

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.

MANCHESTER COUNTRY CLUB
305 SOUTH MAIN STREET
MANCHESTER, CONNECTICUT

POST REPORTING SERVICE
HAMDEN, CT (800) 262-4102

CERTIFICATE

I, Paul Landman, a Notary Public in and for the State of Connecticut, and President of Post Reporting Service, Inc., do hereby certify and attest that, to the best of my knowledge, the foregoing record is a correct and verbatim transcription of the audio recording made of the proceeding hereinto set forth.

I further certify that neither the audio operator nor I are attorney or counsel for, nor directly related to or employed by any of the parties to the action and/or proceeding in which this action is taken; and further, that neither the audio operator nor I are a relative or employee of any attorney or counsel employed by the parties, thereto, or financially interested in any way in the outcome of this action or proceeding.

In witness, whereof I have hereunto set my hand and do so attest to the above, 5th day of March, 2019.



Paul Landman
President

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1 . . .Verbatim proceedings of a hearing
2 before the State of Connecticut, Department of Public
3 Health, Office of Health Strategy, in the matter of
4 Manchester Memorial Hospital, Inc. and Saint Francis
5 Hospital and Medical Center, Inc., establishment of
6 diagnostic cardiac catheterization and primary and
7 elective percutaneous coronary intervention program at
8 Manchester Memorial Hospital without on-site surgical
9 backup, held at Manchester Country Club, 305 South Main
10 Street, Manchester, Connecticut, on February 27, 2019 at
11 3:10 p.m. . . .

12
13
14

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 All the documents have been identified in

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

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

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

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

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

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

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

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

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

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

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

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

24 MS. JOAN FELDMAN: No objection.

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

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

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

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

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

19 HEARING OFFICER MITCHELL: We can do that.

20 MS. VOLPE: All right.

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

24 After the Applicant has presented its

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

6 (Whereupon, the parties were duly sworn
7 in.)

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

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

18 So we will go forward with Mike Collins.

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

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

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

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

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

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

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

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

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

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

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

24 HEARING OFFICER MITCHELL: Thank you. And

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1 we'll go forward with Dr. Rodis.

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

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

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

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

24 Hoffman Heart is a well-recognized and

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

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

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

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

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

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

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

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

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

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1 will be successful.

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

5 HEARING OFFICER MITCHELL: All right,
6 thank you.

7 (Whereupon, public comment was given.)

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

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

15 HEARING OFFICER MITCHELL: Oh, there is
16 one.

17 MS. VOLPE: Thank you.

18 (Whereupon, public comment was given.)

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

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

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

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

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

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

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

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

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

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

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

24 I provide some detail here for the

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

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

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

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

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

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

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

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

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

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

24 We would also meet the recognized Best

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

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

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

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

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

24 There was some question about the volume

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

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

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

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

20 Elective PCI procedures are safely
21 performed in acute care hospitals without on-site
22 surgical services, and it's important to note that, in
23 2017, 96 percent of patients needing an elective PCI
24 received it at the time of their diagnostic

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

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

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

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

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

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

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

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

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

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

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1 The guidelines talk about geographic
2 isolation. The travel time to a hospital the target is
3 30 minutes. The guidelines support that another PCI
4 provider could establish a service if they're located
5 more than 30 minutes away.

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

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

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

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1 median door-to-balloon time for all patients with STEMI
2 that had primary PCI at Saint Francis for fiscal years
3 '15, '16 and '17.

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

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

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

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

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

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1 directly around our hospitals to the hospitals in
2 Hartford.

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

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

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

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

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

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

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

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

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

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

24 We were asked to provide written evidence

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1 that patients would have their cath done at Manchester
2 Memorial Hospital, so we surveyed 506 current and former
3 cardiac rehab patients. We mailed those out and got 153
4 surveys back, a 30 percent response rate. Ninety-four
5 patients said they would have their cath at Manchester,
6 57 said they would not, 61 percent, the majority, said
7 they'd have their cath here in Manchester.

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

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

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

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1 in pink here.

2 That excludes three of our primary service
3 area towns and eight of our secondary service area towns.
4 That excludes 100,000 residents. Almost 1,500 persons
5 used our hospital's Manchester and Rockville Hospital in
6 2018 from these towns, and, for the employed primary care
7 physicians of ECHN, that would exclude over 5,000
8 patients that are regularly cared for from these towns by
9 our doctors.

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

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

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

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

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

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

11 The Prospect provider group is the
12 Connecticut IPA. We have over 300 providers and over
13 50,000 attributed lives.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 MS. VOLPE: I'll leave it to Hearing

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

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

7 MS. VOLPE: Disrupt? No.

8 (Whereupon public comment was given.)

9 MS. VOLPE: We're going to have Dr.
10 Washist speak now.

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

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

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

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

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

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

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

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

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

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1 hospital within our system.

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

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

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

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

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

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

24 First, the proposed services will have a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 MS. VOLPE: Thank you.

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

14 MS. VOLPE: Very good. Thank you.

15 HEARING OFFICER MITCHELL: Thank you.

16 (Off the record)

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

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

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1 first.

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

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

12 (Whereupon, public comment was given.)

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

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

21 MS. VOLPE: Very good. We appreciate
22 that.

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

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

3 MR. McCONVILLE: My name is Dennis
4 McConville.

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

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

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

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

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

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

10 MS. ARMAH: Okay. Elective PCIs are
11 scheduled procedures and not as limited, in terms of time
12 or distance, as opposed to primary PCIs. Why is there a
13 need for an elective PCI program at the hospital since
14 patients can access any of the five providers in the
15 north central region, including Hartford and Saint
16 Francis Hospital, for their procedure within the ideal
17 48-hour treatment window?

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

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

5 MS. ARMAH: As a follow-up to that, page
6 412 of the application indicates --

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

10 MS. ARMAH: 412.

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

13 MS. ARMAH: Yes.

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

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

18 MS. VOLPE: Okay, thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 MS. ARMAH: Okay, thank you.

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

6 DR. VASHIST: Would you repeat the
7 question again?

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

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

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

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

9 MR. FONTANELLA: Thank you.

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

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

19 When I look at this, it looks like this
20 was accessed on February 24, I'm sorry, February 14 of
21 2019, and then you have the typical, so that was for the
22 drive time on February 14 of 2019, and then you have the
23 typical drive time, and then it basically says Google
24 maps, typical drive time departing. Was that a function

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1 of Google maps?

2 MR. McCONVILLE: Yes.

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

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

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

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

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

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

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

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1 understand the question.

2 MR. FONTANELLA: So I'll rephrase.

3 MS. VOLPE: Yeah.

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

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

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

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

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

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

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

23 MS. VOLPE: Correct.

24 MR. FONTANELLA: That are being diverted

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1 currently.

2 MS. VOLPE: Yes.

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

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

8 MR. FONTANELLA: Yeah.

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

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

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

24 MS. VOLPE: Did you want him to get sworn

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1 in? Would you like to get sworn in?

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

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

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

13 DR. ROBERT CARROLL: I did.

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

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

18 HEARING OFFICER MITCHELL: Thank you. Got
19 it.

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

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1 and the rest.

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

10 MR. FONTANELLA: Thank you.

11 DR. CARROLL: You're welcome.

12 MS. VOLPE: Was that responsive, Attorney
13 Fontanella?

14 MR. FONTANELLA: Yes.

15 MS. VOLPE: Thank you.

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

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

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

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

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

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

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

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

24 MS. FELDMAN: Got it.

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1 (Whereupon, public comment was given.)

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

5 DR. VASHIST: No. We're okay.

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

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

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

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

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1 been discussing here.

2 I'd like to finish with or state the next
3 sentence that's in this section of the reference.

4 "Competition with another PCI program in the same
5 geographic area, particularly an established program with
6 surgical backup, may not be in the best interest of the
7 community."

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

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

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

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

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

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

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

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

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

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

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

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

10 MS. ARMAH: So in line with that, on pages
11 1241, 1242 and 1280 --

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

14 MS. ARMAH: Yes.

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

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

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

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1 eight in 2015, two in '16 and two in '17.

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

5 MR. McCONVILLE: I don't believe so.

6 HEARING OFFICER MITCHELL: Why?

7 MS. ARMAH: Why?

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

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

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

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

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

3 In the course of that same time period,
4 for the patients that were transported from Manchester
5 and Rockville Hospitals to Saint Francis for PCI, 71
6 patients in total, we had 19 patients that were beyond
7 120 minutes, so, clearly, by having closer access to this
8 program, more patients will receive their care in a more
9 timely manner.

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

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

14 MS. ARMAH: Oh, I'm sorry. Page 1280, 1-
15 2-8-0.

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

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

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

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

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

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

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

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

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1 providers to another geographic location to better serve
2 the geography.

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

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

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

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

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

20 MS. VOLPE: Can you repeat it, please?

21 MS. ARMAH: Page 411.

22 MS. VOLPE: Yeah, we have that.

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

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

3 MS. ARMAH: Yes.

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

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

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

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

24 MR. McCONVILLE: Not enough volume to

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1 impact those programs negatively.

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

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

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

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

24 MS. ARMAH: Thank you.

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1 (APPLAUSE)

2 MR. COLLINS: So could I just?

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

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

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

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

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

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

17 COURT REPORTER: I'm sorry. Your name?

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

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

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

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

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

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

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

2 MS. ARMAH: Thank you.

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

8 (Off the record)

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

13 (Whereupon, public comment was given.)

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

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

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1 being on the staff.

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

11 MR. FONTANELLA: Do you have anything to
12 add?

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

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

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

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

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

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

14 MR. McCONVILLE: Yes, they would.

15 MR. FONTANELLA: Okay.

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

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

24 MR. FONTANELLA: Thank you. So in light

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

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

8 MR. FONTANELLA: Of course.

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

11 (Off the record)

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

14 So the startup cost, the capital cost
15 required to get this programming running is in the CON at
16 \$3.1 million. That is essentially other than the
17 operating cost of the unit, of the program. Those are
18 the only other costs.

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

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

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

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

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

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

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

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1 MR. VEILLETTE: This is based on
2 reimbursement.

3 MR. FONTANELLA: Thank you.

4 MR. VEILLETTE: You're welcome.

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

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

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

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

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

3 MR. FONTANELLA: Thanks.

4 MS. VOLPE: Have there been any
5 discussions?

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

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

15 MR. McCONVILLE: I do not.

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

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

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

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

12 MR. FONTANELLA: Thank you.

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

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

24 MR. McCONVILLE: Yes. They would cover

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

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

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

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

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

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

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

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

8 MR. FONTANELLA: Yeah.

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

11 MR. FONTANELLA: Yes.

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

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

18 MS. VOLPE: Okay.

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

23 (Off the record)

24 HEARING OFFICER MITCHELL: All right, so,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 So just a couple of requests for late

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

7 In addition to that --

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

10 HEARING OFFICER MITCHELL: 1.

11 MS. VOLPE: Okay.

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

15 MS. VOLPE: Yes.

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

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

22 HEARING OFFICER MITCHELL: Okay.

23 MS. VOLPE: I'm asking.

24 HEARING OFFICER MITCHELL: Yes.

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

2 Okay.

3 HEARING OFFICER MITCHELL: Yes.

4 MS. VOLPE: Thanks.

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

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

14 HEARING OFFICER MITCHELL: All three
15 submissions?

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

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

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

24 HEARING OFFICER MITCHELL: Why don't I

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

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

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

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

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

18 MS. VOLPE: Understood.

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

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

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1 MS. VOLPE: Thank you.

2 HEARING OFFICER MITCHELL: Thank you.

3 (Whereupon, the hearing adjourned at 6:40

4 p.m.)

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