access. Again, planning and working with our colleagues and partners at Yale School of Medicine, the Northeast Medical Group, we

were able to figure out, who else do we need to bring to the community in order to improve that access?

And improving the access thereby increased the volumes that you were asking.

A. (Balcezak) May I add two things?

A. (Diamond) Yes, of course.

A. (Balcezak) Anne mentioned the opening and expansion of the ICU services. That could not have been possible, as Anne mentioned, without the recruitment of a critical care pulmonary physician.

The problem is, is that leaves that unit only covered for those eight hours, five days a week, that are -- that pulmonary critical care physician can work. We were able to augment that coverage through partnership with the Northeast Medical Group and the Yale School of Medicine, as well as install our tele-ICU system.

So although there is no critical care intensivist on campus, there are critical care intensivists caring for those patients 24 by 7. That is the standard of care right now, but it is not present in most U.S.

Hospitals. Most U.S. Hospitals do not have an in-house critical care pulmonary physician 24 by 7. There simply are not enough physicians in the United States to provide that service.

But one of the things after the installation of EPIC, after the installation of the electronic backbone that Lisa Stump mentioned, we were able to put that camera, microphone, et cetera, in every one of those rooms so those patients have that benefit.

The physicians in the community that care for those patients are then comfortable with that care, so they can stay in Milford Hospital, whereas before they would be transferred out to either Bridgeport or New Haven.

The second thing I would say is both Bridgeport and Yale New Haven were quite capacity constrained at the time of the acquisition of Milford. And we saw that one of the areas that we had, which is a prospective payment system exempt unit, which is our rehab unit, each of us had a PPS exempt unit for rehabilitation that had an

average daily census that was only about half of an inpatient unit.

We consolidated those two rehab units at Milford Hospital and were able to decant those sub-acute patients from both the acute campuses of Bridgeport and the acute campus at Yale New Haven, and bring them to the beds at Milford Hospital, immediately increasing that census, and importantly opening beds at Bridgeport and Yale New Haven for the more acute patients which were desperately needed.

A. (Diamond) And if I could just add, the fourth part of the integration process is thrive, and that's really where we are right now. So the thrive occurs between the 25 and 36 month timeframe, and it was during that timeframe that we really brought additional specialty care.

For example, all of our nurses and physicians within the emergency department of the Milford campus have special certifications in geriatrics. And then we expanded that to some of our inpatient units also. So that's just one example of continuing to find validation through

external benchmarking and through external certifications.

That was not present at Milford Hospital. So that's really part of the integration process. So it's really a very defined, highly reliable four-phase process as we take on these new hospitals. And I would see us following something very similar.

A. (Balcezak) I don't want to pile on again, but in addition to the geriatric, the certification --

A. (Diamond) He's my tag team.

A. (Balcezak) She's triggering a memory -- but in addition to the geriatric certification of the nurses, we also received -- because Milford has a particularly aged population, and so we saw geriatric certification of the entire emergency department.

A. (Diamond) Yes.

A. (Balcezak) And we've seen a subsequent increase in local residents, particularly geriatric residents, using that ED in Milford, rather than traveling the nine miles to Bridgeport or the -- I think it's eleven

miles to New Haven.

A. (Diamond) That was part of that, reviving the, you know, the community's trust in their local hospital.

Q. (Lazarus) So following that model, was that also what was followed in L&M?

A. (Balcezak) It was.

Q. (Lazarus) And can you speak a little bit to the L&M experience and the transition there as well? And if the same type of, you know, you saw the same type of increases in utilization there as well, was that as a direct result of this four-phase model?

A. (O'Connor) So I'll jump in. And I'm the Lawrence & Memorial integration member. That also included Westerly Hospital, which I know is in -- within the scope of OHS.

But we -- we ran both of those hospital campuses as a single unit. We did the same process that Anne described wonderfully in terms of, first stabilization. In that case, we had a late understanding of the losses that were being borne by the system at that stage.

It jumped significantly, the negative

$27 million, you know, literally from our understanding in September to close. And -- and -- or with close, I should say.

So we had a pretty acute focus on that in terms of -- of managing the financial losses. Again, the same process that Anne described, going in, assessing where the opportunities were, where the gaps were; began immediately to assess clinical programs that would be able to be either expanded -- for instance, neurosurgery.

They were having difficulty hiring a neurosurgeon into that geography. Working with our partners at the Yale School of Medicine we were able to enhance that program very quickly. Cardiology was also high on the list to -- to support and build.

So each one of these acquisitions has a unique story, and you don't really learn it until you're in during those first few months. In terms of where they've struggled, hiring -- because we're not obviously allowed to know that now as competitors -- and where the opportunities are. And then, as Anne said, you look over time. So it's first

fight the fires, and then rebuild. And that's what we have done consistently.

And you know, again each one of our acquisitions, and I think it's in our testimony, has shown an increase in the utilization of the campuses, an increase in employment in those facilities, and an enhancement overall to the services.

Q. (Lazarus) And that was the same approach that was taken with St. Raphael's?

A. (O'Connor) Same approach.

Q. (Lazarus) Okay.

A. (O'Connor) The same approach. St. Raphael's was a little more unique because the campuses were only eight blocks away from one another. We also had some management efficiencies that were able to be borne out immediately upon the close of the acquisition.

So there were some synergies that were, you know, just by nature of this proximity that happened very quickly. And that's what drove the 600-plus million-dollar number, or part of it that drove it.

Q. (Lazarus) The utilization was mostly for putting this, assessing, using a similar

four-phase model and sort of the doing it, working --

A. (O'Connor) The same, the same process. And in that case -- again, each one has a little different story. In that case, the York Street campus was busting at the seams. And the St. Raphael's campus, we had shut down multiple units because of a lack of utilization.

So we were quickly able to manage programs, to move things like both hospitals did open heart surgery; consolidate that onto the York Street campus, craniotomies consolidate to the York Street campus. But we could enhance and grow the -- the med-surg capacity at St. Raphael's almost overnight.

In addition, a few months into the process, again, we looked at transportation. We implemented a capacity command center that managed that on a minute-by-minute basis proactively versus what we were trying to do initially, which was much more manual.

Q. (Lazarus) So switching gears a little bit to the current project and looking at Prospect and looking at the current bed utilization,

can you talk a little bit about that, and how is that being assessed that required -- what will be the equivalent --

(Interruption from online participant.)

A. (O'Connor) Do they want to answer? So again, as Tom said in his testimony there, we -- we can't undertake that process because we don't have full line of sight in terms of the clinical detail that we would need to -- to fully understand where those opportunities are.

So what we can look at is publicly available data. That's not very helpful really in determining what exactly we're going to do, and it hasn't been historically when we've looked at these other transactions.

So we wait upon close to fully understand where those opportunities are. We do a clinical assessment with our service line leaders and clinical leaders across the system and the school. And then we make determinations in terms of where -- what to

prioritize and invest in quickly.

Q. (Lazarus) So then has Yale assessed at least the current capacity at Prospect Hospitals, at the other hospitals that currently -- what the capacity might be and what the utilization rate is?

And would all those beds still be needed post?

A. (O'Connor) So we actually think we can grow services. And that's in -- I think it's in our worksheet A in terms of what we are seeing at a very high level without detail.

But our -- using our experience over those last three acquisitions that we've spoken about, that we've put in some assumptions in terms of growth, we anticipate that we will have similar success that we have experienced at those other transactions within both the Waterbury and ECHN communities.

MR. LAZARUS: All right. Moving on to --

MR. WANG: Steve -- sorry. Before you go on? So to capture all the kind of changes in utilization, we would hope to get -- provide the inpatient, outpatient and affiliated service lines, including

CPT codes and volumes for the various acquisitions, pre-acquisition, one year post-acquisition and then five years after the acquisition as a late file, just so that we can capture.

MS. RINEHART: Is that for the prior acquisitions?

MR. WANG: The prior acquisitions.

MS. RINEHART: I think we would have to talk internally to know whether it's feasible. Can you just repeat the specific elements you're hoping for?

BY MR. WANG:

Q. (Wang) Sure. So I think just to explain the intent of getting the information is to -- you've described a lot of the benefits and the increases, but we just want to see to what services were the largest, you know, increases captured, or where patients utilized this?

A. (O'Connor) Can you take Milford alone, for instance? I mean, that is an extraordinary amount of information that we're asking for.

Q. (Wang) Okay.

A. (O'Connor) I mean, if we could use one transaction as an example?

A. (Balcezak) One example would be great.

Q. (Wang) Sure. Specifically one example that's readily available?

A. (O'Connor) Is that feasible?

Q. (Wang) Let's go with Milford.

A. (O'Connor) Milford? Yeah, okay.

MS. RINEHART: Milford is nodding. Hopefully that means we can?

THE WITNESS (Diamond): Yes, except it's -- it's been three and a half years, so we won't have that five-year.

BY MR. WANG:

Q. (Wang) That's okay.

A. (O'Connor) But there that's subsumed under the New Haven -- sorry, the Bridgeport Hospital license.

BY MR. LAZARUS:

Q. (Lazarus) So perhaps you can use L&M, because L&M --

A. (O'Connor) I'm concerned that we may not be able to separate out, because it's billed out as Bridgeport Hospital.

A. (Balcezak) No, there's a site of service.

A. (Diamond) There is a site of service. We should be able to do that. And through our independent monitoring, we did that right up

until a few months ago, so.

MS. RINEHART: I guess the one question -- you said before the acquisition, would we have data from --

THE WITNESS (Diamond): We have limited data prior to the acquisition. We have some numbers. I do have them with me. Maybe we can confer, and.

MS. RINEHART: So we may not be able to provide the full requested information for the pre-period, but we'll do the best that we can.

THE WITNESS (Kosyla): And you were looking for inpatient, correct.

MR. WANG: Inpatient, outpatient, and any affiliated affiliations that may -- so the intent is to see where they were before, what were the impacts of being part of Yale New Haven, and then what are the long-term impacts of being part of Yale New Haven?

THE WITNESS (Kosyla): Inpatient DRG would be the --

MR. WANG: Yes, inpatient DRG.

And then outpatient CPT codes, yeah.

THE HEARING OFFICER: I do just want to interrupt to say a couple things.

For the benefit of the people on Zoom, please just try to identify yourself before you speak. And the other thing related to that is there was

just a lot of people speaking over one another, and nobody was identifying themselves.

So it's probably pretty hard for the Court Reporter to figure out who was saying what, and that includes OHS staff, too. So please just try to slow down.

And I'm not trying to quash collaboration in terms of discussion, but I think that would be helpful.

MR. LAZARUS: All right. Steve Lazarus, again.

So Yale New Haven System has stated that the initial plans are to maintain existing services at the Prospect Connecticut Hospital.

BY MR. LAZARUS:

Q. (Lazarus) How will Yale's system improve access to these existing services if you're keeping the existing services the same?

A. (O'Connor) So I'm going to -- Chris O'Connor. I'm going to turn it to Tom Balcezak to speak to that.

A. (Balcezak) Thanks, Chris.

I mean, most of the services that are currently delivering services in those communities in Rockville, Manchester, and Waterbury are really essential services and

basic services; medicine, surgery, basic cardiovascular disease, gastrointestinal disease, newborn care, maternity care, et cetera, et cetera. They're really foundational to community-based care, and we really think that those are important.

I would also add behavioral health to that. The behavioral health crisis we are in across the United States, these services that they are providing right now are also absolutely critical and likely will also need to be expanded.

Emergency services, primary care, all of those services that -- that we said we were going to continue are really basic, very important services for those communities, and the services that they're using, the volumes that you're seeing are evidence of their health. A thousand births, more than a thousand births in both of those institutions is a very healthy maternity service, and it must be maintained.

And for each one of those births, a certain percentage of those need newborn special care. High-quality maternity care is

linked to high-quality neonatal care, and they both have great programs that we think we can build on and continue to stabilize and grow.

Where we think that there are opportunities is in some other services where patients may be driving by or transferred outside of their institutions to be able to repatriate those patients into those communities where they can receive care there.

We mentioned an example at Milford Hospital in our use of tele-ICU for expanding the ICU services. We know that ICU care is one of those services across Connecticut where we receive transfers. Hartford HealthCare, other large organizations receive patients from other institutions. If you're able to bolster care in the community, you can keep them there.

With regard to subspecialty care, there's lots of opportunity to do enhanced services to keep those patients in those communities as well.

Q. (Lazarus) A followup as part of that

four-phase thing. How long would that, after you go in and do the assessment, would you have some sort of plan for services at the Prospect Hospitals?

A. (Balcezak) As we discussed, I mean, we'd begin developing that plan immediately, and we would have a version one of that plan within six months. That's not where it ends.

I mean, you know, medical care continues to evolve. The kinds of services we can provide, the technology necessary for those services, it's a never-ending process.

So we would have an initial plan by six months, but then that plan would get refreshed on a regular basis in conjunction with our service line executives, our -- our partners at the school of medicine, and what the community needs are.

Q. (Lazarus) Based on your past experience with recent affiliations, what were some of the most impactful strategies implemented when the hospital required -- and services that were stabilized?

Would that help to actually increase patient census and improved outcomes?

A. (O'Connor) Chris O'Connor.

I'm going to pass to Tom again.

A. (Balcezak) Sure. So I mean, we mentioned some of those. I mean, you know, tele -- teleservices, we have, I think, nationally gone relatively slowly on, but we are at the cutting edge. And through EPIC -- I'm sorry, through COVID, we showed that there's a lot of opportunity for us to enhance those services.

Already we provide tele-ICU services, tele-neurology, and tele-stroke to all of our health system hospitals, and those are very important services where those patients have an extremely high acuity. Minutes are absolutely mattering. You can't make -- you can't make decisions in the full -- fullness of time. You must make them immediately.

And teleservices allow that to happen in patients where -- and who have a stroke, for example, you know minutes make the difference between a full recovery and a devastating neurologic loss. Putting those services in again will take time, because we need to put in the technological backbone.

Assessing services in some of our other institutions that we've acquired and integrated, you know, we were talking about L&M, for example. There are numerous more examples at Lawrence & Memorial. So for example, we noted that there was a large movement of patients with prostate cancer from the New London area into Rhode Island and Providence.

We were able to effectively recruit a very high-quality Yale-trained prostate surgeon to New London. Now we see much more of that clinical care delivered to prostatectomies, in New London, in an extremely high-quality way.

How did we know that? Because we already had the radiation oncology services that we were delivering, and we were seeing lots of patients that were getting their surgeries in Rhode Island, yet they were getting their radiation in New London. And we heard from those patients that they would prefer to have their surgery if we were able to provide it in a high-quality way with a high-quality surgeon in New London.

So we actually pursued that, and now those patients are able to get probably, I'll modestly say, better care closer to home.

A. (O'Connor) Chris O'Connor. And just to -- to add on to that. And you know, those types of services include investments like multimillion-dollar robotic, and we've purchased multiple for both Westerly Hospital and Lawrence & Memorial.

So it's not just the physician. It's all of the wraparound services that are essential to deliver that in the highest quality of way. So that's staff, equipment, and obviously the provider.

A. (Diamond) This is Anne Diamond. If I could add to that? A perfect example from Milford that really bolstered the community comp -- confidence in our emergency department was adding some high-tech imaging equipment.

So for example, there was a CT scan that was, I think, over 20 years old. It was, I think, a three or six-slice, not capable of doing a head assessment if a patient would be presenting with a probable stroke. We have replaced that. We now have a

state-of-the-art 64-slice CT scanner in Milford's campus. And so that's one example.

As EMS and the patients are self-selecting about where they bring the patients, those are the conversions then into inpatients. So that's certainly -- there's a direct connection there also.

MR. LAZARUS: (Lazarus) Thank you. On page 490, Dr. Thomas Balcezak --

MR. WANG: 1490.

BY MR. LAZARUS:

Q. (Lazarus) 1490. It describes the deployment of a substantial number of specialists from Yale Medicine to L&M after the 2016 un-affiliation was approved.

Can you please describe how many of these types of specialists would be deployed? For how long were they deployed? And how did Yale New Haven Health Services System determine which specialists were needed?

And were the physicians eventually recalled? Were they eventually recalled, replaced, or did they remain in the L&M community?

A. (Balcezak) Thank you. The deployment means

they are permanently deployed there. Chris -- Chris mentioned, I just gave an example of a Yale Medicine-trained and now Yale Medicine-employed prostate cancer surgeon who was deployed there for a very specific reason, which is patients leaving the New London area for prostatectomy yet needing follow-up care, radiation therapy in that community. So that -- that's one example.

Another example Chris mentioned, which is there was a single one neurosurgeon who was on 24/7/365 at New London for years before we acquired that, that individual. That individual, also known to us, and because that individual had an overwhelming number of patients, many of those patients were referred out of the New London market elsewhere for their follow-up care.

So we were able to bolster with Yale School of Medicine neurosurgeons that were recruited specifically for that market to care for those patients. So for that individual neurosurgeon working there who was working so hard, it was a personal relief,

but for the patients in the community of New London, they have access to much better integrated care in neurosurgery.

A. (O'Connor) Can I jump in? Chris O'Connor. I think what's important is the philosophy behind this. So initially in that stabilization mode, we do worry about the use of the word "deployment," because we do utilize faculty physicians from New Haven and the Yale School of Medicine in a short-term gap period.

But the overwhelming opportunity for us is to put physicians in those communities where they stay. They build practices and relationships with referring physicians. So it's not as if folks are getting on 95 and driving down to New London from New Haven routinely.

In fact, we do that to stabilize those programs if necessary. We had to do that in areas like OB and other things, which is great because we have the armament to go and -- and help do short-term needs and put Band-Aids on those types of things. But overall, our success has been seen in

recruiting specific physicians for those geographies.

Now the benefit is, is we have the ability to do things like give them a day of academic work in New Haven. So they can go from New London to New Haven to do some academic work that they wouldn't be able to do if it were Lawrence & Memorial Hospital before the acquisition.

A. (Balcezak) Thanks for pulling me out of the weeds, Chris. I want to give one more weedy example to your point of this is a permanent -- this is not a deployment, as Chris said. We're, you know, beyond a short-term need, that we would send someone there part-time.

Another example is the OB service. There was not a midwife service to augment the local obstetrics care at Lawrence & Memorial prior to acquisition and integration. And we were concerned that the standard of care, like ICU, is the presence of more high -- highly trained individuals for more of that patient's care.

You know, the historical care for

obstetrics was the mom-to-be would come to the emergency department to be admitted, and that obstetrician may come in from their office to deliver that care. We've actually modernized the model at Lawrence & Memorial and brought midwives to cover for those patients while they were initially admitted, and we also augmented the coverage model for the obstetrical service.

So it both supported the community OBs, plus it added an additional layer of protection, which brought the obstetrical care, we believe, in that market up to a really, I think, a national benchmark.

Q. (Lazarus) And the midwives that were brought in, were they employees or contracted by the system?

A. (Balcezak) Employees.

Q. (Lazarus) They were employees?

A. (Balcezak) Yes.

Q. (Lazarus) And they were certified?

A. (Balcezak) Yes.

Q. (Lazarus) Okay. So taking that model now to the Prospect Hospital, what do you initially -- is your initial assessment?

What would the initial needs be for specialists and stuff for the first -- right after the acquisition, for example?

A. (Balcezak) That's a great question. I would ask me in six months.

Q. (Lazarus) That's part of the thing as well. So that, that initial assessment has not been done. That would be part of the phase one when you would go in and do the assessment?

A. (Balcezak) Exactly.

THE HEARING OFFICER: We've been going for over an hour now. I do think we'll take a break in a few minutes, but I wanted to get through a few more questions before we do that.

Does that work for you, Steve?

MR. LAZARUS: Yeah, that's good.

THE HEARING OFFICER: And then my plan is to take lunch probably around like 12:45, one o'clock.

MR. LAZARUS: All right. Steve Lazarus again. The following question is based on the prefiled testimony of Mr. O'Connor's, Bates stamped page 1484.

It states in there that over time we expect Yale New Haven Health Services' reputation will allow us to recruit additional physicians to those

regions.

BY MR. LAZARUS:

Q. (Lazarus) Can you please discuss and provide evidence that Yale New Haven Health Systems' reputation advantage in physician recruitment?

A. (O'Connor) Chris O'Connor, again. Well, it goes back to the example that I just cited.

So I think that, one, the Yale brand carries some weight, and we have had success in just merely after an acquisition if we're looking for a subspecialist, to be able to recruit for that subspecialist.

Whereas formally, if they were a single physician in a subspecialty practice, that puts an enormous burden on that individual. We can bring a cadre of individuals to help support that program. So that's one.

Two, I think the brand itself has value and has proved to be quite helpful in recruiting physicians, but it goes back to the -- as an academic health system, the example that I used earlier of, if it's an individual's interest to pursue some academic portion under the community hospital models,

they would have no avenue to support that work.

Because of our affiliation with the Yale School of Medicine, and Yale Medicine specifically, we've had the ability to offer for those physicians -- in fact, one of those was the urologist that -- that Tom was mentioning, had training at Yale, had a strong connection; would not have come if it was not part of the Yale New Haven Health System.

So I think that's the success that we have seen historically. We would anticipate similar success in Waterbury and in the ECHN communities. And ultimately, you know, we feel very strongly that we could go in there and make an impact very, very quickly.

Q. (Lazarus) Are there any metrics or some sort of measures that you've kept based on your recent experience with acquisitions? And would you be able to share with us the types of specialties that were brought in?

For example, in Milford and Bridgeport.

A. (O'Connor) Chris O'Connor again. I would say we -- we have the ability to show what

services, and the growth of those services. I don't think we keep, you know, a detailed log of the physicians recruited and their duration, geography.

So we can give you part of the picture that certainly describes it, but maybe not some of the detail that is behind it.

Q. (Lazarus) I think that would be helpful.

A. (O'Connor) Okay.

Q. (O'Connor) If we could get that as a late file, a little description of that particular experience, if that's --

A. (O'Connor) I think -- well, that that's going to be in the data that you requested earlier with -- with Milford -- with the Milford Hospital acquisition. So we can then use that to describe what services.

So again, using a single example I think would be helpful, because we can go into more detail versus just giving you data.

Q. (Lazarus) Right, but if you can just tie it into this particular example?

A. (O'Connor) Yeah. Absolutely, we can do that.

MR. WANG: If I could interject? Roy Wang, OHS. So the metrics that we're hoping to capture here is

the recruitment advantages. So I know you were saying the brand -- anything else that might be tracking the actual advantages, just so we have some evidence of it.

BY MR. WANG:

Q. (Wang) I think beyond successfully recruiting a physician to a location --

A. (O'Connor) Yeah?

Q. (Wang) Is there anything about the number that you had to recruit or something to show that --

A. (O'Connor) Well, I think -- I think the backbone of the two employment models that we have to offer. So we have Northeast Medical Group that you've heard about, and obviously will be under a separate CON. That has, you know, over 750 providers in that group. So there's substance there.

But even more importantly, we have the faculty that we've talked about all morning with the -- with Yale Medicine that supports the academic structure. And there's, I think, over 2,000 -- I'm looking for a nod? Yes, okay -- 2,000 physicians in that, clinical physicians in that group.

So they're coming in. We have breadth and depth to offer, and certainly those are the largest groups when you combine them in -- in the state.

MR. LAZARUS: May I proceed?

MR. WANG: Please.

MS. RINEHART: So just to -- I'm sorry, just to clarify in terms of the request. I think what we're hoping to do is that -- what you've asked for is metrics, if we have them on additional recruitment?

MR. LAZARUS: Yeah.

MS. RINEHART: And we can build that into the Milford modeling. So we'll be using the Milford example in trying to build out that information for you. To the extent there are specifics on actual, you know, recruitment, we'll do that.

If not, we will work on the kind of subspecialty growth that Chris mentioned.

MR. LAZARUS: I think that would be helpful.

Thank you.

BY MR. WANG:

Q. (Wang) And two -- Roy Wang again. To Mr. O'Connor's point that you just made about the faculty, the school of medicine, that

narrative that you just shared, if there are any metrics and numbers like the number of faculty --

A. (O'Connor) Sure.

Q. (Wang) -- that would be the additional part on the specific recruitment or retention.

And I think partially that will be captured in the services and the positions that are added. Partially it will highlight the actual recruitment strengths.

A. (O'Connor) Sure, we can do that.

Tom, did you have something?

A. (Balcezak) Yeah -- no, I was going to. I was -- thank you. Tom Balcezak.

I was just going to build on to your point. What we will be able to produce for you is we can -- at each individual medical staff, each individual hospital has its own credentialed medical staff.

What we can show you is the growth in Yale faculty at each institution. There have been some medical staff -- sorry, some faculty at some of these medical staffs in the past. But after integration what you will see is a rapid, very rapid growth in the

Yale medicine faculty at each one of those campuses.

We can take one as an example.

BY MR. LAZARUS:

Q. (Lazarus) And I think that, that would be great. I think we can use the same late file. And just have -- make sure both the services as well as the physician --

A. (O'Connor) Providers, yeah.

Q. (Lazarus) -- providers.

A. (Balcezak) We'll have to -- we can give you department and section so you can perhaps see the cross mark.

MR. LAZARUS: All right.

THE HEARING OFFICER: Let's just break. Okay. So let's take five minutes. We'll come back at 12:13 -- actually, let's just say 12:15. It's a round number.

And again a reminder, please try to be quiet out there. If you need to have conversations have them in here or in the conference room.

(Pause: 12:08 p.m. to 12:18 p.m.)

THE HEARING OFFICER: All right. I think we are ready

to resume.

Faye, you can start the recording again.

Before we continue with questions, I did want to acknowledge that we had to eject someone from the Zoom hearing room because they were making inappropriate noises. And they also, I guess, had an inappropriate name as well.

So again, please maintain decorum to the greatest extent possible. And certainly, none of that will be tolerated. So with that, we will move back into questioning.

And again, it's my hope to get through until one o'clock. I think that will get through most of the questions that we have -- well, most of the OHS questions. I do have some of my own questions as well.

But with that, I will turn it back over to Steve -- I believe?

MR. LAZARUS: Yes. Okay. All right. Steve Lazarus. Just have a couple more questions.

BY MR. LAZARUS:

Q. Dr. Balcezak, you had identified the deployment of EPIC as one of the key methods to extend the clinical excellence to the hospitals. Can you describe the estimate of

the 12 to 18 months-long implementation? I know you referred to it a little bit.

And talking about the necessary changes to the IT infrastructure, resources, training for Prospect, the hospitals, clinical staff, associate medical foundation, those type of things?

A. (Balcezak) Hi, thank you. I wish I could. I don't know that detail, but I do have a colleague -- and I'll phone a friend. Lisa Stump, who is our CIO, can, I'm sure, give you that very exquisite detail.

A. (Stump) Hi. Lisa Stump. When we undertake an implementation of the EPIC platform, it includes not just building the software and systems, but we start first with a very good assessment of the current workflows and clinical services and programs, et cetera.

We then need to, in addition to building the system -- and so our team will configure and do all of the coding in the software itself. We're working very closely with the clinicians and the operational staff around the change in management and the training that supports that conversion.

Q. (Lazarus) The consistent care signature that has been mentioned, is that part of this EPIC process?

A. (Stump) Absolutely.

Q. (Lazarus) What's been the timeline to get to reach that level for maybe -- for perhaps in the past, our experience with Milford and L&M, you can talk about it and what will be expected for these Prospect Hospitals?

A. (Stump) Yeah. So let me take us up a few thousand feet maybe, and go back to a description of the electronic medical record. And we tend to focus on it in those terms, and -- and I would say that is really one aspect of what is really the platform through which we do our business. Right?

And so within the platform are all of the clinical content related to order sets, related to the care pathways that my colleague Dr. Balcezak mentioned.

And so when we bring a site live, when we convert the operation to using EPIC, all of that clinical content is there. All of the clinical decision support rules that say, when a patient of this age and this weight is

prescribed this medication, we flash an alert to a physician that says, you might want to consider adjusting your dose.

Or those care pathways that say, given the patient's clinical condition, their current laboratory values, you might want to consider these other tests that would add to your ability to advance the diagnosis of the care.

And so, I don't mean it to sound trite in any way, but literally the moment we turn the system on, all of that clinical content is brought forward. Tom's example around COVID absolutely exemplified that. And so, literally hour by hour and day by day, as our clinicians were evaluating the evidence about how to best care for patients presenting with COVID, with the few keystrokes that it took to update that pathway, it was immediately propagated to all of our sites of care across the entire health system.

That's the power of that platform. That's much more than just clinically documenting and placing orders that I think sometimes come to mind when we -- when we

reference the electronic medical record.

Q. (Lazarus) And that timeline is still 12 to 18 months?

A. (Stump) So we are hoping and planning to bring live the hospitals within nine months of the acquisition. And the medical groups -- I know that's a little bit outside of the scope of this hearing per se, but the medical groups will be brought live within four months.

So we do view this as a key part of that integration and transition. And so, we -- we look to expedite it as best as we can.

Q. (Lazarus) And when we talk about the medical groups, you're talking in the outpatient setting?

A. (Stump) Correct.

Q. (Lazarus) Okay. Is that the same system?

A. (Stump) It is.

Q. (Lazarus) Or is that like an EPIC-light?

A. (Stump) No. So EPIC is a fully integrated platform. It's got modules with different features and functions that are appropriate for a given site of care, or level of care. So there is an ambulatory set of tools that

are used in the physician offices.

As an example, there's a module that supports the operating room and the anesthesia care, which is very different than -- than other aspects, but it is all fully integrated.

All of the data, as we've talked about, the power of access to information about a patient, all then is consolidated around that individual patient from cradle to grave across that longitudinal health record.

Q. (Lazarus) Thank you. Does Yale New Haven Health System track quality of care measures?

For example, patient experienced measures, 30-day readmission rates, 30-day mortality rates at any of the previous hospitals that it's acquired?

A. (Balcezak) Yes.

A. (O'Connor) We're required to.

Q. (Lazarus) So can you please describe in general some of the changes at the previously acquired hospitals related to quality, specifically based on those measures?

A. (Balcezak) Those are some of those measures. Some of those measures are operational

measures, efficiency measures. Some of the measures are safety measures, and some of the measures are quality measures.

There are literally tens of thousands of quality measures that are available for us to track. Some of the ones that you mentioned are mandated by the Center for Medicare Services, and we do track those and submit them on a regular basis. We do have an enterprise-wide chief quality officer who has really been instrumental in driving the clinical care pathways that myself and others have described, build them into our epic medical record, as Lisa Stump described.

So it is because of those clinical care pathways that we've been able to see reductions in, for example, mortality, one of the most important clinical quality measures in virtually all of our clinical care services.

We have a single enterprise-wide chief infection prevention and epidemiologist who runs all of our programs across our entire health system, Dr. Rick Martinello. He creates the standards for how we do infection

prevention in all of our clinical care areas, whether they be ORs, procedural areas, or even in our -- in our operational units on the inpatient service.

So I -- I would generally say that we have seen improvements in quality, safety, efficiency in all of our institutions as we've integrated them and brought them live. But we've also been able to standardize care, and standardization in and of itself has its own benefits.

Q. (Lazarus) And that was my next question. So these measures, the standard measures, measures that you're using, would we be able to add that as part of that other late file that you're submitting, as an example, to provide some of those quality measures?

A. (Balcezak) Yes, yes.

Q. (Lazarus) Pre and post, so we can see some of the improvements? Maybe you can even explain the trending of that as well?

A. (O'Connor) Yeah, I'm not so sure what we have, as in the previous discussion, what we have available.

This is Chris O'Connor, by the way.

What we have available to us prior to the acquisition -- we certainly can do post-acquisition.

Q. (Lazarus) Yeah, well, like a baseline.

A. (Balcezak) So we can use that first month as a first quarter, as a baseline.

MR. LAZARUS: That would be perfect. With that, I'm going to turn it over to my colleague, Roy, to take the next few questions.

MR. WANG: Sounds good. Thanks, Steve.

Roy Wang, OHS.

So the next series of questions are about improving cost-effectiveness of health care in the region or preventing adverse effects of healthcare affordability to the consumer. My first question pertains to Mr. O'Connor's testimony on Bates, page 1486, when he describes some of the commercial prices for L&M.

BY MR. WANG:

Q. (Wang) So would you please describe the circumstances and strategies that allowed for a decrease in Lawrence & Memorial's inpatient commercial prices five years post-acquisition and an increase in outpatient prices that were less than half of the state's imposed

cap over that same period?

A. (O'Connor) So I'm going to ask to swear in our pararelations expert, Deremius Williams, if we could, to help us answer this question? Hold on. She's in the overflow room.

Q. (Wang) Oh, sure. Thank you.

A. (O'Connor) Thank you, Deremius.

DEREMIUS WILLIAMS: Sure.

THE WITNESS (O'Connor): Would you mind repeating the question?

THE HEARING OFFICER: Before we do that --

THE WITNESS (O'Connor): Oh, yeah, you have to swear -- sorry. Sorry. Sorry. Sorry.

THE HEARING OFFICER: First, can I have your name and your title?

DEREMIUS WILLIAMS: Sure. Deremius Williams, Senior Vice President, Payor Strategy and Innovation for Yale New Haven Health System.

THE HEARING OFFICER: And can you spell your name for the Court Reporter, please?

DEREMIUS WILLIAMS: Sure. D-e-r-e-m-i-u-s, last name W-i-l-l-i-a-m-s.

THE HEARING OFFICER: And now I have to swear you in.

D E R E M I U S W I L L I A M S,

called as a witness, being first duly sworn by the HEARING OFFICER, was examined and testified under oath as follows:

MR. WANG: All right. So just to orient you to the part of the record that I'm referencing, it's on Bates page 1486. It's the top first paragraph where Mr. O'Connor describes the decrease to inpatient commercial prices, and then the increase in outpatient prices that were less than half of the state-imposed cap over that same period.

BY MR. WANG:

Q. (Wang) So my question is just to describe the circumstances and strategies that allows that to happen?

A. (Williams) Sure. So in negotiations with payers, relative to our contracts we take the time to evaluate what the pricing looks like as a baseline and identify opportunities to right price.

Some of the pricing structures in the element agreement at the time were different in terms of methodologies in place versus some of our other hospitals, and the payers

identified some of that a distinct discrepancy, if you will, as well. And so we just looked at opportunities to understand what the appropriate relative pricing would be for those services.

So for example, if there was percent of charge pricing with some of the inpatient services that might cause some of the prices as a baseline to be higher. And so as we attempted to establish fixed pricing over time with that we were able to modify some of the inpatient pricing while at the same time lifting some of the outpatient pricing, and obviously being conscious of the cap and the requirements relative to that.

Q. (Wang) Sure. And so are these strategies applicable to the Prospect Hospitals across the board? At individual hospitals? Could you describe the approach to those rates for the hospital and the system?

A. (Williams) Sure. So first of all, obviously we have not had the opportunity to review those rates, and won't until after the acquisition. As we've indicated in the documentation, we would assume the contracts

as they are pending the agreement and discussion with the payers.

At that time when we have access to that data, we would do a full evaluation of that pricing as well and -- and pursue a common process in collaboration with the payers.

Q. (Wang) Sure. And as the map in the presentation showed, these hospitals are located in a somewhat different, different market than Yale's current market.

How does that impact the negotiation of commercial rates?

A. (Williams) It impacts it only to the extent that the geography that the hospitals sit in matter. Right?

And so as with the existing hospitals within the Yale New Haven Health System, the pricing schedules are not exactly the same. And so that type of difference is maintained relative to what is appropriate for a hospital in its unique geography.

Q. (Wang) Okay.

A. (O'Connor) And this is Chris O'Connor. Just interject one point? And I know we've been using, and appropriately so, our past

examples as predictors for what may be affordable to us going forward.

I -- I do want to in this case be cautious, because the financial environment that you see in schedule A is very different today than it was when we undertook the Lawrence & Memorial transaction. And our ability to absorb that and -- and manage through it is just different given the last two years of operating performance.

So I just want to make clear that, you know, I'm not sure that they are going to be necessarily apples-to-apples at the end of the day.

Q. (Wang) Sure. Absolutely, and I think some of the questions are geared towards lessons learned and strategies that did work, and which of those might --

A. (O'Connor) Absolutely.

Q. (Wang) So since we have you here, I'm going to skip to question 27 and ask that now.

Would you please detail Yale New Haven Health System's annual evaluation of charges process, and how Prospect Hospitals will be integrated into this process?

A. (Williams) So we evaluate all of our charges. As on an annual basis, we have a team that takes the time to evaluate what our costs are relative to our charges, and we have a pretty disciplined process that's in place.

It doesn't necessarily mean that charges will always go up. There are modifications that may happen up or down depending on what the circumstances are, but it is a disciplined process that our revenue team goes to run on a daily basis, and we would expect the Prospect Hospitals' evaluation to be similar.

Q. (Wang) Okay. Continuing to going back to the other questions, has Yale New Haven Health Systems observed any diminishing returns of cost savings from the efficiencies of adding additional hospitals and affiliates dating back to its first acquisition of Bridgeport Hospital in 1996?

This kind of speaks a little bit to the economies of scale. I'm just wondering if there's been any diminishing of the savings as the system has grown.

A. (Kosyla) I think it depends on where -- this

is Gail Kosyla. I think it depends on where those hospitals are coming from and what their particular systems look like today, and the processes that they have today.

So I think that, you know, for example, if, you know, a hospital is a standalone hospital that's doing all the processes on its own, that might look different than one that was connected to another hospital that was potentially sharing services.

So I think it's a matter of once we can -- can get in and understand that aspect of the integration, that's where you would see whether there were, you know, less returns or the same as what we've seen in the past.

A. (O'Connor) Chris O'Connor again. Just for, again using our past experiences, each one of our previous experience has been exactly as Gail was just describing, an independent hospital doing all of those services locally.

So this will be the first acquisition of a system hospital. Obviously, Prospect nationally has -- has that infrastructure. So it's a new example for us that we're going

to have to evaluate. And therefore, we have been more conservative than the expectation around synergies as a result of that.

Q. (Wang) Okay. That does answer my question of if there were any preliminary kind of expectations. So thank you for that.

Does Yale New Haven Hospital System plan to acquire additional systems within the next five years in Connecticut, or neighboring states?

A. (O'Connor) This is Chris O'Connor. You know, there's nothing right now in any discussion I would say that there's any disclosure or any opportunity that I would say has moved into a formal stage.

You know most of the hospitals in Connecticut have formed affiliations with systems. So you know, we're not anticipating major acquisition growth in Connecticut now.

Q. (Wang) Okay. As you know, there are studies that show that consolidation and regionalization can lead to potential increases in prices and costs. Would it be possible to provide a year-over-year cost for the acquired hospitals as an example of

the -- for example, the examples of decreases in costs, or within a certain cap, just to provide additional evidence for our evaluation?

Would that be something as a late file?

A. (O'Connor) Well, so -- this is Chris O'Connor again. And you have that, because we've been required for the last three acquisitions to report on our performance. And I think our -- again, our history thus far would indicate that we have performed exceptionally well under those.

Again, I want to be careful not to use those as examples of how we are going to have to go forward with this. You have both systems operating, and operating deficits. So it's a different environment, but certainly you can look at our past performance.

And I would take issue and I do take issue both publicly as well as within our team with the assumption that acquisition leads to increased costs. That has not been our experience, and we don't believe it would be going forward.

Q. (Wang) Thank you. The next question is regarding the Applicant's submission on Bates page 144 where it states that the Applicants do not anticipate any immediate changes to payer contracts as a result of this proposal.

Under the asset purchase agreement Yale New Haven Health Systems has agreed to assume existing commercial payer agreements subject to the payers consent.

The question is, would you please describe how future commercial contracts will be negotiated for Prospect Connecticut?

A. (Williams) Sure. So in collaboration with the payers we will follow the same discipline process that we have historically, that we do analytics to understand what the baseline looks like. And we pay attention to trends that are important and that influence what the pricing needs to be in aggregate, but also by service. And so we'll follow the same process.

Obviously, we've indicated as you stated that we would assume those contracts, and I also reference that our existing contracts are not exactly the same across the system.

So that same process will be followed, to your point, Chris, and it will be disciplined and objective, and again in collaboration with the payers with an eye towards ensuring value for the community and the constituents that we serve.

Q. (Wang) Okay. Continuing a little bit on these commercial payer contracts, what might cause a payer or group of payers to not consent to Yale New Haven Hospital Systems' assumption of Prospect's payer contracts?

A. (Williams) Sure. So the payers have their own unique administrative and programmatic requirements. And so it's going to depend on what their policies are, what their processes are, and what they're able to administer.

And we will know that once we actually get into those conversations.

Q. (Wang) Switching a little bit back to the savings, I realized as described on Bates page 1486, there were realized savings of 46 million at Lawrence & Memorial post affiliation.

And it goes on to state that the financial benefits were passed on to the

patients as well. And how much and through what financial mechanisms are the financial benefits and savings passed on to patients?

A. (Kosyla) So you indicate the -- the pricing decreases, and some of that is patient share of those costs. And so those will be passed on to the patient, you know, in the course of collections. That was Gail Kosyla.

Q. (Wang) And so with that example of the 46 million and also the 638 million in cost savings at St. Raphael's from 2012 to 2020, I believe, is that similar in terms of how the savings are passed on?

A. (Kosyla) That would be the indication.

Q. (Wang) Okay.

A. (Kosyla) That that would be the patient portion of the bill.

A. (O'Connor) Although -- Chris O'Connor again -- during that time when we had significant synergies the hospital provider tax was implemented. That was a major financial blow that impaired our ability to deliver those savings directly to patients.

Q. (Wang) Okay. So I guess -- oh, sorry.

A. (Kosyla) I was just going to add -- Gail

Kosyla -- I was just going to add also that synergies within a system enable a lower total cost of care, because there are -- with access to patient tests and records there's some duplicate services that are then not performed.

So that is also an additional savings to both the payer and the patient.

MR. WANG: Okay. Would it be possible to get an accounting of the cost savings as a late file, just to show, kind of, where the cost savings are?

MS. RINEHART: Is this the same request that you had said before that, kind of, the areas of the cost savings?

MR. WANG: Well, so this is specifically to speaking to how the patients are benefiting. And just to get, you know, that you're saying that with L&M there are 46 million. Through St. Raphael's there were -- there was 638 from 2012 to 2020.

BY MR. WANG:

Q. (Wang) Just breaking that down by year, perhaps?

A. (Kosyla) I think it would be difficult because that it assumes the mix of patients and the services are exactly the same.

Q. (Wang) Okay.

A. (Kosyla) So you would -- I mean, it would -- again, if everything were exactly the same, you could. You could calculate that, but that's not the way it happens. It's not, you know, it's not a manufacturing organization with patients and different needs, and different things. I think it would be difficult to -- but if my colleagues have a different opinion on that?

A. (O'Connor) Well, and the other caveat to that -- this is Chris O'Connor again -- is that, you know, our ability to deliver those savings has then supported the investments that I also spoke of.

You know, the infrastructure investments on the St. Raphael's campus and now obviously building towards the neuroscience tower, that's going to be a world-class care center. The same is true in New London where -- put a power infrastructure and expanded their emergency department.

So you know, it's not just delivering to, you know, going back from a pricing standpoint. It's also our ability to invest

in the infrastructure and clinical programs at each one of those locations as well. So that's where it gets a little bit complicated. It's never a one-for-one.

Q. (Wang) Sure. So instead of the accounting of these things, is there a way to maybe have a narrative of the methodology that you were describing as to how that is generated?

A. (Kosyla) Perhaps we could provide an example or two of something like that.

Q. (Wang) Sure.

A. (O'Connor) I think a narrative would be more feasible.

MR. WANG: All right. Okay. That concludes my questions. I'll hand it over, back over to Steve to complete the OHS questions -- just the three of us before Hearing Officer Csuka asks his questions.

MR. LAZARUS: All right. Steve Lazarus again. Can you -- let's see. Sorry.

It's on Bates page 168 of the application.

MS. RINEHART: 168?

MR. LAZARUS: 168.

MR. WANG: It's the original application.

BY MR. WANG:

Q. (Wang) Pardon my interjection, Mr. Lazarus. I'm just not sure it's necessary that you find it.

A. (O'Connor) Yeah, If we want to start with the question, and we'll figure out if we can answer it without it.

MR. LAZARUS: That page indicates that Manchester Memorial Hospital provides PET-CT scans as one type of imaging services provided at the facility. There is, however, no further mention of the PET-CT imaging equipment in the application, nor in the acquisition of the equipment supplemental form.

What is the Yale Systems', or the Applicant's plan for the PET-CT scanner? And specifically, is the General Electric Discovery IQ PET-CT scanner?

MS. VOLPE: It was a mobile. Do you want to speak to that?

THE WITNESS (Weymouth): So let me just confer.

MS. VOLPE: Yeah, can you repeat that question?

MR. LAZARUS: Sure. So you know, there was a mention of the PET-CT scans in there. So we're trying to figure out -- there was no mention of the PET-CT scanner after then. There was no supplemental

that was included as part of the imaging.

MS. VOLPE: Right.

BY MR. LAZARUS:

Q. So can you tell us a little bit about the PET-CT scanner and what was the plan for that scanner at this point?

A. (Weymouth) Sure.

It's a contracted service. Sorry, Deborah Weymouth. It's a contracted service. So it's a mobile unit that we don't own that comes in and provides the service and leaves.

Q. (Lazarus) So moving forward, does Yale System plan to continue that service, or take that over? Or no?

A. (O'Connor) This is Chris O'Connor. Highly likely we're going to need PET-CT at our hospital and campuses.

It's a standard of care.

Q. (Lazarus) Okay. So I'm just trying to say, would that not require acquisition of this? It's contracted, but you would take over that contract?

A. (O'Connor) Not necessarily. I think we'd have to look at it. I -- I don't know if we have due diligence that speaks to that.

A. (Kosyla) Gail Kosyla. I was just going to say that whatever cost associated with that lease would be replaced with the cost associated with the acquisition and running on one.

So those typically mirror -- I mean, I haven't seen this one, but those typically mirror normal operating costs. So that would have been, you know, it would be something that we would evaluate whether that lease continues, or whether there was an acquisition of that equipment.

Q. (Lazarus) Do you know when the lease comes up on that piece of equipment?

A. (Kosyla) I do not know that, no. I can get back to you with that answer. It's like -- it's a per-use type of arrangement. So we call them; they drive in and use the system, they leave.

THE HEARING OFFICER: All right.

MR. LAZARUS: All right. I'm just going to put a pin in that topic for now. I just need to discuss that with my colleagues afterwards.

Can you please explain the low utilization volume reported on the Manchester Memorial

Hospital's MRI, and for the two MRI scanners and the two CT scanners operated by Rockville General Hospital, and the Evergreen Imaging Center, LLC?

And can you then provide an update for fiscal year '22? We're trying to see if the volumes have increased. We're trying -- I'm looking at the utilizations of those.

THE HEARING OFFICER: Let's just start with the first part of that question, the low utilization volume.

MR. LAZARUS: Yeah, if we can talk about that as far as --

MS. VOLPE: So I'm sorry. Can you repeat the question?

MR. LAZARUS: Sure.

So can you explain that the low utilization volume reported on the Manchester Memorial Hospital's MRI, and for the two MRI scanners and the two CT scanners operated by Rockville General Hospital and Evergreen Imaging Center, LLC?

MS. RINEHART: Just for convenience, is there any particular page that you can direct us to for the Witness. I apologize. This is Kim Rinehart.

THE WITNESS (Balcezak): 170.

MS. RINEHART: 170? Okay, 170 for those folks.

MS. VOLPE: So you're inquiring on the low volume for the utilization of the imaging equipment?

BY MR. LAZARUS:

Q. (Lazarus) Yeah, the current utilization.

A. (Weymouth) So I'm referring to this -- Deborah Weymouth. Sorry.

Q. (Lazarus) Uh-huh.

A. (Weymouth) I'm referring to the report 450 under Rockville General Hospital, MRI scans year-over-year.

Q. (Lazarus) Uh-huh.

A. (Weymouth) From '21 to '22, it actually increased by 172 scans. So I'm not understanding the question.

Q. (Lazarus) I think we were going off the figures that were submitted as part of the record.

We did not see the one -- so between fiscal year 2021 and 2022, you're saying that the numbers increased?

A. (Weymouth) Yes, that is what I'm saying. They increased both at Rockville General and at Manchester Memorial. There was 231 cases in Manchester and 172 in Lawrence.

BY MS. PIASCIK:

Q. (Piascik) I'm sorry. This is Bozena Piascik From OHS.

A. (Weymouth) Yeah?

Q. (Piascik) You are referring to the HRS report 450 that we had filed?

A. (Weymouth) That is correct, yeah.

MS. PIASCIK: I would like to review it and then talk about it afterwards.

MR. LAZARUS: Okay. We'll put a pin it in. We want to review the report, too.

MS. VOLPE: And there, there may be a discrepancy between that and --

MR. LAZARUS: Lowest file?

MS. VOLPE: -- and the Bates stamp reference.

MR. LAZARUS: Okay. So we'll come back to that later on. We also want to review those 450 reports. Thank you.

MS. VOLPE: Great.

MR. LAZARUS: I think that's it for now.

THE HEARING OFFICER: Okay. So that's all of the questions that the other OHS staff has for right now. We're going to break for lunch now. Steve, do you think an hour?

MR. LAZARUS: Yeah, an hour should be good.

THE HEARING OFFICER: So let's come back at 1:50 and we will pick up where we left off.

A reminder to the public, if you want to make

a public comment, please sign up either in Zoom or at the sign-up sheet up front here.

And also, I don't know whether we'll be keeping the Zoom running, but if we do -- yes, we'll be keeping the Zoom running. Just make sure you turn the volume and the video off while you're not at the computer.

Thank you very much for your time, and we'll see you soon.

(Pause: 12:51 p.m. to 2:01 p.m.)

THE HEARING OFFICER: Welcome back. This is the hearing for Yale New Haven Health Services Corporation and Prospect CT, Inc, Docket Number 22-32594-CON, regarding the acquisition of a healthcare facility pursuant to 19a-638a(2).

We have a couple questions that remain, and a few other things that I'm going to have Steve go over, and then we're going to go into my questions.

In terms of public comment, just a reminder to everybody who's attending via Zoom or anybody in this room or the other room who's a member of the public. If you do want to make a public

comment and you haven't already registered, you can do so any time before three o'clock.

I think we're doing pretty well on time for right now. So we'll reevaluate as we get closer to three, but I think -- I feel pretty good about us being able to finish today and not have to go into tomorrow.

So with that, I'm going to turn it over to Steve to just button up a few items.

MR. LAZARUS: Sure. Steve Lazarus. So when we left off, we were talking about the PET-CT and MRI and the CT volume. So we were able to go back, check 450. So we're fine on that. And I think we can reconcile that ourselves.

Talking specifically about the PET-CT that we talked about that was alluded to on page 168; so that's a service that Yale is planning to take over. That's going to continue that service. So we would probably need a supplemental form submitted as a late file for that one. So this way we can incorporate that as part of this definite need.

MS. RINEHART: We don't -- so we, I think as we sit here today, we don't know the details a hundred percent around that arrangement. We think it's

not a hospital-owned or leased CT -- or PET-CT, and that it is, in fact, billed and operated by another provider site.

So I think we just need some additional information.

MS. VOLPE: Well, you just want to know that that service would continue?

MR. LAZARUS: Well, we need to understand, first of all, what the ownership structure is. And if Yale, as part of this acquisition, is going to continue that service, and how would that be structured?

And if it is, it's best -- in our opinion, it's best to sort of wrap it within this CON than to eventually have to come in for a separate one.

MS. VOLPE: We agree.

MR. LAZARUS: So depending on what we can find out, we can talk as part of the late files.

MS. RINEHART: Yes.

MR. LAZARUS: Afterwards we can decide whether you can submit us -- if it needs a CON, then we suggest you submit it in a supplemental form.

MS. RINEHART: Yeah.

MR. LAZARUS: Does that make sense?

MS. RINEHART: We'll get that information, and we can

talk with you about the right procedure for adding it as needed.

MR. LAZARUS: Yeah. All right.

BY MR. LAZARUS:

Q. (Lazarus) So my last question -- and this goes to more of the community need, is if you can talk or discuss a little bit about the impact of Prospect CT's changing ownership from a for-profit to a non-profit entity?

You know, if the transfer of ownership is approved, what impact would that have on the community itself?

A. (O'Connor) You want me to take that?

Chris O'Connor.

So we anticipate that, as I said in my testimony, that it would -- not only would we continue to support current community activities, but we would and have historically enhanced community relationships after acquisition.

So you know, the community support, you know, it's both in terms of our care that we're going to provide, as well as the community benefit that would be yielded from that care. So we -- we're very confident

that it would be enhanced.

Q. (Lazarus) Perfect. And what about, what impact would it have on anything such as operating agreements, governance, management, taxes? Are there state or local bylaws for the hospital, and any other joint ventures that are involved in this acquisition?

A. (O'Connor) Well, I mean, the first thing that -- in the conversion is that any profits are going to be reinvested into the entity itself. So that, I mean, that's inherent with all of us as not-for-profits.

Governance, you know, we -- we are looking to manage from a regional perspective. So we'd look to have local representation from those communities on a government structure. Yale New Haven maintains local fiduciary boards. So we have a system board that holds, you know, the -- the certain rights and responsibilities. For instance, you know, approving budgets, capital spending, those types of -- of determinations.

But the local presence and govern -- in governance is very much a core part of our

organization's expectation.

Q. (Lazarus) I think it was your testimony at the beginning this morning, you talked a little bit about the community benefits.

Can you talk a little bit about what type of benefits can the local communities for Prospect Hospital expect with Yale, sort of, coming in?

A. (O'Connor) Again, similar to what we have described with the clinical programming. Until we get into the community and hear from them directly, I -- I don't want to sit here and assume where they would best be aided and assisted or -- or enhanced.

We would want to have those conversations in the local communities to make those determinations. But again, you can look at our history and see that we have enhanced it in all of the communities that we've become a part of.

MR. LAZARUS: Okay. Thank you.

MS. VOLPE: And just, Steve, in the conversion legally --

MR. LAZARUS: Uh-huh?

MS. VOLPE: -- they'll be required to conduct community

health needs assessments. So which as a for-profit isn't a requirement. So that, you know, in terms of polling the community and the services, that will be done, you know, via legal requirements of community health needs assessments being conducted.

MR. LAZARUS: Thank you. I think that wraps up my part. I'm all set. Thank you.

THE HEARING OFFICER: Okay. And Bozena, are you all set?

MS. PIASCIK: I'm all set. Thank you.

THE HEARING OFFICER: All right. Roy?

MR. WANG: I'm all set.

THE HEARING OFFICER: Okay. So I have some questions also. Some are going to be directed towards Prospect, others are going to be directed towards Yale. I first wanted to start with the topic of consolidating the Manchester Memorial license with the Rockville General license.

Mr. O'Connor, as you acknowledged earlier, this is unlike other acquisitions Yale has done in the past, because Prospect is not an independent hospital.

So although it has consolidated licenses in the past under similar CON applications, I'm not

entirely convinced that that's going to be an option here just because of the way the CON application has been filed.

So just to give you a little background, in Docket Number 32405, the application also involved the increase in license bed capacity. And in this particular instance, we don't have that.

So just to the attorneys, I'm going to ask that a brief or some sort of memorandum be submitted on that particular issue.

MS. VOLPE: Can we just get some clarity on that?

THE HEARING OFFICER: Sure.

MS. VOLPE: In terms of the bed capacity, we just want to make sure there's no miscommunication. That's an OHCA category in terms of increased licensed beds.

In the docket number for the licensure consolidation, there wasn't a request to increase beds. It's an automatic increase when you consolidate the two campuses, the two facilities under one license, but it's maintaining the existing beds in the communities that are already available and under the existing license.

THE HEARING OFFICER: I understand that.

MS. VOLPE: All right.

THE HEARING OFFICER: I just want to make sure that if this is eventually approved, that we're on firm legal grounds to actually agree to consolidate the licenses.

Because that's what Yale is operating under the assumption of right now, that they're going to be able to do that by us approving this.

MS. VOLPE: Right.

THE HEARING OFFICER: And that's just my concern, and I think it needs to be addressed before this can actually be approved.

MS. VOLPE: Okay.

MS. RINEHART: I'd be happy to submit a memorandum on that and highlighting the areas where at least, you know, the consolidation feature has been made clear in the application.

THE HEARING OFFICER: Okay.

MS. VOLPE: Well, and in terms of the other dockets that you took administrative notice of, I mean, Yale has a history of, in an acquisition, combining it under an existing license; obviously, Milford with Bridgeport, St. Raphael's with Yale, and it's all happened at the time of acquisition. So this transaction, you know, doesn't differ in that respect.

So in terms of legal precedent, I think you do have that with -- although OHS doesn't rely on precedent, you do have the existing dockets that you took administrative notice of to allow legally, you know, to have it be permissible, so.

THE HEARING OFFICER: Except that this is different, as Mr. O'Connor acknowledged. This isn't like the other Yale acquisitions.

MS. VOLPE: Well, in what way?

MS. RINEHART: Right. I think it --

MS. VOLPE: Why isn't it like the others?

THE HEARING OFFICER: Because it's acquiring Prospect, ECHN. And it's two hospitals, and it's saying it's going to consolidate those two hospitals, rather than sort of bringing the hospitals directly under Yale.

MS. VOLPE: Well, a lot of that has to do with geography. Right? I mean, part of it is geography, and fortunately in the other acquisitions, the mileage and proximity, you know, afforded that.

I mean, and to get some of these synergies and efficiencies, and to implement the four-phase plan, I mean, it's imperative that they have the ability to consolidate the licenses.

MS. RINEHART: Can I just add one --

THE HEARING OFFICER: And that's my concern.

I'm not saying it's not in the best interest of -- if this is approved, and I'm not saying it's not in the best interest of Yale to consolidate the licenses.

MS. VOLPE: And the community.

THE HEARING OFFICER: And the community. I'm just saying, I want to make sure we're on good footing to do that in this particular case, since it is different.

And I want to make sure that Yale is comfortable moving forward with their project as well, assuming that that were to go forward.

MS. RINEHART: We will absolutely submit the memo. I just wanted to add that this is an asset purchase agreement, so this isn't a merger of, you know, one hospital into another hospital. It's an asset purchase, and so we have described the structure by which we would purchase it.

It is technically a new hospital at that point. The bed capacity is not being increased, as Michelle noted. The bed capacity is the same, it's just being consolidated. But this is an asset purchase, so I just wanted to make that

clear.

And that, you know, some of those other -- I believe the Milford was as well. Right? So it's simply a way of taking in the assets, and we're just describing the mechanism by which we plan to do that here.

So I think it's actually not different from those other transactions in that, and with respect to this licensure issue I think it's the same.

THE HEARING OFFICER: Okay. Thank you.

So I'll just have you submit a memorandum at the same time as you submit a late file.

MS. RINEHART: Perfect. Thank you.

THE HEARING OFFICER: It doesn't need to be terribly long, it just needs to -- I need to feel comfortable with that as an option.

MS. RINEHART: Absolutely.

THE HEARING OFFICER: So keeping with consolidation, I did want to ask some questions specific to this application and what we could expect if you were to consolidate.

So these questions are directed first towards Prospect and its witnesses. Can you explain what the current process looks like for transferring a patient from Rockville General to Manchester

Memorial, and vice versa? Are there currently any delays in transfer that would be eliminated by your approval of this proposal?

THE WITNESS (Weymouth): Hi. Deborah Weymouth.

To address that question, currently we are not on EPIC, as established earlier. We are on, for our emergency services, a software called Allscripts. So it does require, when we are transferring a patient from the emergency room over to Manchester, a transition from Allscripts to Meditech, which is our in-hospital provider, assuming they're going in as an inpatient.

So there are technological issues there in terms of changing medical records that need to be modified and so forth. We do have a streamlined process that we've established, orders that are standing orders written to allow the facilitation of a transfer as quickly as we can.

But we would anticipate that when this transaction is completed that would be even faster, because as established earlier, it would all be on EPIC instead of jumping back and forth between two separate systems.

And then also, you know, the anticipation would be just because of that communication would

be enhanced. Now we make phonecalls to receiving physicians. They obviously have to go through a Q and A process. Again, much of that would be expedited through the update to EPIC.

So we do have a process now. We move through it as quickly as we can. We are dependent on the local ambulance service to help support us in transfer -- transferring the patient. And that is a variable that we don't directly control, but we work with them on a regular basis and they've been very supportive.

THE HEARING OFFICER: Okay. So in various filings here, I've noticed that Prospect is still on Meditech as their primary HR?

THE WITNESS (Weymouth): Correct.

THE HEARING OFFICER: In that other, the consolidation docket, it was testified to that you were in the process of transitioning over to Cerner, which is what Waterbury Hospital was on. So it's been quite a bit of time since then.

Is there a concern that transitioning over to EPIC would pose a problem here? I'm just not sure why, why you haven't transitioned over to Cerner at this point.

THE WITNESS (Weymouth): So we didn't transition over

to Cerner only because this particular opportunity appeared, and we knew that EPIC was the ultimate goal.

I mean, I'm not saying -- Cerner is not a bad product. I don't know if they're on the line, but EPIC is obviously the gold standard that we would like to go to.

So given that, the other piece to be aware of is a transition with technology. You don't want to be doing them once a year. You know it's a big event. You need to train the people and, you know, buy the appropriate equipment and so forth. So we wanted to have that happen at the time of this transaction, and only do it once instead of having to change and then change again.

THE HEARING OFFICER: Okay. That makes sense.

So in a number of places throughout the application, Yale provided data for ECHN as a whole, rather than by separating out Rockville General or Manchester Memorial.

THE WITNESS (Weymouth): Uh-huh.

THE HEARING OFFICER: So I think for our purposes that is helpful, but we'd still like to have the two separated out as well.

For example, page 81 of the application,

table 9. Page 83 of the application, that's regarding gender, race, ethnicity, and age. And pages 128 to 129 of the application, that's tables C1 and D1. So it's basically just asking you to separate out the utilization and the REL information so that it's not all grouped together as ECHN.

Would that be something you can do?

THE WITNESS (Weymouth): Potentially, that's a problem.

THE HEARING OFFICER: Okay.

THE WITNESS (Weymouth): The version of Meditech we're on is very old and does not have that, in some cases, to that level of detail.

We will certainly make an effort, but I can't guarantee that I can do that in all instances that you just listed.

THE HEARING OFFICER: Okay.

MS. VOLPE: I do know that the CO on the team have looked at that, Dan. I mean, the intent was to, because that was asked, but I think the technology didn't have the ability and capacity to get down to that level.

THE HEARING OFFICER: Okay. Well, we'll make it a late file, and if you can't provide that level of detail, then that's fine.

You can just state as much.

THE WITNESS (Weymouth): We will. Thank you.

MS. RINEHART: Would you mind just reiterating the specific table numbers? I just want to make sure we have a good list.

THE HEARING OFFICER: These were examples. There may be others.

So page 81 of the application, it's table nine. Page 83 of the application, there was some information there provided for gender, race, ethnicity, and age. And then pages 128 to 129 of the application, that's table C1 and D1.

So that's all of the questions I have for Prospect on consolidation. I do have some for Yale as well.

And I'm sorry to belabor this, but I was hoping someone could speak to the specific benefits that consolidation would provide in this particular case?

MS. RINEHART: Tom, do you want to take that?

THE WITNESS (Balcezak): There are three broad categories, cost, quality, and access. Those are the three benefits of consolidation, and the cost one is obvious.

If you're operating two similar services nine

miles apart, consolidating into a single location, it makes an incredible difference in the ability to field a team, high-quality team, and drive down per unit cost.

On the quality side, again there's innumerate -- innumerate pieces of literature to show that volumes are associated with quality. Low-volume programs simply are just not safe, and they're not of high quality.

And the third is around access, which is if you're providing OR services, for example, at Rockville, on the inpatient side only a half a day per week, and you've got your schedules of anesthesiologists, surgical techs, circulators, et cetera, then I don't know how you'd provide access to patients that need surgery on the other six and a half days during the week.

You know, programs we tend to focus -- for clinical programs, we tend to focus a lot on physicians, but we as physicians know that we are kind of the least important group of individuals when you're developing a clinical program.

If you're developing clinical programs like what we develop within our service lines, they are extremely highly dependent upon nurses, techs,

physical therapists, occupational therapists, psychologists, nutritionists, etc. You -- you simply can't put a program that you would want to put around inflammatory bowel disease or, you know, heart failure without that wraparound set of services.

And you're not going to be able to provide access to those patients of what cutting-edge care is in a program that just can't have the number of patients to sustain it, and sustain those wraparound services.

THE HEARING OFFICER: Okay. Thank you. I recall --

MS. RINEHART: Can I just add one very, very minor point on that, the benefit?

THE HEARING OFFICER: Sure.

MS. RINEHART: Which I think has been mentioned in the papers but maybe not explicitly here, which is that there has to actually be -- if there's an inpatient that is transferred, there literally has to be a change in discharge and readmission.

So that's like pure consolidation without considering anything else.

THE HEARING OFFICER: Uh-huh.

MS. RINEHART: Just straight-lines things.

THE HEARING OFFICER: And I recall that from the other

docket as well. And that actually ties into this next question just for my edification on EPIC.

To your knowledge, are you able to open two different clinical records at the same time in EPIC? So for example, if one doctor at Rockville General had opened one medical record, but he wanted to see what was happening at Manchester Memorial, would they be able to do that without licensure consolidation?

THE WITNESS (Balcezak): I'm going to ask Lisa Stump to come up and --

THE HEARING OFFICER: Okay.

THE WITNESS (Stump): Yeah. Lisa Stump, CIO. The record sits around the patient, so it's not a separate record at one hospital or another. It's the patient's record, regardless of where they are seen.

So if Lisa Stump, as a patient, is being seen today at Manchester Memorial, and tomorrow at Bridgeport Hospital, it is one record that is Lisa Stump's. And all of my visits are there, regardless of where I have been seen.

THE HEARING OFFICER: Okay.

THE WITNESS (O'Connor): And multiple people can view that at a single time. Correct?

THE WITNESS (Stump): Correct.

THE WITNESS (Balcezak): It might be useful to give a clinical example. A clinical example is, I think, Lisa, without exception -- perhaps there are small numbers of exception -- every OB practice within Yale New Haven Health is on EPIC.

Why OB is a particular important specialty is babies come all hours of the day and night. There are certain special tests that moms-to-be undergo prior to delivering around antibody testing, certain -- risk of certain infections, beta strep, and so forth, that it's really very, very important when the patient presents to the emergency department for -- or admission to the department for admission upstairs, that they have immediate access to that data.

That data is always collected in the prenatal visits. Those prenatal visits are almost entirely done in the private physician's office, or the community physician's, or whomever. And it's very extremely useful, and it improves duplication of services.

And if that one physician who's been seeing that patient isn't on, a separate physician can immediately look in that record -- which as Lisa

points out, is exactly the same record. They're not mirror images. They are not replications. It is the same record.

And they can see immediately that the antibody tests were done, the beta strep was done, all the prenatal things were checked so that the physician who has to make very rapid decisions for that patient doesn't need to send additional blood tests, doesn't need to do additional evaluations, doesn't even need to make a phonecall. Because as soon as they bring that up, he or she has that information immediately at their fingertips.

That's one. That's one small example, but given the volume of births that we have across our system and are about to add, it's a critically important one, because those decisions really need to be made in the moment.

THE HEARING OFFICER: Okay. Thank you. For this next question, I would like you to turn to page 1041. That's in the response to the completeness letter number one.

Just let me know when you're ready. I don't want to rush you.

MS. RINEHART: Is there a particular area that you'd like them to focus to?

THE HEARING OFFICER: There there's just a quote that I wanted to receive some elaboration on. It starts, YNHHS's preliminary assessments focused on a regional approach.

It's right near the top of the --

THE WITNESS (O'Connor): Yeah.

MS. VOLPE: We're getting there.

THE HEARING OFFICER: I can read it.

MS. VOLPE: We got it.

THE HEARING OFFICER: Okay. It just says, YNHHS has conducted further review and determined that certain services at the ECHN hospitals will be provided more safely and cost effectively, and in a manner that better serves community needs if they are consolidated.

So my question was just, what happened between when you filed the application and responded to the completeness letter? What was that further review that was conducted by Yale?

THE WITNESS (Balcezak): I mean, I don't recall exactly the specifics between the two timeframes, but, I mean, I -- I will tell you that we looked at volumes.

We looked at the average daily census of Rockville being less than five, approximately

three. We looked at the surgical volumes at Rockville. We got a little more information about what kinds of surgeries that were being done there.

There are adequate operating rooms for many kinds of surgeries at Rockville, and as I mentioned before, it's not necessarily the operating rooms or even the availability. It's just the surgeon. It's the entire team in anesthesiology, scrub nurse, circulators, et cetera.

And we believe that having access to those surgeries and having only an average daily census of three just isn't an economy of scale that's large enough to ensure high-quality care.

THE HEARING OFFICER: To your point about med-surg not making sense to continue at Rockville General, probably. I'm not going to hold you to that, because I understand that you do need to conduct your evaluation, but you were talking also about sort of expanding inpatient heart and vascular oncology and neonatology, and urology services.

So I was wondering how you were able. What information were you looking at when you came to that conclusion that those would probably be areas

that could be enhanced or expounded upon?

THE WITNESS (O'Connor): So I don't have the specific answer. This is Chris O'Connor. I don't have the specific answer for the detail, but I can tell you the process that we undergo and will undergo again once we have access to complete information.

And that's our Office of Strategic Management goes through a full, you know, volume and -- and demand analysis within the -- the communities. And then we look at what services match up to our ability to deploy those types of physicians and care teams in those geographies, and then make determinations.

It may not be new demand. It may be demand that's leaving those communities and going to other facilities that we believe would be better served in their local communities if they had an ants -- enhanced services. So I mean, it's not a single data element.

It's, you know, obviously a multivariable process that takes place, and Dr. Ahuja, who is our Chair of Surgery at the Yale School of Medicine -- and if you could swear her in, I think she has some information that would enhance my answer, which I deeply appreciate.

THE HEARING OFFICER: Okay. And I didn't swear you in. Right?

DR. NITA AHUJA: No, not yet. Okay.

THE HEARING OFFICER: Can you state your name for the record and your title?

NITA AHUJA: Nita Ahuja, first name N-i-t-a; last name Ahuja, A-H-U-J-A; Chief of Surgery at Yale University and Chair of Surgery at Yale School of Medicine.

THE HEARING OFFICER: Thank you.

N I T A A H U J A,

called as a witness, being first duly sworn by the HEARING OFFICER, was examined and testified under oath as follows:

THE WITNESS (Ahuja): So I just wanted to expound on some of the comments that Dr. Balcezak and Mr. O'Connor made around the consolidation of services between Rockville and Manchester, and what has changed.

In terms of evaluating the census at Manchester, as Dr. Balcezak mentioned, it's a very low-volume census. In terms of providing safe care at Rockville -- sorry, safe care of these services, I think it's not only providing a

physician but the wraparound services.

So just imagine if you need an acute operation in the middle of the night. You need an anesthesiologist. You need the nurses, the scrub checks, all of those services to be available and around the clock, and to do these in two places would be unsafe.

You really just need all of those, not only the physician, but those services available 24/7. And the distance between the two hospitals is very small. It's less than 10 miles. I think an example of this is what we do very well currently, is at our shoreline emergency room where patients get access to care in the emergency department 24/7 in the middle of the night.

And depending on, you know, and then if they need acute care services, whether it's a heart attack or it's surgery for a gallbladder, or a hernia that's incarcerated or some acute abdominal emergencies, they're able to come in and get that service safely. And I think to us, as we look into all those factors, this makes a lot of sense, that we need to provide the emergency room availability for those patients in this community.

I think the other part is medicine has gotten

more complicated with time, and to provide those services and raise the level of care in these communities. This is where we're seeing that you can't maintain this with three patients a day. That's not essentially safe surgery.

So I hope that helps in understanding some of our decision making.

THE WITNESS (Balcezak): This is Tom Balcezak. I'm just going to pick up on something else that I'm not sure we fully answered for you, which is I think you asked the question of what was the difference between when we initially filed the CON and when we gave you our preliminary plans.

Is that -- is that what you were asking?

THE HEARING OFFICER: Yeah, between when you filed the application and when you responded to the completeness letter responses. I'm not sure --

THE WITNESS (Balcezak): So there was a couple of things. We were able to get more information. We were able to do a facilities tour.

I believe during that period of time -- and I ask my Prospect colleagues to confirm this, is that for a period of time during COVID the inpatient service at Rockville was closed. And when we, I think, filed the first CON it was

either just opening or hadn't yet opened. And we've not seen, and as the time has progressed even though it's now open, we've not seen a rebound in the volume.

And that ties into what Dr. Ahuja just said, which is we would be very loath to operate a service of which is small, as it currently is, because it just certainly just isn't safe.

So the combination of talking to the providers, talking to -- looking at the facilities, looking at the data from when they've reopened after COVID has led us to that additional conclusion that was reflected in those completeness questions.

THE HEARING OFFICER: Okay.

MS. RINEHART: This is Kim Rinehart. I just wanted to mention that when there's a reference to shoreline, they're referring to the Guilford site, which has a standalone ED, but it's part of Yale New Haven Hospital.

So I know you had asked for us to clarify any kind of shorthands that we use, and wanted to make sure that was clear.

THE HEARING OFFICER: I appreciate that. Thank you.

So these next -- I just have two quick

questions about services -- well, sort of about services.

You reference medical-legal partnerships with organizations and other entities in the area. I was curious if Yale had identified any organizations that it might partner up with in any of the locations of these hospitals for purposes of providing medical-legal partnerships.

THE WITNESS (Aseltyne): Sure, I'll take that one. Bill Aseltyne, and I'm the head of the legal department at Yale New Haven Health.

We started our first medical-legal partnership probably about 14 years ago, and we have since expanded it. It's been very successful. My colleague here, Anne Diamond, has requested that we extend what we've done at Bridgeport, and we're working on that.

We partner with the Yale Law School in getting law students to come in and provide legal services along with outside attorneys, and -- and the concept is embedding lawyers in the clinical setting, because sometimes the impediment to health care is actually a legal issue.

So when the lawyer is embedded in the clinic, the lawyer can sometimes resolve that issue in

tandem with the team providing medical care. We have started to reach out to community organizations in the Prospect geography. We've had folks talking to the federally qualified health centers to see what we can do in partnership with those organizations.

We haven't gotten too deep into that because we're letting this process play out, but I'm very enthused about the opportunity that we see here. So we will go all guns ablaze on setting up more medical-legal partnerships in this geography.

THE HEARING OFFICER: Okay. Thank you.

There was also a reference to transition services agreements somewhere in the application. That's a term I had never heard of before, and I was just wondering if some clarity could be brought to that, that term?

THE WITNESS (O'Connor): Sure. Sure. Chris O'Connor. Those are services that we would typically, in a case like this, ask for the -- the purchasee to continue to provide services potentially beyond the date of close to ensure that they have continuity.

THE HEARING OFFICER: Okay.

Are any of those contemplated here?

THE WITNESS (O'Connor): We're -- we're exploring a number of options, and it would depend upon closing and notice. And you know, there's a whole sort of number of factors that would determine whether those would be necessary or not.

THE HEARING OFFICER: Okay.

THE WITNESS (O'Connor): But in this case, again you have a national firm doing centralized functions outside of the local hospital that, you know, we want to ensure that things like billing and coding and things that you know we are going to need to continue as of day one, that we may not have had the opportunity to make the transition abruptly.

So it, again it will depend. And I'm not saying those are the right services. I'm just using those as examples.

THE WITNESS (Balcezak): Tom Balcezak. To what Chris just said -- Lisa could probably help us here, but a perfect example is we've talked about going on to EPIC. We cannot go onto EPIC the day we close the transaction.

We must continue their electronic medical record. It's absolutely key to clinical operations. So we would need to execute an agreement to pay Prospect to continue to operate

Cerner under the current license that they have for a period of time until we're able to transition, not just Cerner, but all the electronic records.

You simply can't operate an organization with no electronic medical record, and we would need a bridge time to get on to EPIC.

THE WITNESS (Stump): Yeah. Tom -- this is Lisa Stump. Tom said that exactly right. So part of the transition services agreement will be just that, to continue to rely on Prospect to give us access to the Cerner electronic medical record as well as the Meditech systems in use, as well as the teams, the IT support teams that work on those systems.

We don't have that expertise internal to Yale New Haven Health at this time, and so for that nine months or so until we transition everyone to EPIC we will be reliant on Prospect to provide us those services.

MS. VOLPE: Ms. Michelle Volpe. And from a legal perspective, that's a fairly common occurrence in this type of transaction.

THE HEARING OFFICER: Okay.

MS. VOLPE: In an acquisition to have a transition services agreement.

THE HEARING OFFICER: Okay. On page 68 of the application you said Yale plans to fund the acquisition entirely out of its cash reserves. And then you said there's no funding or financing anticipated, but Yale may consider obtaining financing if -- there were a few different 'ifs.'

One of which was the timing of the closing is significantly different than planned. And you projected -- or that you hoped the closing would occur in June of 2023. That's obviously probably pretty ambitious and not going to happen.

So I was just wondering, what would significantly different than planned be from June 2023? And with the goal just being, at what point would you have to consider financing under that condition?

THE WITNESS (Kosyla): Gail Kosyla, CFO. We would -- we anticipate financing this through cash, as was indicated. Nothing would change out that other than, you know, other factors where we might want to consider if the -- the bond market were such that it was advantageous to us to do that.

But the plan is to fund it with -- with our cash.

THE HEARING OFFICER: Okay.

THE WITNESS (Kosyla): Our reserves.

THE HEARING OFFICER: I just have a few more questions. If you can turn to pages 146 and 147 of the application, specifically looking at subsection O, little 'o.'

And my question is just these, these prompts were responded to from the perspective of Prospect only, but the statute and the question refer to Yale as well. So I just wanted to make sure that we had Yale providing responses to that as well.

And I wanted to make sure that was possible before we asked for it as a late file.

MS. RINEHART: We can provide it as an --

THE WITNESS (O'Connor): There are no financial gains.

THE HEARING OFFICER: Okay.

THE WITNESS (Aseltyne): Because we're a not-for-profit tax exempt corporation.

THE HEARING OFFICER: I just want to ensure that that's part of the record and that that's clear.

MS. RINEHART: Would you still like that as a late file, or is the answer on the record enough?

THE HEARING OFFICER: Your answer is good enough.

Thank you.

THE WITNESS (O'Connor): That was Chris O'Connor, by the way.

THE HEARING OFFICER: Thank you. Page 178 of the application, you say, Yale will seek consent of other joint venture participants to Yale assuming Prospect's easiest interest.

Has that happened yet? Have there been any communications with the joint venture participants?

THE WITNESS (Aseltyne): Yeah. Bill Aseltyne. That process has started. Each joint venture, I think, has different consent rights. So I know that we've initiated that, or ECHN has initiated that in at least one of the joint ventures.

THE HEARING OFFICER: But you haven't gotten full consent from any of the joint ventures yet?

Okay.

THE WITNESS (Aseltyre): I think, technically, it's probably -- Michelle, it's probably ECHN that gets the consent.

MS. VOLPE: Yeah. And you know, we will.

Like Bill explained, a lot of the operating agreements differ in terms of what's required in getting consensus. Some of them, you know, pursuant to the governing documents, we don't anticipate any problems.

THE HEARING OFFICER: Okay. Keeping in line with the

joint ventures, page 749 of the application, the joint ventures list Prospect ownership percentages but they don't list any of the other percentage ownership.

I was hoping to learn more about those joint ventures and what the other percentage of ownership interests are, and where those lie.

MS. VOLPE: The ones that are a part of this transaction, in the CON?

THE HEARING OFFICER: Yes.

MS. VOLPE: We have others that we filed determinations for that.

THE HEARING OFFICER: So again, that's page 749.

It's Exhibit 11A.

MS. RINEHART: Hearing Officer Csuka, I think that the information you're looking for is on page 179 of the application, actually, for the JVs that are part of this application. And there is a list of the other owners.

Michelle, I think that was what they were asking?

MS. VOLPE: Yeah. I don't know if you have a specific question on that for these?

THE HEARING OFFICER: No, I just wanted to ensure that we had that somewhere and I didn't see it in that.

MS. VOLPE: It's in the org charts.

MS. RINEHART: But again, page number 179 for the three JVs that are relevant have more detailed information on ownership as well as governance.

THE HEARING OFFICER: Okay. Thank you.

And my last question concerns the RFP process, the other proposals, and the FTC filings. I'm not going to ask specific questions about them. In a couple of your responses, you said you have to communicate with the Office of the Attorney General to get more information about this.

I did communicate with the Office of the Attorney General and they said that the Applicants hadn't firmly waived their right to confidentiality. So the Office of the Attorney General cannot speak with us about that.

So we need to find some way for us to be able to communicate with the OAG, whether that's you waiving your right to confidentiality or you providing us with your requested information directly but under seal, or something along those lines?

MS. VOLPE: Yeah. I mean, in terms of your specific inquiry, and we can also invoke executive session

with you, but are there specific questions on that?

I mean, that process that you're referring to, obviously the federal government through the FTC had a significant review and oversight and, you know, allowed this, permitted the transaction to move forward.

The Office of the Attorney General as well has looked at the proposed transaction and gotten comfortable with the parties and proceeding in the manner that it's been described in the certificate of need.

So I guess -- and for those who aren't aware, and I know you're aware, the Office of Health Strategy has a separate CMIR process for the cost market, you know, impact report who is also privy to confidential, non-public information.

So there have been a lot of regulatory bodies reviewing that, those specific and definitive issues. And I guess I would ask, you know, is there something in particular that you feel is necessary for the purposes of OHS in the CON analysis that we could help with, and maybe perhaps have an executive session sidebar or -- so that we could advance this issue?

THE HEARING OFFICER: So in my mind the issue is, I don't know what is in those documents. So how am I going to ask specific questions about them? So maybe some of it would be relevant to the CON. I don't know.

MS. VOLPE: Well, I mean, I guess we would argue it really isn't relevant because the statutory factors that you review, you know, the twelve statutory factors for purposes of determining whether, you know, a CON is permissible, that information doesn't necessarily get invoked in terms of like -- and based on Mr. O'Connor's testimony earlier when he had the chart up, I mean, just from a layman's perspective on the antitrust issues, I mean, these aren't truly overlapping markets from where Yale currently has facilities.

So I guess for purposes of your analysis, you know, we recognize you're not aware of what's in the reports, but what is it that you feel you need based on the statutory factors? Especially because now, you know, this OHS does have the CMIR process as well. So this agency does have an opportunity to weigh in from that perspective, and I know you have a wall internally on that.

But again, is there something specific?

MR. WANG: This is Roy Wang, OHS. Is it possible for us to take a quick break to discuss that question and --

MS. VOLPE: Sure.

MR. WANG: -- that Attorney Volpe just posed regarding the various criteria that CON oversees?

THE HEARING OFFICER: Sure.

MR. WANG: Okay.

MS. RINEHART: I think we could also collaborate on a way to provide, you know, limited information in or to have a limited waiver, whatever. We can work out that legally it functions.

THE WITNESS (Aseltyne): Yeah, I'll weigh in. So again, Bill Aseltyne, Yale New Haven Health.

So the concern, we filed the Hart-Scott pre-merger notification to the Federal Trade Commission, which is copied to the Attorney General. We filed that on May 12th of last year, I believe.

We met previously with both the FTC and the Attorney General, I think, in February of last year to preview what we would be filing. They did give their 30-day clearance, which is a little unusual these days. Usually the FTC automatically

takes an additional 30 days to review transactions like this. They didn't. They had enough data to give that 30-day clearance.

That is expressly filed under a federal statute that says that that is non-public information. We are not willing to waive that, because it contains competitively sensitive information that if it were to become public, it would materially harm us. Our competitors would have a lot of detail about our organization and our strategies.

On the other hand, there's probably a way to negotiate something if we understood your concerns a little more clearly that we could work with you on. And again, we've -- we've stayed in constant communication with the Attorney General's office because we knew this transaction was taking us longer than we had anticipated.

So we are, you know, there is probably something we could work out together.

THE HEARING OFFICER: Okay. Now is probably a good time to take a five-minute break. We'll discuss that.

And then we're going to start with the public comment, and we can sort of come back to this,

this topic later on.

MS. VOLPE: Sure.

THE HEARING OFFICER: But I, otherwise I'm done with my questions. It's really just that, that last one there that we need to figure out a solution to.

MS. VOLPE: Very good. Thank you.

THE HEARING OFFICER: So let's plan to come back at three o'clock. We'll do public comment.

And again, if anybody watching wants to sign up to provide comment, feel free to do so by typing your name in the comments.

THE WITNESS (O'Connor): Do we know how long the approximate list is?

THE HEARING OFFICER: At this time, I think it's just the list that you guys provided. So I don't know how many. I think there's about 30 people.

THE WITNESS (O'Connor): Approximately 30.

THE HEARING OFFICER: Okay. So we'll come back at three.

(Pause: 2:54 p.m. to 3:06 p.m.)

THE HEARING OFFICER: Thank you. Before we get into the public comment portion, I did just want to say one thing about where we left off on the OAG FTC,

all that.

I just wanted to draw counsel's attention to 19a-639, Sub D, Sub 2. So that says, if any deliberations involving the certificate of need application filed that involves the transfer of partnership of a hospital, in addition to the guidelines and principles set forth in subsection A, you need to look at, you know, various things including whether the applicant fairly considered alternative proposals or offers in light of the purpose of maintaining healthcare provider diversity and consumer choice in the healthcare market, and access to affordable quality health care for the affected community; and also, B, whether the plan submitted pursuant to 19a-639a demonstrates in a manner consistent with this chapter how healthcare services will be provided by the new hospital for the first three years following the transfer of ownership of the hospital, including any consolidation, reduction, elimination or expansion of existing services or introduction of new services.

But really we're looking at 2a, which that's the focal point and that's sort of why I'm pushing back on us gaining access to that information.

And if you have provided it to the OAG, if you have provided it as part of the CMIR, in my mind there's no reason why you can't provide it to us either as long as it's done in a confidential way, and in such a way that it wouldn't be made publicly accessible.

So I'll leave it at that, and we can talk about that a little bit more later on, but I wanted to plant that seed and you can think about it as we go forward.

MS. VOLPE: Yeah, if we could speak to that? I mean, it was addressed in the application and we can provide the reference and the Bates stamp in the completeness questions and in the underlying application.

THE HEARING OFFICER: Well, we'll get to that. I just want to move onto the public comment portion, because I understand that there are some elected representatives who are waiting to provide comment, and I don't want to hold them up any longer than necessary.

MS. VOLPE: We agree.

THE HEARING OFFICER: So just as a reminder to everyone, this is the next portion of today's hearing considering the CON application filed by

Yale New Haven Health Services and Prospect CT, Docket Number 22-32542.

We are just about done with the technical portion. So sign-up for the public comment has been all day in person and on the Zoom in the comments section. There were a total of 31 people preregistered by the Applicants.

And just to give a sense of how long we can expect the public comment to take, we normally limit commenters to about three minutes with elected and appointed officials being granted some flexibility on that, that three-minute nomination.

So assuming each of the preregistered individuals speaks for three minutes and no one else signs up, that's still about 1 hour and 30 minutes of comment.

We do have one member of the public who signed up. Her name is Michelle Payton. So she will go somewhere near the end, probably after all the other preregistered individuals.

We will call the names of those who signed up to speak in the order in which they registered. Afterwards I will ask if there is anyone else present who wishes to be heard.

As I mentioned, speaking time is limited to

three minutes, and I'm going to pretty strictly enforce that because I do want to try to get through everybody in as quickly a fashion as possible. If you haven't signed up, or if you're not able to provide public comment today we do encourage you to submit written comments by e-mail to OHS at, CONcomment@CT.gov.

And to the best of your abilities, anyone who's providing comment should try to limit duplication of comment. You know after a certain point it becomes no longer helpful to just hear the same things over and over and over again. So if there are specific things that would be helpful, that's really what we want you to focus on.

So I thank everyone for taking the time to be here today. We're now ready to hear statements from the public. We are going to have first, Mayor Neil O'Leary. Is he available?

Whatever you're ready.

MAYOR NEIL O'LEARY: I am ready. Thank you.

THE HEARING OFFICER: The camera is right there. So if you want to speak to them, you can do that. If you want to speak to us, that's fine, too.

MAYOR NEIL O'LEARY: I try to speak to everyone.

THE HEARING OFFICER: Okay.

MAYOR NEIL O'LEARY: Good afternoon, everyone. I just want to thank the Office of Health Strategy for hosting this meeting today for the CON. My name is Neil O'Leary. I've been the Mayor of the City of Waterbury for nearly 12 years, employed by the City of Waterbury for 43 years.

So I've been around for a little while. I have a little history I would like to share with you regarding Waterbury Hospital, and I'll get to the reasons why.

In 1980 there was a very contentious strike with 520 nurses walking out, which that strike lasted three months. In 1986 there was another strike that lasted four months. And in 2013 there was another strike that fortunately only lasted less than a month.

The only reason I bring all this up is because we've had this history of issues in our city. Fortunately we have two hospitals. We have Waterbury Hospital and we have Trinity Saint Mary's hospital; one Catholic, one non-Catholic.

And there's been some contentious issues over the years involving Waterbury Hospital, much of it, of course, involved with labor, organized

labor. And in 2016 there was the -- Prospect Medical came across and said, listen. You know, we -- the hospital was in a financial crisis. It was well publicized. Prospect Medical came in and purchased the hospital. It went from a nonprofit status to a for-profit status, and it was a very anxious transition, quite frankly.

But at the end of the day I think most people would agree that Prospect, you know, stabilized the finances of the hospital and infused over $50 million in capital to the hospital. It was able to bring some sort of fiscal responsibility to the hospital.

The labor Relations didn't improve greatly, but they improved slightly, at least for a period of time. And quite frankly, we welcome Yale New Haven Health coming into Waterbury Hospital. We were very pleased to hear that Yale was interested in acquiring Waterbury Hospital for so many different reasons.

Our constituents in the community we feel strongly will be better served with Yale New Haven Health coming to town. And I want to make it clear that from 2016 until recently the quality of healthcare at Waterbury Hospital was strong. It

wasn't like there was this lapse in quality of health care, but there was always this issue between labor and the hospital administration, and it didn't change when Prospect came in.

It got slightly better for a period of time, because the hospital was really in such financial straits prior to Prospect Medical Holdings coming in. And you know we're proud to say that, you know, Prospect did provide services that they could during this period of time.

And of course, we all know what COVID did to healthcare. We don't need to go down that path. But at the end of the day the community will have access to world-class healthcare that's offered by Yale, including clinical trials for patients with cancer and rare diseases. We have so many of our people now who are being treated at the Harold Leever Cancer Center, which of course is run by Yale, Smilow as well as St. Mary's Hospital.

But we are really welcoming the opportunity to see more healthcare services come into our community through Yale so that a vast -- a significant population of our people who are suffering from -- and it's not just the city of Waterbury, by the way -- it's the region, as you

well know -- suffer from very different and significant cancers that, quite frankly, Smilow may or may not be able to handle. So if they can't, they have to go to New Haven and that is a huge lift for some of our people, especially our elderly population.

We are thrilled to have the stability. That's why I'm here. The stability of an organization, a world-class organization in health care, that's known across the planet in health care, and the stability to provide the services to our constituents in every area.

And I'll remind you that it was 2004 that I sat and testified as police chief, begging for OHS and the State Department of Public Health to allow the City of Waterbury, both hospitals -- Saint Mary in Waterbury to allow angioplasty procedures.

Prior to 2004 we were putting people in ambulances every day to go down to New Haven and Hartford for angioplasty services. I don't want to tell you how many people didn't make that ride.

You know it's been a long march for us, and we look at this transaction as the pinnacle of healthcare to be provided in the City of Waterbury. That's how important it is to our

constituents. I look at it in my entire life in the City of Waterbury, and the last 43 years with the City of Waterbury, as the most significant opportunity the City has seen since I've been here. And I really mean that from the bottom of my heart. And we're proud to have Yale so interested in our city and the region.

Thank you.

THE HEARING OFFICER: Thank you, Mayor.

Next on the list is Representative Ronald Napoli, Jr. Is he in person, or available via Zoom? Let me just confirm that we have unmuted.

(No response.)

THE HEARING OFFICER: So Representative Napoli, I guess is not here. If he shows up he can just make a statement whenever he becomes available. Just try not to interrupt. Just let us know in between individuals and we will try to take him.

Representative Geraldo Reyes, is he available?

(No response.)

THE HEARING OFFICER: The same thing for him. If he

becomes available we will take his statement.

Representative William Pizzuto?

REP. PIZZUTO (71st): Yes, sir. Thank you.

I'll try to be brief and not repeat what my Honorable Mayor has said. Good afternoon everyone. My name is William Pizzuto. I would like to thank the honorable ladies and gentlemen of the Office of Healthcare Strategy -- or Health Strategy, for the time and consideration you've given us with regards to the transfer of ownership and the application for Prospect Connecticut Hospitals to New Haven.

And so very briefly, by way of my background -- not to bore you, I have a PhD in adult and technical education from UConn. I'm a member of the Connecticut General Assembly representing the 71st District, which is Middlebury and Waterbury.

And I'm a long-serving member of the hospital -- of the Prospect Waterbury Local Advisory Board. I'm a former director of the UConn campus in Waterbury, and former chairman of the Greater Waterbury Chamber of Commerce. I've served as an alderman under different mayors, and I was a former police and fire commissioner as

well. And I bring all that up only to show you my connection to the City, and to the hospital that runs very deep.

While at Waterbury UConn we had an Allied Health Program. That was a program that was only offered at Storrs, and the reason we did that is quite often our students are place-bound, but it gives them entree into the PA and the APRN world, which is wonderful.

It's because of hospitals such as Waterbury and Yale working together that supported the higher ed opportunities for the students to have these opportunities to go on besides being place-bound. They don't have to travel to New Haven or to Storrs.

In my opinion, Yale is the perfect entity to obtain Waterbury Hospital as they have a long-standing relationship with the doctors, the staff, the faculty, the students in Waterbury. Yale brings expertise, opportunity, state-of-the-art everything to a population that would benefit tremendously from this transfer of ownership.

On a personal note, my family and I have a long history with Waterbury Hospital. I was born

in Waterbury. My children were born in Waterbury Hospital. All my grandchildren were born there. We've had major surgery there. Everyone I know that's been -- that's friends/family were either patients or have friends that were patients.

In that 133-year history in Waterbury, thousands of people were born and have been patients there, and literally thousands have worked at Waterbury Hospital and Waterbury Health over the many years to provide for their families and to provide for the necessary health care so critically needed in our urban area.

I strongly believe that Yale is the right organization to take over Waterbury Hospital. I support this change of ownership as it will allow more residents to receive high-quality care closer to home and enhance access to world-class tertiary and quaternary care and clinical trials -- I think the Mayor had mentioned that as well.

The proposed acquisition will preserve jobs, even grow jobs. Health care is important to Greater Waterbury, not just for patient care, but as a source of medical-related jobs, which have tremendous spin-offs in other related areas and careers.

This is an incredible opportunity for our fine City and for the residents of Greater Waterbury and beyond. For these reasons and many others, I respectfully ask that you approve the certificate of need application.

Thank you very much.

THE HEARING OFFICER: Thank you, Representative.

Next on the list is Senator Joan Hartley. Is she available either in person or via Zoom?

(No response.)

THE HEARING OFFICER: Okay. If Senator Hartley becomes available, we will take her in between one of the next people.

Senator Anwar, is he available?

SEN. ANWAR (3rd): Yeah, I am on Zoom.

You guys can hear me, I hope?

THE HEARING OFFICER: We can. There you are. Okay.

SEN. ANWAR (3rd): Okay. All right. Thank you so much. Good afternoon, everyone. I'm Senator Saud Anwar. Honorable members of the Office of Health Strategy, thank you for giving me the opportunity to share my thoughts and my enthusiastic support for this CON.

I'm a physician, a pulmonologist, and an intensivist. I've been in this community around Manchester and the Greater Manchester, Greater Hartford area for some 25 years and have taken care of our patients with lung diseases and intensive care units, the ones who have been critically ill.

I am not employed by ECHN, but I'm affiliated with ECHN. I want to share my enthusiastic support and I want to give you some reasoning that I feel is important to consider.

First and foremost, we need to recognize there are about 300,000 people in this area. I'm not mentioning the Waterbury area, but more so the east of the river community. There's a large population that is dependent on the health and well-being of this healthcare system. So we have a responsibility to have a sustainable health care in this community.

The challenge with private equity is that sometimes private equity and health equity do not go together. As I'm sure many of you are aware of the private equity issues that we have heard with the same organization, Prospect in Rhode Island and Pennsylvania. We have to make sure that we

protect the community that we serve.

And I was trained at Yale. I spent my training in pulmonary medicine, critical care medicine and also did my master's in public health at Yale. Yale is going to be a blessing for the community. This community needs a high-quality group of healthcare workers and also support, and the background that Yale would bring to this community.

Another thing that I think is worthy to mention is that Yale is willing to provide care to individuals who are 250 percent of the poverty level, the federal poverty level, which really increases the number of individuals who will benefit from this acquisition.

And again, the workforce needs that we have across this region, Yale is a natural fit to be able to create a seamless transition of workforce that they are creating to be part of the workforce that are needed over here.

And I have multiple other reasons, but I'm going to leave it at this in the interests of time to say, please consider this. There are so many families in our community and in this region that are hoping that this will move forward. There are

patients who are hoping for this.

You would be surprised how many patients call and say, are we going to be able to connect with Yale support system?

And the answer to them I say is, we are very helpful that the right decision will be made by the Office of Health Strategy, and I urge you to make the right decision and thank you for allowing me to share my thoughts. Thank you.

THE HEARING OFFICER: Thank you, Senator.

Next on the list is Mayor Bob Chatfield and then Mayor Jay Moran.

So starting first with Mr. Chatfield, is he available?

(No response.)

THE HEARING OFFICER: Okay. How about Mayor Jay Moran.

MAYOR JAY MORAN: Good afternoon. This is Mayor Jay Moran of the great Town of Manchester, Connecticut. Sorry for the background.

Without repeating my good friend, Mr. Mayor O'Leary of Waterbury, the reasons of closer-to-home health care, the quality of Yale in the world -- sorry about the Zoom.

I'm here to support this application for several reasons. One, I'm so proud of the staff and the doctors and nurses and everyone that works at Manchester Memorial that serves our community, especially through COVID. They did so much. They were true heroes, and I can't say that enough.

But the importance of a local hospital in connecting with Yale, as Mayor O'Leary said, the best word is "stability," and that's stability for years to come offering quality healthcare and preserving jobs right here in Manchester.

I have told the story of some of you before -- and if you've heard it, I apologize, because I've sat in front of these several times as my nine years as Mayor. You really learn the importance of local hospitals when you've sat in that emergency situation.

It was February 14, 2001, when my daughter who was less than two years old battling Hurler syndrome went into pulmonary arrest. And I'll never forget what the ambulance driver said. He said, Mr. Moran, we're going to Connecticut Children's Medical, but if we get outside your driveway and we realize we're running out of time, we're going right to Manchester Memorial. That's

when I truly understand how time and local hospitals are so important to saving lives.

And also can tell you it was a convenience for a family during some of our roughest times. Instead of traveling to Hartford everyday when she had to have her platelets checked, Manchester Memorial -- they came to us and said, you have the blood done here. So we didn't have to drive to Hartford and find parking.

It was such a convenience.

So I support this, this merger. I think it's so important. My three -- four children were born at Manchester Memorial Hospital. I'm so proud. I've always been proud of that hospital. I'm looking for the stability in this relationship with Yale.

I was not trained at Yale, like my good friend Dr. Saud Anwar, but I'm a graduate. I was born there 60 years ago. So I'm so proud of everything, and I appreciate the time.

I encourage you to approve this application for the betterment of so many people in Manchester and the surrounding area.

Thank you for your time.

THE HEARING OFFICER: Thank you. So there were a

number of other individuals that were preregistered by the Applicants. I'm planning to just take those in the order in which they've been listed. Is that okay with you?

MS. VOLPE: Sure.

THE HEARING OFFICER: Are there any other elected or public officials who haven't spoken yet who wanted to make a comment?

(No response.)

THE HEARING OFFICER: Okay. Hearing none, we're going to move on to Kyle Kelly of Naugatuck Ambulance. Is he available?

(No response.)

THE HEARING OFFICER: I'll actually call out the next three. That way you know who's coming. It's Lynn Ward, John Hopkins and Angie Matthis. Is Lynn available?

STEPHEN DelVECCHIO: Hey, how are you doing? This is on behalf of Lynn Ward. My name is Stephen DelVecchio. I work at the Waterbury Regional Chamber as the Government Affairs and Economic

Development Director.

Unfortunately, Mrs. Ward could not make it today, but I'll be reading her testimony on her behalf.

Can everyone hear me okay?

THE HEARING OFFICER: Yes.

STEPHEN DelVECCHIO: Dear Dr. Gifford and honorable members of the Office of Health Strategy. As president and CEO of the Waterbury regional Chamber of Commerce I am writing to express our strong support for Yale New Haven Health Systems' proposed acquisition of the assets Prospect Medical Holding operation in Connecticut, including Waterbury Hospital and the Waterbury Health Network.

Our members and the larger community will be much better served by this proposal. We support the proposed transaction because it will allow more residents to receive high-quality care closer to home and enhanced access to world-class tertiary and quaternary care and clinical trials.

In addition, it will revert these assets to nonprofit ensuring that capital and other investments are made in the community rather than being distributed to shareholders. The proposed

acquisition will also preserve jobs and stabilize key local assets.

Through the years Yale New Haven Health has been a valuable partner to its local communities. Further, Yale New Haven Health has delivered on its promises with past affiliations including numerous clinical investments at the Hospital of St. Raphael, now a campus of Yale New Haven Hospital, Lawrence & Memorial health care together with Westerly Hospital and Milford Hospital, now a campus of Bridgeport Hospital.

Representatives from both organizations have completed extensive due diligence and concluded along with their respective board of directors that this would be the best outcome for both institutions and the communities they serve.

We agree.

On behalf of the Board of Directors and 900 chamber members we strongly encourage you to approve this application. Sincerely, Lynn G. Ward President and CEO of Waterbury Regional Chamber.

Thank you for your time.

THE HEARING OFFICER: Thank you.

Next on the list is John Hopkins. Is he available?

(No response.)

THE HEARING OFFICER: Angie Matthis.

ANGIE MATTHIS: Hi. Good afternoon. I'm Angie Matthis. I'm the Executive Director of Greater Waterbury Health Partnership. Thanks for inviting me to say a few words to the members of the Office of Health Strategy, and also to Dr. Deidre Gifford.

So I'm happy to be here today to just give a little background, but first and foremost to offer my strong support of this acquisition between Yale New Haven health, and also Waterbury Hospital, Waterbury Health.

I want to kind of just give a little background. Right? Waterbury Hospital, a community hospital, since 1890, operating unparalleled health care is to the members of this great community for over 125 years -- and that's important. Right?

Because my organization Greater Waterbury Health Partnership builds bridges between the healthcare system here in Waterbury and that's done through collaboration. And so I thought we could take a moment first to describe our mission

which is that Greater Waterbury Health Partnership aims to provide access to culturally sensitive and evidence-based health information for the Greater Waterbury region. And we coordinate local healthcare Services to improve overall community health.

Supported by data, our mission is rooted in community collaboration as a critical element to meet the needs of our diverse communities. And want to emphasize that collaboration, because I strongly believe that it's been through the power of collaboration with GWHP partners and Waterbury Hospital that we've been able to accomplish great community benefit.

And I can foresee the future a little bit. Right? That this wonderful pending acquisition, which I strongly support, between Yale and Waterbury Hospital will only develop and enhance that community collaboration that is enhancing the health and the livelihood of so many of our community members which as you -- if you work in this community, you know are suffering from great health disparities.

And so some of the things that we work with Waterbury Hospital on from the standpoint of

community benefit have been the community health needs assessment, which is posted on the website and other hospital websites in our area. We're in the process of doing the community health improvement plan now.

We run something called the community care team which is a clinical and community-based organization integration project, which really takes a look at some of our most in-need patients and are utilizing both hospitals in the area. And we collectively case manage them so that they have better outcomes and can become independent and productive members of this community.

While we also run something called the Waterbury Health Access Program which is housed in Waterbury Hospital. So we have two LCSWs and eight community workers and case managers over there collaborating daily with the emergency department. And we hope and really are looking forward to that continued collaboration.

And then I just wanted to kind of say a couple words about Dr. Justin Lumby and his commitment to the community, and how wonderful that's been as really a strong advocate for our work, but also for this community. I've seen

firsthand how he really gets at the neighborhood level, and then specifically during COVID when I myself went through a large (unintelligible) at Post University Dr. Lumby was out there with his staff doing whatever it takes to make sure that our community is safe and healthy.

And so that's really the spirit of Waterbury Hospital. Right? For over 125 years, meeting the community where they're at and developing relationships.

And so from that standpoint I strongly -- really support this acquisition today, and it really is an honor to be here and be asked to speak on behalf of our collaboration with Waterbury Hospital. And hopefully our continued line of work with, and community benefit with Yale New Haven Health. Thank you.

THE HEARING OFFICER: Thank you, Ms. Matthis.

Kristen Jacoby, is she available?

(No response.)

THE HEARING OFFICER: Okay. The next three are Leslie Swiderski, Angela Holmes and Tony Bocci.

So starting first with Leslie Swiderski, is

she available?

JERED BRUZAS: So on behalf of Kristen Jacoby, President and CEO of United Way of Greater Waterbury, I Jered Bruzas, Chief Impact Officer rise in support of the acquisition.

I'm excited about the great opportunity that this acquisition will have and the impact it will make on our community, especially those most vulnerable, in need of excellent quality world-class care now more than ever.

I've seen firsthand the great impact that Yale has had on the homeless response system in the Greater New Haven area. And as the United Way we are committed, deeply committed to the support of the homeless and those in the (unintelligible) community.

Yale will bring a level of support and expertise to the table that will ensure that those in most need, including potentially medical respite programs for the homeless which are offered in New Haven can come to the forefront here in Waterbury.

We as the United Way are excited and look forward to the acquisition to come to fruition.

THE HEARING OFFICER: Thank you. So I believe Kyle

Kelly who was the first on the list? I saw his name pop up. Is he available?

KYLE KELLY: Hi. Hello? Can you hear me okay.

THE HEARING OFFICER: Yes.

KYLE KELLY: Hi. Thank you. I (unintelligible). I would like to speak up on behalf of the acquisition. Naugatuck (unintelligible) is very excited for the gain of Yale New Haven Health to the area.

We're extremely grateful for the help Waterbury Hospital has afforded us in the EMS world as well as the region.

Over the past several years and the last several months here we have been working on many great strides to better our service together, and I believe with the acquisition that will just help us do that much more and be stronger together as we are stronger with numbers.

We're looking forward to many more great collaborations with Yale and we're happy to be a part of this, and we look forward to it.

THE HEARING OFFICER: Thank you.

Angela Holmes. Is she available?

(No response.)

THE HEARING OFFICER: Tony Bocci?

(No response.)

THE HEARING OFFICER: All right. The next three on the list are Ariana Washington, Dr. David Hill, and Dr. Duncan Belcher.

So starting with Ariana Washington?

(No response.)

THE HEARING OFFICER: Dr. David Hill?

DR. DAVID HILL: Good afternoon. I'd like to thank the Office of Health Strategy for giving me the opportunity to testify.

I am Dr. David Hill. I am a program critical care physician who has practiced here in Waterbury for over 25 years. I've been an attending physician at both Waterbury and Saint Mary's Hospitals for my entire career.

And prior to coming to Waterbury, like my friend Dr. Anwar, I completed my postdoctoral pulmonary and critical care fellowship at Yale.

I've served as a Yale faculty member for the entirety of my career teaching medical students

and residents in my office and at both local hospitals. I also hold the voluntary position of Chair of the Prospect Waterbury Advisory Board. This gives me a unique insight into the difficulties facing community hospitals.

And as a physician and a healthcare leader, I have witnessed our healthcare system change over the course of a career. The practice, the business of healthcare delivery has constantly evolved and is particularly challenging in communities such as ours which have a high proportion of patients with Medicare and Medicaid as their primary insurance.

As a not-for-profit health system, Yale New Haven maintains a strong commitment to serving patients and the community. Similar as a community hospital, Waterbury Hospital and its network has a long history of serving patients in our community.

The proposed acquisition of Waterbury Hospital and Waterbury Health builds upon the strengths of each hospital and will integrate the resources of Yale New Haven Health to improve the health care of our community and our region. It will allow for improved local access to academic

medicine while preserving jobs.

Waterbury Hospital and it's affiliate network, and the Greater Waterbury community will be stronger from this transaction. The transition of Waterbury Health to Yale New Haven Health System is an important opportunity to meet Connecticut's ever-changing healthcare needs with exceptional, high-quality care.

As a long-time practicing physician in the Greater Waterbury community, I am keenly aware that healthcare has evolved and changed, especially following the COVID-19 pandemic. I believe that this transaction will benefit my patients, benefit the community at large, and that is why I strongly urge you to support it.

Thank you.

THE HEARING OFFICER: Thank you, Doctor.

Next on the list is Dr. Duncan Belcher.

DR. DUNCAN BELCHER: Good afternoon, and thank you for having me. I'm Dr. Duncan Belcher. I'm currently Waterbury Hospital's Chief of Staff. I've been a practicing interventional radiologist at Waterbury Hospital for the last 26 years.

For 13 years, I was the Chief of the Waterbury Hospital Radiology Department. I'm also

the managing partner of Diagnostic Radiology Associates, my physician radiology practice that has been serving Waterbury Hospital since 1974.

I'm here to say that I strongly support the proposed acquisition of Waterbury Hospital by Yale. The transaction will have many positive outcomes for the quality of healthcare in the Waterbury community. We'll have access to world-class quality and safety practices that an institution like Yale School can bring.

Patients with more complex medical problems needing treatment both here and in the community will have the benefit of their medical records being a contiguous, seamless network. That's something we see, you know, very positively in our practice because there's a lot of oncology patients who get treated both here and in New Haven.

It's very difficult to make sure that you're seeing their most up-to-date CAT scans or MRIs if they're going back and forth between the two cities. If we work on the separate systems, that will be a great improvement.

One misfortune of the COVID pandemic has been the impact on healthcare workers. Like many

health systems, Waterbury has seen the egress of many experienced professionals due to early retirements, burnout, and people opting for less stressful occupations.

I'm confident that the proposed transaction will help us recruit and retain much highly needed, highly qualified healthcare professionals into our community.

Finally, I do have a friend, a former residency colleague who is a radiologist at one community hospital in Yale's Network. He has remarked to me frequently in the last few months that the best thing that ever happened to their institution was when Yale took over the administration.

I'm confident that if this transaction is approved, I'll be saying the same statement hereto. Thank you for your time.

THE HEARING OFFICER: Thank you, Doctor.

The next three are Trish Gentile, Michelle Diaz, and Addie Geary. So starting first with Trish Gentile. Is she here?

A VOICE: She's in the other room.

THE HEARING OFFICER: Okay. If you can just let me know when she comes back -- or did she exit this

room? Or did she --

MR. WANG: She's in the holding room.

THE HEARING OFFICER: Okay.

MS. VOLPE: Do they have the ability in the holding room to come on Zoom?

THE HEARING OFFICER: They should.

MR. LAZARUS: No.

THE HEARING OFFICER: No? Okay.

MS. RINEHART: Not from Zoom. They can just walk across.

MS. FENTIS: Hey, Dan? Trish isn't here, but she submitted written testimony. So she's not going to be giving public comments.

THE HEARING OFFICER: Okay. Thank you. That was Faye Fentis. She's the one in the other room.

So next is Michelle Diaz. So she's also --

MS. FENTIS: This is Faye again. Michelle is also in this room, and she submitted written testimony. So she will not be giving a public comment.

THE HEARING OFFICER: Okay. Thank you.

Addie Geary? So Zoom from Waterbury.

(No response.)

THE HEARING OFFICER: The next three on the list,

Dr. Neil Schiff, Eureksa Lopez, and Dr. Kweku Sam. So first -- I'm sorry?

MR. WANG: It's Addie Geary.

THE HEARING OFFICER: Oh, Addie?

ADDIE GEARY: Oh, hi.

THE HEARING OFFICER: Hi, sorry.

ADDIE GEARY: Thank you. I wasn't prepared to be speaking tonight, but I -- so I'm just going to speak from the heart.

My name is Addie Geary. I'm one of the nursing directors at Waterbury Hospital, and I'm here to fully support the acquisition of Yale New Haven Hospital. I grew up in Waterbury Hospital. I was born there. I live in the community right next door, and Waterbury Health has been the number one choice for my family for all of their healthcare needs.

I was hired by Waterbury Hospital at the age of 19 as a PCA, and I transitioned over the years. I've been there for 21 years, and I transitioned from a PCA to a student nurse, to a nurse, to a manager, and now as a nursing director. I oversee all of the cardiology services at the hospital.

I'm very particular about Waterbury Hospital. I think we provide high-quality care to all of our

patients. I'm particularly in support of the acquisition for the cardiac services that Yale New Haven Hospital can provide.

We are looking to enhance our cardiac services at the hospital. So we are, you know, looking to be able to provide a lot of cardiac services to our community. Right now we have to send some of our patients out to either Yale, Hartford, Griffin Hospital -- which we can easily, hopefully, do right within our community.

Our patients in our family would have to travel probably over half an hour away to get these services and some of these advanced cardiac procedures that we don't offer now.

So I I'm full support of the transition just in fact that we can provide better cardiac services to our community within the Waterbury area. So thank you.

THE HEARING OFFICER: Thank you. Next is Dr. Neil Schiff.

(No response.)

THE HEARING OFFICER: Eureksa Lopez?

EUREKSA LOPEZ: (Unintelligible).

THE REPORTER: I can't understand her.

THE HEARING OFFICER: We can't hear you, Ms. Lopez.

EUREKSA LOPEZ: Can you hear me now?

THE HEARING OFFICER: It's better. Can you speak up a little bit more?

EUREKSA LOPEZ: Yes, of course. My name is (unintelligible). I'm (unintelligible) Waterbury Hospital.

THE HEARING OFFICER: We're having a very difficult time hearing you.

Are you able to call in using a different laptop, or your phone? I also can't see you. I don't know if you're --

EUREKSA LOPEZ: I did submit my statement. So I'm okay with that.

THE REPORTER: I got that.

THE HEARING OFFICER: Okay. I'm sorry about that. It's one of the pitfalls of technology.

Dr. Kweku Sam?

(No response.)

THE HEARING OFFICER: The next three on the list are Dr. Joanne Joey Cosgriff, Carl Cantadini, and Dr. David Pizzuto. So starting first with

Dr. Cosgrove?

DR. JOANNE COSGRIFF: Good afternoon. Hi. I'm Joey Cosgriff, and I'm the Medical Director of the Intensive Care Unit of Waterbury Hospital, and I also serve as the Chairman of the Department of Medicine.

I serve as a faculty member of the Yale Waterbury Internal Medicine Residency Program, and additional leadership roles include being a member of the staff executive committee and on the Prospect Waterbury Board of Directors.

Thank you to the Office of Health Strategy for your time and consideration you have given to the transfer of ownership application from Prospect, Connecticut, to Yale New Haven Health.

As a pulmonary and critical care physician, I have served patients in the Greater Waterbury area for nearly 20 years. Waterbury Hospital is vital to the health, the quality of life, and the economy of this community.

We provide care to the sickest patients in our community in our ICU. We are able to provide high-quality care for these patients close to home. This allows families to be engaged in the care of their loved ones, which we feel plays a

major role in their healing.

I believe the transition to a Yale New Haven Hospital is in the best interest of our patients and the community. As a faculty member of the Yale Waterbury Internal Medicine Residency Program, I play a part in training the physicians of the future. The internal medicine residency program is the hospital's largest residency program, with about 30 residents and one of its oldest programs with over three decades of experience.

Much like Yale New Haven Health, the Yale Waterbury Internal Medicine Residency Program is affiliated with the Yale School of Medicine, one of the best academic and research institutions in the country. As a community hospital, it is our responsibility to train the new generation of physicians, and our internal medicine residency plays a significant role in this.

I support the proposed transaction for our patients. A transition to Yale will allow our patients to receive high-quality care close to home while giving them access to world-class tertiary and quaternary care at clinical trials.

As a Yale hospital, we will continue to

maintain our community hospital legacy. I urge you to approve this certificate of need application, allowing Yale to take the ownership of Waterbury Hospital. Thank you.

THE HEARING OFFICER: Thank you. Next on the list is Carl Can-tah-di-nee [phonetic] -- Con-tah-di-nee [phonetic], excuse me.

CARL CONTADINI: Close enough. Good afternoon, everyone. My name is Carl Contadini. I'm a resident of Goshen, Connecticut, and I've been associated as a volunteer at Waterbury Hospital for over 25 years.

During that time, I served as chairman for six years and was, as chairman, started a pursuit for a capital partner because of the situation Waterbury Hospital was in -- and that was in 2011.

After two failed attempts and working with other networks within the State of Connecticut, we could not find a capital partner. Prospect Medical came along and made us a proposal that said, we can help you. We can help fix your problem.

We started on that road seven years ago, when we were here at the Marriott, and we were advocating for the approval of the Prospect and

Waterbury purchase. During that period of time and over that seven-year period, we've made a tremendous amount of progress at Waterbury Hospital.

I still sit today on the advisory board. I get to review all the statistics and the hard work that has been done at Waterbury Hospital. We continue to see the key performance indicators on a positive trend. We've also received over $60 million in capital expenditures to the hospital, and that alone has spread new life into this organization.

All of this was made with a lot of hard work. Under Dr. Lombard's -- and his staff had done a lot of heavy lifting these last six years. That heavy lifting has allowed us to become what I consider a very attractive asset for a possible purchase.

Seven years ago, when we signed and inked the papers with Prospect Medical, we knew in five to ten years that we would be back here again looking for approval for a new partner. That's the life of private equity. The only thing that we didn't know back then was, who is it going to be?

Well, we know who that is now. And as I must

say, that we are excited about the opportunities. This will help us to improve patient outcomes. It will allow us to continue to hone all of the skills that we learned under Prospect, and we will be able to have enough additional patient access and the ability to have state-of-the-art medical care here in Waterbury.

Waterbury Hospital, just for your information, last year we did 44,000 ER visits. We had over 65,000 patient days at Waterbury Hospital. So if you look at that and you look at those numbers, you can see the importance Waterbury Hospital is to this community.

With Yale at our side working with us, looking at best practices, we believe the future is bright for that hospital on the hill. I ask all that are here today to get behind this transaction, for it is a generational opportunity to transform health care here in Waterbury for years to come.

I'd like to thank you for giving me this opportunity to speak about my hospital.

Thank you.

THE HEARING OFFICER: Thank you. Next is Dr. David Pizzuto. He's listed as Zoom from Waterbury.

MS. FENTIS: This is Faye. He also has submitted written testimony.

THE HEARING OFFICER: Okay. Thank you.

The next three I have, I believe this is the last three, Steve DelVecchio, Dr. Robert Rodner, and Molly Devanney. And then we have the one write-in, Michelle Payton.

Let's start with Steve DelVecchio. Is he available?

MR. WANG: He did read the testimony of Lynn Ward earlier.

THE HEARING OFFICER: Oh, okay.

MR. WANG: For the President and CEO of Waterbury Chamber.

THE HEARING OFFICER: Okay.

Dr. Robert Rodner, is he available?

DR. ROBERT RODNER: Yes, I am.

THE HEARING OFFICER: Okay. Doctor, you can speak whenever you're ready.

DR. ROBERT RODNER: Okay. I'm a resident of South Windsor, and I'm very much in support of the proposed acquisition of Manchester Memorial Hospital and Rockville General Hospital by Yale New Haven Health System.

As a consumer of services for both health

systems, as well as a retired 40-year practitioner at Eastern Connecticut Health Network, I can see how the transition back to a non-profit will better serve my personal health needs and the Greater Eastern Connecticut community.

The accessibility of the two ECHN facilities paired with a well-recognized world-class medical system is laudable. As my family's need for tertiary healthcare services bourgeons, I became increasingly more familiar with Yale New Haven's clinical offerings, their level of medical excellence and superior customer service.

The promise of incorporating those qualities back into our region is highly desirable and very enticing.

I am aware that healthcare delivery is becoming more consolidated and less competitive. Yet, it takes a strong, well-run, and well-financed system to provide the level of medical and digital technology we expect and require from our medical providers. Adding Yale New Haven Health into our mix of providers can only enhance our quality choices and instill a healthier competitive environment.

We have experienced a disappointing adventure

into the for-profit world in which maximizing profit meant limiting local investment. Yale New Haven has demonstrated its commitment to its regional acquisitions of St. Raphael, Lawrence & Memorial, and Milford Hospitals. Its success at our locale will only shine a favorable light on its ability to enhance regional care with strong tertiary and quaternary services readily available.

I support this proposal because it will strengthen our access to world-class health care and improve customer service, reverse the negative impact of a remote for-profit owner, and enhance the competitive climate of health care in our state. Thank you.

THE HEARING OFFICER: Thank you, Doctor.

MS. RINEHART: I'm sorry, I believe we have had -- Senator Hartley has arrived -- if you want to take her out of order?

THE HEARING OFFICER: Sure, I received a note on that.

Senator Hartley?

SEN. HARTLEY (15th): Good afternoon, and thanks for allowing me to be here, just kind of rolling over from the Capitol. And today we had muscular dystrophy day, and so a lot of conversation about

health care.

So for the record, my name is Joan Hartley. I am the State Senator from the 15th district, that's Waterbury, Naugatuck, Middlebury. And I first of all want to recognize the Office of Health Care Strategy.

I have watched all the iterations legislatively that have gone on, and my hat is off to you all for the work that you've done, and now under the direction of Director Gifford. And in particularly, for the diligent work of the now HSP, the Health System Planning Unit.

And your legislative charge -- and this is obviously no news to you, but is so important to all of us in the state -- is the administration of the CON process, the primary purpose of that which we know is to ensure patient-centric, non-duplicative, quality, affordable, and accessible public health service systems in the State of Connecticut.

And so in pursuit and support of that mission, I am here to speak to you unequivocally in support of the application of Yale New Haven property acquisition, the proposed acquisition of the Prospect Medical Holding entity which includes

also Waterbury Hospital and the Waterbury Health Network, which I am very familiar with having actually served as an elected official in that area for 30 years.

And so I just -- you are all so very aware of the geographic area that we're talking about here. We are talking about a primary service area, that's the city of Waterbury of 110,000 residents and the secondary service area which makes up about 203 approximately thousand residents, a total of over 300,000 residents.

You know, just recently our health network identified this as being, categorizing it as a large, very large health area which obviously you all know and are familiar with the demographics of which many of them are seniors over 65, many of them have transportation challenges as well to get to access primary health care.

The approval of this transaction will be -- will ensure the residents of Waterbury and the Greater Waterbury area, my constituents, family, friends, neighbors and people I have represented, as I said for over 30 years, with the distinguished and long recognized services that the Yale Health System has demonstrated over many

years and in their many acquisitions in other communities, not only just to patient care but also to their employees and the communities in which they have invested themselves; investments in health care, clinical trials, infrastructure and being corporate community partners.

So I am here, first of all, to once again thank you for your diligence and your important work that you do, and also to support this application unequivocally.

So if there are any questions I certainly would entertain them.

THE HEARING OFFICER: Thank you, Senator.

SEN. HARTLEY (15th): And I know it's been a long day. Maybe I'm hoping to end it up for you all. A long day in a small room -- which by the way no one could find. I want you to know that.

I need a map. That's what we're going to do over at the LOB. We're going to put together maps so we can get you all here better.

Thank you once again for this very important work.

THE HEARING OFFICER: So we have two more people. We have Molly Devanney, and then Michelle Payton.

So starting first with Molly Devanney?

MOLLY DEVANNEY: Good afternoon. My name is Molly Devanney. I'm a lifelong resident of Manchester and I was born at Manchester Memorial Hospital 45 years ago in a couple of days.

You know, I'm honored to be here today to talk about Manchester Memorial Hospital and this opportunity with Yale New Haven Health System. This is just a wonderful opportunity for Manchester and the people of Manchester and Greater Manchester will be better served by this, absolutely.

Community affairs is really my background and I have had the opportunity to serve on the advisory board for Eastern Connecticut Health Network for the past few years. I'm honored to do that and I see many advantages to coming to the area.

I, you know, see things going on at Yale University all the time and just think their ideas -- I want to poll them. Like today they had an awesome event going on and I just, you know, again want to say, like, what they're doing as far as the community outreach and the community activities I think go unparalleled to many systems that are out there.

I think that if we could bring that to people in the Manchester, Greater Hartford community, and Waterbury it would be very -- just a huge benefit to the community. I honestly can't tell you how much I look forward to this possibility.

I have a personal connection with Yale as my aunt is a patient there. I've traveled back and forth to the Adler Center many times because I could not get the care locally. It's something that I'm completely impressed by the Yale System.

They've gone above and beyond for my aunt. When we sat there and we talked to the social workers and the care teams that look after her, it's a big difference in the care that you receive at Yale, versus the care in the community.

And not that we're not doing what we can. We're doing what we can in a community-based hospital. I can't say enough about my commitment to the community-based hospital, but I also think that this partnership with Yale would just make it such a more significant care to the community involved.

I think that seeing the care and the social workers that brings things step by step on what to look for and what you can do and what you can't

do, and the possible connections that you can make. I just think they have the ability to give you more.

I just -- I can't say enough. I really researched and, you know, took my time trying to find doctors and the right fit, and Yale University was -- by far blew everybody out of the water.

I really encourage you to approve this application because I think this is something that our community needs and we would be completely better off with the Yale University New Haven Health System becoming part of our community.

Again, I thank you for your time and I would, you know, really appreciate that you would encourage to approve to support this application today.

But my family business is here in our town. I'm not going anywhere, and I would love to see the care for my employees as well. It's something that my employees are always looking for in questions and comments. They're coming into our offices. You know, we have an open-door policy with our family, having a family business.

My three stores, I have over 500 employees

and we're always trying to get them the best care and try to help them and, you know, we're constantly using the services in our communities. And we just think that this would be a better fit for our families, of the people we care.

So thank you for your time and I really appreciate you just listening today.

THE HEARING OFFICER: Thank you.

And lastly, I believe we have Michelle Payton through Zoom, if she's still available?

Oh, there she is.

MICHELLE PAYTON: Thank you for allowing me a moment to speak. I actually had you guys on all day and I was listening, and I decided last minute that I wanted to share some information.

I have worked at Yale New Haven for 25 years and I've heard people talking about how great it's been working at their local delivery networks, their facilities. I completely agree with that.

You know, the people that I work here with, I would want no one else to take care of my children -- but I'm actually speaking as a mom from Beacon Falls. So I'm actually closer to the Waterbury Hospital than I am to Yale.

And when my daughter was little she had

passed out at the dentist, and the EMS refused to take us down to Yale. We had to go to either Waterbury or St. Mary's. So when a couple years ago she was 20 years old she actually ended up with cerebral venous sinus thrombosis. It was actually quite life-threatening for her.

And I refused to call EMS. I actually put her in my car and drove her down to New Haven, because I just refused to bring her to one of the facilities near where I lived.

So I greatly appreciate Yale coming up because I would like my family to have that access. By the time we came down to New Haven her images showed she was actually bleeding into her brain. She was lucky that it wasn't even a few more minutes later. We would have had to have surgery.

Thankfully she is graduating college this year, but I can't wait for Yale to actually acquire a delivery network that is near my home. I have a one and two-year-old at the house -- so we will be using more services as the years continue.

So thank you very much. I really appreciate the opportunity.

THE HEARING OFFICER: Thank you, Ms. Payton.

Did any of the people that I called earlier who haven't given statements, have they arrived? Are they available now?

(No response.)

THE HEARING OFFICER: Okay. I want to take just a two or three minute break to discuss a few things with the OHS staff.

And then we'll probably take a little bit longer of a break after that to hone the late files, and then we'll address the late files and do any closing remarks at that time. So I think probably everybody can just stay put. We'll be right back.

Just a reminder, the video will remain on, the sound will remain on, but the recording will be off.

(Pause: 4:14 p.m. to 4:21 p.m.)

THE HEARING OFFICER: So this is the hearing in Docket Number 22-32594-CON regarding the transfer of ownership involving Yale New Haven Health Services

Corporation and Prospect CT, Inc.

My understanding is that there were some members of the public who attempted to sign up but experienced some difficulty doing so. They appear to be on screen now, at least some of them. So we're going to accept into the record their statements now. If they can all just identify themselves, I would appreciate that.

We're going to start with the gentleman on the left, I believe.

We can't hear you, sir.

(Technical difficulties: 4:21 p.m. to 4:23 p.m.)

THE HEARING OFFICER: Pastor, if you can just state your name?

PAUL SINNOTT: Yes. Pastor Paul Sinnott, S-i-n-n-o-t-t.

THE HEARING OFFICER: Thank you.

PAUL SINNOTT: I'm a retired associate to the bishop for the New England Synod of the Evangelical Lutheran Church in America, and I speak on behalf of 77,000 Lutherans here in New England.

And I'm very much in favor of the buyout for a New Haven Health system. New Haven Hospital has

been providing a very robust clinical pastoral education program for hundreds of aspiring pastors through the years here in New England. And they've done an exceptional job at that.

It's my hope that in this buyout situation, that the CPE students could also work in some of these regional facilities where there's a great need, as there is everywhere, for spiritual guidance on the part of the clergy who are invited in to see their parishioners, who provide that kind of spiritual guidance and assurance for people who are in a crisis situation in the hospital, and almost everybody who's in the hospital who's in some kind of crisis.

I also am part of the Naugatuck Valley Project, and one of the things we've long advocated with Prospect is that we have a robust community benefits agreement. And that has not happened.

I understand that Yale New Haven Health has one for Yale New Haven Hospital, and I would like to see that happen in our region as well moving forward, and to have the Naugatuck Valley Project and our union representatives be represented on some kind of a community board that would be able

to address some of the concerns that those groups have.

So thank you again. It's been a long day for you guys, all of you. You've done a really good job. I was up this morning and watched all of your detailed work, and this public hearing has been the result of all that, that effort and attention to fine print.

So thank you very much for your time.

THE HEARING OFFICER: Thank you, Pastor.

So we're going to go back to the ECHN group again, if possible.

Can you try speaking? We'll see if we can hear you.

(Technical difficulties: 2:27 p.m. to 2:30 p.m.)

ELLEN SOLOMON: Good afternoon. Thank you so much for allowing us to speak on behalf of the transaction that Yale is proposing for Prospect Holdings. My name is Ellen Solomon. I am a senior accreditation and regulatory affairs specialist with the Yale New Haven Health System.

The Milford campus has always been an integral part of the Milford community. At the

time of the integration four years ago, I was at a 25-year history with the hospital and a lifetime in this community. The integration with the Yale Health System at Bridgeport Hospital provided the Milford campus the resources necessary to continue providing care to our city and the surrounding towns.

In addition to financial resources, the main campus of Bridgeport Hospital provided us with the seasoned leadership who guided us successfully through this transition and melded the cultures of both campuses. We just completed a successful joint commission survey where we're fully engaged.

And as my career sunsets, I am so proud that I am able to remain here at the Milford campus and provide health care to the community with the health and resources of the entire Yale Health System. Thank you very much for your consideration.

DOMINICK BUCCITTI, JR.: Hello, my name is Dominick Buccitti. I'm the Manager of Environmental Services at the Milford campus of Bridgeport Hospital.

At the time of integration in 2019, I've been with Milford Hospital for 26 years. Like a lot of

my coworkers, I was a little skeptical and didn't know what to expect. What I learned, it's been a great fit.

Although we're nine miles apart, we share a similar culture as Bridgeport Hospital and that feeling of being part of a team has continued to develop. Before the integration, the Yale New Haven Health System at Bridgeport Hospital made promises to me and my Milford colleagues about keeping our longevity, our benefits, and our jobs. It's meant so much to all of us that they've delivered on their promises and that Milford is thriving again.

I support this.

MICHAEL OREA: Good afternoon, my name is Mike Orea. I'm a carpenter and lead person in the facilities department at Milford Hospital, Milford campus, Bridgeport Hospital.

During my 45-year career at the Milford campus, formerly Milford Hospital, I've witnessed a lot of changes. I think most impactful of these occurred during the last four years since we integrated with Bridgeport Hospital. In 2019, the facilities and engineering team was struggling to maintain and prevent the failure of outdated

systems and equipment. Since then, Bridgeport Hospital and Yale New Haven Health Systems made significant investments in our physical plant and infrastructure.

These mechanical upgrades can contribute directly to staff and patient safety and include new boilers, chillers, the central sterile steam system, and new generators, to name a few.

But the COVID pandemic convinced me of the value of our integration. To see our institution and system work seamlessly and safely, to equip our hospitals and staff, to take care of each other and patients was quite amazing.

Recently, I've also noticed how busy we've become. It's good to see the patient rooms full again, and the operating rooms are busier than I have ever seen. The hospital is running like a well-oiled machine.

Thanks to Yale New Haven Health Systems and to Milford campus, Bridgeport Hospital, everything is running like a well-oiled machine. I am in support of this acquisition.

THE HEARING OFFICER: Thank you to all three of you for your statements and your persistence. I don't believe OHS has -- that concludes the public

comment portion of today's hearing. I don't think OHS has any questions based on the comments that were made.

We're going to take 20 minutes to go over the late files, and then we'll come back and we'll discuss those with everyone, and then we can do closing statements. We're also going to have to address the FTC RFP, that component as well.

So let's come back at four -- let's just say five, I guess. That will give us 25 minutes. So I'll see you back at five, and then we will wrap things up at that point.

(Pause: 4:35 p.m. to 5:05 p.m.)

THE HEARING OFFICER: Welcome back. This is the final component of the hearing in Docket Number 22-32594-CON, the hearing regarding the transfer of ownership of a healthcare facility involving Yale New Haven Health Services Corporation and Prospect CT, Inc.

We are at a point now where we're just going to go through the late-file submissions, and then if either of the attorneys would like to make a closing statement on behalf of their clients they

are free to do so.

So we're going to have Mr. Wang read them out one at a time. If you have any questions or concerns or you wish to discuss them, please feel free to address them as he reads them. So we'll start with number one.

MR. WANG: Okay. Roy Wang, OHS. I have eleven total late files. The first is breakdown of cost savings. As mentioned the 46 million at Lawrence & Memorial and the 638 million at St. Raphael's as described in some of the prefiled testimony; breaking down those financials to show the contribution of acquired hospitals versus affiliations. So that's one.

(Late-Filed Exhibit Number 1, marked for identification and noted in index.)

MR. WANG: Number two is statement of operations for Yale New Haven Health Systems and any affiliated hospitals through March 2023. So six months.

(Late-Filed Exhibit Number 2, marked for identification and noted in index.)

MR. WANG: Number three is the final --

MS. RINEHART: I'm sorry. Can you just pause there?

MR. WANG: Yes.

MS. RINEHART: So it's a statement of operations, not for the system generally, but just for the acquired hospitals?

MS. PIASCIK: Bozena Piascik. It's actually for the Yale New Haven Health Systems and the hospitals that are affiliates, Bridgeport.

THE WITNESS (O'Connor): It's the consolidated, but broken out by delivery network?

MS. PIASCIK: Yes.

THE HEARING OFFICER: And I'll issue a written order tomorrow, too, that contains all of these and if there's additional clarification that's needed you can always respond to that, and we can address it at that point.

MR. WANG: Okay. Moving on onto number three, final fiscal year 2022 audited financial statements for all three Prospect's CT hospitals and non-hospital entities that have an audited financial statement.

(Late-Filed Exhibit Number 3, marked for identification and noted in index.)

BY MR. WANG:

Q. (Wang) Number four is the service utilization data for both Lawrence & Memorial and Bridgeport Hospital separating out Milford Campus. The utilization data should include inpatient, outpatient, and affiliated service lines. So inpatient separated for DRGs, outpatient by CPT codes.

And the time periods for each hospital should include pre-acquisition services, one year post-acquisition or post-implementation of the four-phase integration plan, if that took longer than, say, one year, at the acquired hospitals.

And then three years post-acquisition for Bridgeport Hospital separating out Milford Campus again, and five years post-acquisition for Lawrence & Memorial.

A. (O'Connor) So I'm going to be clear again. This is Chris O'Connor. We do not have pre-acquisition data.

Q. (Wang) Sure.

A. (O'Connor) So we can only give you a baseline of, let's say, the first quarter post-acquisition, and then we can do the

three and five-year look.

Q. (Wang) Sure. Whatever you have available. I know we were discussing sort of what is available and is not.

A. (O'Connor) Okay.

MS. RINEHART: The other thing is that we had agreed to do an example hospital, and the example hospital was Milford. So I assume that's still fine?

BY MR. WANG:

Q. (Wang) So after further discussion about the types of hospitals that are being acquired and kind of the other discussions later on, after we had asked that question, we think that Lawrence & Memorial almost sort of represents what Waterbury might look like as an individual.

And then Bridgeport Hospital, having taken in Milford as a campus, will somewhat resemble the potential relationship between Manchester Memorial Hospital and Rockville General Hospital. So that's why we're asking for both, just to get the examples.

A. (O'Connor) Yeah, I'd caution on trying to draw any true comparison. They're very different communities, very different

hospitals with very different services.

So I -- I think we -- we can see what we can do.

Q. (Wang) Sure.

A. (O'Connor) But I think as I said earlier, when we were talking about this during the Q and A period, that Milford, with its just recency provides us the best opportunity to give you the most detailed information. So -- but if we can do the same for Lawrence & Memorial, we -- we will do that.

Q. (Wang) I appreciate that. And honestly it's to get the examples of the services. As you mentioned, you know, we want to examine your track record.

A. (O'Connor) Absolutely, yeah.

MR. WANG: So that's what we're trying to do here.

MS. VOLPE: And in the written late files that you're going to provide, can you note -- instead of pre-acquisition since they don't have it, that it would be the baseline for the first-quarter instead of pre-acquisition.

(Late-Filed Exhibit Number 4, marked for identification and noted in index.)

MR. WANG: Okay. Number five would be metrics on Yale New Haven Hospital System recruitment advantages or successes. Part of this late file can be submitted as part of the previous late file, as we had discussed during the questions.

Additional narratives regarding the placement of Yale School of Medicine faculty or NAMG clinicians, or specific recruitment successes such as the description of New London, or telehealth advancements can also be part of this late file.

(Late-Filed Exhibit Number 5, marked for identification and noted in index.)

MR. WANG: Number six is quality of care measures for Lawrence & Memorial and Bridgeport Hospital providing baseline measures and then quality measure trends post-acquisition.

(Late-Filed Exhibit Number 6, marked for identification and noted in index.)

MR. WANG: Number seven is narratives describing examples of achieved cost savings at acquired hospitals passing on to patients. And so I think

we were discussing the two types of savings that were passed, on then trying to break that down and get a clearer picture.

(Late-Filed Exhibit Number 7, marked for identification and noted in index.)

MR. WANG: Number eight is regarding the Manchester Memorial Hospital PET-CT scanner. We would like for the Applicants to provide information describing the current arrangement, the proposed services requiring the scanner under Yale New Haven Hospital Health System, if the, you know, application is approved, and that the equipment plan if approved.

So current arrangement, proposed services that will require it going forward and that the equipment plan for that machine.

MS. VOLPE: Can we also do a supplement so it's also included as part of the acquisition as well?

THE HEARING OFFICER: Yeah.

MR. WANG: So the CON acquisition of equipment supplement --

MS. VOLPE: So we have that service noted as already being provided.

MS. RINEHART: Yes, I think we had discussed that, but we will do both, both things.

(Late-Filed Exhibit Number 8, marked for identification and noted in index.)

MR. WANG: Number nine is separating and resubmitting any combined tables that contain ECHN data into Manchester Memorial Hospital and Rockville General Hospital specific tables.

We will be listing the three example tables that Hearing Officer Csuka mentioned during the question, but please provide it for all and any combined ECHN tables that were previously submitted.

MS. RINEHART: And again, we will look again, but we have confirmed that both, for projections, our model did not break out. So for the forward-going projections, they were done based on ECHN in Waterbury. There is no breakdown that we could provide.

And I think that for the things that they had breakdowns, they did provide them in terms of, like, the geographic race age, et cetera, and then some of them they could not. So we will just

confirm that we cannot provide that -- but I think the answer is, we can't.

THE HEARING OFFICER: Okay.

(Late-Filed Exhibit Number 9, marked for identification and noted in index.)

MR. WANG: Number ten and eleven are actually both the last two issues that we had posted to the portal for the prehearing issues. So the first is regarding the RFP.

It states, information and documentation related to the request for proposal or RFP process preceding the proposed acquisition that may include, but is not limited to asset purchase agreements, competing RFPs and presentations on the topic of RFPs given to the Connecticut Office of the Attorney General. That's number ten.

(Late-Filed Exhibit Number 10, marked for identification and noted in index.)

MR. WANG: And number eleven, again taken from the issues is applicants filings with the Federal Trade Commission related to this application and

any notices or documentation of approval from the FTC.

MS. RINEHART: So I think we can at least speak briefly to those two items, and maybe take them in reverse order. You know, we had a suggestion on how to handle the FTC AG piece of things and, Bill Aseltyne can provide a little bit more detail around that.

THE WITNESS (Aseltyne): Sure. We met -- as I think I said during the Q and A, we met with the Attorney General and the Federal Trade Commission in February of 2022, and we made a presentation which included data that ultimately was included in the Hart-Scott filing.

But based on what we heard you describe is the purpose for you review, we think providing that information -- if we can do that in executive session might answer any questions you have about that.

Again, it would have data about our market share as well as other health systems in Connecticut looking at the potential for transactions with the Prospect Hospitals.

MS. RINEHART: And it would be the same presentation that was given to the FTC and the AG's office. So

we would look to do that into executive session, because obviously this is not a confidential format.

THE HEARING OFFICER: So your preference would be to do that right now in executive session?

Or do you want to provide it --

MS. RINEHART: I think we would want to come back.

THE HEARING OFFICER: -- in a written form directly to us?

MS. VOLPE: Not in a written form.

MS. RINEHART: I think we would recommend coming back, because we don't have it ready today to share.

THE HEARING OFFICER: Okay.

MS. RINEHART: But we could come back for an additional session that would be closed and provide it that way.

THE HEARING OFFICER: Okay. I think that will work.

MS. RINEHART: Okay.

THE HEARING OFFICER: And we can coordinate when that can be.

MS. RINEHART: That's terrific. And I think they're going to propose essentially that, you know, that same time. And we cannot be present for their description of our due process except at the high level of the process itself.

So Michelle, do you want to add a little bit of detail around what you would propose as well?

MS. VOLPE: I think what we can do is share so you have some confidence that in the RFP process in terms of the selection on the preservation of provider diversity and patient choice, and talk a little bit about, you know, the other proposals to give you some assurances on that.

And we would propose we do that as well in executive session, you know, sort of at the same time, but different group, each back-to-back type thing.

THE HEARING OFFICER: Okay. That would be fine.

MS. VOLPE: Okay.

(Late-Filed Exhibit Number 11, marked for identification and noted in index.)

MR. WANG: And that concludes the list.

MS. VOLPE: We'd want to confirm in that executive session. Obviously, it would be confidential, not subject to FOIA.

THE HEARING OFFICER: Correct.

MS. VOLPE: And there would be no, you know, nothing in the record.

THE HEARING OFFICER: Right.
MS. VOLPE: Or transcribed.
THE HEARING OFFICER: Well, it will be transcribed, but it will say, executive session, confidential, et cetera.
MS. VOLPE: Okay.
THE HEARING OFFICER: I think we're required to do that by the FOI Act.
MS. VOLPE: We'll all look at that as lawyers. I'm not sure about that.
THE HEARING OFFICER: I mean, I'm not going to be posting it to the portal or anything like that, but I think we are required to keep some record of it.
MS. VOLPE: We can take that offline in terms of legal requirements on that.
THE HEARING OFFICER: Okay.
MS. RINEHART: We have one for follow-up clarification request on the quality metrics question.
THE HEARING OFFICER: Uh-huh?
MS. RINEHART: You said basically from the, you know, starting when we first did the acquisition application and then showing trends. Was there a specific time period? You know, obviously for Milford it's less than five years, but are you

looking for, you know, essentially, like, five years if we had it?

Or whatever we have for Milford?

MR. WANG: Exactly, yeah. Very similar to the fourth one on the utilization data. This would be three years post-acquisition for Milford and then five years whatever trend data you might have for L&M?

MS. RINEHART: Okay. Thank you.

MR. WANG: Thanks for the clarification.

MS. RINEHART: And the we can obviously talk about finding -- we would suggest three weeks if that is acceptable to you. Some of these data requests may be fairly numerous, and hopefully we can address the executive session piece in the interim and accomplish that as well.

THE HEARING OFFICER: That's fine with me. I was actually going to say four weeks given your comments on how difficult it was probably going to be -- it was probably going to be to pull together.

MS. RINEHART: If we need an extension we can let you know, but we think we can accomplish it in three weeks.

THE HEARING OFFICER: Just one thing I will note is Attorney Wang will probably not be present --

MR. WANG: I'm not an attorney.

THE HEARING OFFICER: Attorney?

MR. WANG: But I appreciate the honorary degree. Is that how that works?

THE HEARING OFFICER: Mr. Wang will probably not be present for the executive session. So just someone else may be present, is my point, a different analyst. Okay.

MS. VOLPE: Do we have the memo on the consolidation? Was that noted?

MS. RINEHART: Yes, that was.

THE HEARING OFFICER: Yeah, but that's not really -- I guess that's a late file, but it's more like legal in nature. I would think you can have until the same deadline, three weeks if that works.

MS. RINEHART: Yeah.

MS. VOLPE: Yeah.

THE HEARING OFFICER: So I'll write something about that in the order. It just won't be included as a late file, per se. Do you have any additional questions or concerns?

MS. RINEHART: No.

MS. VOLPE: I don't think so.

THE HEARING OFFICER: Okay. And did either one of you want to make a closing remark?

MS. VOLPE: I'll defer to Kim, if she would like to make one.

MS. RINEHART: I would like to defer to my client, Mr. O'Connor.

THE WITNESS (O'Connor): Well, I'll be very brief. I just want to say, thank you. Thank you for the diligence and the opportunity this afternoon -- well, all day, I guess, to spend focusing on this very important transaction.

As we've said all throughout, we believe that it's in the best interests of both of these communities to complete this acquisition and we're especially sensitive -- and I made sure in my comments to elaborate that, you know, it's -- it's a very difficult time in healthcare and that approaching this differently is going to be essential for our success in the long term.

So thank you.

THE HEARING OFFICER: Thank you. And thank you to everyone still here. And thank you to the public as well.

So that concludes today's hearing. As I mentioned, I'll be issuing an order tomorrow that includes everything that we just discussed. And thank you, so much for your time and your effort.

(End: 5:21 p.m.)

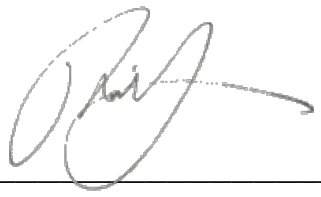
STATE OF CONNECTICUT

I, ROBERT G. DIXON, a Certified Verbatim Reporter within and for the State of Connecticut, do hereby certify that I took the above 280 pages of proceedings in the STATE OF CONNECTICUT, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF HEALTH STRATEGY PUBLIC HEARING, In Re: 22-32594-CON, YALE NEW HAVEN HEALTH SERVICES CORPORATION and PROSPECT CT, INC., TRANSFER OF PROSPECT CT, INC., HOSPITAL SYSTEMS (PROSPECT MANCHESTER HOSPITAL, INC. D/B/A MANCHESTER MEMORIAL HOSPITAL; PROSPECT ROCKVILLE HOSPITAL, INC., D/B/A ROCKVILLE GENERAL HOSPITAL; AND PROSPECT WATERBURY, INC., D/B/A WATERBURY HOSPITAL) AND IMAGING EQUIPMENT OWNED BY SAID HOSPITAL SYSTEMS TO YALE NEW HAVEN HEALTH SERVICES CORPORATION.; held before: DANIEL CSUKA, ESQ., THE HEARING OFFICER, on April 26, 2023, (via teleconference).

I further certify that the within testimony was taken by me stenographically and reduced to typewritten form under my direction by means of computer assisted transcription; and I further certify that said deposition is a true record of the testimony given in these proceedings.

I further certify that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

WITNESS my hand and seal the 10th day of May, 2023.



Robert G. Dixon, N.P., CVR-M No. 857

My Commission Expires 6/30/2025

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