STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

OFFICE OF HEALTH STRATEGY

MANCHESTER MEMORIAL HOSPITAL, INC. AND
SAINT FRANCIS HOSPITAL AND MEDICAL CENTER, INC.

ESTABLISHMENT OF DIAGNOSTIC CARDIAC CATHETERIZATION AND PRIMARY AND ELECTIVE PERCUTANEOUS CORONARY INTERVENTION PROGRAM AT MANCHESTER MEMORIAL HOSPITAL WITHOUT ON-SITE SURGICAL BACKUP

DOCKET NO. 18-32224-CON

FEBRUARY 27, 2019

3:10 P.M.

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. . .Verbatim proceedings of a hearing before the State of Connecticut, Department of Public Health, Office of Health Strategy, in the matter of Manchester Memorial Hospital, Inc. and Saint Francis Hospital and Medical Center, Inc., establishment of diagnostic cardiac catheterization and primary and elective percutaneous coronary intervention program at Manchester Memorial Hospital without on-site surgical backup, held at Manchester Country Club, 305 South Main Street, Manchester, Connecticut, on February 27, 2019 at 3:10 p.m. . . .

HEARING OFFICER MICHEALA MITCHELL: So good afternoon, everyone. This public hearing before the Health Systems Planning Unit of the Office of Health Strategy, identified by Docket No. 18-32224-CON, is being held on February 27 of 2019 to consider Manchester Memorial Hospital and Saint Francis Hospital and Medical Center’s application to establish a diagnostic cardiac catheterization and primary elective percutaneous coronary intervention program at Manchester Hospital without on-site surgical backup.

This public hearing is being held pursuant to Connecticut General Statute 19a-639a and will be conducted as a contested case, in accordance with the provisions of Chapter 54 of the Connecticut General Statutes.

My name is Micheala Mitchell. Victoria Veltri, the Executive Director of the Office of Health Strategy, has designated me to serve as the Hearing Officer in this matter.

My colleague, Olga Armah, is also assigned to this application, and then to my right is our general counsel, Demian Fontanella.

Additional staff who are present from the Office of Health Strategy are Leslie Greer and Juliet Manalan. Leslie and Juliet, if you wouldn’t mind raising your hand, so that everyone knows who you are? Thank you.

The Certificate of Need process is a regulatory process, and, as such, the highest level of respect will be accorded to the parties, the members of the public and staff. Decorum will be maintained throughout the hearing.

It is our priority to ensure that the integrity and the transparency of this process is --

basically, it's our priority that the integrity and the transparency of this process will be evident throughout the hearing.

Should any member of the public have questions or need assistance, just make sure that you raise your hand and that Ms. Greer or Ms. Manalan see you. They will be happy to come and assist you.

At this time, I just want to notify everyone that the hearing is being recorded, and it's going to be transcribed by Post Reporting Services.

All documents related to the hearing that have been or will be submitted to the Office of Health Strategy will be available through our CON portal.

Instructions to access the portal are on your information sheet, which was provided to you once you came in the room.

In making its decision, HSP will consider and make written findings concerning the principles and guidelines set forth in Section 19a-639 of the Connecticut General Statutes.

At this time, I'm going to ask Ms. Armah to read into the record those documents already appearing in HSP's Table of Record.

All the documents have been identified in

the Table of Record for reference purposes, with the exception of a few administrative concerns that counsel for the Applicants and I have discussed prior to the hearing, which I'll state on the record.

MS. OLGA ARMAH: Thank you. Good afternoon. My name is Olga Armah. I'm an analyst for the Office of Health Strategy.

At this time, I'd like to read into the record Exhibit A to Exhibit Q.

HEARING OFFICER: MITCHELL: Okay and I just want to note that, with regard to Exhibit J, the letters of support, those were uploaded by the Applicants back on December 21st of 2018.

They include comment from the public, patients, legislators and public officials. Included with that will be an additional letter that was submitted by I believe it was Mr. Doucette, Representative Doucette. I'm sorry. Correction on that. That's also going to be added to those public comments.

In addition, with regard to Exhibit O, I just want to note for the record that we included the Applicant's response to our list of issues and our request for pre-filed testimony, which was revised on February 21st of 2019.

We do note that the original was received by the due date on February 20th of 2019, but we needed to make a correction or, actually, a revision to that document before it was included in our Table of Record.

I also discussed with counsel, prior to the commencement of the hearing, Exhibits R, which is the designation of the Hearing Officer, which is myself, for this hearing, Exhibit S, which is OHS's ischemic heart disease and AMI discharge counts, and then, also, Exhibit T, which is a PowerPoint presentation that is going to be presented by the Applicants.

I do note that we agree that it will be electronically uploaded to the portal for the public's view, and I just want to ask counsel if I give you until Friday to do that? So that would be March 1st. Is that amenable?

MS. MICHELE VOLPE: Yes. Hi. It's Michele Volpe, counsel for the Applicant, ECHN.

For the record, that's acceptable. We'll have it downloaded in the portal by Friday.

HEARING OFFICER MITCHELL: All right. Any objections by either Attorney Volpe or Attorney Feldman with regard to the Table of Record being included?

MS. JOAN FELDMAN: No objection.

MS. VOLPE: No objection. Thank you for the clarification.

HEARING OFFICER MITCHELL: Thank you. All right, just give me one moment here.

All right, so, we are going to proceed as follows. The Applicant is going to present its Direct testimony, although we do have an addition to that.

I believe there's a legislative official that's here that's also going to speak, so, from what I understand, the order is going to be Mike Collins, Dr. John Rodis and then Senator Champagne. Got it right? I see counsel nodding their heads.

MS. VOLPE: Yeah. Hi. Michele Volpe again, counsel. We'd like to have the public officials be able to speak after Mr. Collins and Dr. Rodis, if that's okay, so we don't -- their time is valuable, and we don't want them to wait around too long for our presentation.

HEARING OFFICER MITCHELL: We can do that.

MS. VOLPE: All right.

HEARING OFFICER MITCHELL: And then I also note that Mr. Doucette is also here, too, Representative Doucette, so we will have you go after Senator Champagne.

After the Applicant has presented its

Direct testimony, we will ask questions, and then we will hear from the public, so, prior to taking testimony, I would just like all of the individuals, who are going to testify on behalf of the parties, to stand and raise your right hand, so that you can be sworn in.

(Whereupon, the parties were duly sworn in.)

HEARING OFFICER MITCHELL: All right and just a reminder. When you testify, just make sure that you state your name. If you have submitted pre-filed testimony, make sure that you adopt the pre-filed testimony.

If you use any acronyms, make sure that you identify what the acronym is before you state them, just for the clarity of the record and just so that people, who are here, who may not know what the acronym is, they understand what you're talking about.

So we will go forward with Mike Collins.

MR. MICHAEL COLLINS: Thank you. Good afternoon. My name is Michael Collins. I am the CEO of Eastern Connecticut Health Network, and I'm here to support the Certificate of Need application for a full service cardiac cath lab at Manchester Hospital. I also adopt my pre-filed testimony.

Thank you for this opportunity to come before OHS and present this application. What is most telling in this application is the significant documented support from the EMS community, the medical community, as well as the citizens of our surrounding towns.

Manchester Hospital is seeking to establish these services to respond to the needs of our community, specifically by providing a high-quality service, with greater access and lower cost.

We are committed to investing in service lines, as well as working with regional partners to address needed services, which we have done in the past, with the addition of 38 psychiatric beds in our system over the past three years.

We focus on the needs of our service area, specifically, the patients east of the river. There are many patients in our area that rely solely on ECHN for all of their healthcare needs.

We treat them in our affiliated Primary Care and Specialist Office, as well as our two hospitals and multiple outpatient access centers throughout our service area.

Despite the geographic distance to Downtown Hartford, some of these patients will not

electively seek care across the river and, in emergency situations, are forced to seek care outside of our system. We can do better than that for our community.

The application before you demonstrates the need for diagnostic cardiac cath, as well as elective and primary cardiac intervention.

I would also like to introduce the individuals here to present testimony in support of the application. John Rodis, the Chief Executive Officer of Saint Francis Hospital; Dennis McConville from ECHN, who will be giving the presentation on the public need for these services; Dr. Vashist from Saint Francis Hospital, who will speak to the clinical benefits and can respond to questions on the clinical and quality aspects of this program; and then the senior financial individuals from our respective institutions. To my left, Mike Veillette from ECHN, and Jim Harris from Saint Francis.

In addition to these individuals, we have other distinguished guests, who will include local cardiologists, interventionalists, physicians, EMS community leaders, local and state officials, our own ED leadership from ECHN and our hospital partner, Saint Francis. Thank you.

HEARING OFFICER MITCHELL: Thank you. And

we'll go forward with Dr. Rodis.

DR. JOHN RODIS: Good afternoon, Attorney Mitchell and OHS staff. My name is Dr. John Rodis. I'm the President of Saint Francis Hospital. It's my pleasure to be before you today to lend Saint Francis' full support to the proposed CON application for Manchester Hospital to provide diagnostic cardiac catheterization of primary and elective angioplasty services.

I appreciate your willingness to accommodate my schedule, as I have a Board meeting this evening, so I apologize, and I appreciate your accommodating my schedule.

I urge this Office to approve this application before it. Saint Francis has been serving the community for well over a century, offering a full array of hospital services. We're one of only three level one adult trauma service hospitals in the state, and we've recently been recognized as one of the top 250 hospitals in America by Healthgrades.

Included in our services are interventional cardiac services provided through Hoffman Heart and Vascular Institute.

Hoffman Heart is a well-recognized and

award-winning cardiac and vascular center, and we're proud of the patient outcomes of quality recognition that Hoffman Heart has received.

As you may know, Saint Francis Hospital and Manchester Hospital have had a long and collaborative working history, especially, but not limited to, the area of cardiology.

We've had a positive history of collaboration and oversight in our past provision of diagnostic cardiac catheterization services, and we currently collaborate in gynecologic oncology surgery, maternal-fetal medicine, occupational medicine and cancer Tumor Board services.

For years, Manchester's sickest cardiology patients were transferred or referred by Manchester Hospital to Saint Francis Hospital when the needs of Manchester Hospital's cardiac patients exceeded their capabilities.

When Manchester Hospital decided to pursue this application for the proposed angioplasty program before you today, it was only natural they chose Saint Francis Hospital, their preferred community partner, to provide the clinical support that they would need to pursue this clinical initiative.

We're committed to collaborating with Prospect ECHN and their provision of interventional cardiology services. We've worked with Manchester Hospital to come up with a sound clinical plan that would allow Manchester Hospital to provide the clinical services that they strongly believe their community needs.

We recognize that patients desire better access to cardiac services within their own community. Saint Francis sees the benefit of this collaboration, and while there will be some loss in volume, it will have no impact on the quality of the Hoffman Heart and Vascular Institute or any other program or service we provide.

Accordingly, as President of Saint Francis Hospital and Medical Center, I fully support this application and will commit the resources necessary to provide the support that Manchester Hospital needs, in order to fully successfully address the needs of their community.

Dr. Vashist, our interventional cardiologist, is here today to discuss how Hoffman physicians and staff will provide the necessary oversight for Manchester Hospital and how quality and provision services in that relationship between our two facilities

will be successful.

I think now we're passing it over to whatever your next is, but thank you so much again. I appreciate it.

HEARING OFFICER MITCHELL: All right, thank you.

(Whereupon, public comment was given.)

HEARING OFFICER MITCHELL: Okay, so, at this time, I'm going to actually go over to the Applicants. I didn't have counsel introduce themselves for the record, so if you'd just do that prior to introducing your witnesses? Thanks.

MS. VOLPE: I just want to make sure there aren't any other public officials in the room.

HEARING OFFICER MITCHELL: Oh, there is one.

MS. VOLPE: Thank you.

(Whereupon, public comment was given.)

HEARING OFFICER MITCHELL: We're going to turn it over to the Applicant.

MS. VOLPE: Thank you, Hearing Officer Mitchell. I'd like to introduce Dennis McConville. He's the Senior Vice President and Chief Strategy Officer for ECHN, and he's going to provide a presentation on the

need for the services that are before you today in our application.

MR. DENNIS McCONVILLE: Good afternoon, Attorney Mitchell, members of the Office of Health Strategy staff. My name is Dennis McConville, Senior Vice President and Chief Strategy Officer for Eastern Connecticut Health Network, and I adopt my pre-filed testimony.

What I'm going to cover this afternoon is an overview of the proposal that we've made in our application, and I'm going to look to address the issues that you've asked us to cover in this proceeding.

I'm going to start off with some context for the members of the community. This is the ECHN service area. It's 19 towns east of the Connecticut River, 347,000 residents, nine primary service area towns highlighted in yellow and 10 secondary service area towns in blue.

I have been doing the planning for Eastern Connecticut Health Network for 20 years, and this is the geography that I have focused on for all of our service line planning, community health needs assessments and plans and the medical staff development plans and physician recruitment.

ECHN is a very important economic partner for the region, provide almost 3,200 jobs. We paid $178 million in wages and benefits in 2018. We paid sales and property taxes of $5.1 million as a for-profit organization, a hospital tax of $8.4 million, and IRS-recognized community benefits of $23.7 million.

We continue to make those community benefit investments, even as a for-profit organization. Significant amounts of these benefits are directed towards addressing community health needs.

For heart disease, our focus for these efforts are in educating and addressing the determinants of heart health; blood pressure, smoking, diabetes, physical activity, nutrition and weight control, and we do that through a variety of means; lectures, health screening, support groups and subsidies. The subsidy for our diabetes program alone is $300,000 a year.

The Community Health Needs Assessment that we’re working from right now was conducted in 2016. These are the significant health needs that were identified through that study; heart disease and stroke, diabetes, cancer care, access to providers and behavioral health and addiction care.

I provide some detail here for the

behavioral health efforts, because we've made significant effort to try and address this community need. We've constructed an Eating Disorders Unit at Rockville General Hospital. It's a 30-bed unit. It's only the second of its kind in the United States, and we draw patients from beyond our state borders there.

A new Adult Behavior Health Unit was constructed at Rockville for 24 adult behavioral health patients last year.

We renovated a unit at Manchester to address a program that was sorely needed by our community, a geropsychiatry program. We have 22 beds that we opened a year ago for that service.

We're partnered with the Manchester Police Department for their HOPE program, with the Connecticut Community for Addiction Recovery to provide counseling services in our Emergency Department, and we're working on the Zero Suicide Initiative with CHR here in town.

Heart disease is the number one leading cause of death in the United States, in Connecticut and in our service area.

When we look at the mortality data published by the Connecticut Department of Public Health for ischemic heart disease and myocardial infarction, 10

area towns have higher mortality rates for coronary artery disease than the state average. Seven towns have greater averages, greater rates, excuse me, than the Connecticut average for ischemic heart disease, and seven towns have a greater rate of mortality than the state average for acute myocardial infarction, or heart attack.

We can safely offer more to address this critical need for the residents east of the river. Our proposal is that Manchester Memorial and St. Francis Hospitals offer cardiac catheterization services at Manchester Memorial, including diagnostic, elective PCI, or Percutaneous Coronary Intervention, and primary PCI procedures with the St. Francis Hoffman Heart Vascular Institute.

This will improve the health of our community, offer quality outcomes and reduce cost to the system. It’s a regional approach, improving access to a service that doesn’t exist in our community.

We would move from a 120-minute to a 90-minute target for emergency treatment for patients. We would be able to manage our patients within their network of care close to their providers, avoiding handoffs of patients and managing the cost of care.

We would also meet the recognized Best

Practice guidelines by the experts, and the Hoffman Heart Institute program, with its medical oversight training and quality program, would be offered here.

We have the number of physicians we need, with the required experience to staff both the lab at Rockville, excuse me, ECHN and Saint Francis.

We will be operating with research-proven selection and treatment protocols, and, in the end, we'll have a stronger, more formal system of transport for patients needing tertiary care.

We use the ChimeData from the Connecticut Hospital Association to make our plans and proposals. The ChimeData comes from all hospitals submitting their claims data each month. That data is scrubbed and corrected, and it's the most comprehensive and reliable dataset that we have, and what it shows for the State of Connecticut over the last four years is growth in all cardiac procedures that we're discussing today, and the overall average annual growth rate has been five percent during this time period.

When we look at our local trends, the ECHN service area, there's an overall 6.5 percent average annual growth rate in procedures.

There was some question about the volume

of procedures at Saint Francis. Information has been used from reports that are made with the financial filings each year, the report 450.

We rely on the ChimeData, because it is, as I mentioned, more accurate, scrubbed, validated and more reliable, and you can see that there's been a steady volume of procedures at Saint Francis. Overall, the average annual growth rate has been 7.7 percent. The issue with the report 450 is there are no uniform reporting standards.

As expected, there's been a shift of elective procedures to outpatient settings. We've been witnessing and experiencing this for years, and it's been no different with elective cardiac procedures. You can see that, over this five-year period, the outpatient growth has been 7.1 percent.

Advanced techniques, refined selection protocols have resulted in desired outcomes for patients being treated in outpatient settings.

Elective PCI procedures are safely performed in acute care hospitals without on-site surgical services, and it's important to note that, in 2017, 96 percent of patients needing an elective PCI received it at the time of their diagnostic

catheterization, and the reason I bring that up is because, in 2002, Rockville General Hospital and Saint Francis Hospital and the Hoffman Heart Institute received seal and approval for a diagnostic cath lab at Rockville.

We expected that we would perform 300, 350 diagnostic procedures a year, year-over-year, with the expected outcomes, and, from there, we could apply to modify our CON and start performing interventional procedures.

That didn't happen. We saw the volumes climb, the utilization was strong in the first couple of years, but then we saw it drop off, and we saw it drop off, because our cardiologists said it just isn't fair to take a patient to the cath lab, find a lesion, and then have to recover them and send them into Hartford for a second procedure. It's not right for the patient, it's not good care, and it's costly to the system.

So the procedure volumes for this proposal are, again, based on the ChimeData. We first removed the tertiary diagnosis. These are patients with diagnoses that would not be cared for at Manchester Memorial Hospital. They've had cardiac surgery, where their risks would be too high to be cared for in a site without on-site cardiac surgical backup.

We modeled that 41 percent of the elective procedures, which is our Emergency Department market share, would be performed at the Manchester cath lab.

For the STEMIs, the ST-Elevated Myocardial Infarction patients, the patients having a heart attack, we modeled that 75 percent of those primary PCIs would be performed at Manchester Hospital. This is a conservative projection, given that Manchester is closer to all towns than the hospitals in Hartford.

We would meet the best practice minimum thresholds with those projections. The Best Practice guidelines say that you should annually be providing at least 36, greater than 36 STEMI procedures and greater than 200 total PCI procedures as a cath lab.

We would be performing 85 STEMI procedures and 255 total PCI procedures, well above the minimum thresholds.

The other thing that’s important with this proposal is we’re not going to be creating any low, we’re not going to be ending up with any low-volume providers.

Saint Francis in Hartford, once we account for the shift of procedures, based on their market share, to Manchester, would be still providing three to five times the minimum required procedures.

The guidelines talk about geographic isolation. The travel time to a hospital the target is 30 minutes. The guidelines support that another PCI provider could establish a service if they're located more than 30 minutes away.

When you consider the drive time during the morning commute to Hartford, Manchester to Saint Francis is up to 40 minutes away in decent traffic and 35 minutes away to Hartford, so Manchester is geographically isolated for primary PCI.

More important is the geographic isolation of patients from the towns, in the surrounding towns. If you consider the drive times during the morning commute to Saint Francis, Hartford and Manchester from the center of the towns that we serve, 13 towns have travel times greater than 30 minutes to Saint Francis, 12 towns greater than 30 minutes to Hartford, and even four towns, or 31 to 34 minutes, away from Manchester. The patient population is geographically isolated for primary PCI. Manchester Hospital is the closest hospital to all the ECHN service area towns.

We talked about 30 minutes to get the patient to the lab. The standard target is 90 minutes door-to-balloon time. We were asked to provide the

median door-to-balloon time for all patients with STEMI that had primary PCI at Saint Francis for fiscal years ’15, ’16 and ’17.

You can see on the graph the blue bars. The times were 51 to 65.5 minutes, well within the 90-minute target.

When a patient presents to one of our Emergency Departments, we don’t have PCI capability, we tack on another 30 minutes to the target.

Our position is every patient deserves that 90-minute target and the opportunity to get to the cath lab and a device as quickly as possible.

You can see the range when you look at the median door-to-balloon times for the patient’s transfer to Saint Francis in those three years from our Emergency Departments that the median times were anywhere from 101 to 113 minutes, and some patients waited as long as 207 minutes for their treatment. Nineteen patients out of that dataset experienced times greater than 120 minutes.

In 2012, the Department of Public Health issued guidance to the EMS community and essentially directed EMS providers, where they had patients with STEMI or impending MIs, to be transported to the nearest PCI facility directly, so patients are transported

directly around our hospitals to the hospitals in Hartford.

The issue is 81 percent of the patients that come to our Emergency Departments come by car. We will always have patients present to our Emergency Department with STEMI or unstable angina.

So what have we done, in terms of improving door-in to door-out times in our Emergency Departments? We've made the collaboration between our hospital ED staff and the local EMS staff for timely transfers a focus.

We've provided ongoing education to those staffs. We've modified our STEMI guidelines for medication and testing, developed an order form to assure clear communication among providers, both in the field and at the hospital. We've made adjustments to nurse staffing to reduce door-to-medication times.

There are some important positive cost implications to this proposal. When we consider the patient mix for the patients, who would be served at the Manchester lab, and we consider what the payers would pay on average per procedure per patient for these procedures, comparing Manchester's average cost to Saint Francis' average cost or payment, I should say payment,

there's a savings of $2,900 per patient on average. That, in the first full year of this proposal, is a savings of $2.34 million.

When we look at and include years one, two and three of this proposal, as we're ramping up to that third year, the savings is $5.4 million less cost to the system over those three years.

We had tremendous public support for this application; our medical community, our EMS providers. I've met with leadership of all these towns; Manchester, Vernon, Andover, Coventry, Ellington and Tolland.

This is an access issue. When patients have to be transported into the City, that could be an hour, an hour and a half if they're away from their towns and unavailable to the residents of their communities.

It's also sometimes difficult for them to convince patients that they need to go Downtown when they have their providers here and they usually get their care here.

We had over 1,450 letters of support, signatures and testimonials from the community, elected officials, and we have a letter of support from Anthem for this proposal.

We were asked to provide written evidence

that patients would have their cath done at Manchester Memorial Hospital, so we surveyed 506 current and former cardiac rehab patients. We mailed those out and got 153 surveys back, a 30 percent response rate. Ninety-four patients said they would have their cath at Manchester, 57 said they would not, 61 percent, the majority, said they'd have their cath here in Manchester.

Interestingly enough, that's St. Francis' market share for cardiac procedures. Thirty-five percent is Hartford's market share for cardiac procedures, and this is based on 2017 data, and these are patients that have typically had cardiac surgery or an angiography, and we're not surprised that patients, who were treated at Hartford, are loyal to their providers and not surprised to see that 37 percent response. The takeaway is that patients would have their care here.

Back to the ECHN service area. As I described, the 19-town service area that we've been using for planning. I should point out that, in recent and past CON applications, the Office of Health Care Access has essentially confirmed that this is our service area.

During the first round of completeness questions, it was suggested that this proposal would only treat eight towns, as you see shaded I guess it would be

in pink here.

That excludes three of our primary service area towns and eight of our secondary service area towns. That excludes 100,000 residents. Almost 1,500 persons used our hospital's Manchester and Rockville Hospital in 2018 from these towns, and, for the employed primary care physicians of ECHN, that would exclude over 5,000 patients that are regularly cared for from these towns by our doctors.

When we include the drive times, the transport times, you can see that these are the geographically-isolated towns, and there is no other program and service offered in the northeast quadrant of the State of Connecticut.

So, with that, if we do the calculations for the care or the number of procedures that would be performed in the modified service area using the capture rate for ED patients in those eight towns, it's 48.5 percent. Applying that to the elective procedures available in the market, that would be 140 procedures.

When we add the 75 percent of the STEMI procedures that existed in that service, in the service area of those eight towns, it would be 65 more PCI procedures.

In total, we would meet the minimum thresholds of greater than 36 for primary PCI and greater than 200 annual procedures for total PCI.

One of the main reasons that the Board of Trustees of Eastern Connecticut Health Network selected Prospect Medical Holdings as its acquire in 2016 was Prospect's experience of population health management.

Prospect aligns its hospitals and its physicians in independent practice groups in a system of care called Coordinated Regional Care.

The Prospect provider group is the Connecticut IPA. We have over 300 providers and over 50,000 attributed lives.

The CRC staff has been very busy standing up programs in the community, care management programs for residents of our community. They have a Transitions of Care program that addresses patients, who are discharged from the hospital, to ensure that they have the right contact and the right resources, so as not to be readmitted to the hospital and recover at home.

They have a Comprehensive Care Management program, where they assess patients for risk, patients with chronic illness that are cared for by our physicians and other providers to ensure that they have the

resources they need to get the best possible care in the lowest cost settings, again, at home.

We have an Emergency Department Care Management program, where we identify patients, who are regularly using our Emergency Departments for primary care, making sure that we can connect those individuals with primary care providers, so as not to use the high cost care of resources of the Emergency Department.

And then we have a Post-Acute Community Care Management program. The CRC staff meets with clinical leadership of various skilled nursing facilities, again, to make sure they have the care plans, treatment and resources to keep them well where they live.

There are many quality programs associated with the various value-based relationships, risk-based relationships we have with the payers. They're all focused on adherence to specific chronic condition preventative measures that are evidence-based.

I would have to provide you about four or five slides, lists of those, if I were to include them. There are so many.

We are asked about the value-based relations that we have with payers. We've been very

active in pursuing risk-based arrangements, value-based arrangements with both governmental and private payers. We participate in the Person-Centered Medical Home Plus program, State of Connecticut, the Community and Clinical Integration Program, and the CCIP Program.

We participate in a Medicare Next Generation Accountable Care Organization under the CMS program. It's called Prospect ACO Northeast. It includes all of the Connecticut providers in the Prospect system, as well as our Rhode Island providers and the patients attributed to those providers.

We have value-based arrangements with Anthem, Aetna, Cigna, ConnectiCare, WellCare and Care Partners of Connecticut. We are aggressively and actively moving towards risk-based payer arrangements.

This proposal distinguishes itself from other CON proposals looking to provide these services. It meets the statutory CON application criteria, consistent with the statewide Health Care Facilities Plan. It meets the Best Practice guidelines. It addresses public need where no providers exist. It improves access, preserves choice, and it relieves the emotional burdens of patients that live east of the river.

I've lived here all my life. It isn't until you live here and you talk to people that you realize they don't like going across that river. As many bridges as you might put, we don't like to go there.

It will not result in unnecessary duplication of services. It will be the Hoffman Heart and Vascular Institute program offered here, without diffusion of the professional expertise.

It doesn't threaten the best practice volume of others. There will be no low volume providers as a result of this proposal. It's not a partial service center. It's a full service catheterization lab.

It's financially-feasible, it's cost effective, and the quality of the healthcare delivery will not be compromised. It will be improved, not just for emergency patients, not just for patients with STEMI, but it allows patients to stay within their system of care with their providers, who they're familiar with and trust, near their families, but yet we can still have a more formal system of care with a renowned tertiary provider for patients, who are a higher risk or that need services that would not be provided at Manchester Hospital, namely, cardiac surgery.

MS. VOLPE: I'll leave it to Hearing

Officer Mitchell if you want to go out of order. I know we have some other public officials, who joined us. If we want to offer them an opportunity to speak now, or, if you'd prefer, we'll continue with our testimony.

HEARING OFFICER MITCHELL: If you believe that it's not going to affect the flow.

MS. VOLPE: Disrupt? No.

(Whereupon public comment was given.)

MS. VOLPE: We're going to have Dr. Vashist speak now.

DR. ASEEM VASHIST: Good afternoon, Attorney Mitchell and OHS staff. My name is Aseem Vashist, and I'm a Board Certified and fellowship-trained cardiologist specializing in interventional cardiology.

I appreciate the opportunity to speak to you today on behalf of Trinity Health of New England and Saint Francis Hospital and Medical Center in support of the application that's before you.

My C.V. is attached for your ease of reference. I adopt my pre-filed testimony as my own.

As stated in the application, our Saint Francis Hospital Medical Center interventional cardiology team is prepared to provide Manchester Memorial Hospital with the necessary clinical and operational expertise and

support to establish and maintain a cardiac catheterization laboratory with the capability of providing not only diagnostic cardiac catheterization, but, also, primary PCI and elective PCIs.

In providing our clinical support, we are committed to adhering to the same evidence-based clinical standards that it adheres when providing services at our own institution.

I'm happy to answer any questions Attorney Mitchell and OHS staff may have with respect to the role of Saint Francis Hospital and Medical Center in supporting the Manchester Memorial Hospital cardiac catheterization laboratory and this clinical endeavor. Thank you.

MS. VOLPE: Now we'd like to offer financial testimony. Next, we're going to have a representative from Saint Francis. Mr. Harris is going to adopt his pre-filed testimony. If you can step over here to this spot for me? Thank you.

MR. JAMES HARRIS: Good afternoon. My name is James Harris. I'm the Regional Director for Trinity Health of New England. Trinity Health of New England comprises of five hospitals, four acute hospitals, Saint Francis Hospital being the largest

hospital within our system.

Saint Francis Hospital is also the largest hospital in New England, largest Catholic hospital in New England. Sorry.

I'm here to adopt my testimony as my own. I will offer any type of financial questions that you may have for Saint Francis associated with this application, and Saint Francis supports this application.

MS. VOLPE: I'd like to introduce Mr. Veillette. He's here on behalf of ECHN. He is the Chief Financial Officer, and I'll just remind him to adopt his pre-filed testimony.

MR. MIKE VEILLETTE: Good afternoon, Attorney Mitchell and other members of the Office of Health Strategy staff.

My name is Mike Veillette, and I adopt my pre-filed testimony. I am, in hospital segment, Chief Financial Officer for the Northeast Region of Prospect Medical Holdings, Inc.

I currently oversee financial operations at Prospect Medical Holdings, Rhode Island and Connecticut hospitals, which include Manchester Hospital and Rockville Hospital.

First, the proposed services will have a

positive impact to the Manchester hospital system. Community hospitals, such as Manchester, have a significant financial burden of offering a full range of needed services, without the economies of scale and resources of a large hospital.

Our financial team at Manchester Hospital has carefully reviewed and vetted all the projections used throughout the application.

Although there are some startup costs associated with outfitting the physical space, as well as costs associated with staffing and coverage, we will still operate with a financially-positive result. Overall, there are no financial concerns with the proposal.

Second, the revenue from these services enables the hospital to offset the cost of other vital healthcare services in the community. ECHN can continue to invest in needed services in the community, such as behavioral health, without passing costs onto patients, payers, or other healthcare stakeholders.

Third, Manchester Hospital will be a lower cost provider of cardiac services. This is supported by our evidence that our cost per adjusted equivalent discharge are lower.

Our patients have access to lower cost services at Manchester Hospital. This is set forth in our financial projections on the cost of cardiac services. Lower overall costs translate to lower costs for patients and all healthcare stakeholders.

Lastly, we have worked closely with Saint Francis during this process to review the financial impact to their program.

Our analysis indicates that Saint Francis' cardiac program will continue to operate with an overall positive financial gain.

Along with my colleagues, both from Manchester Hospital and Saint Francis, I respectfully request that the Office of Health Strategy approve this application in full. Thank you.

MS. VOLPE: That concludes our testimony, and we welcome questions from OHS at this time.

HEARING OFFICER MITCHELL: Okay, so, unless there are other elected officials in the room -- any?

We're just going to take a brief break to review our questions. Some of them you addressed, and, so, we just want to make sure we're not asking you questions that you've already answered, so we're going to

take a break until 4:30, and then we'll come back.

MS. VOLPE: Hearing Officer Mitchell, I think there are individuals from the public that would like an opportunity to speak. I'll defer to you whether you'd like to hear them now, prior to your questions possibly, so we don't have to keep them.

HEARING OFFICER MITCHELL: So what we'll do is we'll take the break until 4:30, and then I will let a few people go. Does that sound fair to the public? Everybody is looking. Okay, so, we'll do that.

MS. VOLPE: Thank you.

HEARING OFFICER MITCHELL: We'll come back, and we'll take a few people.

MS. VOLPE: Very good. Thank you.

HEARING OFFICER MITCHELL: Thank you.

(Off the record)

HEARING OFFICER MITCHELL: So before OHS asks questions, we are going to take some comments from the public, and each person, who wishes to speak, should have, you know, written their name on the sign-up sheet that was provided by Ms. Greer, who is sitting in the front with the purple blouse and black blazer.

We're going to call people up in the order in which they signed up, with elected officials coming

first.

While speaking, we just ask everybody to keep their comments to three minutes, and I just want you to know we strongly encourage you, if you would like to, to submit any further comments to OHS by e-mail or mail no later than March 6th of 2019.

If you're interested, our contact information is on our website and on the public information sheet that you were provided when you came to the hearing today. Thank you for taking the time to be here.

(Whereupon, public comment was given.)

HEARING OFFICER MITCHELL: At this time, we're going to ask a few of OHS's questions. We're not going to ask them all. We're going to break them up, and then we will get back to the public comment.

MS. ARMAH: Thank you. Attorney Volpe, I'm not sure who is going to answer the questions, so, when I pose them, then you can decide on who will take the question.

MS. VOLPE: Very good. We appreciate that.

MS. ARMAH: Thank you. The first one is explain why Manchester Hospital has chosen to apply for

primary and elective PCI programs, as opposed to just a primary PCI program.

MR. McCONVILLE: My name is Dennis McConville.

A cath lab that would only provide primary PCI is not sustainable. A cath lab with diagnostic procedures and primary PCI we know those exist in other parts of the state, but we know from our firsthand experience at Rockville General Hospital, in partnership with Hoffman Heart and Saint Francis, that our cardiologists have made it clear, and they've done this through their clinical decision-making, they want to see that a patient that's undergoing a diagnostic procedure has the opportunity to have that lesion treated, should there be one discovered.

So we believe that the best possible option for care for heart disease in this community is to offer a full service program.

HEARING OFFICER MITCHELL: May I just? I'd like to ask a follow-up question. When you said it's not sustainable, can you clarify what you mean by that?

MR. McCONVILLE: Well if we just offered PCI, we're talking about, in the course of, with the projections that I had presented, talking about in the

third year 85 PCIs, we have to train a staff that are skilled and experienced, and that volume of procedures needs to be accompanied by regular diagnostic procedures, as well as other PCI procedures. We think that the best possible quality of the program will exist with all of the volumes that we have projected.

It's about quality. It's about the cost of the care for these patients, and, again, just doing 85 procedures we don't think is appropriate.

MS. ARMAH: Okay. Elective PCIs are scheduled procedures and not as limited, in terms of time or distance, as opposed to primary PCIs. Why is there a need for an elective PCI program at the hospital since patients can access any of the five providers in the north central region, including Hartford and Saint Francis Hospital, for their procedure within the ideal 48-hour treatment window?

MR. McCONVILLE: I think you've heard here repeatedly that we are geographically-isolated from those programs, the distance of travel, and, again, if we were to just offer a diagnostic procedure to our patients, without the PCI capability that we're proposing, the program would have very limited volume, and we would not achieve what we are setting out to achieve, and that is

local access to a service that's not currently available, that's needed by residents of this community, that's more cost effective and would be as high a quality as one might expect.

MS. ARMAH: As a follow-up to that, page 412 of the application indicates --

MS. VOLPE: Okay. I'm sorry. Can you repeat the page? I'm sorry to interrupt you. Can you repeat the page that you're referencing?

MS. ARMAH: 412.

MS. VOLPE: 412. Is that the Bates stamped page?

MS. ARMAH: Yes.

MS. VOLPE: Would you like us to refer to it now?

MS. ARMAH: Yes, you can refer to it right now.

MS. VOLPE: Okay, thank you.

MS. ARMAH: On that page is a definition of geographic isolation, which is if the emergency transport time to another facility is more than 30 minutes, so how does that impact emergency, I'm sorry, elective PCIs?

MR. McCONVILLE: Excuse me. I'll be right

there. So you can see from this exhibit that, at certain times of the day, the program at Manchester would be greater than 30 minutes away to the nearest PCI-capable hospital and, therefore, geographically isolated.

Now these are the typical drive times and the ranges of typical drive times. For those of us that have traveled into Hartford on any given day, they can be even greater than this in the outer limit.

MS. ARMAH: So that's relevant to primary PCI. My question was how does that affect elective PCIs?

MR. McCONVILLE: The issue for us is really, you know, access cost and the time to a PCI.

MS. VOLPE: I don't want to testify for my client, but I think he does want to -- we do want to point out that there were a number of cardiologists, professionals in the room, that explained the importance of being able to offer that elective procedure at the time the patient is having their cardiac cath.

It's the most cost effective means of doing it, and it provides the best quality and outcome, so I think it's important not to separate those out.

I think, if the Department were taking the position that to have that procedure done at the same time they're having their cardiac cath would be

considered an emergent procedure, then I think we're all, you know, we would all agree, but if you're viewing that as an elective procedure, I think that the point is in the literature, you know, is documented. There are a lot of medical professionals in the room that would attest to that.

MR. McCONVILLE: Again, you know, we provided the statistic that 96 percent of the patients undergoing a diagnostic procedure would have their PCI procedure at that time of that test.

They would not be recovered and put through another procedure, so, to Attorney Volpe's point, if a lesion was found in the course of a diagnostic procedure, one could consider that an urgent condition for therapy.

MS. ARMAH: The experts indicate this 24 to 48 hours for the patients to receive the PCI if it's unelected.

MR. McCONVILLE: So that would incur a second -- that would mean a second procedure. That's correct. So that would be more costly, and it would expose the patient to the risks of a second interventional procedure, which we understand is not good practice.

MS. ARMAH: Okay, thank you.

MR. DEMIAN FONTANELLA: Just two quick follow-up questions. Could you explain briefly what those risks and the likelihood of those risks with having a follow-up elective procedure would be?

DR. VASHIST: Would you repeat the question again?

MR. FONTANELLA: Could you briefly explain what the risks for having a follow-up elective procedure to the primary PCI would be and what the likelihood of those risks are?

DR. VASHIST: They could be not necessarily classified as risks. They could be a procedure that’s done, and, when we do a procedure on an angiogram, we access the arteries, and we have to stop the procedure, which means we have to either seal the artery or leave the sheath in and then transfer the patient emergently or on an expeditious manner, so those might be some of the considerations, in terms of doing a diagnostic cath first, and then they have to restart the procedure again.

So let’s say we did seal the artery up in an institution that does not have PCI capabilities and said, well, we’ll do this procedure on another day, then

the first component of the procedure has to be repeated again, which means you have to re-access the artery again, retake the pictures again, and then perform the procedure, so, technically, that wouldn't necessarily qualify as a risk necessarily, a medical risk necessarily, but it does lend itself to repeat of that part of the procedure. It would require a duplication of some sort of that effort.

MR. FONTANELLA: Thank you.

MS. VOLPE: And it would increase the cost. I thank that's -- that's an important key factor, I mean, for all healthcare stakeholders, right, is cost, as well as access.

HEARING OFFICER MITCHELL: Just a follow-up with regard to the PowerPoint, the times with regard to geographic isolation, and, just for reference, this is Exhibit T, and you actually had it on the right. It looked like it moved. Yeah, that one.

When I look at this, it looks like this was accessed on February 24, I'm sorry, February 14 of 2019, and then you have the typical, so that was for the drive time on February 14 of 2019, and then you have the typical drive time, and then it basically says Google maps, typical drive time departing. Was that a function

of Google maps?

MR. McCONVILLE: Yes.

HEARING OFFICER MITCHELL: Okay. I just wanted to make sure I was clear on what period of time that was.

MR. McCONVILLE: Correct. It was the same time, and that's a function that you can access at the time that you're looking for the driving directions.

HEARING OFFICER MITCHELL: Does it give you the average, I guess the period of time that it's considering?

MR. McCONVILLE: You can set, you can change the departure times, and changing the departure times result in a different typical drive time window.

HEARING OFFICER MITCHELL: Got it. Okay, thank you.

MR. FONTANELLA: One last quick request. I guess not really a question, per se. Do you have the ability to give us some numbers of, for instance, statistics on the admit time for patients that would be subject to this service, so we can get an idea what time the typical patient of day, what time of day the typical patient would be needing these services?

MS. VOLPE: Yeah. I want to make sure we

understand the question.

MR. FONTANELLA: So I'll rephrase.

MS. VOLPE: Yeah.

MR. FONTANELLA: So for the patients that would be receiving this service, if this is approved.

MS. VOLPE: On an elective basis? I mean you've been talking about --

MR. FONTANELLA: Both. Both. Primary and elective.

MS. VOLPE: Well, I mean, if it's primary, it's an emergent, it can be any time of day.

MR. FONTANELLA: I'm asking historically. What is the admit time? You've repeatedly cited, understandably, the traffic, the timing, rush hour. I'm wondering what time the average patient is coming in for these services.

MS. VOLPE: Well we don't have the services now. I want to make sure we're understanding your question. You mean when they present an evidence at the ED, whether by ambulance or they drive themselves?

MR. FONTANELLA: The patients that you're contemplating to be treated at Manchester.

MS. VOLPE: Correct.

MR. FONTANELLA: That are being diverted

currently.

MS. VOLPE: Yes.

MR. FONTANELLA: What time are they currently, in say the past year, have presented and have had to be diverted?

MS. VOLPE: Oh, you mean in our emergency room?

MR. FONTANELLA: Yeah.

MS. VOLPE: Because, I mean, from the ambulance perspective -- I think they left. You know, if they know somebody is experiencing cardiac issues, it's mandated by the State of Connecticut that they bypass us, so if we're talking about -- we can look in our discharge information if somebody presented at our ER, as to what time of day they presented at our ER with a cardiac issue. Is that what you're asking?

MR. FONTANELLA: We're just trying to get a grasp on the scope of the commute issue on the patient population.

HEARING OFFICER MITCHELL: Hold on one moment. I just want to make sure that I understand who is testifying. I understand that you gave public comment. Is this a witness for you, Attorney Volpe?

MS. VOLPE: Did you want him to get sworn

in? Would you like to get sworn in?

HEARING OFFICER MITCHELL: So he's going to be your witness?

MS. VOLPE: If he can be responsive to your question, absolutely. I mean we really want to make sure we get all of your questions answered today, and, you know, to the extent that you have an issue, as to why you think this application should not be approved, we want to hear from you today and we want to address it, so, absolutely, we'd like to get him sworn in.

HEARING OFFICER MITCHELL: So you were sworn in? You stood up?

DR. ROBERT CARROLL: I did.

HEARING OFFICER MITCHELL: Okay, just state your name again for me, just for me.

DR. CARROLL: Sure. Dr. Robert Carroll, Chair of the Emergency Departments.

HEARING OFFICER MITCHELL: Thank you. Got it.

DR. CARROLL: So I believe the question was the typical time of day when these services would be needed. We have a pretty standard volume curve of arrivals through an Emergency Department, and Manchester is no different than Hartford, Saint Francis, Waterbury

and the rest.

The arrivals start to increase around 7:00 a.m., they peak around 11:00 a.m., and they remain in a pretty steady state until about 8:00 at night, where they start to dip down, and they nadir at about 2:00 or 3:00 in the morning, so the typical time we would expect the highest volume is between, say, 9:00 a.m. and about 9:00 p.m. There's no window for heart attacks that occurs within there, but that is the busier time of the day.

MR. FONTANELLA: Thank you.

DR. CARROLL: You're welcome.

MS. VOLPE: Was that responsive, Attorney Fontanella?

MR. FONTANELLA: Yes.

MS. VOLPE: Thank you.

MS. ARMAH: Please turn to page 596 of the application. Now this is the guidelines, the expert guidelines, and it indicates that the PCI program without on-site surgery should be established only in areas where access to programs -- where surgical backup is lacking and competition with another PCI program in the same geographic area, particularly an established program with surgical backup, may not be in the best interest of the community.

How do you reconcile that statement with your request to establish a primary and elective program within 30 minutes' radius of Hartford and Saint Francis?

MS. VOLPE: I mean, first, I guess we would dispute the fact that we're in the same geographic area. I mean that's what a lot of the questions were before, but, having said that, if you can repeat it, we'd like one of our medical experts to address it.

MS. FELDMAN: Yeah. Joan Feldman on behalf of Saint Francis Hospital and Medical Center.

We're just going to take a second to review that page, and then we'll get back to you.

HEARING OFFICER MITCHELL: While you're doing that, is it okay if we call someone up to give public comment?

MS. FELDMAN: Sure. If you could just restate the question one more time, so, as we're reviewing it, the doctor can focus on the answer?

MS. ARMAH: Well the section indicates that if you're bringing a program into an area that already has a program, which is within 30 minutes' drive, it's not in the best interest of the community, so I want you to reconcile that statement with the fact that --

MS. FELDMAN: Got it.

(Whereupon, public comment was given.)

HEARING OFFICER MITCHELL: Okay, we're going to turn back to the Applicant. Did you need us to go over the question one more time, or are you all set?

DR. VASHIST: No. We're okay.

HEARING OFFICER MITCHELL: You're all set? Okay.

DR. VASHIST: So I would like to read out the appropriate and quote the document, which states that it is, and I quote, "It is only appropriate to consider initiation of a PCI program without on-site cardiac surgical backup if this program will clearly fill a void in the healthcare needs of the community."

I will take that to believe that, with all the testimony that we've heard from all the physicians, and I'm going to let Dennis also chime in, whether that would probably be the void that needs to be filled by this cath lab, and, so, I would leave it to Dennis to take it from there, but that, I think, is what is probably meant by that interpretation there.

MR. McCONVILLE: I believe we've demonstrated there's clearly a void and clearly a need within this community for local access to these services, you know, beyond the 30-minute time frames that we've all

been discussing here.

I'd like to finish with or state the next sentence that's in this section of the reference. "Competition with another PCI program in the same geographic area, particularly an established program with surgical backup, may not be in the best interest of the community."

We're here today with just such a program, because both organizations feel that this is not about competition. This is about what's best for the community that we both serve here east of the river.

We're going to provide more timely and comprehensive access to program and services together, so this is not about competition, and I think it's important to reference that.

If this was about competition, then I could understand where there might be an issue, but we are both, as organizations, understanding what the benefits will be to this community if we offered the service together.

MS. VOLPE: There's no reference to the 30 minutes on this page, and I think, to speak to the competition issue, you know, it says, it says, unless the program will clearly fill a void, and I think we've heard

a lot of testimony here today that says it certainly will fill a void.

And I think the other important point to note is you can't pick anything out in isolation on these guidelines and these national quality guidelines.

I mean you're also not going to be diffusing expertise and experience, and we're not surrounded by any low-volume providers, so I think this application can be distinguished from other applications before OHS.

I know you don't rely on precedent, but this is clearly distinguishable, because we are not surrounded by low-volume providers in this greater region.

MS. ARMAH: Patients in the area are currently receiving care in Saint Francis or Hartford Hospital, so to say there's a void it's not very clear how there's a void, because patients are already receiving care in Saint Francis and Hartford Hospital.

MR. McCONVILLE: So there's a burden to those patients to have to get their care at Saint Francis Hospital and Hartford Hospital, and you've heard plenty of testimony with respect to that already, but in the case of a patient, who needs an emergent procedure for

primary PCI, there is a void. There's an extra 30 minutes added onto the target to get these patients to a device and open that coronary artery. That is clearly a void.

If it were me and I live in Manchester, I want my care here. I don't want to risk another 30 minutes to get into the City for my care, and I don't think there's anybody in the room that would take a different position from that.

MS. ARMAH: So in line with that, on pages 1241, 1242 and 1280 --

MS. VOLPE: Is this from our completeness questions? Is that where you're referencing?

MS. ARMAH: Yes.

MS. VOLPE: Okay. Thank you. Is there a specific question that you want to direct us to?

MS. ARMAH: Yes. I am going to. So we see on those three pages, one, that, at St. Francis Hospital, about 18 patients between 2015 and 2017 exceeded a recommended time of 120 minutes. Those are patients transferred from Manchester to Saint Francis.

Now patients, who also arrived directly at Saint Francis Hospital either by EMS or private auto, also exceeded the recommended 90 minutes. There were

eight in 2015, two in ’16 and two in ’17.

Is it possible that, even if Manchester had a primary PCI program, that the hospital could still exceed to the recommended time?

MR. McCONVILLE: I don’t believe so.

HEARING OFFICER MITCHELL: Why?

MS. ARMAH: Why?

MR. McCONVILLE: Because we are that much closer to the patients than patients that are traveling into Hartford for these procedures. Restate the question again, please. I want to make sure that I understand it clearly.

MS. ARMAH: I’m saying that transferred patients at Saint Francis Hospital exceeded the time, so that’s one of the arguments you’re making that you need a program at Manchester.

Now patients that arrive directly at Hartford Hospital, some of them also exceed the 90 minutes’ time, even though they are arriving directly at Saint Francis Hospital.

MR. McCONVILLE: There’s always the chance, but I do not believe that would be the norm. You know, of the 280 patients, who received primary PCI at Saint Francis over those three fiscal years, 12 patients

exceeded the 90-minute time frame. I don't know by how much.

In the course of that same time period, for the patients that were transported from Manchester and Rockville Hospitals to Saint Francis for PCI, 71 patients in total, we had 19 patients that were beyond 120 minutes, so, clearly, by having closer access to this program, more patients will receive their care in a more timely manner.

MS. ARMAH: The numbers at Saint Francis Hospital were actually declining pretty steady in 2015.

MS. VOLPE: Yeah. Can you let us know what --

MS. ARMAH: Oh, I'm sorry. Page 1280, 1-2-8-0.

MS. VOLPE: 1-2-8-0.

MS. ARMAH: 1-2-8-0. So that actually shows improvement.

MR. McCONVILLE: Yeah, so, there is some incremental improvement, but we're still using 120-minute door-to-balloon time. Patients deserve 90 minutes. They deserve the same target that the experts agree patients should be subjected to, because they stop -- and, again, the EMS protocols have certainly influenced this. I

believe that, but 81 percent of the patients that come to our EDs come by car, so we will never capture and there will always be patients, who will show up at our Emergency Departments, and, without this PCI capability, they're going to -- there are going to be delays in their care.

We want the same standard for the patients from these -- for these patients in our communities. We don't want the extra 30 minutes attached to the targets.

MS. VOLPE: And just to add to that, from our perspective, I mean, if we're providing greater access at lower cost with the same quality and the volume and utilization is there to support it, we need to understand, you know, why it wouldn't be approved, because that's what we're here to talk about.

It's greater access at lower cost, with the trend showing up, with the same quality, and there's no diffusion of providers, and there's no movement from low volume providers, so everyone can sustain high-quality numbers that are required under national guidelines, so we want your questions. We want to know why.

MR. McCONVILLE: We would be extending the Hoffman Heart and Vascular Institute program with those

providers to another geographic location to better serve the geography.

MS. ARMAH: Well please turn to page 411, which is a follow-up. It's going to be a follow-up question to this one. Page 411. Page 411, under the access to primary PCI in the United States.

According to experts, the addition of more PCI centers has not substantially improved access to PCI services for most patients.

Taking into account that assertion, how will access be improved in the area by these additional programs?

MS. VOLPE: Again, you know, we'll be responsive to it, but we're lifting, you know, one statement out of the entire literature, so can you direct us to where, where you are?

MS. ARMAH: In the section that indicates access to primary PCI in the United States, and it's in the middle. It's the last sentence in that section.

MS. VOLPE: Can you repeat it, please?

MS. ARMAH: Page 411.

MS. VOLPE: Yeah, we have that.

MS. ARMAH: Access to primary PCI in the United States. The last sentence in that section.

MS. VOLPE: "In total, this data supports the argument?" Is that where you are?

MS. ARMAH: Yes.

MS. VOLPE: Well, again, you know, that may be more programs with lower volume numbers without utilization to support it. I think what was put forth today and in the 3,000 pages that were submitted we don't have a situation where there isn't the utilization and the trend in Connecticut in the geographic region to diffuse it.

MR. McCONVILLE: So the sentence before says, "Finally, Horwitz, et al, showed that hospitals are more likely to introduce new invasive cardiac services when neighboring hospitals already offer such services and confirm that the increase in the number of hospitals offering invasive services has not led to a corresponding increase in geographic access."

That's not the case here. We're going to increase the geographic access to these services.

MS. ARMAH: But your application shows a shift in volume, patients receiving access from Saint Francis and Hartford being shifted back to Manchester Hospital.

MR. McCONVILLE: Not enough volume to

impact those programs negatively.

MS. ARMAH: No, but it's still a shift in volume.

MR. McCONVILLE: It's a shift in volume and an improvement in the response times for patients, and we expect better clinical outcomes for a patient and better opportunity for patients to get their treatment more expeditiously.

We are basically taking the geography. We are reallocating the resources through that geography and this partnership with Saint Francis, providing better door-to-balloon times, better response times for patients with the same program, same providers, with very careful clinical protocols for those patients that are getting elective procedures.

We're essentially creating a better network of care for patients with cardiac disease, and, at the same time, there is a lower cost to the system for the care for these patients, so if you can get the same care and quality of care locally and even improved upon care for those patients that are in emergent situations from an established, well-regarded, highly-awarded system, why would you not support that?

MS. ARMAH: Thank you.

(APPLAUSE)

MR. COLLINS: So could I just?

HEARING OFFICER MITCHELL: Yes. Yes, you can follow-up.

MR. COLLINS: All right, so, it seems we're arguing about 30 or 40 minutes, right, and we can sit here and argue about our times being 42 minutes, right, and I could argue the point of the 30 minutes.

So I'm assuming by your question your position is that why don't we just let it continue to go to Saint Francis and Hartford? Is that a fair statement?

MS. ARMAH: It's not a position, no.

HEARING OFFICER MITCHELL: It was just based on the evidential guidelines. We were just asking follow-up questions.

MR. COLLINS: What I think the issue is --

COURT REPORTER: I'm sorry. Your name?

MR. COLLINS: Michael Collins. Sorry. So you heard at least seven cardiologists and emergency room physicians talk about time is muscle, so the questions lead me to believe, and you can correct me if I'm wrong, that it's okay to extend the transport time from Manchester to Downtown Hartford by 30 minutes, and what we're saying --

HEARING OFFICER MITCHELL: No, that's not what we were saying. We were just asking questions, based on the guidelines.

MR. COLLINS: Okay, but I do think you heard what we've said repeatedly, right? It is lower cost, right? And it will be quicker access, because you're removing transport time.

HEARING OFFICER MITCHELL: Okay. Thank you for your comments.

MR. McCONVILLE: May I add? This is Dennis McConville. With respect to the shift in volume, we are here today with the provider for these services, the leading provider for these services in these towns. They perform 65 percent of these procedures already for residents here.

They're here with us, because they understand that this is a better delivery system, and the impact on their organization is not going to result in lower quality, and it's only going to improve not only access, but cost, so, in terms of the shift, we have a partner here, saying we understand there will be a shift, and the shift, the largest shift is going to come from our organization, but we're here, because this is a better system and a better delivery of care, with better

outcomes for our patients. They're our patients now.

MS. ARMAH: Thank you.

HEARING OFFICER MITCHELL: All right, so, we are going to take a brief 10-minute break, and then, when we come back, we are going to follow-up with more public comment, and then we'll go back to OHS's questions.

(Off the record)

HEARING OFFICER MITCHELL: We're going to go back on the record. At this time, we're going to take the remaining four people that have come to render public comment.

(Whereupon, public comment was given.)

MR. FONTANELLA: Thanks for your patience. Just a few more questions. One concerns the staff. I just want to make sure I understood the staffing. Will Saint Francis providers be giving support for the proposed center?

DR. VASHIST: So, currently, we have some of the interventional cardiologists from Manchester Hospital that have also privileges at Saint Francis Hospital, and they come over to Saint Francis Hospital and do procedures there, including participate in angioplasty call at Saint Francis Hospital as a part of

being on the staff.

The proposal for staff coverage would include the same physicians, who have PCI privileges at Saint Francis Hospital, take calls for emergent PCIs here, as well, and, similarly, they would also be the same folks, who would do elective PCIs and diagnostic catheterizations at Manchester Hospital, but the pool of people that would do this would be the same folks currently that we know of, who are going to be at Saint Francis Hospital.

MR. FONTANELLA: Do you have anything to add?

MR. McCONVILLE: May I just add? This is Dennis McConville. In our application, we provided a schedule that shows there will be no overlap or conflicts with the on-call schedule.

There would be sufficient interventionalists available for emergencies at Manchester and at Saint Francis.

DR. VASHIST: And just to add to that, there would be other physicians at Saint Francis Hospital, who have shown interest in being available for primary PCI here at Manchester Hospital, and, as a part of the request by OHS, that list of physicians was made

available, including their residential address, in terms of how far they'll live from Manchester Hospital, should they be on call, and how quickly could they be available for performing PCIs, so that's a part of the document that's already in the application process.

MR. FONTANELLA: Thank you. And then I guess one kind of related question is a couple of the speakers had commented on the follow-up care and the inconvenience to go into Hartford for weeks and months of care that's necessitated after an event.

Would these patients be able to receive the care in Manchester, in the community, even if it's not a Manchester provider that does the intervention?

MR. McCONVILLE: Yes, they would.

MR. FONTANELLA: Okay.

MR. McCONVILLE: Right. You know, we have sufficient numbers of cardiologists with practices in the community that are essentially serving the population of this region.

If you look at medical staffing, cardiologist medical staffing, far and away the numbers of providers that are located in these communities are associated and on the staff of ECHN.

MR. FONTANELLA: Thank you. So in light

of the costs, the startup and operational costs for a facility like this, can you explain in detail why the cost to the overall system will not increase as a result of this proposal, given that you haven't really cited much of an increase in volume?

MR. VEILLETTE: May we just have two minutes to confer?

MR. FONTANELLA: Of course.

HEARING OFFICER MITCHELL: We're going to go off the record for a few moments.

(Off the record)

MR. VEILLETTE: Michael Veillette, just so you have it. Thank you for the extra time.

So the startup cost, the capital cost required to get this programming running is in the CON at $3.1 million. That is essentially other than the operating cost of the unit, of the program. Those are the only other costs.

Those costs would be recovered by the volume generated from this, an all-in program, as you've heard the other speakers talk about.

MR. FONTANELLA: Are the reimbursement rates expected to increase for the services or are they going to remain -- let me restate this. Sorry.

Is there an approximate equivalence in the reimbursement between the two hospitals at this point for this service, and is there an expectation that your reimbursement will increase or will be higher than the current cost at Saint Francis if the service is provided in Manchester?

MR. VEILLETTE: Sounded like there were two or three questions there, so, if I don't answer them right, just redirect me.

We're not expecting any change in reimbursement that we would have if we were receiving these services now, so there would be no change in what those rates would be if we were actually seeing these patients now.

As far as how our rates compare, you know, we modeled the volume and the overall payments that Saint Francis is receiving, so our overall reimbursement, I guess, in this schedule that was in the PowerPoint presented by Dennis, does demonstrate what that delta is on average reimbursement and what the overall savings would be by having that volume, those patients serviced at Manchester in a comparable program.

MR. FONTANELLA: Just for clarification, these are hospital charges or reimbursement rates?

MR. VEILLETTE: This is based on reimbursement.

MR. FONTANELLA: Thank you.

MR. VEILLETTE: You're welcome.

MS. VOLPE: And we also would like to direct you to, in the pre-filed testimony in the issues list, there's also a support letter from one of the largest payers in the state, Anthem, saying that they would very much be in favor of implementing these services at this community hospital, based, you know, on cost, as well, and reimbursement.

MR. FONTANELLA: Thank you, Attorney Volpe. That actually leads nicely to another question that I have.

We have noticed that letter from a larger payer, and have there been discussions with them about the addition of this service and possible reimbursement that anyone knows of?

MS. VOLPE: I think we're asking if there have been any discussions. I mean, you know, we have an existing participating provider contract, and, you know, they have fees, based on our community hospital, and I think the understanding is they would just extend, and this is a lower cost provider, hence the same service

would be at a lower cost in the community hospital setting.

MR. FONTANELLA: Thanks.

MS. VOLPE: Have there been any discussions?

MR. McCONVILLE: I can't answer that directly. I do know that the person who does our contracting was the person who had discussion about this proposal with the representatives from Anthem, and the result of those discussions is the letter that you see in the application.

MR. FONTANELLA: Okay. Do you know if those discussions included physicians' fees into those rates?

MR. McCONVILLE: I do not.

MR. FONTANELLA: Thank you. Can you discuss how consumers' out-of-pocket costs will be affected?

MS. VOLPE: Yeah. That's what I think we would say, too. I'll let Mike speak to this, but, as you know, every single payer has hundreds of different plans with varying out-of-pocket costs, and, you know, some have a high deductible, so, certainly, you know, until you meet your deductible, whether you're meeting that at

any other facility is going to be the same, but I think the important point here, and I'll let the financial people address it, is that we are a lower-cost institution and facility, but to the extent that they have a deductible, they have a deductible, irrespective of where they would go.

MR. VEILLETTE: Mike Veillette here again. I wouldn't change or rephrase what Attorney Volpe just responded to. Again, I think the best answer that I could provide is that the overall cost still would be lower.

MR. FONTANELLA: Thank you.

MS. VOLPE: And, you know, we would just also add that, based on some of the regional care models, which we've talked about and you've asked in the issue list, I mean that would actually help patients and all healthcare stakeholders if we're keeping it within some sort of global bundled payment, caring for the patient within a network, so that also may reduce out-of-pocket cost for a patient possibly.

MR. FONTANELLA: Thank you for that. Will there be facility fees associated with the service, independent of the professional cost?

MR. McCONVILLE: Yes. They would cover

the cost of, you know, the operations and the standby cost of the laboratory. There would have to be. No different than the emergency room or the operating room.

MR. FONTANELLA: Attorney Volpe had mentioned that you do have existing contracts with multiple payers. Do any of them contemplate or include provisions for the service, or it sounds like you're in discussion?

MS. VOLPE: Gina was sworn in earlier. Just state your name for the record.

MS. GINA KLINE: My name is Gina Kline. So in terms of the existing managed care contracts for the specific cardiac services that we're talking about in this application, there is not a specific provision in the managed care contracts, however, all the contracts are setup with a blanket base rate, DRG case rate, where it says this is the base rate that we're using, and we apply it to the DRG weight to calculate what the reimbursement would be for this particular service. That's for the inpatient side.

For the outpatient services, most of the contracts do either have a fee schedule or a case rate that's addressed by the specific CPT code procedure or by the revenue code that's associated with these services,

so, in that context, the existing contracts would cover our reimbursement.

MR. FONTANELLA: Thank you. Would you be able to provide us with a list of all the existing contracts with managed care organizations that you have?

MS. VOLPE: You mean a list of payers, which the hospital participates?

MR. FONTANELLA: Yeah.

MS. VOLPE: Sure. All the payers we participate? Yes.

MR. FONTANELLA: Yes.

MS. VOLPE: It may even be online, but, yes, absolutely. Would you like that to be marked as a late file?

HEARING OFFICER MITCHELL: Yes. Yes. Actually, there's a few late files that we wanted, so we'll wait until the end.

MS. VOLPE: Okay.

HEARING OFFICER MITCHELL: Can we go off the record just for two more minutes? We just want to make sure that we have asked all the questions that we need to ask. Just two minutes.

(Off the record)

HEARING OFFICER MITCHELL: All right, so,

we're back on the record. We don't have any additional questions. I just want to turn to the Applicants to see if there's any additional information that you'd like us to hear that we haven't heard already.

MS. VOLPE: Yes. If we can make a closing statement? Dennis would like to make a very brief closing statement.

The other thing we wanted you to consider, and it was discussed even with Saint Francis here, is that we do want you to have it viewed as really an extension.

You know, this program is really an extension of Saint Francis' program, as well, and really need to take into account the aging population and the trend. I mean there was a dip in the state levels of this service, but we've seen it, you know, start to climb up.

And I think Dennis, if you would indulge us, would just like to make a few closing remarks.

MR. McCONVILLE: Thank you. This is Dennis McConville.

ECHN is a responsible organization that's continued to actively address health needs of the communities east of the Connecticut River. We spent

millions of dollars in resources to improve the lives of our residents and patients.

With a continued shortage of primary care physicians, we started a graduate medical education program to train primary care physicians in our community, with the goal of them staying to serve these communities.

In recognizing serious behavioral health needs of our communities, we've spent millions of dollars to increase the services made available to patients with life-threatening eating disorders and behavioral health conditions for adolescents, adults and seniors.

With refined techniques, drug therapies and scientific advances, the research supports the shift of treatments to community hospitals and to outpatient settings.

Unfortunately, regulatory barriers exist that block the transfer of safe and lower-cost procedures and treatments from the shift from tertiary hospitals to community hospitals like ours.

This proposal has enormous benefits to our local health network, its providers and its patients. The ability to safely care for heart disease supports our reform of healthcare delivery, with the goals for our

patients of improving their health, improving their healthcare experience and ensuring that they receive the desired outcomes and quality of care at lower cost within their network of providers.

This approval will allow us to draw and retain talented providers to the region and raise the level of healthcare throughout our organization.

I would be remiss if I did not commend Saint Francis Hospital and Medical Center and Trinity Health New England for their part in this proposal. There was never any hesitation on their part to partner with us.

It is clear that Saint Francis' mission is mission-focused and truly wants what's best for their patients.

This afternoon, we've proven that this is a unique regional proposal from our two hospitals. It meets statutory requirements for its approval.

Regulatory decisions should support data-driven proposals that challenge the status quo when the health of our residents can be improved. Thank you.

HEARING OFFICER MITCHELL: Thank you. Anything else from the Applicants? No? Okay.

So just a couple of requests for late

file. I know we talked about Exhibit S, and we just want to make sure that the counts and related rates are not duplicated on pages 93 and 94 of Exhibit O, so we provided you with what we had, and we just wanted to see if you could duplicate the math, just to see if maybe we're off, or there is something different.

In addition to that --

MS. VOLPE: I'm sorry. That would be Late File 1?

HEARING OFFICER MITCHELL: 1.

MS. VOLPE: Okay.

HEARING OFFICER MITCHELL: Yeah. In addition to that, Late File 2 is easy. That's just the electronic copy of the PowerPoint presentation.

MS. VOLPE: Yes.

HEARING OFFICER MITCHELL: And then 3. We'd like you to provide us with a list of all current managed care contracts for Manchester Hospital, inclusive of their expiration dates.

MS. VOLPE: Okay, so, if some don't expire in the evergreen, we'll just note that.

HEARING OFFICER MITCHELL: Okay.

MS. VOLPE: I'm asking.

HEARING OFFICER MITCHELL: Yes.

MS. VOLPE: Is that what you'd like? Okay.

HEARING OFFICER MITCHELL: Yes.

MS. VOLPE: Thanks.

HEARING OFFICER MITCHELL: And how long do you think that you need, in order to provide everything? Would you like to do it all at once?

MS. VOLPE: I think we'll provide it as soon as it's ready. We'll download it in the portal, and I think we would like to try to have it to you by Friday. If we run into some trouble pulling all the contracts, we'll let you know, but I think we should -- we'll plan for Friday.

HEARING OFFICER MITCHELL: All three submissions?

MS. VOLPE: Yeah, the end of the day Friday.

HEARING OFFICER MITCHELL: You sure you don't need a couple of extra days?

MS. VOLPE: If once we get into looking at the Exhibit S you provided, if it appears it's going to take longer, we'll get right in touch with you, but we're going to plan for Friday.

HEARING OFFICER MITCHELL: Why don't I

just go ahead and give you the extra cushion now? So what about if we say a week from today, just in case? So then, if you get it to us earlier, that's fine.

MS. VOLPE: It's our understanding, just in terms of closing the record, then, it won't close until the late files have been submitted?

HEARING OFFICER MITCHELL: It won't, and then we also leave the record open for a week for public comment, just in the normal course of business.

MS. VOLPE: So we're going to go ahead and get it done. We appreciate the extra week, but I think, you know, our preference is that we would have these Late Files 1, 2 and 3 submitted before close of business on Friday.

HEARING OFFICER MITCHELL: Okay, so, that's fine, but the record will still stay open until March 6th for any additional public comment.

MS. VOLPE: Understood.

HEARING OFFICER MITCHELL: Okay. Anything else, though, from the Applicants? No?

All right, thank you, everybody, for your time and your patience with us. I appreciate all of the testimony and the comments that were made, and we are adjourned.

MS. VOLPE: Thank you.

HEARING OFFICER MITCHELL: Thank you.

(Whereupon, the hearing adjourned at 6:40 p.m.)

AGENDA